Expanding Behavioral Health Care Workforce Participation in Medicare, Medicaid, and Marketplace Plans (2024)

DETAILS

324 pages | 6 x 9 | PAPERBACK
ISBN 978-0-309-71872-1 | DOI 10.17226/27759

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SUGGESTED CITATION

National Academies of Sciences, Engineering, and Medicine 2024. *Expanding Behavioral Health Care Workforce Participation in Medicare, Medicaid, and Marketplace Plans*. Washington, DC: The National Academies Press. https://doi.org/10.17226/27759.

NATIONAL ACADEMIES *Sciences Engineering Medicine*

NATIONAL ACADEMIES PRESS
Washington, DC

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Daniel Polsky, Abigail Godwin, and Udara Perera, *Editors*

Committee on Strategies to Improve Access to Behavioral Health Care Services through Medicare and Medicaid

Board on Health Care Services

Health and Medicine Division

Consensus Study Report

NATIONAL ACADEMIES PRESS 500 Fifth Street, NW Washington, DC 20001

This activity was supported by contracts between the National Academy of Sciences and the Center for Medicare and Medicaid Services and the Substance Abuse and Mental Health Services Administration through A-G Associates (AWD-001983). Any opinions, findings, conclusions, or recommendations expressed in this publication do not necessarily reflect the views of any organization or agency that provided support for the project.

International Standard Book Number-13: 978-0-309-71872-1
International Standard Book Number-10: 0-309-71872-4
Digital Object Identifier: https://doi.org/10.17226/27759

This publication is available from the National Academies Press, 500 Fifth Street, NW, Keck 360, Washington, DC 20001; (800) 624-6242 or (202) 334-3313; http://www.nap.edu.

Printed in the United States of America.

Suggested citation: National Academies of Sciences, Engineering, and Medicine. 2024. *Expanding behavioral health care workforce participation in Medicare, Medicaid, and Marketplace plans*. Washington, DC: The National Academies Press. https://doi.org/10.17226/27759.

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This Consensus Study Report was reviewed in draft form by individuals chosen for their diverse perspectives and technical expertise. The purpose of this independent review is to provide candid and critical comments that will assist the National Academies of Sciences, Engineering, and Medicine in making each published report as sound as possible and to ensure that it meets the institutional standards for quality, objectivity, evidence, and responsiveness to the study charge. The review comments and draft manuscript remain confidential to protect the integrity of the deliberative process.

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Although the reviewers listed above provided many constructive comments and suggestions, they were not asked to endorse the conclusions or recommendations of this report nor did they see the final draft before its release. The review of this report was overseen by **JACK EBELER,** Former Member of Health and Medicine Division Committee, and **LINDA C. DEGUTIS,** Yale University School of Public Health. They were responsible for making certain that an independent examination of this report was carried out in accordance with the standards of the National Academies and that all review comments were carefully considered. Responsibility for the final content rests entirely with the authoring committee and the National Academies.

Acknowledgments

The committee extends its sincere thanks to the many individuals who shared their time and expertise to support its work and inform its deliberations. This study was sponsored by the Centers for Medicare & Medicaid Services (CMS) and the Substance Abuse and Mental Health Services Administration (SAMHSA) through A-G Associates.

The committee benefited greatly from discussions with the individuals who presented at the committee's webinars: Keris Jän Myrick, Audrey Levine, Laura Van Tosh, Lisa Butler, Laura Marshal, Eboni S. Dabney, Warren Ng, Karin Jeffers, Margaret Adam, Rakhee Patel, Tyler Vermillion, Heather Jefferies, Cara Cheevers, Brook Hall, Paula Stone, Sean M. Robbins, Lindsey Browning, and Douglas Jacobs. Agendas for the public meetings are provided in Appendix D.

Our appreciation goes to the reviewers for their invaluable feedback on an earlier draft of the report and to the monitor and coordinator who oversaw the report review. The committee acknowledges the many staff within the Health and Medicine Division who provided support in various ways to this project, including Udara Perera (study director), Abigail Godwin (research associate), Marc Meisnere (senior program officer), Elizabeth Ferré (research associate), Torrie Brown (program coordinator), Eliza Souser (senior program assistant), Emma Rooney (research assistant), and Greysi Patton (finance business partner). The committee extends great thanks and appreciation to Sharyl J. Nass, senior director, Board on Health Care Services, who oversaw

the project. The committee also appreciates Anne Marie Houppert and Christopher Lao-Scott (senior librarians) for their research assistance and fact checking. The report review, production, and communications staff all provided valuable guidance to ensure the success of the final product. Robert Pool is credited for the superb editorial assistance in preparing the final report.

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Preface

About one in five people in the United States have a mental health condition, but only half of them get needed treatment. These statistics suggest that just about everyone reading this report has experience with, either personally or through a loved one, a mental health or substance use challenge. The statistics also suggest that we know someone who has benefitted from treatment and/or faced barriers accessing needed care in a timely way. Our committee came together over the past year to look beyond anecdote and experience to examine the evidence and propose strategies to increase participation of the behavioral health workforce in Medicare, Medicaid, and Marketplace programs.

The challenges are daunting, but the opportunities to improve access to behavioral health providers have the potential to be transformative through a coordinated approach across Medicare, Medicaid, and Marketplace. It is not just that these programs offer insurance coverage to half of Americans, but also that they provide a safety net to the most vulnerable. The context of behavioral health care, when centered on the patient experience, is one of fragmentation, confusion, and disruption. This is not a system organized around the whole-person needs of those served by this system. When the context is centered on behavioral health providers caring for those covered in Medicare, Medicaid, and Marketplace, the system is not organized around enabling provider participation.

In this complex interaction of settings and coverage, we submit nine recommendations for improving provider participation in Medicare, Medicaid, and Marketplace. These recommendations come at an inflection point for behavioral health as the landscape of mental health care delivery

is undergoing a profound evolution. COVID-19 brought behavioral health to the forefront, shifting the landscape of mental health care delivery, propelled by advancements in technology, shifting societal norms, and changing patient preferences. In addition, the inflection point extends to the Medicare, Medicaid, and Marketplace programs themselves because the vast majority of care now flows through managed care organization; provider payment, provider availability, and access arrangements for behavioral health must be considered in this context.

As we navigate these transformations, it becomes increasingly evident that our traditional clinical settings, training programs, and policy approaches are insufficient to meet the diverse needs of individuals seeking mental health support. And we must not lose sight of the broader vision for advancing mental health care access and delivery that this report was commissioned to begin to address through the lens of provider participation. From this lens, it also became clear to all of us on the committee that broader delivery transformation may also be necessary to move towards a care experience in behavioral health that prioritizes whole-person needs.

This work, conducted at the request of the Centers for Medicare & Medicaid Services and the Substance Abuse and Mental Health Services Administration, provided a statement of task that gave us a focus to recommend a number of actions that could be implemented in the short term under existing statutory authorities. These action steps for federal policy makers have the potential to improve provider participation in Medicare, Medicaid, and Marketplace. Longer-term actions have also been recommended under a vision of attaining behavioral health provider participation sufficient to meet the whole-person care needs of those seeking behavioral health care in Medicare, Medicaid, and Marketplace programs.

Daniel E. Polsky, *Chair*
Committee on Strategies to Improve Access to
Behavioral Health Care Services through
Medicare and Medicaid

Acronyms and Abbreviations

AAPI	Asian American and Pacific Islander
ACA	Affordable Care Act
ACE	adverse childhood experience
ACO	accountable care organization
ACT	assertive community treatment
ADHD	attention-deficit/hyperactivity disorder
AHRQ	Agency for Healthcare Research and Quality
AMC	academic medical center
AMI	any mental illness
APA	American Psychological Association
APRN	advanced practice registered nurse
AUD	alcohol use disorder
BCBS	Blue Cross Blue Shield
BHI	behavioral health integration
BHSS	behavioral health support specialist
BHWET	Behavioral Health Workforce Education and Training (program)
CCBHC	certified community behavioral health clinic
CHIP	Children's Health Insurance Program
CHW	community health worker
CIC	community-initiated care
CMHC	community mental health center
CMS	Centers for Medicare & Medicare Services

COE	Centers of Excellence (program)
COPD	chronic obstructive pulmonary disease
CTBS	communication technology–based service
DGME	Direct Graduate Medical Education (program)
DSM	Diagnostic and Statistical Manual of Mental Disorders
ECDS	Electronic Clinical Data Systems
EHR	electronic health record
EPSDT	Early and Periodic Screening, Diagnostic and Treatment (program)
FFS	fee-for-service
FQHC	federally qualified health center
FY	fiscal year
GAO	U.S. Government Accountability Office
GME	graduate medical education
GPE	graduate psychology education
HCBS	home and community-based services
HCOP	Health Careers Opportunity Program
HHS	Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act of 1996
HPSA	health professional shortage area
HRSA	Health Resources and Services Administration
IBH	Innovation in Behavioral Health (model)
ICD	International Statistical Classification of Diseases and Health Related Problems
IHS	Indian Health Service
IME	Indirect Medical Education (program)
IOP	intensive outpatient services
LGBTQ+	lesbian, gay, bisexual, transsexual, queer, etc.
LCPC	licensed clinical professional counselor
LCSW	licensed clinical social worker
LMFT	licensed marriage and family therapist
MA	Medicare Advantage
MACPAC	Medicaid and CHIP Payment and Access Commission
MAT	medication-assisted therapy
MCO	managed care organization

MedPAC	Medicare Payment Advisory Commission
MFT	marriage and family therapist
MHC	mental health counselor
MHPAEA	Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act
MIPS	Medicare's Merit-Based Incentive Payment System
MSSP	Medicare Shared Savings Program
NCQA	National Committee for Quality Assurance
NHSC	National Health Service Corps
NSDUH	National Survey on Drug Use and Health
NWD	Nursing Workforce Diversity (program)
OIG	Office of the Inspector General
OT	occupational therapy
OUD	opioid use disorder
PCMH	patient-centered medical home
PMH	psychiatric–mental health
PMHNP	psychiatric mental health nurse practitioner
PPS	Prospective Payment System
PSS	peer support specialist
PTSD	post-traumatic stress disorder
QHP	qualified health plan
RBRVS	resource-based relative value scale
RFI	request for information
RHC	rural health center
SAMHSA	Substance Abuse and Mental Health Services Administration
SBHC	school-based health center
SMI	serious mental illness
SSDI	Social Security disability insurance
SUD	substance use disorder
THCGME	Teaching Health Center Graduate Medical Education (program)
VBID	Medicare Advantage Value-Based Insurance Design
VBP	value-based payment

Summary

Behavioral health care in the United States faces significant challenges despite its importance in promoting whole person health and driving health positive outcomes. Access to behavioral health care remains limited as a result of various factors such as inadequate insurance coverage, fragmented delivery systems, and both a coverage shortage and maldistribution of care providers. The COVID-19 pandemic further exacerbated the demand for behavioral health services while straining an already struggling system, drawing increased attention to the existing acute disparities in access to care.

In 2023, the National Academies of Sciences, Engineering, and Medicine convened the Committee on Strategies to Improve Access to Behavioral Health Care Services through Medicare, Medicaid, and Marketplace insurance. The committee was tasked with proposing strategies to significantly bolster the participation of the behavioral health care workforce in Medicare, Medicaid, and Marketplace insurance programs in response to the critical need to enhance equitable access to vital behavioral health care services.

To tackle the complex challenge of increasing behavioral health care workforce participation in Medicare, Medicaid, and Marketplace programs, the committee structured this report to offer a comprehensive overview of the behavioral health care system as well as the beneficiaries and clinicians participating in public and Marketplace insurance programs. This report highlights the need to recruit and expand the behavioral health care workforce to reflect the racially, ethnically, and linguistically diverse patient populations that need access to care. This report also examines the myriad challenges in retaining and supporting the current workforce participating in public and Marketplace insurance plans. In developing its recommendations,

the committee considered the potential benefits and drawbacks of using the existing behavioral health care infrastructure to establish a more provider-friendly, patient-centered system.

BEHAVIORAL HEALTH WORKFORCE AND STRUCTURAL BARRIERS

In addition to the increasing demand for services, there are many reasons the nation is in need of more behavioral health professionals. These include a lack of investment in infrastructure and behavioral health care training, disparities in services or care providers who are reimbursable in Medicare and Medicaid, and reimbursement rates that are inadequate to cover the costs of care. The chronic under-investment in behavioral health care stems from both historical stigma and a behavioral health system that has evolved separately from physical health care. Additional contributors to current workforce issues include: the costs and administrative burden associated with licensure and credentialing; large student loan payments; dilapidated and overcrowded mental health facilities; high workloads leading to burnout; a lack of training to serve diverse populations; and an aging workforce. While a number of federal programs have been somewhat successful at growing the behavioral health care workforce pipeline, the growth has been uneven and the distribution of behavioral health care providers across the United States remains misaligned with patient needs.

CHALLENGING INSURANCE PRACTICES

Problems persist in engaging behavioral health providers in insurance systems, particularly the U.S. public insurance system. Studies suggest that the rate of psychiatrist acceptance of insurance ranks among the lowest across physician specialties. Research on care provider participation in Medicare, Medicaid, and Marketplace plans has focused predominantly on psychiatrists. However, anecdotal evidence from the grey literature and media suggests that the rate of public insurance acceptable among psychologists and other mental health professionals is also low, driven in part by lower payments compared with the commercial and private pay markets and a historic undervaluation of behavioral health providers' efforts and practice costs. Payers across insurance types exacerbate the burden on the workforce by delaying payments, creating administrative barriers, or rejecting patients' prescribed treatment, fueling clinician burnout and diminishing job satisfaction. Health insurers that offer Marketplace Plans and Medicaid Managed Care Plans must comply with the Mental Health Parity and Addiction Equity Act (MHPAEA), which is a federal law that requires certain health plans to provide the same level of benefits for mental health and substance use disorder (MH/SUD) as they

do for medical and surgical care (MED/SURG). This means that deductibles, copays, out-of-pocket maximums, and treatment limitations for MH/SUD must not be more restrictive than those for MED/SURG benefits. Even though MHPAEA was enacted in 2008 and many regulations and additional guidance have been issued since then to clarify how to comply with MHPAEA's requirements and ways to improve enforcement efforts, parity has not been fully achieved. Barriers to parity continue to exist for behavioral health providers and their patients, primarily because of "treatment limitations" that are often difficult for regulators to detect and eliminate. These are referred to in the Act as "non quantitative treatment limitations (NQTLs)." Examples of NQTLs that create administrative barriers for BH providers and discourage them from joining health plan networks include excessive prior authorization requirements, prescription drug formulary design, fail first and step therapy protocols, and inadequate reimbursement. Some of these treatment limitations may be MHPAEA violations. Continued improvements in compliance and enforcement efforts are critical.

Payment structures and the behavioral health care infrastructure shape the interactions and responses of care providers, beneficiaries, and other stakeholders within the system, and the complexity of public insurance structures stands out as particularly vexing. Since care provider behavior often reflects rational responses to the system's framework, it is imperative to develop policies that acknowledge and influence the behaviors of care providers, beneficiaries, and insurers. Thus, the committee assessed the challenges and examined the evidence supporting policy and regulatory reforms as potential solutions.

THE URGENT CALL FOR INNOVATION

While this report addresses various system-level structures contributing to barriers to participation in the targeted insurance plans, the obvious need for systemic reform was at the forefront of the committee's work. The committee investigated approaches aimed at increasing access to an array of services while stressing the challenges due to fragmented coverage, particularly for those with complex needs. Insufficient risk adjustment in managed care plans limits access to services, while current network adequacy regulations are ineffective, emphasizing the need for outcome-based and patient-focused measures to enhance regulatory oversight. Addressing the technology gap will be crucial for advancing integrated care, but the rapid innovation in telehealth necessitates implementing more flexible regulations and providing user education. Harnessing innovative approaches to support patients and to deliver and finance care is pivotal in ensuring equitable access to behavioral health services. This underscores the urgency of not only enhancing care provider participation but also prioritizing improvements in care navigation.

FOCUSING ON THE INDIVIDUAL'S NEEDS

Individuals with behavioral health conditions are not a homogenous population, and their specific and distinct needs warrant an appropriate continuum of response. It has become increasingly clear that the current delivery of care is failing to provide equitable, appropriate, and accessible care for the diverse and sometimes complex needs of individuals with behavioral health conditions.

The consequences of untreated or ineffectively treated behavioral health conditions are significant. Poor physical health outcomes and increased health care costs reduce the quality of life and life span for individuals of all ages. While the committee's task was focused on addressing the care provider perspectives and the challenges that hinder provider participation in delivering behavioral health care within the current parameters and constructs of the Medicare, Medicaid, and Marketplace plans, it is essential to center an overarching health system objective of making an array of services available to meet the wide range of needs of the individuals seeking care.

Greater accessibility to appropriate behavioral health care leads to better overall health and lower health care costs in the long term. Access to this care can help alleviate strain on other parts of the health care system, such as emergency departments and hospitals, by providing appropriate care earlier in the treatment process which may prevent the development of emergent needs.

COMMITTEE GOALS AND RECOMMENDATIONS

The committee's report and recommendations focus heavily on building the supply and increasing the diversity of a behavioral health care workforce that is more likely to serve public programs; increasing workforce capacity to better meet the needs of publicly insured populations; supporting and sustaining care providers currently participating in Medicare, Medicaid, and Marketplace plans; and developing innovative payment and clinical care models that optimize behavioral health provider retention, satisfaction, and efficacy in fully serving their clients. To ensure that every Medicare, Medicaid, and Marketplace beneficiary has access to appropriate behavioral health care services through improved care provider participation in Medicare, Medicaid, and Marketplace plans, the committee's recommendations fall under three overarching goals.

1. *Grow the pie*: Bolster state and federal efforts to promote and ease entry into Medicare and Medicaid along the behavioral health care workforce continuum by reducing credentialling, enrollment, and licensing barriers and by focusing training programs and telehealth support where Medicare, Medicaid, and Marketplace beneficiary access gaps are greatest.

2. *Make participation worthwhile*: Strengthen support structures for behavioral health care providers and alleviate administrative and financial impediments to participation.
3. *Optimize performance and accountability*: Improve opportunities for behavioral health care providers to increase care delivery capacity and to provide more person-centered care, while strengthening managed care organization (MCO) accountability for access and care delivery and provider accountability for performance.

Goal 1: Grow the Pie

The workforce and funding for training from both Centers for Medicare & Medicaid Services (CMS) and the Substance Abuse and Mental Health Services Administration (SAMHSA) presently support care delivery sites or institutions (I.E., CMS: graduate medical education (GME) funding; SAMHSA: certified community behavioral health centers). This funding is ongoing, year-after-year, and dependable. However, there are no requirements for institutional recipients of funds to report on workforce pathways after training is completed, so it is not possible to assess either the positive or negative effects of a training environment on long-term career choice. Psychiatrist training, like other physician training, is supported by CMS GME funding, but psychiatrists are the physician specialty least likely to accept patients with Medicare and Medicaid plans. In this context, CMS should predicate ongoing funding of workforce training with consistent reporting of post-trainee career trajectories to facilitate institutional comparisons among grantees. SAMHSA has similar opportunities with its grants that support environments where training occurs, largely supporting the non-physician behavioral health care workforce. Programs can then be developed to support training environments in which more trainees care for populations covered by Medicare, Medicaid, and Marketplace plans.

CMS could pilot alternative GME payment methods, award new Medicare-funded GME training positions in priority disciplines and geographic areas and develop models within the CMS Center for Medicare and Medicaid Innovation to add other behavioral health care professions to the educational funding aspects of these programs that increase access to care. Medically underserved areas and underrepresented and minoritized communities should be prioritized, with strong consideration given to modeling these CMS and SAMHSA pilots after existing Health Resources and Services Administration (HRSA) programs with this focus, such as the National Health Service Corps, Behavioral Health Workforce and Education Training Program, Graduate Psychology Education Program, Health Careers Opportunity Program, and Nursing Workforce Diversity Program. These HRSA programs have a proven track record of increasing the supply

of behavioral health care providers in underserved areas and diversifying the behavioral health care workforce to better reflect the communities served, including under-resourced populations, based on patient needs, race, ethnicity, and lived experience. This approach has been shown to increase access to care for all Medicaid beneficiaries.

Much of the funding for training presently supports care delivery sites or institutions rather than directly supporting the workforce required to care for beneficiaries and individuals in these funded settings. This creates a more extreme challenge in behavioral health care because while CMS allows for physicians in training to bill for services under the supervision and license of a preceptor, similar parity does not exist for other behavioral health care professionals. This limits non-physician behavioral health trainee exposure to caring for Medicare and Medicaid beneficiaries and has a strong potential to influence which patients these care providers serve when they finish training.

RECOMMENDATION 1: CMS and SAMHSA should restructure current workforce and training mechanisms and their funding to better incentivize robust training environments that support career choices that will more directly impact care for Medicare and Medicaid beneficiaries.

1-1 The CMS and SAMHSA restructuring of the current workforce and training mechanisms should have two interrelated priorities: first, a focus on the providers serving populations with the highest need for greater access to behavioral health provision in Medicaid, such as rural, child/adolescent, and racial/ethnic minoritized populations; second, a focus on workforce demographic diversity, modeled after and aligned with existing HRSA programs that have successfully grown and diversified the behavioral health care workforce in underserved areas.

1-2 CMS should predicate ongoing funding of the workforce training with consistent reporting of post-trainee career trajectories to facilitate institutional comparisons among grantees and ultimately provide a mechanism for greater accountability between CMS funding of training and the rate at which trained providers serve Medicare and Medicaid beneficiaries.

1-3 CMS should allow for behavioral health care trainees to bill for services under the supervision of a licensed care provider, as already exists for physician trainees.

A lengthy, repetitive, and burdensome credentialing process discourages behavioral health care providers from enrolling with multiple payers. Credentialing delays also delay the ability to bill and receive payments.

Behavioral health care providers are less likely than other care providers to have an administrative support system that enables them to navigate unnecessary complexities. Adopting certain technological and administrative tools would eliminate many of these difficulties.

RECOMMENDATION 2: CMS should use its regulatory authorities over Medicare (including Medicare Advantage) and provide assistance to state Medicaid programs and Marketplaces plans to streamline behavioral health provider credentialing and enrollment processes.

2-1 CMS should develop guidance for states on funding mechanisms and provide models for developing, implementing, and operating a single state-wide platform for care provider credentialing and enrollment. For instance, states could use available funding mechanisms to upgrade their Medicaid Management Information System provider enrollment modules, creating a single, state-wide platform for Medicaid, its managed care organizations (MCOs), or other Medicaid payers to use for credentialing, enrollment, renewals, and licensure checks.

2-2 CMS should allow states to include connectivity to state and federal licensing entities as part of the allowable costs of implementing the system.

2-3 CMS should encourage states to accept Medicare credentialing and enrollment for Medicaid purposes, and Medicare should reciprocate.

2-4 CMS should work with states to modify Medicare's and Medicaid's enrollment systems and processes to check ex parte information sources before requiring additional information from behavioral health care providers for initial enrollment or renewal as a care provider. This would allow behavioral health care providers to keep their enrollment information current in either a state Medicaid or a state Medicare system, and it would facilitate more rapid initial enrollment.

2-5 Whenever possible, CMS should impose time limits on the credentialing process, or support enforcement if there are existing time limits, employing a centralized database to streamline this process. CMS should encourage state regulators to do the same.

As a field, behavioral health has had the largest sustained use of telehealth and continues to drive innovation in telehealth for all of health care.

In this context, CMS has a key opportunity to use telehealth as one tool to improve access to behavioral health care services in Medicare, Medicaid, and Marketplace as it offers a mechanism to address the documented maldistribution of behavioral health providers across geographies and populations. In addition, the rapidly evolving nature of telehealth applications in behavioral health, recommendations to support the next generation of telehealth applications are also critical. While 90 percent of Americans today already have access to a smartphone or computer able to connect to audio or video telehealth (synchronous telehealth), inequities in broadband access and digital literacy limit the applicability and reach of telehealth. In addition, the effects of telehealth and new technology-powered tools on clinicians are unknown. The recommendation seeks to balance the opportunity for telehealth to address geographic maldistribution of behavioral health care providers with the considerations that support equitable access to high-quality behavioral health care services.

RECOMMENDATION 3: CMS should develop an agile and flexible interagency strategy to set guidelines for coverage and payment for telehealth for behavioral health needs across settings, modalities, and care providers. This strategy should include:

3-1 Efforts to establish coverage consistency of telehealth across states in order to simplify cross-state telehealth health care provider engagement.

3-2 Development of processes to reimburse telehealth based on a thoughtful consideration of the value provided and the cost of delivery—as is done with in-person care. Flexibility on the use and reimbursement of these services will be essential to maximizing the benefit to patients and the system at large. Given the rapid changes in modalities for telehealth, these policies should be evaluated regularly.

3-3 Establishing skill needs and promoting digital skills training for clinicians and digital health literacy skills for patients that will increase equitable adoption.

Expediting the process of cross-state and cross-territory professional licensure will increase the number of behavioral health care professionals who practice across jurisdictional boundaries and provide services in underserved communities across the lifespan. Occupational interstate compacts should be developed and adopted for *all* behavioral health professions across all states and territories.

RECOMMENDATION 4: The Department of Health and Human Services (HHS) and its agencies should develop a uniform strategy to promote and adopt evidence-based approaches to reduce multi-state licensure barriers as a mechanism to expand access to behavioral health providers in Medicare, Medicaid, and the Marketplace.

4-1 HHS should actively collaborate with organizations such as the Department of Defense, the Council of State Governments, and its National Center for Interstate Compacts; the relevant national professional associations; and states to create and adopt interstate compacts for those behavioral health care professions not currently covered in an occupational interstate compact. Provisions for telehealth across state and jurisdictional lines should be included.

4-2 HHS should actively collaborate with organizations such as the Department of Defense, the Council of State Governments, and its National Center for Interstate Compacts; the relevant national professional associations; and states to ensure that states join existing occupational interstate compacts.

4-3 HRSA should incentivize states by including language in its request for proposals grantmaking process to join existing occupational licensure interstate compacts.

4-4 HHS should encourage states to review existing occupational professional interstate compacts to allow for the provision of telehealth across state and jurisdictional lines.

Goal 2: Make Participation Worthwhile

Based upon patient and care provider pressure, negative feedback, and state legislative and regulatory actions, gradual and fragmented efforts are underway to streamline health plan prior authorization processes. To accomplish Recommendation 5 (below), a coordinated, comprehensive, and expeditious effort is called for, including the active participation of stakeholders, particularly states since Medicaid is a joint federal/state program. There is likely sufficient interest in this topic to attract private grant support for the data analysis and convening of stakeholders, which will be prerequisites for the CMS rulemaking on this topic.

A critical focus on cost-containment necessitates MCO and health plan use of prior authorization and other cost management tools. Data exist on the substantial cost savings associated with applying prior authorization for

specific services and medications. Likewise, there are some services and treatments where data shows that imposition of prior authorization is of little cost-saving value. These data should be used to identify the low-cost-savings ("low-value prior authorization") applications. Policies recently adopted by some states and CMS and voiced by the broad-based participants in the January 2018 "Consensus Statement on Improving the Prior Authorization Process" provide guidance for achieving reform. Implementing these policies expeditiously will take a concerted effort by CMS and states, given the changes each payer will need to make to data analytics, clinical criteria reviews, process automation, and other medical care coordination and processes. A process for ongoing monitoring of prior authorization reforms will be needed to respond to evolving consequences. This process should require continual data analysis and periodic assessments of whether revisions are needed.

RECOMMENDATION 5: CMS should use its authority to adopt policies and issue rules and guidance and to monitor managed care plan access standards to quickly reduce provider administrative burdens and related adverse patient impacts associated with low-value prior authorization and other medical usage review instruments applied to behavioral health care services.

5-1 CMS should use its authority to identify and, to the fullest extent possible, disallow low-value prior authorization practices within Medicare plans. CMS should provide states with technical assistance to similarly eliminate and monitor for low-value prior authorization practices within Medicaid managed care.

5-2 CMS should adopt policies and the standards that require or incentivize insurers to focus behavioral health prior authorization only where high-cost waste and misuse are evident. These policies and rules should articulate clear responsibilities and guidelines for the mechanisms of rigorous regulatory oversight of insurer prior authorization review activities by state and federal agencies.

Inadequate reimbursement negatively affects care provider participation in insurance plans, particularly in public and publicly subsidized payer markets. This, in turn, affects access to behavioral health care for vulnerable populations, including older adults, persons with disabilities, the rural population, and racial and ethnic minoritized individuals. CMS is well positioned to be a federal leader on reimbursement policies across public and publicly subsidized insurance markets and can play a critical role in guiding behavioral health reimbursement and coverage policies. CMS has recently proposed a 19 percent increase over 4 years in the "work value" component

of the resource-based relative value scale (RBRVS). While this is a positive start, CMS has not yet addressed the practice cost component of the RBRVS.

CMS has several potential avenues to ensure that reimbursement rates and coverage of services are sufficient to support behavioral health care providers across a range of core behavioral health services and health care provider types and are, where appropriate, in accordance with the Mental Health Parity and Addiction Equity Act.

RECOMMENDATION 6: CMS should provide guidance on setting Medicare and Medicaid fee-for-service reimbursement rates to ensure adequate access to a full continuum of behavioral health care services, which includes accounting for the actual costs of care and adjusting for past and current undervaluation of work efforts of behavioral health care providers. To address this undervaluation, CMS should continue to revisit and revise the RBRVS.

6-1 CMS should conduct an updated cost study to remedy the acknowledged bias in the current RBRVS formulation. Improving the formulation of the Medicare fee schedule may also help to influence Medicaid fee-for-service rates.

6-2 Within Medicaid fee-for-service, CMS should encourage state Medicaid agencies to adopt regular rate reviews to adjust for inflation and account for market forces that could be discouraging behavioral health providers from enrolling in Medicaid fee-for-service. CMS should encourage consideration of rate differentials in underserved areas where there is an inadequate workforce within Medicaid and ensure proposed rates are sufficient to support access to behavioral health providers consistent with the general population. CMS should provide comparison rate and provider access information to states for Medicare, Medicare Advantage, Marketplace, and private plans to assist states in developing access monitoring review plans (AMRP) for behavioral health services that better determine whether state payment rates are sufficient to ensure access to care for beneficiaries at least comparable to the general population.

A concerted effort to improve the cash flow for behavioral health care providers through an efficient revenue cycle infrastructure, including prompt payment and claims management, by all parties should result in marked improvement in the participation of behavioral health providers in these plans. A broad-based approach will have a greater effect than individual insurance plans making their own adjustments, which could add complexity and confusion. Developing effective billing and payment

processes will take collaboration and cooperation across all payers and regulators, including CMS, state Medicaid agencies, state insurance commissioners, and managed care organizations serving Medicare, Medicaid, and Marketplace beneficiaries. By prioritizing prompt pay and charging the oversight to state Medicaid programs and insurance regulators, CMS will be able to help reduce financial strain on behavioral health providers who participate in Medicare, Medicaid, and Marketplace plans.

RECOMMENDATION 7: CMS should use its regulatory and incentive structures to ensure prompt payment and eliminate inappropriate claims denials of behavioral health care services.

7-1 To adequately enforce prompt pay laws and regulations, CMS should use its monitoring authority over state Medicaid programs and state Marketplace plans to ensure that plans are in compliance with prompt pay laws. Specifically, state Medicaid agency single audits should include monitoring of prompt payment of Medicaid managed care plan behavioral health claims. State insurance regulators should include similar monitoring of prompt payment in Marketplace plans.

7-2 CMS, in consultation with state Medicaid officials, should ensure that Medicare and Medicaid provider claims are not rejected or denied for non-substantive reasons (such as using Dr. instead of Drive in an address). This may necessitate updating claims payment systems, manuals, managed care contracts, or other actions to ensure that payments are received in a timely manner following claims submission. Medicare and Medicaid payers should be required to provide regular training opportunities for behavioral health care providers on billing and claims submission and clear, accurate, and up-to-date instructions to participating care providers.

7-3 CMS should develop a common set of behavioral health diagnostic codes that qualify for reimbursement. CMS, through its federal authority, and Medicaid and insurance regulators, through their state authority, would hold responsibility for enforcing compliance.

7-4 CMS should develop policies that address the findings of the HHS Office of Inspector General report related to Medicare Advantage plans' inappropriate payment denials for services provided that meet Medicare coverage rules and medical assistance organizations' billing rules.

Goal 3: Optimize Performance and Accountability

Managed care organizations have the responsibility to deliver a care provider network sufficient to ensure access to beneficiaries. Managed care contracts include requirements and financial incentives for delivering an adequate network, but not access. Access is more than a provider network or directory; access requires that the individual receive timely behavioral health services to achieve the best possible outcome. Managed care organizations have greater flexibility to address barriers to care provider participation, service availability—and improve behavioral health care access among their beneficiaries compared with traditional Medicare and Medicaid. Outcome measures for access should include service availability, quality of care and beneficiary affordability. Beneficiaries should be able to access the services they need when they need them, without gaps in the continuum of behavioral health services available in network or at financial cost not in line with their income. The following recommendation is designed to maximize the flexibilities that managed care plans have to address market forces and barriers inhibiting behavioral health care provider availability as well as barriers to beneficiary access such that timely, appropriate behavioral health services are made available to beneficiaries.

RECOMMENDATION 8: CMS should develop behavioral health care access outcome standards, along with significant financial penalties and bonuses, for managed care organizations participating in Medicare. CMS should work with states to develop similar standards and financial models to incentivize behavioral health care access in Medicaid managed care.

8-1 Both Medicare and Medicaid increasingly rely on third-party managed care organizations to deliver health care services to beneficiaries. CMS should work with states to establish an outcome-based behavioral health care access standard for payment, which can be adopted widely in a contract model.

8-2 CMS should convene Medicare and state Medicaid leadership to develop a model managed care contract for behavioral health services that establishes quality metrics for access, measuring the managed care organization's delivery of timely, appropriate behavioral health care services to enrollees, and that is enforced through financial incentives (e.g., penalties and bonuses). In establishing quality metrics, CMS and states should recognize that meeting access outcome standards will require managed care organizations to build a full continuum of behavioral health providers and services, culturally aligned with the beneficiary population, and establish bi-directional integration of behavioral

and physical health. It will also require addressing beneficiary barriers to seeking, receiving, and benefiting from services.

8-3 CMS and SAMHSA should implement a technical assistance function to support states and managed care organizations (Medicare Advantage and Medicaid MCOs) in implementing these access measures and to help plans adopt additional efforts to support and build the behavioral health workforce and improve beneficiary access to care.

8-4 SAMHSA should work with states to align state grant funds to supplement managed care investments in building the continuum of care providers and services needed for MCOs to meet quality metrics for access.

Value-based payment and alternative payment models in Medicare, Medicaid, and Marketplace plans are increasingly prevalent and represent the direction that an evolving health care delivery system is taking in the U.S. One implication of this trend is that health care professional will be delivering care under arrangements that measure performance and demand accountability. At the core of accountability for value is the measurement of performance towards desired goals of care and tying these measures to payment. Those measures need to be accompanied by consequences related to performance. Unfortunately, the current set of measures in behavioral health are inadequate in that they do not fully capture the desired goals and can be burdensome. Even coding for the behavioral health risk is inadequate, as it misaligns rewards for the managed care plans that embrace care for behavioral health because they are paid risk-adjusted per-member, per-month rates for beneficiaries. As a result, value-based arrangements for behavioral health care do not create incentives for health plans to ensure access to appropriate-high quality care. As a result, too often the supply of professionals that can address the needs of people covered by Medicare, Medicaid and Marketplace plans is insufficient.

RECOMMENDATION 9: CMS should invest in the development of improved quality and risk adjustment measures for behavioral health care. These measures should improve the measurement of performance of care toward desired goals of care and be linked to payment. These measures should carefully consider the administrative measurement burden that would fall on care providers.

9-1 CMS should lead in the development of new performance metrics. CMS should coordinate with states and MCOs to agree on a limited set of measures that apply across Medicare, Medicaid,

and the Marketplace. Measures should offer insight into whole-person health by considering social (e.g., educational attainment, employment levels, housing stability) and emotional (e.g., quality of life, loneliness, self-efficacy) needs. Without this emphasis, value-based models in behavioral health run the risk of perpetuating disparities and leaving vulnerable populations behind.

9-2 CMS and states should work with MCOs and CMS-supported, value-based payment programs to incentivize care providers based on these newly developed measures. These efforts should include sunsetting legacy measures and aligning measures across insurance segments to reduce the burden to care providers participating in these programs.

9-3 CMS should create targeted financial support for practice transformation costs, recognizing that behavioral health care providers need technical assistance for developing new operations, reporting, billing, and health record systems.

9-4 In its development of new measures, CMS should also consider modifying the existing measures for behavioral health risk adjustment.

Some recommendations can be implemented in the short term and put into action within a year or two, especially those that apply to existing systems. These focus on immediate actions within current frameworks. The recommendations that can be implemented in the short term are Recommendation 1-3; Recommendations 2-1, 2-2, and 2-3; Recommendation 3; Recommendation 4; Recommendation 5; Recommendation 6-1; Recommendations 7-1 and 7-4; Recommendations 8-1 and 8-2; and Recommendation 9-3. All recommendations have at least one aspect that can be implemented in the short term. The remaining recommendations primarily address systemic changes, which may take longer to fully implement. Appendix F contains a crosswalk between the recommendations and supporting conclusions.

1

Introduction

The history of health insurance covering mental health and substance use disorders is complicated and evolving. Despite the pervasive, global impact of mental illness and substance use disorders, the critical challenge of accessing care persists as a formidable barrier for individuals in need. Throughout this report the committee uses the term "behavioral health" to encompass both mental illness and substance use disorders, acknowledging the distinct systems they often operate within, each governed by its own set of regulations and practices with significant differences in the availability and effectiveness of treatment options. The term is operationalized throughout the report when referring to behavioral health overall, with distinctions when referring specifically to mental health or substance use disorders.

Historically, these conditions are difficult for individuals to manage on their own, and many people have limited access to treatment (Coombs et al., 2021). The Mental Health Parity Act of 1996[1] aimed to address the disparities in coverage between mental health and other medical conditions, and the 2008 Mental Health Parity and Addiction Equity Act[2,3] extended parity requirements to substance use disorders

[1]H.R.4058—104th Congress (1995–1996): Mental Health Parity Act of 1996. September 27, 1996.

[2]H.R.6983—110th Congress (2007–2008): Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008. September 23, 2008.

[3]The report shares observations at the point in time of final committee review and approval. By the publication date, some observations may already be out of date, given regulatory agency and health management changes.

(CMS, 2023). These pieces of legislation, along with increased awareness and advocacy, have gradually helped improve access to behavioral health services through private insurance plans, public programs such as Medicare and Medicaid, and, more recently, Health Insurance Marketplace insurance programs. Despite these insurance advances, challenges persist with disparities in coverage, behavioral health provider availability, and other barriers to accessing care. Efforts to achieve parity in coverage and to ensure equitable access to services continue to shape the evolution of health insurance coverage for behavioral health care (Barry et al., 2010). This report examines various approaches to overcome obstacles and support facilitators and strategies to grow the pipeline of behavioral health practitioners participating in Medicare, Medicaid, and Marketplace and better distribute these care providers in underserved areas, with a particular focus on addressing the needs of beneficiaries with complex social, economic, and environmental needs. The committee presents evidence-based findings and conclusions which form the basis for recommendations for action by federal entities to address workforce recruitment, expansion, and distribution.

BACKGROUND

A large proportion of the nationwide struggle to access behavioral health care services results from either limited availability or limited affordability (Mental Health America, 2022; Wang et al., 2023). Amidst the global challenges of addressing mental health and substance use disorders, the United States stands out for its array of cutting-edge research and treatments and its vast network of specialized behavioral health care providers. However, even with substantial investments and advancements, disparities in access to care and fragmented delivery systems persist (Coombs et al., 2021). While the United States spends more on health care than any other high-income country, meaningful metrics such as life expectancy and ongoing deficiencies in accessibility, affordability, and outcomes remain a consistent problem (Gunja et al., 2023; Wager et al., 2024). This underscores the need for ongoing efforts to address more structural and foundational issues challenging the U.S. mental health system.

The United States embarked on a distinct path in 1965 when it established Medicare and Medicaid to address critical gaps in health care coverage and accessibility, though the nation still grapples with addressing issues related to health care access and coverage (Berkowitz, 2005). Medicaid was designed to provide health coverage to low-income individuals and families who could otherwise not afford health care services, while Medicare was designed to offer health coverage primarily to Americans aged 65 and older as well as to some younger individuals with disabilities.

Congress created these programs to ensure that vulnerable populations, including the elderly, low-income individuals, and people with disabilities, could access essential health care services, thereby promoting health equity and improving overall well-being in the nation. The creation of the Affordable Care Act (ACA) Marketplace, also known as the Health Insurance Marketplace® and referred to in this report as Marketplace insurance, was a key provision of the ACA enacted in 2010. It was established with the aim of centralizing health insurance shopping for individuals and small businesses. Through subsidies and tax credits, it strives to make coverage more affordable, while also incentivizing competition among insurers to enhance care quality and drive down costs.

Despite the creation of the Marketplace and enactment of the Mental Health Parity Act and subsequent amendments, access and affordability barriers remain. While the laws require parity in coverage, enforcement and compliance remain a challenge. Some insurers may still impose discriminatory practices or impose higher out-of-pocket costs for mental health and substance use disorder services than out-of-pocket costs for non-mental health and substance use disorder health care services (Rapfogel, 2022). Gaps arise in the scope of covered services, network adequacy, and access to behavioral health providers, particularly in determining what adequate care for an individual is (Rapfogel, 2022). Some insurance plans may lack transparency regarding mental health and substance use disorder benefits, making it difficult for consumers to understand their coverage and appeal denials for services.

There is also an ongoing shortage of mental health and substance use disorder providers, particularly in certain geographical regions and for certain populations who are part of accessible networks (Mongelli et al., 2020). Limited care provider availability hinders access to care, even with parity laws in place, affecting the quality of treatment and the willingness of individuals to seek help. Furthermore, the COVID-19 pandemic revealed existing vulnerabilities, arising from longstanding inequities, that only grew worse for children and families. Emphasizing this evolving crisis, in 2021, the American Academy of Pediatrics, the American Academy of Child and Adolescent Psychiatry, and the Children's Hospital Association joined together to declare a national state of emergency in children's mental health, stating that between 2010 and 2020 the rates of childhood mental health concerns and suicide rose steadily (AACAP, 2021). By 2018, suicide was the second leading cause of death for youth of ages 10 to 24 (AACAP, 2021). Addressing these challenges requires continued efforts to strengthen enforcement, improve transparency in coverage, expand provider networks, combat stigma, and ensure comprehensive coverage for the full continuum of mental health and substance use disorder services.

MEDICARE, MEDICAID, AND MARKETPLACE BENEFICIARIES

Millions of individuals with mental illness rely on Medicare coverage. Approximately 18.7 percent of the population, or 66 million people, experience some form of mental health condition. Serious mental illness, such as bipolar disorder or schizophrenia, is notably prevalent among beneficiaries under 65 who qualify for Medicare disability benefits, with roughly a third of all disabled Medicare beneficiaries facing severe mental disorders (Center for Medicare Advocacy, 2013). Moreover, dually eligible beneficiaries—those eligible for both Medicare and Medicaid—are more likely to struggle with mental disorders compared with individuals solely covered by Medicare (Center for Medicare Advocacy, 2013).

Medicaid, the primary payer for behavioral health services in the United States, plays a crucial role in facilitating access to care for individuals grappling with behavioral health conditions by extending health coverage to approximately one in four adults facing mental health issues. In 2020, Medicaid supported 23 percent of nonelderly adults who were coping with mental illness, 26 percent of nonelderly adults who had serious mental illness, and 21 percent who had substance use disorder (SUD), compared with its 18 percent coverage for the general nonelderly adult population (Saunders and Rudowitz, 2022).

Marketplace plans expanded coverage to 21.3 million Americans during the 2024 open enrollment period, yet affordable access to mental health care remains elusive. Nationwide, Marketplace networks can often limit the number of available behavioral health providers and restrict options for beneficiaries resulting in more narrow networks. Analysis of 2016 ACA Marketplace data of 531 provider networks revealed considerably lower participation of behavioral health providers compared with primary care providers (Zhu et al., 2017). While this practice aids cost control for plans, it may deter enrollment and leave people who need services without access, exacerbating health equity disparities (GAO, 2022). Because of these coverage provisions, beneficiaries of Medicare, Medicaid, and Marketplace plans often experience unmet needs and encounter barriers to accessing appropriate behavioral health care services. Factors such as state coverage policies affect access to treatment for Medicaid and Marketplace beneficiaries, while specialty mental health services remain insufficiently available in community outpatient settings. Beneficiaries may also struggle to find behavioral health care providers willing to accept new patients, which has been attributed to challenges perceived by care providers, such as cumbersome paperwork or lower reimbursement rates via Medicare or Medicaid (MACPAC, 2021).

PROJECT ORIGIN AND STATEMENT OF TASK

In response to these challenges, the White House launched a new mental health–focused initiative in 2022, which was aimed at revolutionizing the understanding, accessibility, treatment, and integration of mental health care. Many states, supported by recent legislative measures, are also taking steps to bolster access to mental health care services (Pestaina, 2022). However, the effect of these efforts may be limited if mental health care providers are unwilling to consistently accept patients with Medicare, Medicaid, or Marketplace coverage.

The landscape of the mental health workforce across the United States exhibits significant variations, not only between states but also within counties. Despite the evident variability, almost universal concerns arise when examining both the current and projected numbers of mental health professionals.

The Mental Health Access Improvement Act of 2022[4] broadens the range of eligible care providers under Medicare to include licensed professional counselors, potentially granting Medicare beneficiaries access to over 225,000 additional mental health professionals. Still, questions linger regarding how this change will affect overall and equitable access to behavioral health care among Medicare beneficiaries. A recent report from the Office of Inspector General (OIG) found that there was a shortage of behavioral health professionals providing care to Medicare and Medicaid beneficiaries, with only one-third of the behavioral health care workforce in the 20 counties they reviewed participating in these programs (OIG, 2024). While the report found that most enrollees in public insurance programs had access to in-person appointments with their behavioral health providers, many of them faced substantial travel distances to get to those appointments.

Adding to the complexity is the issue of diversity within the mental health workforce. Specifically, there is a relatively low number of providers who identify as racial minorities: 6.2 percent of psychologists, 5.6 percent of advanced practice psychiatric nurses, 12.6 percent of social workers, and 21.3 percent of psychiatrists. It is important to have more providers who are racially, ethnically, and linguistically diverse to provide much-needed care to the diverse population (Hoge et al., 2013). However, to effectively address access to care issues, it will be necessary for all providers to strive to be culturally competent and to demonstrate cultural humility. The report proposes several measures

[4] H.R.432—117th Congress (2021–2022): Mental Health Access Improvement Act of 2021. February 2, 2021.

to improve access to behavioral health services for publicly insured enrollees. These include encouraging more care providers to serve these populations, expanding network participation coverage to additional behavioral health professions, using network adequacy standards to boost care provider numbers in Medicare Advantage and Medicaid, and enhancing monitoring of enrollees' use of behavioral health services. The Centers for Medicare & Medicaid Services (CMS) agreed with or supported the intent behind all four recommendations of the OIG report. Compounding these challenges is the impending retirement of a significant portion of the behavioral health workforce, further underscoring the urgency of addressing workforce issues. Recent projections from the Health Resources and Services Administration underscore the pressing need for comprehensive strategies that encompass a wide array of factors affecting the mental health workforce. Only through targeted and concerted efforts can the nation respond adequately to the escalating demand for mental health and SUD services and ensure equitable access for all individuals in need.

Responding to a request from the Substance Abuse and Mental Health Services Administration, the National Academies of Sciences, Engineering, and Medicine formed an ad hoc committee to examine the current challenges to ensuring broad access to high-quality behavioral health care services through the Medicare, Medicaid, and Marketplace programs and to propose strategies to address those challenges. The Committee on Strategies to Improve Access to Behavioral Health Care Services through Medicare, Medicaid, and Marketplace consisted of 17 members with diverse expertise, including clinical behavioral health care delivery, behavioral health care policy, economics of mental health and substance abuse care, insurance regulations and laws for mental health care, behavioral health and primary care integration, behavioral health informatics, revenue-cycle management in certified community behavioral health clinics and federally qualified health centers, and behavioral health professional education. Appendix A includes brief biographies of the committee members and staff. Box 1-1 provides the statement of task for the resulting study.

This consensus report, the product of the committee's work, examines factors that incentivize or disincentivize behavioral health care provider participation in the Medicare, Medicaid, and Marketplace programs and considers ways to clarify, simplify, or streamline administrative processes and policies to reduce perceived barriers to participation and improve access to care. It also recommends innovative models, policies, and strategies to further increase and enhance behavioral health provider participation in these programs.

BOX 1-1
Statement of Task

An ad hoc committee of the National Academies of Sciences, Engineering, and Medicine will examine the current challenges in ensuring broad access to high-quality behavioral health care services through the Medicare, Medicaid, and Marketplace programs and will propose strategies to address those challenges. In particular, the committee will propose strategies to increase the participation of the behavioral health workforce in these programs in order to ensure adequate capacity and access to care amid increased demand for behavioral health care by Medicare and Medicaid beneficiaries.

In developing its findings and recommendations, the committee will consider the following:

- Factors that incentivize or disincentivize behavioral health care provider participation in the Medicare, Medicaid, and Marketplace programs, with attention to provider type (e.g., physician, psychologist, advance practice nurse, and social worker), including:
  - Current perceptions and/or experiences among behavioral health care professionals and trainees about the challenges that impede participation
  - Current administrative processes and policies that produce perceived or experienced burden, and how these might be clarified, simplified, or streamlined to reduce barriers to participation and improve access to care
  - Infrastructure requirements (e.g., electronic health records, participation in third-party billing systems, capacity to contract with managed care or other payers, data collection and reporting)
- Barriers and potential facilitators and innovative strategies that could encourage behavioral health practitioners to work with Medicare and Medicaid beneficiaries, including those with complex social, economic, and environmental needs.

The committee will make recommendations that could be implemented in the short term under existing statutory authorities as well as recommendations for initiatives that may require additional authorities or require a longer timeframe to implement. The committee will also host multiple public webinars to seek input from experts and the public on potential solutions. A proceeding of those public sessions will be prepared and published before the release of the committee's final report with conclusions and recommendations.

SCOPE OF THE REPORT AND GUIDING PRINCIPLES

The primary task before this ad hoc committee was to "propose strategies to increase the participation of the behavioral health workforce" in order to establish "adequate capacity and access to care" for Medicare, Medicaid, and Marketplace beneficiaries. While the ad hoc committee respected this request, it thought it was paramount to acknowledge from the outset two foundational issues that constrain the committee's recommendations for how to best support access to high-quality behavioral services and supports for beneficiaries. First, recommendations should always prioritize the needs of the beneficiaries over any other aspect of the work. Individuals in need of behavioral health care require a system that can alleviate their symptoms and enhance their quality of life. This is a challenging proposition when considering the second foundational issue, which is that the current behavioral health system is incapable of meeting the nation's needs. The structures of this system are flawed and need to be reassessed for it to become an actual system of care, one that delivers on the promise of quality, equity, and outcomes that the nation's communities want and need.

The committee also recognized how essential it is to remember that all services, no matter who provides them, must be created and delivered in a manner designed to meet the specific needs of the individuals seeking the care. Individuals with behavioral health conditions are not a homogenous population, and their needs warrant a full continuum of services to address a variety of unique considerations. This also means that the issue of who provides care may also shift with where an individual falls on the continuum of care. While the committee gave some attention to this issue, the vast majority of its report addresses the current clinical workforce.

In addition to considering and discussing the research in this space, the committee also convened three public webinars to provide a perspective from people who interact or have been involved with the current behavioral health system. One public webinar involved two panels that focused on the needs of adults and the experiences of families and caregivers with children and youth. All the participants expressed the need for tools to navigate an increasingly complicated behavioral health system and find the right care provider who accepted their type of insurance to meet their specific needs. From their perspective, the system is fragmented and opaque, and individuals seeking behavioral health care do not fit neatly into the existing structures. Furthermore, they emphasized that the behavioral health system they encountered did not address their needs holistically, often limiting the effectiveness of those services and not providing the array of support they required to sustain their recovery and rehabilitation, let alone facilitate thriving.

The landscape of behavioral health care delivery is undergoing a profound evolution, propelled by advances in technology, shifting societal

norms, and patient preferences. While these transformations unfold, it is becoming increasingly evident that traditional clinical settings alone are insufficient to meet the diverse needs of individuals seeking behavioral health treatment. Embracing new ways to deliver care, whether through telehealth platforms, community-based interventions, or digital therapeutics, is essential in ensuring equitable access to behavioral health services. The behavioral health workforce must be responsive to these trends.

Navigating the complexities of the country's mental health care system raised challenges for the committee. To address this, the committee engaged in thorough discussions and deliberations on the research available in order to determine the essential information needed to inform its findings and conclusions. In conducting its research and formulating recommendations, the committee opted to craft findings, conclusions, and recommendations applicable across diverse types of care providers and policies. Therefore, this report attempts to offer a way forward to increase behavioral health care workforce participation in Medicare, Medicaid, and Marketplace plans in order to provide more access to behavioral health care services for these beneficiaries. Chapter 7 contains a complete summary of the committee's recommendations.

COMMITTEE'S APPROACH

The committee met five times, either in person or virtually, between August 2023 and May 2024. It also held numerous online workgroup meetings and three public webinars. During these five meetings, the committee considered and discussed relevant research, heard from members of the public, and discussed the approach of how to engage more behavioral health care providers in U.S. public insurance programs.

The webinars provided real-life personal experiences from a range of people interacting with the behavioral health care system. Each webinar hosted two panels of up to three speakers. The two panels in the first webinar focused on capturing real-life experiences of those seeking adequate and competent mental health care through public insurance programs. Panel 1 focused on adults using the public insurance programs, while the second panel focused on caregivers to children who needed behavioral health care through public insurance. The second webinar centered on behavioral health care providers who interact with Medicare, Medicaid, and Marketplace insurance. Wanting to include a broad range of behavioral health care providers perspectives, the committee included a peer counselor, a licensed psychological associate, a psychiatrist, a primary care provider with experience in integrated care, a licensed mental health counselor, and a licensed registered art therapist.

For the third webinar, the committee wanted to center on a solution-focused approach and thus invited professionals who manage innovations to improve mental health and SUD treatment access in public insurance plans. This included professionals working in state insurance divisions, CMS's Center for Medicare, the Blue Cross Blue Shield Association, and a state department of human services/Medicaid program. The proceedings in brief in Appendix D provides condensed talking points from each presenter and their bios.

The committee also completed an extensive examination of the peer-reviewed literature, ultimately considering more than 3,000 articles and targeting English-language, U.S.-focused articles published since 2010 concerning behavioral health care providers, delivery, and funding. In addition, the committee reviewed gray literature, including publications by private organizations and government, with a focus on strategies to improve access to quality behavioral health care. The committee also sought to gather more behavioral health provider perceptions of insurance participation in addition to what was discussed at the second webinar. To collect this additional input, a request for information (RFI) was created and released to a range of professional networks and working groups. This RFI included short questions aiming to supplement gaps in research and bolster the current research available through a literature review on the perceptions of behavioral health care providers. Aside from requesting basic demographic information, setting of provider and type of care provider, the RFI included two open-ended questions:

1. As a provider, please share your experiences working with Medicare, Medicaid, and/or Marketplace insurance programs. Please be specific about program type in your response.
2. If you do not participate in Medicare, Medicaid, and/or Marketplace programs, please indicate why. Please be specific about program type in your response.

The committee did not conduct a statistical analysis of the information the RFI produced. However, the report uses quotes for illustrative purposes to bolster the behavioral health care providers' perspectives and aid in comprehending their engagement or non-engagement with these public insurance programs.

ORGANIZATION OF THE REPORT

The next two chapters in this report offer a comprehensive background on the behavioral health care system and the populations using the public insurance systems discussed. Chapter 4 addresses the need for workforce

recruitment, expansion, and redistribution to increase the availability of a racially, ethnically, and linguistically diverse workforce. That chapter proposes strategies to integrate new behavioral health care providers into the networks of Medicare, Medicaid, and the Marketplace and sets the stage for Chapter 5, which concerns retaining and supporting the existing workforce. The chapter investigates the challenges faced by behavioral health care providers currently operating within the public and Marketplace insurance markets and explores factors contributing to behavioral health care provider attrition. Chapter 6 provides an overview of the current system infrastructure, taking a broad view of the levers that should be employed to establish a system that has fewer barriers and prioritizes patient-centered care. Chapter 7 contains the committee's goals and recommendations as they relate to the study's charge to improve the system.

The report's appendices present supplemental information on conducting the study. Box 1-2 in this chapter provides the committee's definitions

BOX 1-2
Committee Definitions of Select Terms

Defining **need and unmet need for behavioral health services** is complex and still evolving. Traditionally, need has been gauged by the percentage of individuals with diagnosable conditions who receive treatment, though this overlooks individual perceptions of need. An alternative approach considers both the diagnosed population and those actually receiving care. The Substance Abuse and Mental Health Services Administration reports on the percentage of individuals perceiving unmet need, highlighting a gap between treatment and perceived need. Surprisingly, a significant portion of those with unmet need still receive care. Complicating matters, data suggest that many receiving mental health services lack diagnosable conditions or significant impairments. A pragmatic approach might involve focusing on symptom and impairment combinations to define need, acknowledging the complexity of individual circumstances.

Managed care organization plans are any type of public or private health coverage that uses a network of contracted providers to direct enrollees to effective health care services that offer value and affordability. For the purposes of this report, the term includes health maintenance organizations, preferred provider organizations, and exclusive provider organizations.

continued

BOX 1-2 Continued

The committee encountered difficulties in defining **health equity** due to the discrepancy between the ideal of equal opportunity for all individuals to attain optimal health and the reality of existing disparities. Achieving health equity will require societal efforts to rectify injustices, clear barriers, and eliminate disparities in health. Additionally, it will entail the equal valuation of every individual, irrespective of factors such as race, ethnicity, gender, disability, sexual orientation, socioeconomic status, or language.

Network adequacy essentially ensures that individuals can access a variety of behavioral health services promptly, without facing significant obstacles such as extended wait times or restricted provider options. Regulatory bodies establish standards for ensuring network adequacy, considering factors such as the number and distribution of available providers as well as the scope of services offered to meet the needs of the covered population.

The primary concern addressed by the committee with **health professional shortages** is the limited access to care within Medicare, Medicaid, and the Marketplaces due to supply constraints. Practical indicators of shortages in these programs include the participation rate of clinicians from various disciplines, their willingness to accept new patients from these programs compared with overall new patient acceptance, and the alignment of distribution for behavioral health providers with the prevalence of illness. Stratifying these indicators by geography, race, ethnicity, and income can provide a more comprehensive understanding.

Transitioning to value-based or **alternative payment models** offers a significant opportunity to address the diverse needs of individuals with mental illnesses and substance use disorders. These models promote a shift from rigid, one-size-fits-all approaches to dynamic, outcome-driven systems, allowing health care providers to tailor care to patients' unique needs. The effectiveness of these models relies on having robust performance measures, particularly those assessing how well health plans and providers address social needs, including outcomes related to quality of life, loneliness, and other patient-reported experiences.

Risk adjustment is a statistical tool in health care financing used to address variations in the health status and demographics of insured individuals. It is designed to distribute financial resources fairly by compensating for differences in expected care costs. While it helps offset incentives for plans to avoid high-cost beneficiaries, it often inadequately accounts for those with mental illnesses and substance use disorders. Striking a balance between access to care and effective care management is crucial for ensuring that risk adjustment addresses health disparities while sustaining health care systems.

of select terms that are used throughout the report. Appendix A provides committee and staff biographies. Appendix B provides information on the disclosure of an unavoidable conflict of interest. Appendix C contains supplemental tables and figures from chapter 3. Appendix D lists panelists who spoke at the committee's three public webinars. Appendix E contains the proceedings in brief for the webinars. Finally, Appendix F contains a crosswalk between the committee's recommendations and conclusions from supporting chapters.

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2

Behavioral Health Needs in the United States

The demand for behavioral health care in the United States is large and growing. Data from the Substance Abuse and Mental Health Services Administration (SAMHSA) found that 1 in 5 adults, adolescents, and youth—equivalent to over 50 million Americans—experienced a behavioral health issue between 2019 and 2020. An analysis of data from the Behavioral Risk Factor Surveillance System shows that there was an increase in the number of adults reporting poor mental health for more than 14 days in the past month from 11.5 percent to 14.1 percent from 2013 to 2022 (KFF, 2022).

The high and rising prevalence of behavioral health disorders in the United States has created a growing challenge to meet care needs. In 2021, fewer than half the adults with a mental health issue accessed timely care, and those with a substance use disorder (SUD) were even less likely to access care (Counts, 2023). The situation is even more dire for youth, with one study finding that only one-quarter of children and adolescents with a behavioral health problem receive treatment (Sturm et al., 2001). In this chapter, the committee describes behavior health components across the lifespan, discusses the unmet behavioral health care needs of the American public, and provides an overview of the U.S. behavioral health care delivery system.

BEHAVIORAL HEALTH ACROSS THE LIFESPAN

Behavioral health is an all-encompassing term that SAMHSA uses to refer to both mental health and substance use. SAMHSA defines behavioral health as "the promotion of mental health, resilience, and well-being;

the treatment of mental and substance use disorders; and the support of those who experience or are in recovery from these conditions, along with their families and communities" (SAMHSA, 2023b).

Mental Health

SAMHSA defines mental health as including emotional, psychological, and social well-being (SAMHSA, 2023c). A person's mental health affects how he or she thinks, feels, acts, and develops. It also plays a role in determining how a person handles stress, relates to others, and makes health choices. Mental health is important at every stage of life, from childhood and adolescence through adulthood, and a person's mental health can change.

Many factors contribute to mental health conditions, including:

- Biological factors such as genetics, brain chemistry, physical health, and age;
- Health behaviors such as sleep, diet, and substance use/misuse;
- Life experiences such as trauma and abuse;
- Psychological factors such as beliefs, perceptions, and emotions;
- The environment in which a person lives, works, and plays;
- Social factors such as relationships, family, culture, work, financial status, and housing; and
- Family history of mental health problems.

Being mentally healthy during childhood means reaching developmental and emotional milestones and learning healthy social skills and how to cope when there are problems. Mentally healthy children have a positive quality of life and can function well at home, in school, and in their communities. Being mentally healthy as an adult implies a state of well-being in which "individuals recognize their abilities, are able to cope with the normal stresses of life, work productively and fruitfully, and make a contribution to their communities" (Srivastava, 2011, p.75). Resilience, which the American Psychological Association defines as "the process and outcome of successfully adapting to difficult or challenging life experiences, especially through mental, emotional, and behavioral flexibility and adjustment to external and internal demands," is an important characteristic of being mentally healthy (VandenBos and APA, 2015).

Mental Illness

SAMHSA defines any mental illness (AMI) as "any mental, behavior, or emotional disorder in the past year that met [Diagnostic and Statistical Manual]-VTR criteria (excluding developmental and substance use disorders"

and defines serious mental illness (SMI) as "any mental, behavior, or emotional disorder that substantially interfered with or limited one or more major life activities" (SAMHSA, 2023c). In 2022, an estimated 15.4 million U.S. adults aged 18 and older had an SMI in the past year, representing 6.0 percent of all U.S. adults (SAMHSA, 2023a). Some 4.0 million, or 11.6 percent, of young adults aged 18 to 25 had an SMI, while 7.8 million, or 7.6 percent, of adults aged 26 to 49 and 3.5 million, or 3.0 percent, of adults aged 50 and older had an SMI in the past year (SAMHSA, 2023a). The Centers for Disease Control and Prevention describes mental disorders among children as serious changes in the way children typically learn, behave, or handle their emotions, which cause distress and problems getting through the day (CDC, 2023).

Mental illnesses (Boxes 2-1 and 2-2) can vary in the way they affect a person and range from no impairment to mild, moderate, and even severe impairment. SMIs result in significant functional impairment that interferes substantially with or limits one or more major life activities. SAMHSA states that, "Despite common misperceptions, having an SMI is not a choice, a weakness, or a character flaw. It is not something that just 'passes' or can be 'snapped out of' with willpower" (SAMHSA, 2023c). Though mental illness and SMI are relatively common, as noted above, research shows that medical and other therapeutic treatments for mental illness and SMI are effective.

BOX 2-1
Mental Illnesses in Adults

The National Institute of Mental Health classifies mental illnesses affecting adults into the following discrete conditions:

- Anxiety disorders
- Attention-deficit/hyperactivity disorder
- Bipolar disorder
- Personality disorders
- Depression
- Disruptive mood dysregulation disorder
- Eating disorders
- Obsessive-compulsive disorder
- Phobias
- Post-traumatic stress disorder
- Schizophrenia

SOURCE: NIMH, n.d.

BOX 2-2
Mental Illnesses in Children and Adolescents

The National Institute of Mental Health and Centers for Disease Control and Prevention classify mental illnesses affecting children and adolescents into the following discrete conditions.

- Anxiety disorders
- Attention-deficit/hyperactivity disorder
- Conduct disorder
- Depression and other mood disorders
- Eating disorders
- Obsessive-compulsive disorder
- Post-traumatic stress disorder
- Tourette syndrome

SOURCE: CDC, 2023.

Data from the 2022 National Survey on Drug Use and Health (NSDUH) found that 21.8 percent of all adults aged 18 or older received some mental health treatment in the previous year. The percentage of adults aged 18 or older with AMI in the previous year was highest among young adults aged 18 to 25, at 36.2 percent, followed by adults aged 26 to 49 at 29.4 percent, and adults aged 50 or older at 13.9 percent. Among the 59.3 million adults with AMI in the previous year, 50.6 percent had received mental health treatment in the previous year (SAMHSA, 2023a).

In 2022, 6.0 percent of adults aged 18 or older had had SMI in the past year (SAMHSA, 2023a). The percentage of adults with SMI was highest among young adults aged 18 to 25, at 11.6 percent, followed by adults aged 26–49 at 7.6 percent and adults aged 50 or older at 3.0 percent. Among the 15.4 million adults with SMI, 66.7 percent had received mental health treatment in the previous year (SAMHSA, 2023a).

Anxiety disorders are generally the earliest mental illness to appear, with first appearances usually around age 11. An estimated 19.1 percent of U.S. adults experience an anxiety disorder every year, with an estimated 31.1 percent of U.S. adults having experienced an anxiety disorder at some point during in their lives (ADAA, 2022; NIMH, n.d.). An estimated 9.7 percent of U.S. adults experience a mood disorder such as bipolar disorder or major depression in a given year, with an estimated lifetime prevalence of 21.4 percent (NIMH, n.d.). Among those aged 18 to 44,

impulse control disorders such as attention-deficit/hyperactivity disorder (ADHD) and oppositional defiant disorder appear relatively early, around age 11, and are more prevalent among adults aged 18 to 29 (27 percent) than among adults aged 30 to 44 (23 percent) (SAMHSA, 2013).

In 2022, 29.8 percent of adolescents aged 12 to 17 had received mental health treatment within the previous year. Though NSDUH does not report data on SMI in adolescents, it does report specifically on major depressive disorder, and among the 4.8 million adolescents who experienced major depressive disorder, 56.8 percent had received mental health treatment in the previous year. NSDUH identifies people with major depressive disorder through structured interviews based on Diagnostic and Statistical Manual of Mental Disorders (DSM) criteria, regardless of whether they have received treatment or a formal diagnosis. However, more than 40 percent of adolescents who experienced major depressive disorder in the preceding 12 months did not receive mental health treatment (SAMHSA, 2023a).

Substance Use Disorders

SUD is a condition that affects a person's brain and behavior, leading to the person's inability to control the use of substances, such as legal or illegal drugs, alcohol, or medications. Symptoms can be mild to severe, with addiction being the most severe form of SUD. People with SUD may also have other mental health disorders, and people with mental health disorders may also struggle with substance use (Ross and Peselow, 2012). Research suggests that adolescents with SUD also have high rates of co-occurring mental illness, with over 60 percent of adolescents enrolled in treatment programs also meeting the diagnostic criteria for another mental illness (Hser et al., 2001).

Experimentation with alcohol peaks during adolescence, while young adults are likely to experiment with other substances, such as marijuana, cocaine, and prescription medications such as Adderall. Adults who have used alcohol and illicit substances may have an undiagnosed alcohol use disorder, and others will develop late-onset SUD (Schulte and Hser, 2013; Stewart et al., 2023). Research has shown that early initiation of substance use increases the risk for subsequent development of SUD (Behrendt et al., 2009). The severity of alcohol and drug use during adolescence increases the risk of developing SUD as an adult (McCabe et al., 2022; Volkow and Wargo, 2022).

According to NSDUH data, in 2022, SUD had affected 17.3 percent of people aged 12 or older, or 48.7 million people, in the previous year, including 29.5 million who had an alcohol use disorder (AUD), 27.2 million who had a drug use disorder, and 8.0 million people who had both an AUD and drug use disorder (SAMHSA, 2023a). In 2022, the percentage of people

aged 12 or older with an SUD in the past year was highest among young adults aged 18 to 25, at 27.8 percent or 9.7 million people, followed by 16.6 percent or 36.8 million adults aged 26 or older and 8.7 percent or 2.2 million adolescents aged 12 to 17 (SAMHSA, 2023a).

Among the 29.5 million people aged 12 or older in 2022 with a past-year AUD, 59.1 percent had what NSDUH characterized as a mild disorder, compared with 20.7 percent who had a severe disorder. Among the 19.0 million people aged 12 or older in 2022 with a past-year marijuana use disorder, 55.1 percent had a mild disorder, compared with 17.3 percent who had a severe disorder (SAMHSA, 2023a).

Life Stressors and Crises

Stressful experiences are a normal part of life, and the stress response is a survival mechanism that primes the body to respond to threats. However, an extensive body of research has shown that life stressors, particularly toxic stress during childhood and adverse childhood experiences (ACEs), can lead to the development, maintenance, or exacerbation of several mental health conditions, including anxiety disorders, depression, bipolar disorder, post-traumatic stress disorder (PTSD), personality disorders, and suicidality (Bourvis et al., 2017; Green et al., 2010; Johnson et al., 1999; Kendler et al., 1999). One study, for example, found a dose–response relationship between Adverse Childhood Experiences (ACEs), a considerable source of stress during childhood, and the likelihood of developing mild to moderate SUD, heavy drinking, depression, and suicide attempts in adulthood (Merrick et al., 2017). Severe stress can trigger a range of physiological consequences affecting the musculoskeletal, respiratory, cardiovascular, endocrine, gastrointestinal, nervous, and reproductive systems (APA, 2023; Yaribeygi et al., 2017). In terms of life stressors from a health equity standpoint, an extensive body of research has demonstrated an association between experiences of racism and poorer mental health outcomes among racial and ethnic minority populations (Paradies et al., 2015).

Co-Occurring Disorders

Despite the historic separation of behavioral health and physical health, the two are intertwined, and the co-occurrence of behavioral health and physical health conditions is not uncommon (Han et al., 2019). For example, the prevalence of depression and anxiety ranged from 6 percent to as high as 80 percent among patients with chronic obstructive pulmonary disease (COPD) and from 10 percent to as high as 60 percent among patients with heart failure (Yohannes et al., 2010). SUD, HIV/AIDS, and hepatitis C are common co-occurring illnesses (Granados-García et al., 2019; Hartzler

et al., 2017). One study found that 25 percent of adults with obesity and chronic physical illness such as asthma, diabetes, heart disease, hypertension, or osteoarthritis had an SMI (Shen et al., 2008), while another study identified clusters of clinically meaningful co-occurrence of mental illness, AUD, and physical health that included hypertension, arthritis, digestive and bowel problems, emerging multimorbidity, and complex multimorbidity (Gomez et al., 2023). A 2021 scoping review emphasized the co-occurrence of anxiety, mood, and attention disorders among children with epilepsy, asthma, and allergies (Romano et al., 2021).

When physical health conditions and behavioral health disorders (Horvitz-Lennon et al., 2006) occur together, they can shorten a person's lifespan by as much as 10 to 20 years (Chesney et al., 2014). Co-occurring behavioral and physical health problems can complicate diagnosis, treatment, and disease progression so that conditions often go undiagnosed among patients with co-occurring physical and mental illnesses (Owens et al., 2018). For example, COPD and heart failure may mask or mirror symptoms of depression, anxiety, and PTSD, making their recognition and diagnosis less likely (Ratcliff et al., 2017). In addition, physical health conditions can increase the risk of psychological distress, exacerbate mental disorders, and compound functional impairment (Horvitz-Lennon et al., 2006; Whooley et al., 2008). Similarly, individuals with an SMI have higher rates of chronic conditions, including hypertension and diabetes (Zolezzi et al., 2017).

People with an SUD are at elevated risk of developing a co-occurring mental health problem and vice versa. According to SAMHSA's 2022 NSDUH, approximately 21.5 million U.S. adults have a co-occurring mental health problem and SUD (SAMHSA, 2023b). One study found that approximately 3.3 percent of the U.S. population had had a co-occurring SUD and SMI in the preceding 12 months, with 52.5 percent receiving neither mental health care nor SUD treatment (Han et al., 2017).

Unique Issues that Apply to Children and Adolescents

Common mental health issues in children (Box 2-2) include anxiety; depression; oppositional defiant disorder, characterized by constant disobedience and hostility; conduct disorder, characterized by aggression and law-breaking tendencies; and ADHD, characterized by inattention, impulsivity, and overactivity (CDC, 2023). Children with ADHD often have difficulty concentrating and are easily distracted. Many children with ADHD say they do not understand why they sometimes feel out of control or lonely. Early life adversity in the form of psychosocial and material neglect; exposure to intimate partner violence; and physical, sexual, and emotional abuse are strongly correlated with higher rates of almost all commonly occurring mental health issues, including mood, anxiety, and SUD (Kim and

Cicchetti, 2010; McLaughlin et al., 2010). Mental health issues associated with early life adversity are more severe, persistent, and treatment resistant than mental health issues not associated with early life adversity (McLaughlin et al., 2010).

For many individuals, adolescence is a time of experimentation and becoming involved in risk-taking behaviors such as using alcohol, tobacco, and other drugs that can have a major effect on a person's mental health. Adolescence is a time of identity formation, particularly regarding sexual orientation and gender identification. There is strong evidence that when adolescents who identify as LGBTQ+ cannot express their true selves, they either hide or deny their attractions and identity (Rafferty et al., 2018). Because of the stigma and bullying they face, LGBTQ+-identifying adolescents are at higher risk of mental health problems, including depression, suicidality, altered body image, and substance use (Levine et al., 2013; Parsons et al., 2007). Adolescents experiencing gender dysphoria are at increased risk of emotional health problems, including depression and suicidality, victimization and violence, eating disorders, and substance use (Rafferty et al., 2018).

Stigma often deters individuals from seeking care despite experiencing symptoms or discomfort. Suicide is the second leading cause of death in adolescents. According to a 2017 survey of high school students, 7.4 percent of high school students had attempted suicide within the previous 12 months, and 13.6 percent had made a suicide plan (CDC, 2018). In 2021, 45 percent of LGBTQ+ adolescents considered attempting suicide (The Trevor Project, 2022). A 2023 systematic review and meta-analysis found that 36 percent of adolescents had received treatment for depressive episodes and 20 percent had received treatment for anxiety disorders (Wang et al., 2023). Eating disorders most commonly develop during adolescence and are often accompanied by other mental health problems (NIMH, 2024). After researching this topic and given the multitude of news stories highlighting the mental health crisis affecting children and adolescents, the committee concurs with the Surgeon General that there is a need to "improve mental health data collection and integration to understand youth mental health needs, trends, services, and evidence-based interventions" (U.S. Surgeon General, 2021).

UNMET BEHAVIORAL HEALTH NEEDS

There is significant unmet need for behavioral health care in the United States, though assessing unmet need is not straightforward (Box 2-3). Nonetheless, according to NSDUH data, 21.8 percent of adults aged 18 and older had received mental health treatment in the previous year, with 50.6 percent of those with AMI receiving treatment and 66.7 percent of adults aged 18 or older with an SMI receiving treatment in the previous year (SAMHSA, 2023b).

BOX 2-3
Defining Need and Unmet Need for Behavioral Health Services

Defining need for mental health and SUD care has long been a complicated and largely unresolved issue. In practice, various observers and government agencies frequently report the percentage of people with a diagnosable condition (based on epidemiological surveys) who receive treatment as an indicator of need that has been met (see the NSDUH). The implicit assumption is that having a diagnosable condition means needing care. Others have suggested that such measures leave the affected individual's perception of need unrecognized. Other observers have proposed summing the unique number of people who have a diagnosable condition and the number of people receiving behavioral health care. That approach recognizes the fact that what people view as need may differ from the strict criteria of the Diagnostic and Statistical Manual.

Each year, SAMHSA also reports the number of people who perceived that they had unmet need for mental health care, typically as the percentage of people with a diagnosable condition who perceived unmet need. In 2022, that was reported to be about 26.5 percent. Surprisingly, over half of those reporting unmet need also received mental health services. The implication is that given that about 50 percent of people with a diagnosable condition get treated and 26 percent have unmet need, many of whom received care, there is a significant plurality of people with a diagnosable condition who do not receive treatment and do not perceive unmet need. Further complicating the definitional challenge are data from the Medical Expenditure Panel Survey and NSDUH suggesting that high percentages of people using mental health services have neither a diagnosable mental illness nor significant impairments (Germack et al., 2020; author's tabulations from the NSDUH).

Perhaps a practical approach to defining need and unmet need is to begin with a focus on combinations of symptoms and impairments on the assumption that someone with a diagnosable condition with impairment would likely need care. Likewise, someone with symptoms of behavioral health conditions that fall below diagnostic thresholds but produce impairments that affect functioning would also qualify as needing care.

Among adults aged 18 or older with AMI who did not receive mental health treatment in the previous year, 4.1 percent sought treatment but were unable to receive it, while 22.4 percent thought they should get treatment did not seek it, and 73.4 percent did not seek treatment and did not think they needed it. Among the reasons people with AMI who sought or

thought they should receive treatment gave for why they did not receive treatment, 35.7 percent said they did not have health insurance coverage for mental health treatment, 40.8 percent said their health insurance would not pay enough of the costs for treatment, and 20.1 percent said there were no openings in the treatment program or health care professional to which they wanted to go (SAMHSA, 2023b).

Among people aged 18 or older with past-year SMI who did not receive mental health treatment in the previous year, 8.0 percent sought treatment and were not able to receive it, 41.7 percent thought they should get treatment did not seek it, and 50.3 percent did not seek treatment and did not think they needed it (SAMHSA, 2023b). Among the reasons people with SMI who sought or thought they should receive treatment gave for why they did not receive treatment, 46.1 percent said they did not have health insurance coverage for mental health treatment, 43.5 percent said their health insurance would not pay enough of the costs for treatment, and 21.9 percent said there were no openings in the treatment program or health care professional to which they wanted to go (SAMHSA, 2023a).

For youth aged 12 to 17, 29.8 percent received mental health treatment, and of those who did not receive treatment, 2.1 percent sought treatment, 10.3 percent thought they should get treatment but did not seek it, and 87.6 percent did not seek treatment and did not think they needed it (SAMHSA, 2023a). Among the reasons people aged 12 to 17 who did not receive mental health treatment and sought or thought should get mental health treatment in past year gave for why they did not receive treatment, 8.2 percent did not have health insurance coverage for mental health treatment, 6.0 percent said their health insurance would not pay enough of the costs for treatment, and 7.1 percent said there were no openings in the treatment program or health care professional to which they wanted to go (SAMHSA, 2023a). The most common reason for why youth aged 12 to 17 did not seek treatment was because they thought they should be able to handle their mental health issues on their own. NSDUH did not produce unmet needs data for SMI in youth aged 12 to 17 (SAMHSA, 2023a).

For SUD including AUD, 4.7 percent of adults aged 18 and older received SUD treatment in the past year, while 4.6 percent of youth aged 12 to 17 received SUD treatment (SAMHSA, 2023a). For people aged 12 or older—NSDUH did not parse the data by age group—who did receive treatment, 3.225 million people were Medicaid or Children's Health Insurance Program beneficiaries, and 1.509 million had Medicare, military-related health care, or any other type of health insurance other than private insurance (SAMHSA, 2023a). For those individuals aged 12 and older who sought or thought they should get treatment but did not, 39.1 percent did not have health insurance coverage for alcohol or drug use treatment, 33.8 percent said their health insurance would not pay enough of

the costs for treatment, and 11.9 percent said there were no openings in the treatment program or health care professional to which they wanted to go. Many individuals with SUD also have co-occurring mental illness. In 2022, among adults aged 18 and older, 32.2 percent also had AMI excluding SMI and 48.2 percent had SMI (SAMHSA, 2023a,b).

Disparities in Unmet Behavioral Health Needs and Mental Health Outcomes

Studies show an increased disparity in mental health care services in terms of the quality of care, availability, and service usage across different races, cultures, ethnicities, age groups, and economic strata in society (American Psychiatric Association, 2023). Racial, ethnic, gender, and sexual minoritized individuals often suffer from poor mental health outcomes resulting from multiple factors, including inaccessibility of high-quality mental health care services, cultural stigma surrounding mental health care, and discrimination.

According to NSDUH data, among individuals aged 18 or older in 2022, 35.2 percent of multiracial adults had AMI in the previous year, compared with 24.6 percent of White adults, 21.4 percent of Hispanic adults, 19.7 percent of Black adults, 19.6 percent of American Indian or Alaska Native adults, and 16.8 percent of Asian adults (SAMHSA, 2022a). Among adults aged 18 or older in 2022, 11.8 percent of multiracial adults had SMI, compared with 6.5 percent of White adults, 5.3 percent of Hispanic adults, 4.7 percent of Black adults, 4.1 percent of Asian adults, and 3.5 percent of Native Hawaiian or Other Pacific Islander adults (SAMHSA, 2022a). The percentages of people aged 12 or older with a past-year SUD ranged from 9.0 percent of Asian Americans to 24.0 percent of American Indian or Alaska Native people. Except for Asian people, percentages did not differ significantly by race or ethnicity (SAMHSA, 2022a).

Compared with non-Hispanic White Americans, Black Americans with AMI have lower rates of any mental health service use, including prescription medications and outpatient services, but higher use of inpatient services (Center for Behavioral Health Statistics and Quality, 2021). Only one-third of Black Americans who need mental health services receive it, and compared with White Americans, Black Americans are less likely to receive guideline-consistent care. In addition, Black Americans are more frequently diagnosed with schizophrenia and less frequently diagnosed with mood disorders than their White counterparts (Bell et al., 2015).

In 2021 only 36 percent of Hispanic and Latino Americans who had AMI received mental health services, compared with 52.4 percent of non-Hispanic White Americans with AMI (SAMHSA, 2022b). Latino youth have higher rates of unmet needs than White youth, leading to greater

suicidal thoughts and attempts, depression, anxiety, and rates of dropping out of high school than White youth (Kataoka et al., 2002). Hispanic and Latino Americans experience barriers to receiving mental health services which include experiences of racism and discrimination stemming from structural and systemic factors, stigma based in culture, language access issues, and a lack of ethnically and linguistically competent care providers.

Asian Americans and Pacific Islander (AAPI) adults are least likely among all racial and ethnic groups to seek behavioral health services, and they are three times less likely to access behavioral health services than non-Hispanic White Americans (Bloom and Black, 2016; SAMHSA, 2022b). There is, however, wide variation among AAPI ethnic subgroups, with Vietnamese Americans, Native Hawaiians, and Pacific Islanders reporting mental health issues at rates closer to the U.S. average than to their AAPI counterparts.

The high rates of alcohol, substance use and mental health disorders, suicide, and behavior-related morbidity and mortality in American Indian and Alaska Native communities continue to be disproportionately higher than the rest of the U.S. population (Gone and Trimble, 2012). Studies show Indigenous people have disproportionately higher rates of mental health problems such as suicide, PTSD, and substance use disorders. These high rates result in American Indian and Alaska Native people reporting serious psychological distress 2.5 times more often than the general population over a month's time (IHS, 2015; NCHS, 2023).

LGBTQ+ individuals are more than twice as likely as heterosexual men and women to have a mental health disorder in their lifetime and 2.5 times more likely to experience depression, anxiety, and substance use compared with heterosexual individuals (American Psychiatric Association, 2017). Some 42 percent of LGBTQ+ youth seriously considered attempting suicide in the past year, including more than half of transgender and nonbinary youth, while 48 percent of LGBTQ+ youth reported they wanted care from a mental health profession but could not receive it in the past year. Over 70 percent of LGBTQ+ youth reported symptoms of generalized anxiety disorder in the past 2 weeks, including more than three-quarters of transgender and nonbinary youth; 62 percent of LGBTQ+ youth reported symptoms of major depressive disorder in the past 2 weeks, including more than two-thirds of transgender and nonbinary youth; and 70 percent of LGBTQ+ youth reported that their mental health was poor during the COVID-19 pandemic (The Trevor Project, 2021).

Child and Adolescent Behavioral Health Care Services and Access

Two of the populations with prevalent critical deficits for mental health care who are undiagnosed and undertreated are children and adolescents.

There are approximately 10,500 practicing child and adolescent psychiatrists in the United States and the national average age of practicing child and adolescent psychiatrists is 52 years (AACAP, 2022). Medicaid is the largest insurer of children and the single-largest payer of behavioral health services. Studies have documented that numerous Medicaid-insured children with mental health and behavioral disorders do not receive any psychosocial treatment, including psychotherapy. Medicaid-insured children and adolescents have been overlooked in the current supply of behavioral health services (Harati et al., 2020).

One clear example for the committee that stands out was learned through our webinar for child and adolescent access and ease of obtaining behavioral health care. In Michigan the mother of an early age teen sought care for his disruptive, dangerous mental health issues. After months and many promises for care, he was placed in a juvenile correction locked facility in Montana. The geographic distance alone does not support family involvement, much less rehabilitative opportunities. Thus, this exemplifies the critically poor supply of reasonable treatment for children and adolescents.

This clearly points to the workforce issues of the committee's statement of task. Without increased professionals practicing with these populations, the dire situation will not change. Training for psychiatrists, psychologists, advance practice nurses, and clinical social workers to increase the provider pool specializing in children and adolescents is an important issue for health care leaders to address.

Behavioral health care services for children and adolescents are concentrated in few locations, which also reduces geographic access to services for the Medicaid-insured population. Confounding the access factor is the issue that adolescents may often come for health care with physical symptoms that are the result of their mental turmoil and confidentiality is a huge issue. Many articles cite the load of adolescent cases in a pediatrician's office as being a quarter of the total caseload. For instance, one publication reflects on the various domains whereby this age group requires attention (Trent, 2020).

Studies also suggest that, in general, the treatment rates for mental health disorders among children and adolescents were low, especially for depression and anxiety. Targeted intervention policies and effective measures should be designed and implemented to improve treatment rates of psychiatric disorders among youth (Harati et al., 2020). In one study to support the underserviced children, researchers identified 63,314 providers, practices, or centers in the Medicaid claims data that provided psychosocial services to Medicaid-insured children in either 2012 or 2013. The median provider-level per- year caseload was less than 25 children and more than 250 visits across all provider types. Providers with a mental health

center–related taxonomy accounted for more than 40% of visits for more than 30% of patients. Fewer than 10% of providers and locations accounted for more than 50% of patients and visits (Harati et al., 2020).

Likewise in a meta-analysis of 40 studies including 310,584 children and adolescents, the combined treatment rate was 38% (95% CI, 30%–45%) for any mental disorder, 36% (95% CI, 29%–43%) for depressive disorders, 31% (95% CI, 21%–42%) for anxiety disorders, 58% (95% CI, 42%–73%) for attention-deficit/hyperactivity disorder, and 49% for behavior disorders (95% CI, 35%–64%) (Wang et al., 2023). Age, income level, and region were significantly associated with treatment rates for mental disorders among youth. The data highlights a significant problem for the mental health of children and adolescents and the impact on future generations if remedies are not immediately sought by organizations, agencies, and payers (Wang et al., 2023). More professional providers should be trained and incentivized to offer care in more locations and to accept increased numbers of Medicaid-insured patients of this age group.

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3

The U.S. Behavioral Health Care System

The U.S. behavioral health care system is highly complex, relying on professionals with various training, certifications, and job titles, working across different settings, to deliver care. Financing of behavioral health care is also diverse and fragmented across private and public payers. The public payers—Medicare, Medicaid (including the Children's Health Insurance Program [CHIP]), and the Affordable Care Act (ACA) Marketplace—are the largest payers for these services, together accounting for more than half of all behavioral health spending and nearly three-quarters of substance use disorder (SUD) treatment spending. In this chapter, the committee describes this landscape with particular attention to the workforce, financing, and delivery systems serving beneficiaries enrolled in publicly sponsored coverage or subsidized insurance programs provided by Medicare, Medicaid, and the ACA Marketplace.

THE BEHAVIORAL HEALTH WORKFORCE

The behavioral health workforce includes many different types of clinicians, each with their own unique approach to training and profession norms and identity. Many provide similar sets of services such as therapy and counseling. To deliver that care, the workforce must have some sort of licensing, registration, certification, or credentialing that requires an appropriate level of education and training (Box 3-1). Behavioral health professionals are subject to unique state or territorial licensure requirements, which may include minimum requirements on education and clinical practice hours, exams, and background checks. Health care providers

BOX 3-1
Workforce Standards and Definitions

Licensing is a process that ensures that a practitioner is trained to legally practice in a particular state. Attaining one's licenses to practice typically involves a background check and a rigorous education exam. Although each state holds its own requirements for licensing, those two conditions are standard and are meant to protect the public's safety by mandating that health care professionals maintain a certain amount of knowledge and skill within their specialty (Federation of State Medical Board, n.d.).

Credentialing is a process by which payers and health care institutions assess and verify the qualifications of a licensed health care provider before beginning a formal relationship with that care provider. To receive the accreditation required for payers to conduct business and also for legal liability reasons, a payer must credential all care providers in its network. The credentialing process is normally conducted by the payer or by a third-party organization and involves assessing and verifying the applicant's education, training, registrations, licensing, certifications, and medical practice history, including provider-related disciplinary actions and malpractice allegations (NLM, 2022).

Certifications demonstrate that a behavioral health care professional has acquired skills and knowledge within a particular area of behavioral health from an accredited program, such as correctional behavioral health, mental health rehabilitation, marriage and family therapy, and SUD identification and treatment. Many public, private, and online institutions offer certification courses (Horton, 2019).

are expected to maintain and renew their licenses, which often requires an annual fee, continuing education, and self-reporting disciplinary actions.

Behavioral health care providers in the United States include prescribers, like psychiatrists and psychiatric mental health nurse practitioners (PMHNPs) who primarily oversee medication management, and those who perform therapy and counseling services, including psychologists, social workers, and licensed therapists and counselors.

There are approximately 45,000 psychiatrists and 35,000 PMHNPs in the U.S. who assess, diagnose, and treat mental illnesses and SUDs through a combination of psychotherapy and medications (American Psychiatric Association, 2023; Delany, 2023). All *psychiatrists* complete a 4-year residency program once they graduate from medical school, and they often complete additional specialized fellowship training in sub-specialties such as child and adolescent psychiatry. Every state mandates that practicing

psychiatrists obtain licensure (HRSA, 2017). The behavioral health system is increasingly reliant on *Psychiatric–Mental Health Advanced Practice Nurses* (PMHNPs) to meet growing demand for mental health and substance use services. PMHNPs also diagnose and treat individuals and have the authority to prescribe and manage psycho-active medications for behavioral health conditions (Delaney, 2023). PMHNPs have completed a graduate degree focused on developing competencies in these practice areas and leading to national certification and licensing as care providers by state boards of nursing. Upon receiving their graduate degree, all advanced practice psychiatric nurses and psychiatric nurse practitioners must take a national certification examination (Hanrahan and Staten, 2017). Recent evidence suggests that the number of PMHNPs serving Medicare patients increased 162% during 2011–2019 and provided nearly 1 in 3 mental health prescriber visits to Medicare patients nationally in 2019, offsetting the drop in psychiatrists treating this population (Cai et al., 2022).

Importantly, *primary care clinicians* are also playing a growing role in the delivery of behavioral health services, thanks in part to challenges in accessing specialists and a trend towards integrating behavioral health with physical health care. From 2006 to 2018, the proportion of adult primary care visits that addressed mental health concerns increased by approximately 50% (Rotenstein et al., 2023). Primary care includes family medicine, general internal medicine, or general pediatrics physicians; nurse practitioners; and physician assistants who advise range of health-related issues and may also coordinate care with specialists (CMS, 2024e). Primary care clinicians have become the primary behavioral health care provider for many patients. One study found that approximately 40 percent of office visits for mental health concerns such as depression and anxiety occur in primary care offices and 47 percent of prescriptions for any mental illness are written by primary care physicians (Jetty et al., 2021). *Addiction medicine physicians* are credentialed clinicians that subspecialize in addiction medicine to provide prevention, evaluation, diagnosis, and treatment services for patients with SUD or substance-related health conditions. Physicians who are certified in any primary specialty can become certified in the subspecialty of addiction medicine (NIDA, 2018).[1]

Complementing medication management are therapy and counseling (psychotherapy) services, which are delivered by a wide swath of specialized behavioral health providers. Clinical *psychologists* hold doctoral degrees in psychology and assess, diagnose, and treat mental disorders and learning disabilities, as well as cognitive, behavioral, and emotional problems using a

[1]Addiction medicine physicians were added after release of the prepublication version of the report in order to be more comprehensive in describing the behavioral health workforce.

variety of evidence-based therapeutic approaches.[2,3] *Mental health counselors* are licensed professionals who work with individuals, couples, and groups to deal with anxiety, depression, grief, stress, suicidal impulses, and other mental and emotional health issues. While licensing requirements vary from state to state, mental health counselors generally hold an accredited master's degree in counseling and have 2–3 years of supervised counseling practice. *Social workers* similarly diagnose and treat mental illnesses and SUDs in the form of individual or group counseling, crisis management, case management, client advocacy, and preventive service, either by working directly with clients or by working as part of a health care team. All clinical social workers have a master's degree, are licensed, and meet certain additional requirements. Social workers with a graduate degree are employed in mental health and substance use treatment centers, physicians' offices, clinics, hospitals, and colleges, as well as in private practice, research, planning, or teaching (HRSA, 2017; Lombardi et al., 2017).

There are important subsets of behavioral health professionals that may specialize in certain areas of clinical practice. For example, *marriage and family therapists* may be psychologists or social workers by training but specialize in diagnosing and treating behavioral health conditions in marriage and family relationships. Marriage and family therapists can help individuals, couples, and families address issues such as low self-esteem, stress, substance use, eating disorders, and chronic illness that can lead to marital or family distress. *Addiction counselors* provide treatment and support to people who suffer from addiction to alcohol or other drugs and other behavioral health problems, such as gambling addiction. *School counselors* guide students through academic, emotional, and social challenges, fostering healthy behaviors and essential life skills such as collaboration and perseverance.

Finally, the behavioral health workforce also includes community health workers and behavioral health paraprofessionals who provide unique sets of services, engender community engagement and trust, and support and complement the activities of other behavioral health professionals. *Community health workers* (CHWs) are frontline public health workers who are typically trusted members of the community and have a close understanding of the community served. The CHW serves as a liaison, link, and intermediary between health and social services and the community to facilitate access to

[2]42 CFR §410.71.

[3]A growing number of states have established additional education and training standards—beyond the doctoral degree and other health service psychologist licensure requirements—for prescribing psychologists. Prescribing psychologists complete a master of science degree in clinical psychopharmacology plus supervised clinical training. There are now an estimated 200 prescribing psychologists authorized to prescribe psychotropic medications practicing in the states of Colorado, Idaho, Iowa, Illinois, Louisiana, New Mexico, and Utah and in the Department of Defense, Public Health Service, and Indian Health Service (APA Services, 2024; Curtis et al., 2023).

services and improve the quality and cultural competence of service delivery (APHA, 2023). Licensing and certification vary by state in the U.S., hindering the full integration of roles into healthcare due to the absence of national uniformity. *Peer support specialists* leverage their personal experiences with mental health or substance use disorder to provide empathetic support and practical guidance, acting as advocates and role models to empower individuals in their recovery. Most states require a certification for peer support specialists. *Certified prevention specialists* focus on educating communities, especially at-risk youth, about healthy lifestyles and steering them away from substance abuse. *Psychiatric rehabilitation counselors, psychiatric technicians/aides, and mental health paraprofessionals* work under licensed professionals and connect individuals to resources to help facilitate treatment engagement, and teach coping skills, enhancing support for those in need. With varying certification requirements and duties, these professionals collectively contribute to holistic behavioral health care, addressing diverse needs and extending support amid workforce constraints.

Although the number of people treated for behavioral health conditions has risen each year, the capacity and distribution of behavioral health services in the United States is insufficient to deliver care for all who need it, given the ongoing increase in demand (Reinert et al., 2022). There has been consistent policy attention on the supply side of the behavioral health sector, with focus on reported workforce shortages. While some specific behavioral health professions, such as child and adolescent psychiatrists, are in short supply (Tobin-Tyler et al., 2017, p.1)., the Committee notes that there is general disagreement among experts regarding the extent to which there is an aggregate shortage of behavioral health providers in the U.S., particularly given known geographic maldistribution, low provider participation in insurance programs, and the possibility for complementary and even substitutable care among provider types (Glied and Aguilar, 2023). (See Table 3-1 for professional licensing and credentialing qualifications.) Compounding these workforce concerns is a persistent lack of diversity among behavioral health professionals that is needed to reflect the growing heterogeneity of the U.S. population. While the behavioral health workforce remains disproportionately White (Buche et al., 2017), relative to the general population, research has shown that providers from diverse backgrounds, and language and cultural affinities, are more likely to enhance patient satisfaction, build trust with diverse populations, improve service engagement, strengthens therapeutic alliances, and enhance the effectiveness of care (Liang, 2022; NASEM, 2022). Access to these services will improve through increasing the benefits that racially, ethnically, culturally and linguistically diverse populations derive from behavioral health services (Liang, 2022; Saha et al., 2006; Sullivan Commission on Diversity in the Healthcare Workforce, 2004). It should be noted that the need for increased diversity of the workforce does not diminish the importance of ensuring that providers, regardless of race, ethnicity, or other forms of diversity are striving to be culturally competent.

TABLE 3-1 Professional Licensure and Credentialing Qualifications in Behavioral Health Care

Professional	Licensure, credentialing qualifications	Counts
Marriage and Family Therapists	All states license marriage and family therapists, and licensure generally requires a master's or doctoral degree in marriage and family therapy or a related discipline and 2 years of supervised clinical experience. In addition, licensed marriage and family therapists must pass a state-recognized exam and fulfill annual continuing education requirements (AAMFT, 2023; HRSA, 2017; Wampler et al., 2019).	National Employment estimate: 63, 340 (BLS, 2024)
Addiction counselors	Licensure and certification requirements for addiction counselors vary by state (HRSA, 2017).	Numbers not available
School counselors	School counselors in the U.S. generally require a master's degree in school counseling or a related field, state licensure or certification, including passing an exam and completing supervised hours, and adherence to state-specific requirements like background checks and continuing education (ASCA, 2023).	National average ratio is 385 students to 1 school counselor (ASCA, 2023)

Growing the workforce in the long run is a necessary approach to addressing supply-side challenges in behavioral health, as are additional levers to better utilize the existing behavioral health workforce in the service of care access, quality, and equity. The committee's statement of task is centered on behavioral health provider participation in Medicare, Medicaid, and Marketplace. Thus, we focus on current systems of financing, payment, and delivery for Medicare, Medicaid, and Marketplace enrollees, and set the foundation to identify policy responses to improve behavioral health provider participation in these programs under the existing total supply of providers. Given that the persistent geographic maldistribution of the behavioral health workforce and the lack of diversity disproportionately affect Medicare, Medicaid, and Marketplace beneficiaries, we do consider these issues in scope.

MEDICARE, MEDICAID, AND MARKETPLACE INSURANCE PROGRAMS

As of January 2024, 67 million Americans were enrolled in Medicare, and 84.5 million Americans were enrolled in Medicaid and CHIP (CMS, 2024d; Medicaid.gov, 2024c). In addition, nearly 13 million dual-eligible Americans were enrolled in both Medicare and Medicaid in 2022. As of early 2024, about 21.6 million people had individual health insurance coverage via the Marketplace. While policies during the COVID-19 pandemic led to increases in Medicaid enrollment, there has since been widespread Medicaid

disenrollment, affecting millions. Income fluctuations, administrative obstacles, and shifts in state policies have left approximately 23 percent of those disenrolled currently uninsured (KFF, 2024).

While Medicare, Medicaid, and Marketplace insurance programs provide behavioral health coverage or insurance benefits for children and adults, enrollees struggle to find care providers that accept their insurance. A recent Department of Health and Human Services (HHS) Office of the Inspector General report found that only one-third of the total behavioral health care workforce accepted Medicare or Medicaid enrollees and one-quarter of the counties surveyed had fewer than one active care provider per 1,000 enrollees in traditional Medicare and in Medicaid (OIG, 2024).

Throughout this report, the committee focuses on the role of managed care organizations (MCOs) as they play a major role in Medicare, Medicaid, and Marketplace insurance programs. For the purposes of this report, MCOs are insurance companies that provide managed care plans to Medicare and Medicaid beneficiaries and sell health plans in the Marketplace. We take an inclusive view of managed care plans. They are any type of public or private health coverage that uses a network of contracted care providers to direct enrollees to effective health care services that offer value and affordability. For the purposes of this report, the term includes health maintenance organizations, preferred provider organizations, and exclusive provider organizations.

MEDICARE AND MEDICARE ADVANTAGE

In 2023, Medicare provided health insurance coverage to over 65 million people in the United States, including 57 million older adults and nearly 8 million younger adults with disabilities that qualified for Social Security disability insurance (SSDI) (Worstell, 2024). Traditional Medicare benefits include three parts: hospital insurance (Part A), supplementary medical insurance (Part B), and the outpatient prescription drug benefit (Part D). Medicare Part A covers inpatient hospital care, skilled nursing facility care, hospice care, lab tests, and surgery, while Part B covers physician services and the services of other practitioners, preventive and screening services, outpatient hospital care, care in other outpatient settings, other medical services and supplies, and drugs that people cannot self-administer. Part A and Part B also cover up to 28 hours a week of post-acute home health care if an individual requires part-time or intermittent skilled services and is homebound.[4] Some 31.6 million adults aged 65 years and older are enrolled in Medicare Advantage plans, which cover Part A and Part B; most plans also include Part D

[4]Medicare defines being homebound as having trouble leaving one's home without help, such as using a cane, wheelchair, walker, crutches, special transportation services, or only with help from another person because of an illness or injury; or when leaving home is not recommended because of the individual's condition; or if leaving the home requires a major effort. https://www.medicare.gov/coverage/home-health-services (accessed June 7, 2024).

coverage (MedPAC, 2024). The Medicare Advantage program spends significantly more per average Medicare Advantage enrollee than the average cost of coverage for a similar traditional Medicare enrollee (Fuglesten Biniek et al., 2024). The Medicare Shared Savings program is another Medicare program that promotes accountability for a population of Medicare beneficiaries and improves the coordination of fee-for-service (FFS) items and services. In this program, care providers participating in an accountable care organization (ACO) continue to receive traditional Medicare FFS payments under Parts A and B, and ACOs that meet quality and savings requirements share a percentage of any savings realized with Medicare.

Medicare covers inpatient mental health services under Part A and outpatient mental health services, including evaluation and visits with a mental health care provider, under Part B. Part B covers 80 percent of the cost for outpatient mental health services provided by a psychiatrist or other doctor, clinical psychologist, clinical social workers, clinical nurse specialist, nurse practitioner, or physician assistant (Table 3-2). Starting January 1, 2024, Medicare Part B also began covering mental health services provided by marriage and family therapists, and mental health counselors. Medicare will only cover 190 days of care in a lifetime in a hospital that specializes in treating mental health conditions, with days spent in a general hospital

TABLE 3-2 Medicare Provider Payment Rates for Mental Health and SUD Services

Provider Type	Provider Payment Rate
Psychiatrist	Paid at 100% under Medicare Physician Fee Schedule
Clinical Psychologist	Paid at 100% under Medicare Physician Fee Schedule*
Clinical Social Worker	Paid at 75% of clinical psychologist's Medicare Physician Fee Schedule*
Clinical Nurse Specialist	Paid at 80% of the lesser of actual charge or 85% of amount a physician gets under Medicare Physician Fee Schedule*
Nurse Practitioner	Paid at 80% of the lesser of actual charge or 85% of amount a physician gets under Medicare Physician Fee Schedule*
Physician Assistant	Paid at 80% of the lesser of actual charge or 85% of amount a physician gets under Medicare Physician Fee Schedule*
Marriage and Family Therapist	Paid at 75% of the lesser of actual charge of 80% of amount a psychologist gets under Medicare Physician Fee Schedule* **
Mental Health Counselor	Paid at 75% of the lesser of actual charge of 80% of amount a psychologist gets under Medicare Physician Fee Schedule* **

NOTES: *Paid only on assignment; **Reimbursement does not begin until January 1, 2024.
SUD = substance use disorder.
SOURCE: Freed et al. (2023).

being treated for a mental health condition not counting toward the 190-day limit (CMS, 2023a). Table C-2 in Appendix C provides a list of behavioral health and wellness services covered by Medicare.

A 2022 analysis found that 60 percent of psychiatrists were accepting new Medicare patients, compared with 81 percent of general and family practitioners (Freed et al., 2023). In addition, 7.5 percent of psychiatrists opted out of Medicare in 2022, the highest rate of any medical specialty. Physicians, including psychiatrists, who opt out of participating in Medicare contract directly with their Medicare patients and bill them any amount they determine is appropriate. Because of the high demand for behavioral health services and the limited access to behavioral health care providers, many care providers can choose to only accept patients who pay directly, out of pocket. Behavioral health care providers can charge patients who pay directly more than the amount that Medicare would pay while also avoiding the administrative requirements for billing Medicare. One challenge for individuals enrolled in Medicare Advantage plans is that they often lack access to in-network behavioral health providers and instead must turn to more expensive out-of-network care (Zhu et al., 2023). One analysis found that, on average, only 23 percent of psychiatrists were in-network for Medicare Advantage plans (Jacobson et al., 2017).

In 2021, Medicare Advantage enrollees were more likely to be Black or Hispanic, have incomes below $20,000 per person (Figure 3-1), live in urban areas, and have lower levels of education in contrast with traditional Medicare beneficiaries (Clerveau et al., 2023). As of 2020, approximately 55 percent of Hispanic or Latina/o Medicare enrollees and 54 percent of Black Medicare enrollees choose Medicare Advantage plans.

MEDICAID AND CHIP

Medicaid and CHIP are federal–state programs that cover medical costs for individuals with limited income. Administered by states and territories under federal guidelines, Medicaid is the largest payer for behavioral health services in the United States, with increasing reimbursements for SUD services (CMS, 20222). As of 2019, nearly a quarter of adult Medicaid and CHIP beneficiaries received mental health or SUD services, with almost

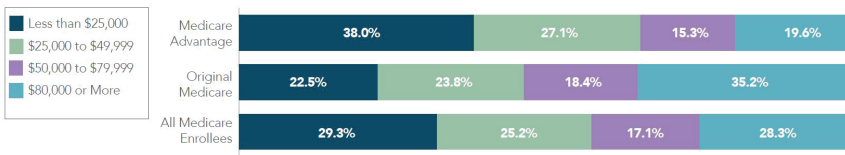

FIGURE 3-1 Income range of Medicare enrollees by coverage type.
SOURCE: AHIP, 2023.

four times as many beneficiaries receiving mental health services as SUD services (CMS, 2022).

The CHIP program extends low-cost health coverage to children in families above Medicaid income thresholds. States can choose to structure a CHIP program as an expansion of Medicaid, a separate program, or a combination, with different federal rules applying. As of January 2024, slightly more than 7 million individuals were enrolled in CHIP, for a total of 37.8 million enrollees under Medicaid and CHIP combined (Medicaid.gov, 2024c).

Medicaid rules ensure that mental health and substance use services are covered equally for those enrolled in Medicaid managed care and those in alternative benefit plans, regardless of how the services are provided. Similar parity standards apply to CHIP coverage. Medicaid excludes certain inpatient services because of its "institutions for medical disease" exclusion, which parity regulations do not address (Pestaina, 2022). To help children and youth receive the appropriate preventive, dental, behavioral health, and developmental health services they need through the Medicaid program, states are required to comply with the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program under the federal EPSDT law.[5] Under the EPSDT program, states are "to provide comprehensive services and furnish all Medicaid coverable, appropriate, and medically necessary services needed to correct and ameliorate health conditions." The EPSDT program helps to pay for behavioral health care services for Medicaid-covered children and youth up to age 21 (Medicaid.gov, 2024b), but remains an underused resource, with half of all eligible Medicaid beneficiaries not receiving services under the EPSDT benefit in 2017.

The Center for Medicaid and CHIP Services has started several Medicaid and CHIP inititives aimed at making mental health and SUD treatment more readily available at nonspecialized health care settings, including primary care, and at nontraditional settings such as schools, jails, and prisons. These initiatives are intended to increase access to treatment in nonspecialized settings with the hope of also addressing health-related social needs and reducing stigma associated with mental health and SUD conditions (CMCS, 2023).

Demographically, Medicaid/CHIP enrollees come from diverse racial and ethnic backgrounds. In 2020, 43043 percent of Medicaid/CHIP enrollees were non-Hispanic White, 28 percent were Hispanic, 21 percent were Black, and 5.55 percent were Asian (Medicaid.gov, 2020). Medicaid/CHIP enrollees are slightly more likely to reside in rural areas than the total U.S. population, with enrollees in rural areas more likely to be non-Hispanic White and non-Hispanic American Indian and Alaska Native than enrollees in non-rural areas. Medicaid/CHIP enrollees with a primary language other than English

[5]49 FR 43666, Oct. 31, 1984.

are more likely to be Hispanic or non-Hispanic Asian/Pacific Islander compared with enrollees whose primary language is English. Disability-based eligibility is significant with most but not all recipients also receiving Supplemental Security Income (Proctor, 2023). While states have been expanding coverage of behavioral health care services under Medicaid, accessibility remains a challenge because of workforce shortages, despite efforts to provide more widespread coverage of services (Guth et al., 2023a).

Medicaid Home and Community-Based Services

Medicaid's Home and Community-Based Services (HCBS) offer nearly 5.2 million Medicaid beneficiaries' opportunities to receive care in their communities instead of in institutions. HCBS caters to various groups such as those with disabilities and mental illness and those who need assistance with daily activities (Watts et al., 2022). HCBS plans, which are optional for states, cover some benefits under Medicaid Section 1915(i) state plan amendments and 1915(c) waivers, with variations in delivery, covered services, and eligibility criteria. States differ in HCBS offerings, with some using 1115 waivers for experimental projects (Medicaid.gov, 2024a). Conversely, disparities exist in eligibility and services across states, with some imposing limits or waiting lists because of care provider shortages, underlining challenges in access despite Medicaid coverage.

DUALLY ELIGIBLE BENEFICIARIES

Individuals enrolled in both Medicare and Medicaid are known as dual eligibles. Medicare is the primary payer for dual-eligible beneficiaries, covering medical services such as professional services provided by a physician, inpatient and outpatient acute care, and post-acute skilled-level care. Dual-eligible beneficiaries are eligible for the same Medicare benefits as other Medicare beneficiaries, but they have lower incomes that make it difficult to afford the Medicare-required premiums and services not covered by the Medicare program (MedPAC, 2022). As of 2022, 87 percent of dual eligibles had an income of less than $20,000, and 40 percent had an income of less than $10,000, compared with 20 percent of all Medicare beneficiaries without Medicaid coverage (MedPAC, 2022). Medicaid supplements Medicare's coverage by providing financial assistance to dually eligible beneficiaries, who receive different levels of Medicaid assistance, depending on household income. Medicaid covers services like case management, nursing home care, and psychosocial rehabilitation services.

About half of all dual eligibles had a mental health issue, compared with 24 percent of Medicare beneficiaries without Medicaid coverage (Figure 3-2) (Nardone et al., 2014; Peña et al., 2023). 40 percent of

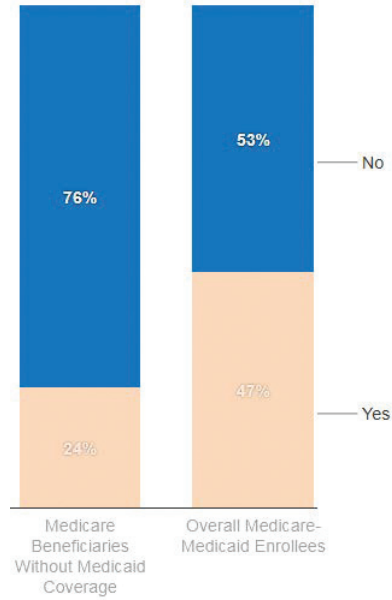

FIGURE 3-2 Share of Medicare beneficiaries with mental health conditions by Medicaid coverage status, 2020.
SOURCE: Peña et al., 2023.

partial-benefit dual-eligible enrollees had a mental health condition. Dually eligible beneficiaries receive a diagnosis of having a serious mental illness three times more often than Medicare beneficiaries who are not dually eligible (CBO, 2013).

MARKETPLACE PLANS

ACA Health Insurance Marketplaces are run by the federal government in 32 states, with 18 states and the District of Columbia running their own Marketplaces. The Marketplace enables consumers to shop for coverage if they need to buy health insurance on their own. Income-based premiums and cost-sharing subsidies are available through the Marketplace to make coverage affordable for individuals and families (CMS, 2024c).

As of January 2024, 21.3 million people enrolled in Marketplace plans, including 5 million who were first-time enrollees (CMS, 2024a,c). All Marketplace plans must cover behavioral health treatment, including mental health and SUD inpatient and outpatient treatment, as one of 10 essential health benefits that all Marketplace plans must include. However, the behavioral health services included in Marketplace plans benefits

vary across states. States select a state-specific "benchmark plan," such as the state's largest small group market plan. Marketplace plans must then provide benefits that are substantially equal to the benefits the benchmark plan offers, often aligning those benefits with the state's small group commercially insured health plan with the largest enrollment. This requirement does not extend to large employer plans under the ACA's essential health benefits mandate. Self-insured private employer plans, commonly offered by large and some small employers, are not obligated to cover behavioral health services as they can be exempt from these state mandates and the ACA's essential health benefit requirements. Parity protections only come into effect if these plans offer behavioral health coverage.

The Mental Health Parity and Addiction Equity Act

In 2008, Congress passed the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)[6,7] to make it easier for people to obtain treatment for mental health and SUDs by requiring health plans that cover these conditions to do so on par with other health needs (MACPAC, 2021; CMS, 2023b). MHPAEA helps ensure most plans include preventive behavioral health services such as depression screening and behavioral assessments for children. The law prohibits health plans from charging higher copayments, separate deductibles, or from imposing more restrictive requirements on care management functions such as preauthorization or medical necessity reviews for these services than they do for covered medical-surgical services.

As originally crafted, the Act only applied to group health plans and group health insurance coverage and Medicaid managed care. However, the ACA made mental health and SUD coverage essential benefits and extended application of these parity provisions to the individual health insurance market, commercially insured small employer group market, and CHIP, though not to Medicare, Medicare Advantage Plans, or traditional FFS Medicaid.

PAYMENT MODELS FOR BEHAVIORAL HEALTH SERVICES

There are three approaches that Medicare, Medicaid, and Marketplace plans use to pay for behavioral health services: FFS, capitated payment, and

[6]81 FR 18390.

[7]This report shares observations on MHPAEA at the point in time of final committee review and approval. By the publication date, some observations may already be out of date given regulatory agency and health management changes.

value-based payment (VBP). FFS,[8] the traditional model of health care reimbursement, is the most common. FFS payments reward care providers for doing more and tend to be very restrictive with respect to the definitions of services that a FFS plan will cover. This can limit the ability of care providers to tailor care to individual needs. Most payments to health plans are based on a fixed amount per person (capitated), but some plans pay doctors and hospitals based on the services they provide (fee-for-service). Different payment programs, such as Accountable Care Organizations (ACOs), focus on improving care at the plan level, while others like the Merit-based Incentive Payment System (MIPS) aim to improve care by rewarding individual providers.

Capitated payment is a population-based payment in which payers often make a risk-adjusted, prospective payment for each enrolled person to a health plan regardless of the costs actually incurred. For Medicare Advantage plans, that amount is frequently risk-adjusted to account for the health status and complexity of the population of patients insured; plans are paid more for enrolling sicker people. In a capitated payment system, the entity receiving the fixed monthly payment bears the risk of spending more than it receives and realizes any savings that result from spending less than the fixed amount. Many state Medicaid agencies also operate a capitation system in which the state pays MCOs a fixed, monthly amount per enrollee.

VBP programs reward health care providers for both achieving savings and for the quality of care they provide to Medicare beneficiaries rather than the quantity of services they provide. Through financial incentives and other methods, value-based care programs aim to hold health plans and care providers more accountable for the quality of care, along with spending, while also giving them greater flexibility to deliver the right care at the right time. An example of a VBP is the voluntary Medicare Shared Savings program. This program allows care providers to form ACOs that can share in savings from efficient management of care if they reach quality-of-care thresholds. One of CMS's attempts to develop a value-based approach began in 2024 with the Innovation in Behavioral Health (IBH) model. With this approach, care can be more targeted to Medicaid and Medicare beneficiaries dealing with moderate to severe mental health conditions and SUD by providing those individuals with better access to treatment programs and safety net providers (CMS, 2024b). One goal of the IBH model is to mitigate frequent emergency department visits and hospitalizations by offering outpatient mental health and SUD services to more vulnerable populations, since emergency department visit rates for adults with mental health disorders reached 52.9 per 1,000 people from 2017 to 2019 (Santo et al., 2021).

[8]FFS is a system of health insurance payment in which a doctor or other health care provider is paid a fee for each service rendered, essentially rewarding medical providers for the volume and quantity of services provided, regardless of the outcome. Traditional Medicare is an example of the FFS model. See https://www.health care.gov/glossary/fee-for-service/ (accessed May 2, 2024).

Medicaid Managed Care

Historically, Medicaid paid for services, including those for behavioral health conditions, on a FFS basis; Medicaid then paid providers for each distinct billable service they delivered. Over the past several decades, however, Medicaid payment has shifted to managed care arrangements, through which state Medicaid programs pay health plans based on capitation. Health plans in turn contract with care providers for services provided to Medicaid recipients (Figure 3-3).

In 2022, the majority of Medicaid beneficiaries (74%) received care through comprehensive, risk-based MCOs (Hinton and Raphael, 2023a,b; KFF, 2021). Behavioral health services are mostly provided through managed care arrangements, and though some states "carve out" behavioral health services from their MCO contracts, there is evidence that more states are moving to integrate, or "carve in," behavioral and physical health care (Hinton and Raphael, 2023a). However, some states carve out coverage for serious mental illnesses specifically. As of 2023, behavioral health managed care companies administered 42 state

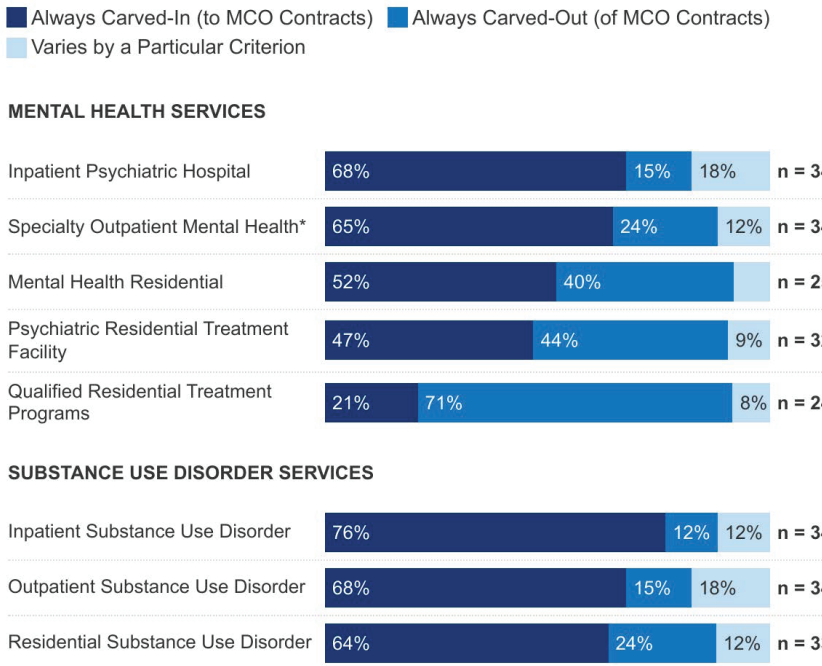

FIGURE 3-3 MCO coverage of behavioral health services as of July 2022.
NOTE: MCO = managed care organization.
SOURCE: Guth et al., 2023b.

Medicaid programs (Kaye and Wilkniss, 2023). While the majority of Medicaid-reimbursed services are FFS, several states have implemented alternative payment models for specific services, such as case management, or for high-risk populations, such as individuals with schizophrenia (Gifford et al., 2019).

SETTINGS FOR DELIVERING BEHAVIORAL HEALTH CARE

The behavioral health workforce functions in a wide range of prevention, health care, and social service settings. These settings include prevention programs, community-based programs, inpatient treatment programs, primary care health delivery systems, private practitioners' offices, emergency rooms, criminal justice systems, schools, or higher education institutions (Figure 3-4). Estimates place the number of U.S. behavioral health treatment facilities at over 12,000 (SAMHSA, 2020). In addition, there are designated rural health centers (RHCs), Indian Health Service clinics, and Tribal health centers that offer behavioral health services in their respective communities (Box 3-2).

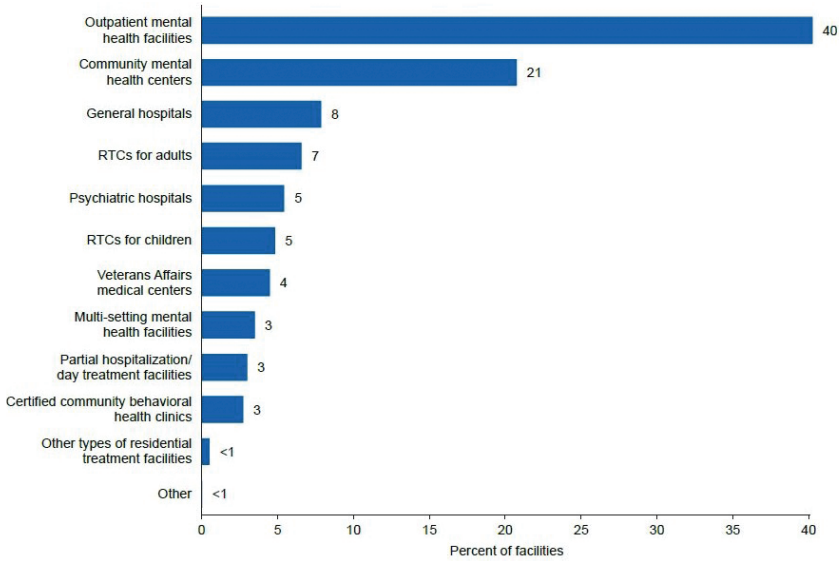

FIGURE 3-4 Number of U.S behavioral health facilities by facility type, 2020.
NOTE: CMHC = community mental health center; RTC = residential treatment center; VAMC = Veterans Affairs Medical Center. General hospitals include only non-federal general hospitals with separate psychiatric units.
SOURCE: SAMHSA, 2020.

BOX 3-2
A Note on Rural Health Centers, Indian Health Services, and Tribal Health Clinics

RHCs, created by the Rural Health Services Act of 1977, are designated health care facilities that provide team-based primary care services in rural communities. While there are over 5,300 U.S. RHCs, CMS certification does not require RHCs to provide behavioral health services or have behavioral health professionals on staff, and as a result, behavioral health care has constituted a small proportion of their services (Gale, 2022). However, CMS recently changed its Medicare reimbursement policies to include services provided at RHCs by marriage and family therapists and mental health counselors in addition to clinical psychologists and clinical social workers (CMS Medicare Learning Network, 2024). Between 2013 and 2019, RHCs increased behavioral health staffing in response to Medicaid expansion (Han and Ku, 2019).

The Indian Health Service (IHS), an agency within HHS, is responsible for providing federal health services to American Indians and Alaska Natives. IHS delivers health care to approximately 2.2 million American Indians and Alaska Natives. IHS operates a Division of Behavioral Health and administers a variety of behavioral health programs (CMS, 2024g). In addition, over the past decade, tribes have increasingly contracted or compacted via the Indian Self-Determination and Education Assistance Act to provide these services. Currently, more than 50 percent of the mental health programs and over 90 percent of the alcohol and substance abuse programs are tribally operated. As a result, there is now a less centralized and more diverse network of care provided by federal, Tribal, and urban Indian health programs (IHS, 2023).

Community-Based Settings

Community-based behavioral health care is delivered in a number of settings, many of which are described below. Community-based care addresses population needs in ways that are accessible and acceptable to members of the community; builds on the goals and strengths of people who experience mental illnesses; promotes a network of supports, services, and resources; emphasizes evidence-based, recovery-oriented services; and uses peer expertise in service design and delivery (Keet et al., 2019; Thornicroft et al., 2011). For example, Medicaid launched a new program in 2021 to support community-based mobile crisis intervention services. These services, staffed by both behavioral health professionals and paraprofessionals,

meet people experiencing mental health or substance use crises where they are and connect them to a behavioral health specialist 24 hours per day, 365 days a year (CMS, 2021). This new option gives states the flexibility to design programs that work for their communities.

A considerable portion of individuals with Medicaid or Medicare coverage seek care in community health settings, which have become integral components of the nation's health safety net system. For the purposes of this report, the following overview will focus on community mental health centers (CMHCs), federally qualified centers (FQHCs), certified community behavioral health clinics (CCBHCs), and school-based health centers (SBHCs) as examples of the community-based settings in which people can receive behavioral health care. Though the federal government supports a variety of different approaches to providing community-based care, some states are also funding experiments in this area. Box 3-3 provides an example of a state-organized demonstration project.

BOX 3-3
An Example of Promising State Practices in Behavioral Health

In addition to federal initiatives, states also have a critical role in systems transformation with equitable access to high-quality behavioral health services and supports, including public and commercial payers. The Mental Health Resource Guide for State Policy Makers addresses challenges and solutions in mental health policy; the guide was the result of collaboration between The Commonwealth Fund and the Council on State Governments. One example is the Massachusetts Roadmap for Behavioral Health Reform, the result of a multi-year blueprint informed by the input of more than 700 stakeholders. Along with state legislation addressing barriers to behavioral health care, the roadmap set a vision for access and invested in a "no wrong door" approach. Using a combination of federal and state funds, the Massachusetts Roadmap has five major pillars:

1. Improved structural support through administrative simplification and targeted workforce development;
2. Increased access through a unified behavioral health help line;
3. Integrated primary care;
4. Improved patient experience with crisis, urgent, and acute care; and
5. Designated community behavioral health centers.

BOX 3-3 Continued

Since the roadmap became operational in January 2023, there has been a 59 percent reduction in behavioral health hospital emergency department boarding for Medicaid recipients in Massachusetts, while 40,000 individuals have made 357,000 outpatient visits and there have been 19,000 urgent crisis care evaluations.

SOURCE: Galbreath et al., 2024.

Community Mental Health Centers

CMHCs are mostly nonprofit, community-based programs that offer a variety of services to support mental health. CMHCs primarily offer outpatient behavioral health services, though some CMHCs also offer inpatient psychiatric hospitalization, residential care, and crisis stabilization. The centers treat both children and adults, including individuals who are severely and persistently mentally ill or have been discharged from an inpatient mental health facility. The specific clinical services that CMHCs offer include diagnostic evaluation, screening and triage, crisis intervention, individual and group psychotherapy, psychiatric medication management, partial hospitalization or day treatment, psychosocial rehabilitation, SUD treatment, and case management. Additional services include vocational rehabilitation, training and education, and collaboration with schools, social service agencies, law enforcement, and community-based organizations.

CMHCs originated with the Community Mental Health Act of 1963.[9] Community mental health was envisioned to be an inclusive, multidisciplinary, systemic approach to providing publicly funded behavioral health services to everyone living in a given geographical locale and without consideration of ability to pay (Beck, 2008). Before the act's passage, individuals with mental illness in the United States were frequently institutionalized for their lifetime, and the quality of the treatment they received varied significantly. The act called for establishing and funding a network of behavioral health centers meant to provide care within one's community, as opposed to in an institution. The Community Mental Health Act helped to facilitate the closure of many state-run mental hospitals, as patients were transferred to community-based care. The policy initiative transformed the landscape of behavioral health treatment in the 20th century and laid

[9] Community Mental Health Act of 1963, Public Law 88-16, 77 Stat. 282.

the groundwork for all of the country's CMHCs, of which there were 2,548 as of 2020 (SAMHSA, 2020).

Medicaid and state mental health agencies using federal grants and state revenue funding are the primary payers for services within CMHCs, with a small proportion of a CMHCs funding coming from private commercial insurance, sliding scale fee payment for uninsured individuals, and donations. Depending on the services and populations covered in a state's Medicaid program, a sizable percentage of the revenue at a CMHC may be from Medicaid reimbursements. Medicare participation is minimal unless individuals are dually enrolled in Medicaid and Medicare.

The Substance Abuse and Mental Health Services Administration (SAMHSA) is the main federal agency responsible for administering federal grants funding community behavioral health services via two block grant programs: the Community Mental Health Services Block Grant and the Substance Use Prevention, Treatment, and Recovery Services Block Grant. SAMHSA distributes funds to each state to support a state behavioral health system. State mental health agencies distribute these grant funds, often along with other state and federal funds, through grants or contracts with CMHCs or local government entities. The architecture of CMHC government funding, therefore, varies significantly by county and state based on the state Medicaid program and on state programs for behavioral health services and public health. A county may contract with a CMHC to provide school-based behavioral health services, for example, and a state mental health agency may fund behavioral health programs for specific populations, such as those who are unhoused or under/uninsured, through these grants and contracts.

Federally Qualified Health Centers

FQHCs are nonprofit primary care organizations that provide accessible, comprehensive care, particularly to under-resourced populations such as people experiencing homelessness, people who work in agriculture, and veterans. They are typically in areas characterized by economic, geographic, or cultural barriers that limit access to affordable health care. In 2021, FQHCs provided care for 18 percent of all Medicaid beneficiaries, while accounting for only 2.1 percent of Medicaid spending, and also provided care for 22 percent of all uninsured individuals (NACHC, 2023b). FQHCs offer many services, including preventive care, chronic condition management, and mental health support, and often provide enabling services such as case management and legal aid.

Governed by community-led boards and overseen by the Bureau of Primary Health Care within the Health Resources and Services Administration (HRSA), FQHCs play a crucial role in the health care safety net, serving millions of individuals across diverse communities. FQHCs have expanded

behavioral health services over the years, integrating them into primary care to enhance accessibility and coordination. Together, these sites serve approximately 1 in 11 people in every U.S. state, the District of Columbia, Puerto Rico, the Virgin Islands, and the Pacific Basin. In 2022, these sites employed over 285,000 staff, including 18,800 behavioral health specialists, and provided care for 3 million individuals with behavioral health issues (NACHC, 2023a).

Today, virtually all FQHCs provide behavioral health services either directly or through referral, in large part as a result of significant investments by HRSA to increase access to mental health and SUD services. In fact, the capacity of FQHCs to provide behavioral health services increased from over 5,000 behavioral health specialists in 2010 to almost 18,800 in 2021. FQHCs employ a variety of licensed behavioral health care providers, including clinical social workers, psychiatrists, psychologists, advanced practice registered nurses and nurse practitioners, professional counselors, marriage and family therapists, and other professionals, who collectively constitute an average 11.7 percent of the health care team at FQHCs nationally (NACHC, 2023b).

Although the growth and integration of behavioral health professionals at FQHCs is a vital part of improving the behavioral health landscape, it addresses only a fraction of the overall care needed. Research has shown that people with mental illnesses are at higher risk for deaths from physical ailments, pointing to the importance of whole person care (Momen et al., 2022; Prior et al., 1996; Tan et al., 2021). Studies have also shown this integrated approach improves access and treatment for children of color (Sheldrick et al., 2022).

While Medicaid is a major source of funding, FQHCs also rely on Medicare, commercial insurance, and other grants to sustain their operations, with payment structures such as the Prospective Payment System (PPS) supporting their services or other approved alternative payment models (MACPAC, 2017). PPS is a method of reimbursement in which the Medicaid and Medicare payment is made according to a predetermined, fixed amount based on a per visit rate predicated on the cost of services. The payment rate is typically higher than the usual and customary reimbursement and is designed to cover a broader, more flexible range of clinical services. While these rates are updated annually to reflect inflation and the costs of new services, the payment amounts have fallen behind the cost of providing care (NACHC, 2023b).

Certified Community Behavioral Health Clinics

CMHCs evolved from federally mandated guidelines to services provided by state mental health agencies that are supported by ongoing federal financial aid such as SAMHSA block grants for community mental health

and substance abuse services.[10] The Protecting Access to Medicare Act of 2014[11] sanctioned establishing CCBHCs as a pilot initiative to reform the conventional model of behavioral health service delivery and payment within CMHCs.

CCBHCs are required to provide a range of services, including crisis services that are available 24 hours a day, 7 days a week. Today, there are more than 500 CCBHCs in 46 states, the District of Columbia, Guam, and Puerto Rico, serving about 2.1 million people (National Council for Mental Wellbeing, 2022). CCBHCs are usually CMHCs and show significant outcomes, including reductions in hospitalizations, homelessness, and jail time, with extensive service provision to children and youth, often within the school setting. The centers emphasize collaboration with law enforcement, offer re-entry support, and provide medication-assisted therapy (MAT) for SUD. In 2022, 82 percent of CCBHCs offered at least one type of MAT, compared with 56 percent of behavioral health clinics nationwide (National Council for Mental Wellbeing, 2022). CCBHCs have required collaboration with law enforcement agencies and other partners to improve outcomes for people involved with or are at risk of involvement with the criminal justice system (SAMHSA, 2019). In addition, 65 percent of CCBHCs train law enforcement officers in Mental Health First Aid and other awareness training and 64 percent provide re-entry support to individuals return to the community from incarceration (National Council for Mental Wellbeing, 2022).

One difference between a CMHC and a CCBHC is how they are reimbursed for services rendered. A CMHC bills for and is reimbursed for each service the center provides, while a CCBHC is usually funded through a per-person per-month model that includes administrative costs (Moore and Stangler, 2022). Both SAMHSA and Medicaid have programs to support CCBHCs, though CCBHCs developed under SAMHSA and those created through Medicaid have different funding mechanisms. Medicaid funds demonstrations authorized by Section 223, Demonstration Program to Improve Community Mental Health Services, and participating states receive enhanced reimbursements to support their CCBHCs. States awarded SAMHSA-administered CCBHC expansion grants receive $2 million annually, paid directly to clinics. States receiving Medicaid demonstration funds may not apply for SAMHSA grants (National Council for Mental Wellbeing, 2022). States can also fund CCBHCs independent of these two mechanisms.

[10]Public Law 102-321; ADAMHA Reorganization Act; Sections 201 for mental health and Section 202 for substance abuse; July 10, 1992.

[11]Public Law No: 113-93; H.R.4302 - Protecting Access to Medicare Act of 2014.

School-Based Health Centers

SBHCs provide primary care, behavioral care, and other services in or near schools, reducing scheduling and transportation barriers for students. SBHCs are often in communities with higher rates of free or reduced lunches. According to the School-Based Health Alliance, "SBHCs operate through partnerships between health care organizations, school communities, community-based organizations, families, and youth. This collaboration, care coordination, and youth engagement improves student, school staff, and community health literacy and outcomes and contributes to positive educational results, including reduced absenteeism, decreased disciplinary actions, and improved graduation rates" (Soleimanpour et al., 2023, p. 1). SBHCs offer a variety of services to students including social/emotional well-being counseling, crisis intervention, classroom behavior/learning support, individual counseling, peer mediation/peer group counseling, mental health screenings (e.g., depression, anxiety, attention deficit hyperactivity disorder, trauma), case management, evaluation of need for individualized learning plans, prescribing and managing mental health medications, sexual assault counseling (Foney and Buche, 2018). Approximately 80 percent of schools served by SBHCs are Title 1 schools that receive federal funding to support high percentages of children from families with low incomes, and some 70 percent of students in schools with access to SBHCs are Black, Indigenous, and other people of color. In a 2022 national survey of SBHCs, 75% reported serving populations besides students, compared to 62% in 2017. Of those serving other populations, almost 60 percent of SBHCs reported serving school staff, 47 percent serve students' family members, and 33 percent serve other community members (Figure 3-5) (Soleimanpour et al., 2023).

Approximately 83 percent of SBHCs offer behavioral health services (Keeton et al., 2012; Soleimanpour et al., 2023). A review of the evidence on SBHCs suggests that they might be well suited to address youth gun violence, adverse childhood experiences, and the health of American Indian and Native American communities (Arenson et al., 2019). In addition to health care, SBHCs provide support that addresses the social determinants of health (Figure 3-6). Most SBHCs screen clients for health and social needs, including 31 percent that screen for adverse childhood experiences or trauma and 30 percent that screen for social determinants of health (Soleimanpour et al., 2023).

Academic Medical Center/Teaching Hospital/Regional Health System

Academic medical centers (AMCs) and teaching hospitals provide behavioral health services on both an outpatient and inpatient basis. They also

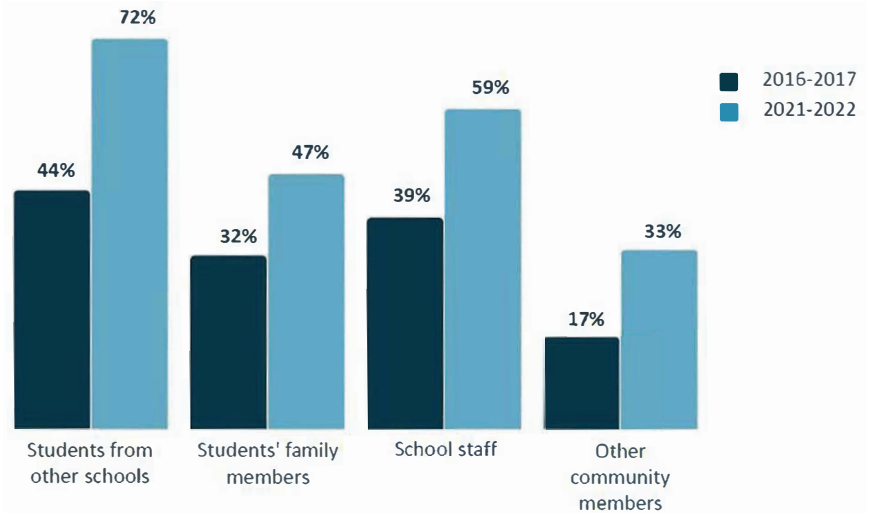

FIGURE 3-5 Populations served by SBHCs.
NOTE: SBHCs = School-Based Health Centers.
SOURCE: Soleimanpour et al., 2023.

serve as the primary training grounds for the behavioral health care workforce. AMCs and teaching hospitals represent a minority of hospital systems, with AMCs accounting for approximately 6 percent of U.S. hospitals (Burke et al., 2023) and teaching hospitals accounting for approximately 55 percent of U.S. hospitals (Fisher, 2019).

Though not specific to behavioral health, data from the American Association for Medical Colleges indicate that Medicare payments represent over 30 percent of the net patient revenue mix for AMCs and teaching hospitals, with Medicaid payments accounting for another 17 to 18 percent (AAMC, 2023). Several studies have found that teaching status is associated with better clinical outcomes in the hospital setting for Medicare beneficiaries and that a larger number of AMCs in an area may be associated with better clinical outcomes in neighboring non-academic hospitals (Burke et al., 2023).

Inpatient and Residential Settings

Receiving behavioral health care in a specialized psychiatric hospital or psychiatric unit in a general hospital is typically reserved for individuals in the acute phase of a serious mental illness. Psychiatric hospitals treat mental illnesses exclusively, although physicians are available to address medical conditions. A few psychiatric hospitals provide drug and alcohol

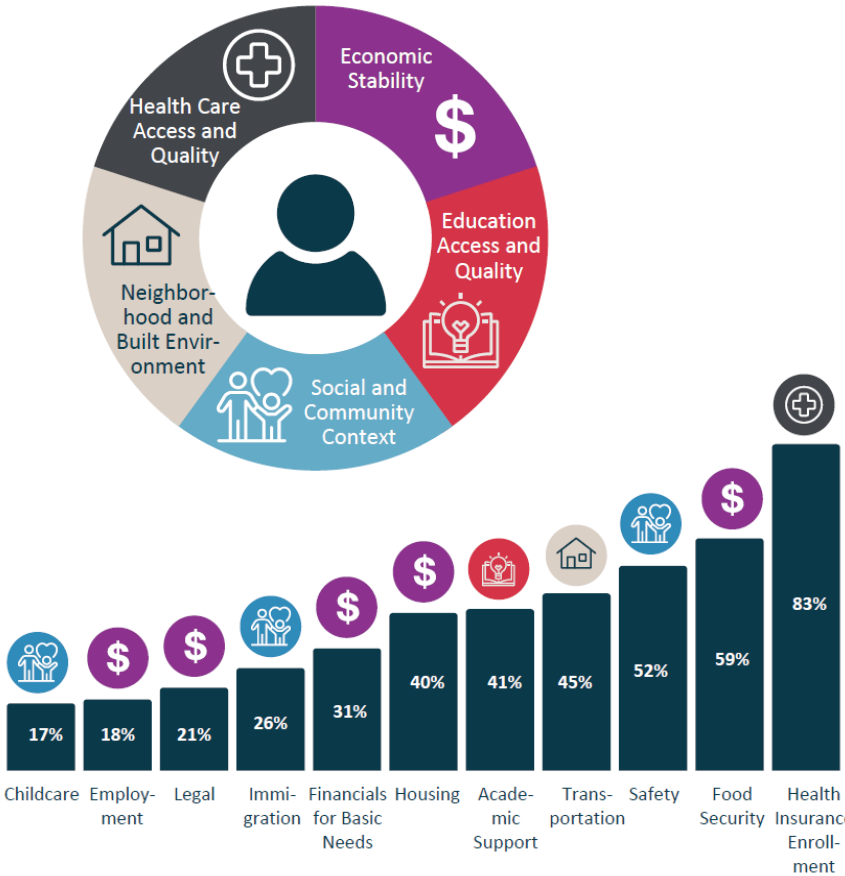

FIGURE 3-6 Supports provided to clients and their families to obtain services to address social determinants of health.
SOURCE: Soleimanpour et al., 2023.

detoxification as well as inpatient drug and alcohol rehabilitation services and provide longer stays. A psychiatric hospital might have specialty units for eating disorders, geriatric concerns, child and adolescent services, and substance abuse services. Some experts in the field believe the nation needs more inpatient psychiatric beds (McBain et al., 2022; Mundt et al., 2022), given the growing practice of holding psychiatric patients in crisis in emergency departments because of a lack of beds to admit them (Alakeson et al., 2010; Nordstrom et al., 2019). There are also arguments that the United States has not built the continuum of services that would allow individuals to be treated in the community to prevent the need for acute

inpatient care, provide crisis stabilization, or enable more rapid return to community with proper services and supports so that beds turn over more rapidly (American Psychiatric Association, 2022).

Residential mental health treatment environments generally provide longer-term care for individuals. Most residential treatment settings provide medical care but are designed to be more comfortable and less like a hospital ward than inpatient hospitals. Psychiatric residential centers for adults are tailored for people with a chronic psychiatric disorder that impairs their ability to function independently, such as schizophrenia or bipolar disorder, or who have a dual diagnosis, such as a mental health disorder and SUD. Alcohol and drug rehabilitation facilities are inpatient centers that treat addictions and may provide detoxification services. Patients typically reside in this type of facility for 30 days but stays may be individualized according to each facility's policy.

Wraparound services are best suited to providing care for youth with a serious mental illness. However, a young person may require residential treatment when available community-based alternatives have been unsuccessful at addressing the person's needs, when the complexity of their needs confounds community-based care and requires a 24-hour environment to accurately understand those needs and adequately respond, or when the severity of the behavioral problems requires a 24-hour treatment environment to keep the person safe and prepare them to be responsive to community-based care (MHA, 2015). Residential facilities for youth cover a wide spectrum of needs and can serve as a good alternative to jail or a locked mental health treatment facility. Research has shown, though, that short-term residential treatment with a link to family-based aftercare is more effective than long-term residential treatment for youth (James, 2011; Preyde et al., 2011).

General hospital psychiatric units also provide acute inpatient services to patients with a mental health disorder. In 2019 there were 1,053 hospitals in the U.S. that had specialty psychiatric units, though access to these services is not universal across the United States, and, particularly in rural areas (NASMHPD, 2022).

Medicaid does not reimburse states for the cost of treatment in "institutions for mental diseases" except for people aged 21 or younger and individuals aged 65 or older (Medicaid.gov, n.d.). This exclusion has been a Medicaid policy since its inception, and it was meant to ensure that the responsibility to fund inpatient psychiatric services remained with the states and to encourage the development of community-based care. In turn, that means limited federal funds are available for inpatient behavioral health care (CRS, 2023). Medicaid expects that individuals are transitioned to community services or non-Medicaid inpatient services no later than age 22. For Medicare recipients, Part A covers inpatient mental

health care services, while Medicare Part B covers services provided in an inpatient setting. However, if an inpatient stay extends beyond 150 days, the Medicare-covered individual is responsible for 100 percent of the cost (Medicare.gov, n.d.).

Private Office-Based Practice

Behavioral health professionals working in a private practice provide individual, family, and group therapy as well as psychopharmacology. With regular meetings, a behavioral health care provider can provide a person with a better understanding of relationships, feelings, behaviors, and how to manage symptoms and reduce the risk of relapse. Many behavioral health professionals working in private practice do not accept insurance. Data from 2021 found that the national average out-of-pocket cost for a 60-minute, self-pay psychotherapy visit was $176.46, with the lowest per-visit cost being $93.92 and the highest $286.89 (Davenport et al., 2023). In comparison, the national average out-of-pocket cost for a commercial, in-network 60-minute visit was $22.71, with a range of $0.98 to $45.50, and for an out-of-network visit was $52.87, with a range of $24.08 to $97.84. The national average out-of-pocket cost for a 60-minute visit for a Medicare FFS beneficiary was $29.12, with a range of $25.61 to $37.33, and for a Medicare Advantage beneficiary was $13.83, with a range of $5.92 to $29.92 (Davenport et al., 2023).

The literature makes it clear that there is a dearth of behavioral health care providers participating in public insurance programs. There are not enough care providers, especially care providers of color, trained to meet the special behavioral health needs of the publicly insured populations, and of those available, many are not willing to provide services through Medicare, Medicaid, and the ACA Marketplace. One group analyzed data from the National Ambulatory Medical Care Survey, a nationally representative survey administered by the Centers for Disease Control and Prevention's National Center for Health Statistics to determine the rates of acceptance by psychiatrists of private non-capitated insurance, Medicare, and Medicaid compared with other specialties (Bishop et al., 2014). In addition, the investigators compared the characteristics of psychiatrists who accepted insurance and those who did not. The study found that only 55 percent of psychiatrists accepted private insurance as compared with 89 percent of physicians in other specialties in 2009–2010. The disparity was similar for Medicare and Medicaid (Bishop et al., 2014).

The resulting report cited low reimbursement as a primary reason for not accepting insurance. While reimbursement rates are generally based on procedure codes rather than specialty, disparities exist across different types of providers. The acceptance rates for all types of insurance were

significantly lower for psychiatrists than for physicians in other specialties, thus contributing to a shortage of psychiatrists in the system. For similar behavioral health services, nonpsychiatric medical doctors received 13–20 percent higher in-network reimbursement than psychiatrists. On the other hand, for services provided out-of-network, the median reimbursement was 6–28 percent higher for psychiatrists than for nonpsychiatric physicians (Mark et al., 2018). Other workforce titles such as social workers, clinical psychologists, marriage and family therapists, and advanced practice psychiatric nurses operate within office-based settings. Tracking estimates for some of these titles can be difficult if they are self-employed or if, in a social worker's case, tracking does not distinguish among their possible types of specialized work, e.g., mental health, medical, or school social work (Heisler, 2018).

Retail Mental Health Care

Since 2000, retailers have moved into the physical health care space by opening health care clinics that provide basic services inside their stores. Today, many of the same retailers are adding behavioral health care to the menu of services that their in-store clinics offer, while others are opening stand-alone, walk-in clinics similar to stand-alone urgent care operations (Gliadkovskaya, 2023). One company, for example, has developed a business model featuring 24/7 walk-in access to behavioral health care to address unmet needs and provide urgent behavioral health care. With a $20 million private equity investment, MIND 24-7 has opened three stand-alone urgent care locations for behavioral health services that include express care, crisis services, 23-hour observation, intensive outpatient care, and a program it calls Progressions. The Progressions program provides transitional behavioral health care before patients are placed in a specialized care setting or referred to other community or medical partners (Larson, 2022).

CVS Health has expanded their retail clinic services to include behavioral health care, with CVS Health specifically incorporating behavioral health counseling services into its MinuteClinic offerings. However, as of 2024, trends are beginning to show a retreat from the retail model among some national chains providing both in-person and remote health services (Cavale and Vanaik, 2024).

Telehealth

Telehealth refers to a broad scope of remote health care and public health services, including clinical services, remote monitoring, consultation, and other services (HHS, 2024), while telemedicine is specific to the

provision of direct clinical services. Telehealth was originally developed to provide basic health care to rural and underserved patients (Gajarawala and Pelkowski, 2021), but today there are several behavioral telehealth delivery models possible that target broad populations (Warren and Smalley, 2020). A hub-and-spoke model uses a centralized hub that provides on-site services connected to satellite locations—the spokes—via telehealth. In this model, which is often used by hospital systems with a network of clinics, patients need to travel to their local clinic to connect with a remote care provider (Warren and Smalley, 2020).

In the integrated care model, primary care offices contract with a behavioral health care provider to connect with the primary care practice's patients via telehealth. The patient attends the telehealth appointment at the primary care practice's office. In direct-to-consumer models, the patient can consult virtually with a behavioral health care provider from his or her home and need not travel to a remote site. To engage in at-home telehealth, the patient needs the appropriate technology, such as a smartphone or tablet and an internet connection.

Synchronous telehealth occurs in real-time settings, where the patient interacts with the care provider via phone or video. Asynchronous telehealth involves transmitting messages, text, images, or other materials that are sent and received at different times. Mobile health applications and remote monitoring programs can support longer-term interventions or the management of behavioral health programs by tracking medication adherence, for example, monitoring symptoms, and providing patients with advice on self-managing their care (RHIhub, 2023).

Multiple studies support the use of telehealth as feasible, acceptable, and effective for providing behavioral health treatment across the lifespan and for a range of disorders (Bashshur et al., 2016; Gajarawala and Pelkowski, 2021). One study found that telepsychiatry in RHCs was effective for individuals screening positive for bipolar disorder or post-traumatic stress disorder (Fortney et al., 2021). Another study of Medicare enrollees with schizophrenia or bipolar disorder found that greater tele-mental health use was associated with more mental health visits, but not with changes in medication adherence, hospital and emergency department use, or mortality (Wilcock et al., 2023).

Existing evidence, while mixed, suggests that telehealth may help increase access, engagement, and longitudinal care. Telehealth, especially asynchronous telehealth, may also help address the shortage of behavioral health care workers. Studies have demonstrated high degrees of clinician satisfaction with telehealth, with the potential to improve longer-term work satisfaction, work–life balance, and burnout among health care professionals if implemented to improve flexibility, increase care provider capacity, and reduce redundancies (Hoff and Lee, 2022).

Telehealth can be valuable for delivering care to rural settings (RHIhub, 2023). Two examples of rural telehealth programs are:

- Alaska Veterans Telehealth and Biofeedback Services uses biofeedback techniques to help veterans address symptoms of trauma, including stress, sleeping issues, and chronic pain. Veterans measured biofeedback responses with a smartphone application, and trained counselors reviewed progress and provided trauma-informed therapy via telehealth technology.[12]
- Greater Oregon Behavioral Health's Direct-to-Patient Tele-Behavioral Health Services program increases access to care for Medicaid patients in 14 rural and frontier counties in Eastern Oregon. Patients use a telehealth platform installed on their smartphones, tablets, or computers to communicate with behavioral health clinicians and receive, for example, counseling and medication management.[13]

During the COVID-19 pandemic, telehealth use expanded dramatically (Cantor et al., 2023). Studies have found that the volume of behavioral health services remained stable throughout the pandemic because of telehealth visits (McBain et al., 2023; Zhu et al., 2022b). Behavioral health, unlike other conditions, has sustained high use rates following the jump in usage tied to lockdowns (Cantor et al., 2023). Studies suggest that 30 to 40 percent of behavioral health encounters had continued to be telehealth visits as of 2022. Telehealth availability also increased substantially, with one study estimating an increase of 77 percent from 2020 to 2021 for mental health treatment facilities and by 143 percent for SUD treatment facilities (Cantor et al., 2022; Lee, 2023). Major shifts in corporate investments are currently affecting the telehealth landscape, with some companies expanding telehealth capabilities while others have reported declines in virtual visits since 2021, cut jobs, and filed for bankruptcy (Emerson, 2024).

Primary and Integrated Care

Research has shown that integrating behavioral health care with primary care is a cost-effective way for improving outcomes for individuals with some behavioral health conditions, expanding access to behavioral health care, and reducing overall costs of health care per person (Crocker et al., 2021; Jetty et al., 2021; Jolly et al., 2016; Maeng et al., 2022).

[12] Additional information is available at https://www.ruralhealthinfo.org/toolkits/telehealth/3/alaska-public-health (accessed June 7, 2024).

[13] Additional information is available at https://www.ruralhealthinfo.org/toolkits/telehealth/3/oregon-behavioral-health (accessed June 7, 2024).

Though behavioral health care services through primary care providers are an important avenue to accessing behavioral health care, there are various levels of care integration. Bi-directional integration of care is discussed in chapter 6. There are three delivery methods for collaborating behavioral health care within primary care (Collins et al., 2010):

1. **Coordinated**. Behavioral health care providers and primary care physicians work within physically separate facilities and have separate health record systems. Care providers communicate rarely about cases; if communication occurs, it is usually based on a particular need for specific information about a mutual patient.
2. **Co-located**. Behavioral health care providers and primary care physicians deliver care in the same physical location or practice. Patient care is often still siloed to areas of expertise. Because of being co-located, there may be occasional meetings between care providers to discuss mutual patients.
3. **Fully integrated**. Behavioral health care providers and primary care physicians function as a team, working together in the same physical space to design and implement a patient care plan. Care providers understand the different roles that team members play and structure the delivery of care to better achieve patient goals. Care providers and patients view the clinical operation as a single system treating the whole person.

Behavioral health integration occurs during a regular clinic visit when either the patient expresses a need for behavioral health care or when the primary care physician discovers a need through conversation or observation. At that point, a "warm handoff" can occur with a licensed clinical social worker, who then conducts a brief triage assessment and determines the best level of care and interventions for the patient. Based on clinical indications, interventions can include short-term therapy; group therapy; referral to community resources such as housing, food, and transportation assistance; connection to psychiatric resources in the community, and crisis intervention.

Starting on January 1, 2023, CMS began paying for integrated behavioral health care services provided by clinical psychologists and clinical social workers as part of a primary care team, where the behavioral health services furnished by a clinical psychologist or clinical social worker serve as the focal point of care integration (HHS, 2022). In 2022, to promote and assist with developing integrated behavioral health services, the HHS Office of the Assistant Secretary for Planning and Evaluation developed the HHS Roadmap for Behavioral Health Integration and the Agency for Healthcare Research and Quality established the Academy for Integration

Behavioral Health and Primary Care. One aim is to expand access to integrated behavioral health care for historically underserved populations that experience a high burden of behavioral health conditions, such as individuals experiencing homelessness, justice-involved individuals, individuals with co-occurring disabilities, individuals involved with the child welfare system, and victims of domestic violence, trafficking, and other forms of trauma. A particular focus of the roadmap will be to address the critical shortage of behavioral health care providers trained to serve children and adolescents (Becerra et al., 2022).

In 2022 and 2023, several states expanded their service coverage to enhance the integration of physical and behavioral health care. Despite evidence linking comprehensive, integrated behavioral health coverage to increased provider acceptance of Medicaid beneficiaries (Andrews et al., 2018), uptake has been limited, likely due to implementation barriers.

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4

Factors Contributing to the Expansion and Recruitment of Behavioral Health Providers Serving Medicare, Medicaid, and Marketplace Beneficiaries

The current system of mental health and substance use treatment in the United States is facing significant challenges, particularly in terms of access to care. As described in Chapter 3, several measures of supply and demand for behavioral health services indicate that many behavioral health care provider types (including psychiatrists, psychologists, and nurse practitioners) are maldistributed, with care providers being unevenly distributed geographically. The result is a critical shortage of behavioral health providers in many areas, particularly among underserved communities (Mauri et al., 2019; Zhu et al., 2022). Services for these high-need populations tend to be densely concentrated in a few areas, creating inequitable geographic accessibility. For other behavioral health care provider types, *both* maldistribution and outright shortages are a challenge. For example, among child and adolescent psychiatrists, there have been well-documented supply shortages across all areas of the country (McBain et al., 2019). As a consequence, certain high-risk populations, such as children and adolescents, are experiencing an increase in behavioral health distress while facing even more barriers to securing treatment (Harati et al., 2020; Office of the Surgeon General, 2021).

The shortage of behavioral health providers in certain areas has significant consequences for those seeking treatment. Individuals living in areas with limited access to mental health or substance use disorder (SUD) services often face long wait times for appointments—weeks if not months—which can delay or lead to inadequate treatment. This can have serious consequences for those experiencing mental health crises, as they may not access the care they need in a timely manner. Moreover, the lack of

behavioral health providers in certain areas can have a disproportionate effect on marginalized communities. Research has shown that individuals from racial and ethnic minoritized groups and those from low-income backgrounds are less likely to have access to behavioral health services. This can perpetuate health disparities and exacerbate existing social and economic inequalities.

To address these challenges, it is crucial to recruit mental health and SUD providers to areas where they are needed most. Doing so requires a multifaceted approach that includes targeted recruitment efforts, training and education programs, and financial incentives for behavioral health providers to offer care in more locations and to accept more patients facing increased disparities in access, including Medicaid-insured children and adolescents.

Request for Information from Behavioral Health Care Providers

Because of the limited evidence on behavioral health provider barriers to insurance participation in behavioral health, the committee conducted an electronic questionnaire of behavioral health providers across settings and care provider types using a public request for information (RFI). Respondents had access to the public RFI through the National Academies of Sciences, Engineering, and Medicine's (National Academies) website or may have received an invited link through professional organizations, employers, or directly from the National Academies. To gather additional input from behavioral health clinicians, the questionnaire asked respondents to share their experiences working with Medicare, Medicaid, and Marketplace insurance programs and, if they did not participate in these insurance programs, to explain reasons for not accepting these insurances. The committee collected data in November and December 2023 using Alchemer Survey Software. Responses to the RFI were received from a wide variety of behavioral health professionals, both prescribing and non-prescribing. A total of 1,047 behavioral health professionals completed the questionnaire. Responses from the RFI are discussed later in this chapter.

WORKFORCE EDUCATION PROGRAMS

The Health Resources Services Administration (HRSA) oversees several programs that include innovative strategies to encourage behavioral health practitioners to work with Medicare and Medicaid beneficiaries with complex social, economic, and environmental needs, specifically those in medically underserved areas. HRSA's Bureau of HealthCare Workforce supports two main behavioral health professions training grants to strengthen the workforce of behavioral health providers. The Behavioral Health Workforce

Education and Training (BHWET) program provides a funding mechanism for institutions to enhance the quality of education and clinical training in behavioral health and increase the number of practicing behavioral health professionals and health support workers. In particular, BHWET emphasizes integrating behavioral health into primary care, and given the acute need for child and adolescent services access, programs focusing on programming for children, adolescents, and transitional-age youth are among those that can apply for BHWET. The graduate psychology education (GPE) training program supports expansion of interprofessional training, with a focus on integrated behavioral health and primary care in doctoral-level health psychology programs.

BHWET and GPE outcomes indicate that the programs have increased the number of behavioral health professionals trained, with a significant number of BHWET and GPE program graduates choosing to practice in high-need areas. From 2014 to 2022, BHWET program awardees supported clinical training of 39,926 graduate-level behavioral health providers, and nearly 70 percent (27,522) graduated and entered the behavioral health workforce. Of the total graduated, 9,892 new health support workers began work as community health workers (CHWs), peer paraprofessionals, and substance use/addictions workers. Of the 17,630 new behavioral health professionals, there were 887 new psychologists; 10,738 new social workers; 1,352 new mental health nurse practitioners; 442 new marriage and family therapists; 4,044 new professional, school, addiction, or mental health counselors; and 80 new psychiatrists.

In the post-graduate employment data collected at one year follow up (2021 to 2022), 46 percent of BHWET graduates and 55 percent of GPE graduates worked in medically underserved communities (HRSA, 2024a). Both BHWET and GPS prioritize programs with a high or increased rate of graduates placed in practice settings focused on serving residents of medically underserved communities (HRSA, 2021). Taken together, outcome data from BHWET and GPE from over the past decade show they are affective at increasing the number of behavioral health professionals working with under-resourced populations. Furthermore, the BHWET and GPE programs have reduced projected behavioral health workforce shortages by 39 percent and are expected to have ongoing positive effects on the behavioral health workforce supply (HRSA, 2022a,b).

HRSA's National Health Service Corps (NHSC) is another set of programs providing incentives for behavioral health professional to work in geographically underserved areas. NHSC provides scholarship and loan repayment programs for primary care, dental, and behavioral health providers. Health care providers accepted to the program receive loan repayment funding or scholarships in exchange for providing services at participating sites in health professions shortage areas (HPSAs, previously defined

in Chapter 3). NHSC has played a growing role in supporting behavioral health providers in these underserved areas; as of 2017, behavioral health providers accounted for nearly one-third of NHSC providers (Olson et al., 2020). In 2023, NHSC supported over 8,700 behavioral health providers (HHS, 2024b). Particularly relevant to shortages of child and adolescent care providers, child and adolescent psychiatrists (see Box 4-1) are among the physician provider types eligible for NHSC's loan repayment program (HRSA, 2024b).

Congress has persistently underfunded NHSC, especially when viewed through a behavioral health lens. As of 2020, mandatory funding for NHSC had not increased significantly in a decade (Olson et al., 2020). A 2021

BOX 4-1
Child and Adolescent Psychiatrists

Historically, the United States has had a dearth of child and adolescent psychiatrists. While the number of child psychiatrists has increased in recent years, as of 2016 there were an estimated 9.75 child psychiatrists per 100,000 children; by contrast, the American Academy of Child and Adolescent Psychiatry estimates a need for 47 psychiatrists per 100,0000 children (McBain et al., 2019). Moreover, the existing supply of child and adolescent psychiatrists is concentrated in metropolitan areas, with 70 percent of counties having no behavioral health care providers. Demand far outstrips this supply, as recent data suggests an acute rise in the prevalence of youth diagnosed with depression, attention deficit/hyperactivity disorder, and bipolar disorders. Pediatric emergency visits for mental health conditions have also increased, with high rates of revisits along with low rates of post-emergency department outpatient follow-up. Together, these data underscore the fact that inadequate access to pediatric specialty outpatient care and intervention may play a role in these trends.

There have been multiple proposals to expand the child psychiatry workforce, including early career exposure and enrichment programs, developing alternative and expedited child psychiatry residency programs, and improving coding and billing requirements to account for the complexity of caring for children and adolescents with behavioral health needs. In addition, consultation and integrated, team-based care models that include child psychiatry have been implemented to improve the capacity of present and future specialists.

SOURCES: Bommersbach et al., 2023; Cushing et al., 2023; Hoffmann et al., 2023; McBain et al., 2019; Shapiro, 2022.

Government Accountability Office study found that in fiscal year 2020, 43 percent of behavioral health care providers who newly applied to receive awards from NHSC were denied. NHSC's largest program, the General Loan Repayment Program, rejected hundreds of applicants despite them having HPSA scores in the upper range that would have received awards per HRSA guidance if more funding had been available. In this same year, relevant to behavioral health, more than 10 percent of treatment sites had unfilled positions for licensed clinical social workers and licensed professional counselors (GAO, 2021).

Finding: HRSA's Bureau of Health care Workforce Education and Training and Graduate Psychology Education programs have been shown to have ongoing positive impacts on behavioral health workforce supply, including reducing projected behavioral health workforce shortages by 39 percent and increasing the number of behavioral health professionals and support specialists of multiple disciplines working with under-resourced populations. HRSA's National Health Services Corps program has similarly increased the supply of physicians providing behavioral health services to under-resourced populations. These are populations that disproportionately enroll in Medicare, Medicaid, and the Affordable Care Act Marketplace.

Conclusion 4-1: In addition to short-term improvements in behavioral health care provider participation among the existing workforce, strengthening the pipeline of federally subsidized behavioral health providers would build a workforce more likely to continue serving Medicare and Medicaid populations after the end of their training. Bolstering workforce programs and policies, including successful pathway or pipeline programs, would increase the number of people who want to enter the behavioral health field and support care provider retention over time.

DIVERSE REPRESENTATION IN THE BEHAVIORAL HEALTH WORKFORCE

Racial, ethnic, gender, and sexual minoritized individuals often suffer from poorer mental health outcomes resulting from complex social, economic, and environmental needs, including inaccessibility of high-quality behavioral health care services, cultural stigma surrounding mental health care, discrimination, an overall lack of awareness about mental health, and a lack of access to appropriate care for racially, ethnically, culturally, and linguistically diverse populations. For example, patients of minoritized identity enrolled in Medicaid/Child Health

Insurance Program (CHIP) and in Medicare Advantage experience disparities in mental health and SUD care access and quality; over half of Medicaid/CHIP beneficiaries are of a racial or ethnic minoritized identity, with Hispanic and non-Hispanic Black individuals accounting for a disproportionate share of Medicaid/CHIP beneficiaries (CMS, 2023c; MACPAC, 2021). In addition, the 1.2 million lesbian, gay, bisexual, and transgender Medicaid beneficiaries have higher rates of self-reported unmet mental health and substance use care needs than their non-minoritized counterparts (MACPAC, 2022; Ochieng et al., 2023). It should be noted that relying solely on minority mental health providers to address access disparities for Medicaid-insured patients and those in shortage areas overlooks the need for broader workforce diversity. The concept of racial concordance, pairing non-white providers with patients to reduce health inequities, assumes certain advantages but risks perpetuating segregation in healthcare, reinforcing systemic biases favoring white populations (Boyd, 2019).

Physician acceptance of Medicaid is lower in areas with higher concentrations of racial and ethnic minoritized individuals (Daly and Mellor, 2020; Greene et al., 2006). Medicaid-insured individuals of Black or African American identity have less access to substance use disorder (SUD) treatment (Heflinger et al., 2006; Stein et al., 2018). An analysis of six Medicaid programs found that Black or African American and Hispanic Medicaid beneficiaries were less likely to receive behavioral health services in community-based settings than their White counterparts and that Black or African American beneficiaries were more likely to receive services in inpatient and emergency room settings than their White counterparts (Samnaliev et al., 2009). Medicaid-insured Black or African American and Hispanic children are less likely to receive behavioral health services than their White counterparts (MACPAC, 2022).

Enrollment in Medicare Advantage has increased more rapidly among racial and ethnic minoritized Medicare beneficiaries than among their White counterparts, and as of 2021 more than half of Black, Hispanic, and Asian/Pacific Islander Medicare beneficiaries were enrolled in a Medicare Advantage plan (Ochieng et al., 2023). A 2023 review from the Kaiser Family Foundation examined disparities in quality-of-care metrics by race and ethnicity in the Medicare Advantage program, finding that racial and ethnic minoritized individuals fared poorly compared with White enrollees on most metrics, including access to medication and appropriate follow-up care (Ochieng et al., 2023).

As the 2023 National Academies' report *Federal Policy to Advance Racial, Ethnic, and Tribal Health Equity* (NASEM, 2023) noted, cultural congruency between patient and health care professional (e.g.,

concordance in race, ethnicity, and language) improves patient satisfaction and affects outcomes for racial and ethnic minoritized patients (Diamond et al., 2019; Jones et al., 2017; Ku and Vichare, 2023). Indeed, race concordance between behavioral health care provider and patient has been associated with higher self-report of satisfaction with care and self-report of receiving better quality care among Black and Hispanic patients (Cooper et al., 2003; Saha et al., 1999). A 2023 study provides a recent compelling example, finding that higher Black representation in the primary care physician workforce was associated with higher life expectancy and lower all-cause mortality among Black patients (Snyder et al., 2023).

A 2011 meta-analysis of the literature on this phenomenon specific to behavioral health care examined three variables regrading racial and ethnic match between patient and therapist: patient preference, the patient's positive versus negative perception of therapist, and treatment outcome (Cabral and Smith, 2011). The meta-analysis revealed that patients preferred receiving treatment from therapists who were racially and ethnically concordant and that racial and ethnic minoritized patients had positive perceptions of race- and ethnicity-matched therapists. For Black or African American patients, these associations were particularly strong, and there was also an association between racial and ethnicity match and positive treatment outcome (Cabral and Smith, 2011. Thus, as the abovecited 2023 National Academies report concluded, "A lack of inclusion and representation in the health care workforce may perpetuate health inequities, given the evidence that suggests better health outcomes when there is identity concordance between patients and providers" (NASEM, 2023, p.118).

Beyond the benefit of specifically addressing disparities for historically marginalized communities, there are data suggesting that increased representation of racial and ethnic minoritized identity in the behavioral health care provider workforce could more broadly improve access to the Medicaid program. Research examining the self-reported practice characteristics of minorized and non-minoritized physician graduates of seven California medical schools found that minoritized physicians saw a higher percentage of Medicaid-insured patients than their non-minoritized counterparts. In addition, a higher proportion of minoritized physicians reported practicing in an area with a shortage of health care providers (Davidson and Montoya, 1987). A 2019 survey of physicians, nurse practitioners, and physician assistants on Medicaid acceptance following the Medicaid expansion found that racially minoritized care providers were more likely to report accepting new Medicaid patients, with Black-identifying physicians exhibiting the highest likelihood (Tipirneni et al., 2019). An analysis of data

from the 2010 Medical Expenditure Panel Survey found that Medicaid-insured adults were more likely to receive care from care providers of racial or ethnic minoritized identity than from White physicians (Marrast et al., 2014). These data suggest that efforts to increase representation of racial or ethnic minoritized health care providers in the behavioral health care workforce could benefit all Medicaid beneficiaries by increasing access to care.

Additional study of best practice for increasing representation of individuals with minoritized identities in the health care workforce is needed, though some existing literature highlights promising directions and approaches. A report from the National Council on Mental Health Wellbeing addressed the factors affecting the recruitment and retention of staff of color, particularly Black or African American men (National Council for Mental Wellbeing, 2022). The report provides findings from two focus groups conducted with Black and African American male mental health and SUD professionals. Focus group participants highlighted the lack of diversity at the leadership and executive level of health care organizations as well as the stigma and historical mistrust of health care institutions in Black and African American communities as factors deterring Black and African American men from pursuing behavioral health careers. The participants also highlighted issues related to pay, noting that African Americans face race-based pay inequities, further complicating issues related to salary and wages. This report's recommendations to address recruitment barriers include increasing community education to address stigma; increasing partnerships with community-based organizations, particularly faith-based organizations, to address historical mistrust; and providing higher wages and flexible financial support options such as loan repayment, housing stipends, and retirement plans to address the pay barriers. The report further recommends increasing technical assistance resources for mental health and SUD treatment organizations to enhance their understanding of recruitment strategies and establishing learning communities across organizations to share ideas on recruitment strategies and mentorship programs (National Council for Mental Wellbeing, 2022).

HRSA's NHSC program has proven to increase diversity in the workforce and increase the workforce serving the underserved–largely Medicaid patients. The demographics of the NHSC workforce compared with the national workforce reflects NHSC's effect on health care provider workforce diversity. A 2020 study reported that among the NHSC workforce, 13 percent of health care providers identified as Black or African American, 10 percent as Hispanic, 7 percent as Asian or Pacific Islander, and 2 percent as American Indian or Alaska Native. Data from 2016 show that 17 percent of NHSC physicians identified as Black or African American compared

with the 4 percent of physicians who identify as Black or African American nationally (Olson et al., 2020).

Several decades of evidence support the association between participation in pathway or pipeline programs—programs that support and increase educational opportunities for systematically and structurally excluded students, including from underrepresented racial and ethnically minoritized populations—and increased matriculation in medical school (Taylor et al., 2022) and health professions in general (HHS, 2009) among students of these backgrounds. Federal pipeline and pathway programs with a proven track record of success include the HRSA's Health Careers Opportunity Program (HCOP) (HRSA, 2022c), Centers of Excellence Program (COE) (HRSA, 2023a), and Nursing Workforce Diversity Program (NWD) (HRSA, 2023b). HCOP and COE provide grants to health profession schools, including medical schools and behavioral health graduate programs. HCOP grantees provide social and educational supports to increase matriculation of high school and undergraduate students from disadvantaged backgrounds, while COE grantees enhance education resources in health professions schools to support increased diversity and address minority health. NWD aims to increase nursing education opportunities for individuals from disadvantaged backgrounds.

Between 2015 and 2020, 6,856 students participated in HCOP, over 70 percent of whom were from underrepresented racial and ethnic minoritized backgrounds. Their graduation rates from high school or secondary school met or exceeded national averages, and a significant proportion indicated that they intended to continue on to health professions school (HRSA, 2022c). Over 16,000 individuals completed COE programs between 2015 and 2020, with 96 percent of the participants from an underrepresented racial and ethnic minoritized background and 58 percent of those who completed a graduate-level program intending to work or train in a medically underserved community (HRSA, 2023a). Between 2014 and 2019, over 15,000 trainees graduated from NWD programs. Black and African American and Hispanic and Latino representation among NWD nurses was two to five times higher than national averages, and more than half of NWD training sites provided services to individuals with complex needs, including those with lower income, older adults, and individuals with disabilities (HRSA, 2023b).

> Finding: Patients of racial/ethnic minoritized identity experience disparities in behavioral health care, including poorer quality of care and lesser access to care, and are over-represented among Medicaid beneficiaries. They also constitute a rapidly growing proportion of Medicare Advantage beneficiaries.

Finding: Evidence supports improved satisfaction and outcomes for racial and ethnic minoritized patients when there is racial and ethnic concordance between patient and health care provider. Data also suggests that health care providers of racial and ethnic minoritized identity are more likely than behavioral health care providers of other racial or ethnic identities to participate in Medicaid.

Finding: Participation in pathway or pipeline programs is consistently associated with increasing the matriculation of students of minoritized racial/ethnic identity in some health professions schools.

Conclusion 4-2: The behavioral health workforce does not reflect the diversity of the population it serves. Increasing historically underrepresented racial and ethnic identities, as well as language and cultural representation, in the behavioral health workforce is one mechanism to address disparities in access to care facing Medicaid and Medicare programs. Within Medicaid specifically, increased representation of historically underrepresented racial and ethnic identities in the health care workforce could expand access to care for beneficiaries more broadly, regardless of identity.

Conclusion 4-3: Efforts to decrease stigma, dispel historical mistrust, and provide financial incentives associated with behavioral health professions may address recruitment barriers, particularly those affecting communities of color.

GRADUATE MEDICAL EDUCATION FUNDING

The committee considered the current structure and distribution of graduate medical education (GME) funding, given the role that Medicare and Medicaid play in supporting GME as well as the potential for training environment to be a factor in incentivizing or disincentivizing future participation in Medicare, and Marketplace programs among health care providers-in-training. A 2014 Institute of Medicine report, *Graduate Medical Education That Meets the Nation's Health Needs*, stated that "Medicare GME payments are based on statutory formulas that were developed at a time when hospitals were the central—if not exclusive—site for physician training" (p. 61). The rules, codified in 1997, continue to reflect that era (IOM, 2014). Most GME funding continues to be paid to hospitals, even though inpatient care is decreasing, outpatient care is increasing, and the training of physicians has not shifted to reflect this reality.

The Centers for Medicare & Medicaid Services (CMS) has the opportunity to influence the supply of the nation's physicians. Medicare is the largest source of federal GME funding, and Medicaid is the second largest source of support for GME. In addition, the federal government shares payment for Medicaid expenses through federal matching funds (Heisler et al., 2018; Mitchell et al., 2023).

While GME funding has not changed, the country's health care delivery system continues to undergo dramatic changes. A 2018 report illustrates the growing role of outpatient settings in health care delivery. Per this report, while hospital inpatient stays declined by 6.6 percent between 2005 and 2015, outpatient visit increased by 14 percent, and gross outpatient revenue per visit increased by 45 percent (Abrams et al., 2018). A figure from this report (Figure 4-1) demonstrates the increasing proportion of hospital revenue generated by outpatient care.

Despite this ongoing change, CMS has not changed the basic formulas and processes it uses to fund residency training, nor has CMS accounted for

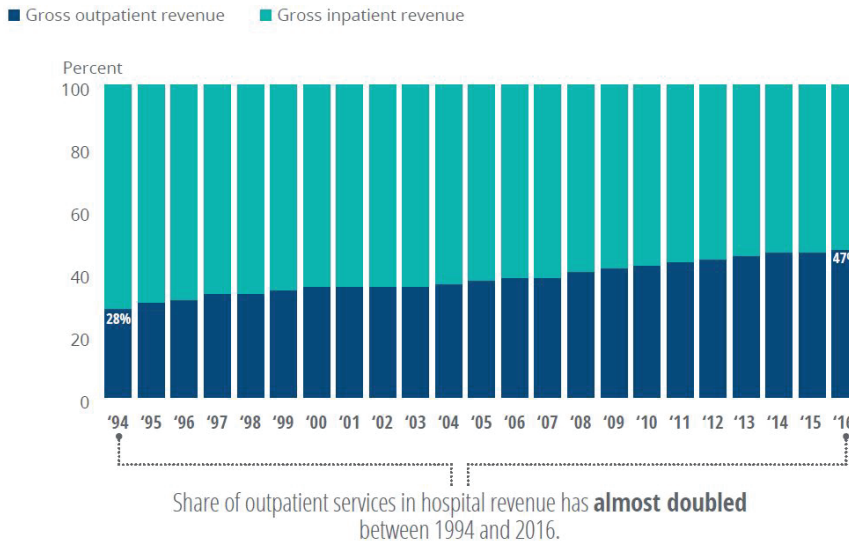

FIGURE 4-1 Outpatient services as part of overall hospital revenue grew between 1994 and 2016.
NOTE: The figure is based on Deloitte analyses, using data from the American Hospital Association annual survey and Medicare cost reports via Truven Health Analytics.
SOURCE: Abrams et al., 2018.

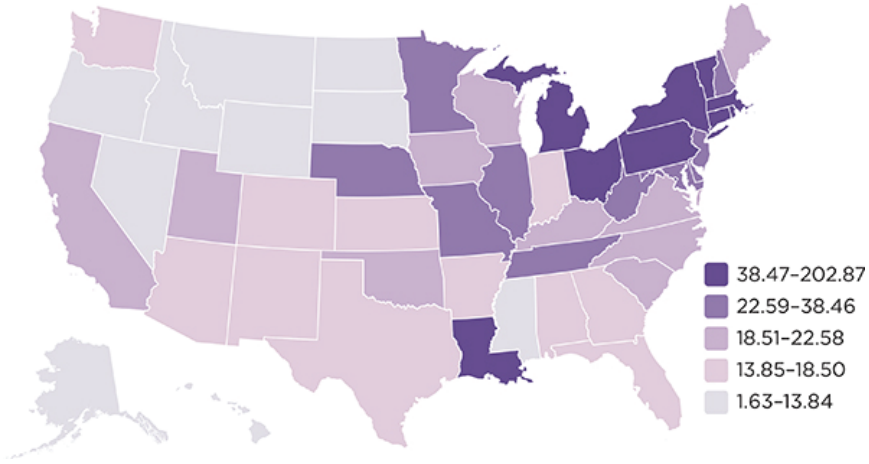

FIGURE 4-2 Number of Medicare-funded training positions per 100,000 population. SOURCE: Mullan et al., 2013.

geographic maldistribution of residency slots which are currently concentrated in the Northeastern states (Figure 4-2). While Congress passed legislation calling for CMS to add 1,000 Medicare-funded residency training slots over 5 years, with a focus on geographic needs—the first such increase since 1997 (Schleiter Hitchell and Johnson, 2022)—adding 200 physician slots across the country per year will not align the country's physician supply with the needs of the country, particularly in the case of psychiatrists. Even if all 1,000 residency slots were solely for training psychiatrists, psychiatrists are the physician specialty with the lowest acceptance of Medicare and Medicaid. In addition, other than the ongoing addition of 1,000 residency training that began in 2023, Medicare-supported training slots are essentially frozen where they existed almost two decades ago, perpetuating inequities in the geographic distribution of training slots and ignoring changes in the geography and demography of the U.S. population (GAO, 2017).

When initially legislated, CMS calculated Medicare Graduate Medical Education (GME) payments to teaching hospitals based solely on hospitals' costs. In 1983, CMS established two GME funding streams for teaching hospitals: (1) Direct Graduate Medical Education (DGME) funding to cover the direct expenses associated with residency training (e.g., residents' and faculty salaries and benefits and certain administrative and overhead costs); and (2) Indirect Medical Education (IME) funding, an adjustment to individual teaching hospitals to help defray the additional costs of providing patient care associated with sponsoring residency programs. Of the more

than $15 billion CMS pays annually to hospitals, approximately one-third is paid as DGME and two-thirds as IME. Physicians who train in Medicare or Medicaid-supported residencies are under no obligation to accept Medicare or Medicaid patients when they enter practice, nor are they required to provide any other services to these programs, despite CMS largely paying for their training (IOM, 2014).

Medicare GME funding is formula-driven and does not take into account national health care needs or priorities. The GME financing system offers little incentive to improve the quality or efficiency of physician training and no incentive for institutions to align residency slots with local or national health care needs. It does incentivize adding residency slots to training programs that allow hospitals to care for higher-cost, often procedure-based specialty care, as opposed to primary care or behavioral health care (IOM, 2014). In addition, because the Medicare formulas are linked to Medicare patient volume, the system disadvantages children's hospitals, safety net hospitals, and other training sites that care for mostly non-elderly patients (IOM, 2014).

Research has shown that psychiatric mental health nurse practitioners (PMHNPs) have begun to provide an increasingly large percentage of necessary care to Medicare-insured behavioral health patients. A recent analysis of Medicare claims for office visits demonstrated a 162 percent increase in PMHNPs serving Medicare patients from 2011 to 2019, while the number of psychiatrists billing Medicare dropped 6 percent during this same period. Over the same period, the growth in the PMHNP workforce mitigated losses in mental health specialist visits—while psychiatrist-provided visits dropped by 30 percent, the net decrease in behavioral health specialist visits was just over 10 percent because of the increase in PMHNP-provided visits (Cai et al., 2022).

However, Medicare does not support training programs beyond those for physicians even though non-physicians treat a growing percentage of Medicare beneficiaries in higher-need specialties. Aside from primary care physicians and psychiatrists, Medicare does not financially support the training of the behavioral health workforce needed to deliver services to those covered by Medicare. It does not support advanced practice registered nurses (APRNs), social workers, or psychologists despite both a national mental health crisis and national SUD crisis. The need continues to grow, but CMS has not redistributed the dollars to support the workforce in a way that reflects this current reality. Even among physicians and in the midst of an ongoing opioid crisis. In the CY 2024 PFS (Physician Fee Schedule) final rule, CMS finalized addiction counselors or drug and alcohol counselors who meet the applicable requirements to be a mental health counselor (MHC), could enroll in Medicare as MHCs (CMS 2023a).

HRSA has used funding to create the Teaching Health Center Graduate Medical Education (THCGME) program, which helps communities grow their health workforces by training physicians and dentists in community-based settings, with a focus on rural and underserved communities. The THCGME program funds the majority of training in the community-based outpatient settings where most people receive their health care, such as community health centers. Teaching health centers receive a payment for each resident they train to cover the training costs, including the resident's salary and benefits. In many ways, THCGME resembles CMS' Medicare IME and DGME funding.

An analysis of the THCGME program shows significant retention of the workforce serving these communities. Patients seen in these settings are largely Medicare and Medicaid beneficiaries. THCGME graduates were significantly more likely than other graduates to practice in a rural location, to practice within 5 miles of their residency program, and to care for medically underserved populations. Their scope of practice was wider than other graduates and more likely to include services such as buprenorphine prescribing and behavioral health care (Davis et al., 2022), even though this program supports medical training, not behavioral health training.

Given this success, the committee believes that both the Substance Abuse and Mental Health Services Administration (SAMHSA) and CMS have an opportunity to increase funding for such programs. As the 2014 National Academies report *Graduate Medical Education That Meets the Nation's Health Needs* (IOM, 2014) suggests, CMS can create one Medicare GME fund with two subsidiary funds:

1. A GME operational fund to distribute ongoing support for residency training positions that are currently approved and funded.
2. A GME transformation fund to finance initiatives to develop and evaluate innovative GME programs, determine and validate GME performance measures, pilot alternative GME payment methods, and award new Medicare-funded GME training positions in priority disciplines and geographic areas (see Figure 4-3). This could include changes and enhancements both from the Center for Medicare and Medicaid Innovation and Section 1115 waiver authorities[1] to states to increase the federal medical assistance percentage matching funds to support state-based investments in behavioral health workforce training.

[1]Section 1115 waiver authorities allow states to test new approaches to administering Medicaid and CHIP programs beyond what is required by federal statute.

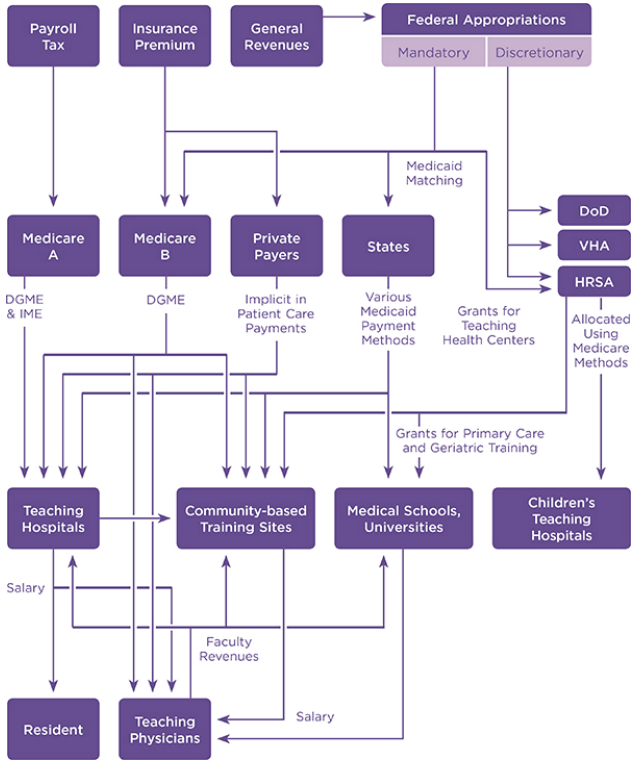

FIGURE 4-3 Current flow of GME funds.
SOURCE: IOM, 2014.

While the 2014 National Academies report recommendations were specific to CMS, SAMHSA, with a necessary and appropriate focus on the behavioral health workforce beyond physicians, can:

1. Either work in partnership with HRSA to develop integrated training programs for both primary care and behavioral health, or
2. Use discreet and directed grant funding to create a behavioral health teaching health center—or other specific setting—to train the behavioral health workforce. This grant funding should be multi-year funding to both establish and continue training programs for the life of the training period, which would avoid trainees not completing their training because of a lack of funding. Modeling this largely after the THCGME training program, if done *de novo,* would allow for a successful blueprint for many aspects of initial implementation and ongoing evaluation, assessment, and impact.

Finding: CMS provides significant funding to support physician training; SAMHSA likewise provides significant funding to support training and care delivery. These funding streams do not require recipient institutions to report on long-term outcomes regarding career choice, practice environment, or service provision to Medicare and Medicaid beneficiaries.

Finding: Teaching Health Center Graduate Medical Education (THCGME) Programs support significant retention of workforce serving the communities where these programs are in place. Patients seen in these settings are largely Medicare and Medicaid beneficiaries.

Conclusion 4-4: There is a demonstrated inconsistency between the primary source of GME program funding (e.g., Medicare and Medicaid) and participation in public insurance programs among health care providers whose training is funded by GME. While GME program funding primarily comes from Medicare and Medicaid, many trainees do not subsequently participate in these programs.

BILLING CAPABILITY FOR BEHAVIORAL HEALTH CARE PROVIDERS-IN-TRAINING IN MEDICARE, MEDICAID, AND ACA MARKETPLACE INSURANCES

Because CMS has long permitted those in medical residency training programs to bill Medicare and Medicaid under the supervision of an attending physician, the committee considered billing capability for behavioral health care providers-in-training as a potential factor that might incentivize those in training to participate in Medicare, Medicaid, and Marketplace programs after completing their training. The access and availability of high-quality supervised training opportunities for behavioral health trainees remains one of the most critical issues in behavioral health workforce development and behavioral health care provider participation in public health insurance programs.

There is a shortage of clinical training sites across behavioral health professions (BHWAC, 2022). Increasing the availability of training sites, which can provide supervised training toward licensure, certification, or other requisite credential to practice, requires sustainable funding. Such funding can be severely lacking for many behavioral health clinical training sites. CMS allows reimbursement for teaching physicians, interns, and residents in certain approved settings and training programs (CMS, 2023b), but there is no corresponding comprehensive guide or policy for non-physician behavioral health trainees. Similarly, these trainees are not eligible for funding through GME that would help subsidize the cost of required residency training (APA, 2022a).

Existing mechanisms for billing by supervised trainees can vary greatly by state, profession, insurance plan, and practice setting. For example, some states allow psychology trainee billing under various mechanisms, such as trainee license, registration, or under the "incident to" billing provision (APA, 2014). Such practices are not permissible under Medicare, however (APA, 2022b). The American Psychological Association, for example, has stated that not allowing billing for services provided by trainees "presents a significant challenge to training programs that offer needed services to the public yet must find other ways to support the costs associated with running a quality training program" (APA, 2014).

Responders to the committee's RFI raised many of these training and billing issues (see Table 4-1 for a selection of relevant quotes from RFI responders).

While various solutions and workarounds have been implemented, including apprenticeship programs and grant funding for training sites (i.e., BHWET and GPE grant programs discussed earlier), allowing billing for services provided by trainees under an approved supervisor or preceptor might be a more comprehensive, equitable, and scalable approach to this problem. One proposal, for example, calls for Congress to create a billing modifier that Medicare, Medicaid, and commercial payers would use to bill for services performed by trainees under supervision (Gajewski et al., 2022). This proposal would include "an additional 10 percent of the base code's Medicare fee, compensating training sites for the time clinicians spend teaching" (Gajewski et al., 2022). Under this policy, a teaching practice would generate 10 percent more reimbursement revenue than a private practice clinician for providing any mental health service involving a resident. The proposed policy would offset the cost of supervision and enable teaching practices to offer more competitive salaries to prospective clinical educators. The policy should apply to all payers if it is to create a reliable revenue stream that encourages practices to treat every patient equitably.

Creating a pathway in which all mental health and SUD trainees can provide reimbursable services with Medicare, Medicaid, and Marketplace plans would not just increase the supply of workers. It would help build a pipeline of behavioral health care providers who would be more likely to continue serving these populations after their training ends. Research has linked health care provider retention to training programs and training (Bazemore et al., 2015; Dahal and Skillman, 2022). In other words, creating such a pathway would make it feasible to develop training sites across different practice settings where public insurance beneficiaries receive services, thereby covering the cost of training and increasing the odds of more behavioral health providers "staying where they train" and providing services to these populations long-term, post-graduation, in permanent, non-training positions.

TABLE 4-1 RFI Selected Quotes: Trainee Issues

"As a trainee in Florida, I was unable to work with any Medicaid populations, which left a major gap in my training."
"As a trainee, I am unable to work with Medicare patients, which feels arbitrary, means that our Medicare patients may have to wait longer for services, and limits my training since I rarely if ever see older adults."
"My primary concern is that Medicare doesn't allow trainees (neuropsychology interns and fellows) to see patients. This is a huge problem, as it impedes the ability of our trainees to gain experience with the aging population."
"Our training clinic is a community mental health center, and most patients have Medicare/Medicaid. *Without our clinic, access to services would be limited, and we would not be able to train future clinicians on campus*."
"It's difficult as a CSWI [clinical social work intern] to work with Medicaid. Medicaid makes it very difficult for CSWIs to be credentialed because they have to apply for a different provider type. This limits access to care and makes more hurdles for patients. *Interns should be able to bill Medicaid just as easily as we can bill private insurance*."
"*Our Behavioral Health Clinic (Illinois) is able to bill for intern and extern therapy services, which is a huge factor in having sufficient providers and sustaining our training program's budget*. However, there isn't a good mechanism for billing testing (e.g., no equivalent in Medicaid for 96138). This has led to a lack of available staff and huge waitlists (over a year)."
"Currently, I'm in leadership in an FQHC [federally qualified health center]. In NV, licensed MH [mental health] interns (of any licensure) and LCPCs [licensed clinical professional counselors] cannot bill Medicaid under the FQHC provider type. *This is a huge barrier in a state with a significant provider shortage*."
"At our institution, all providers are enrolled with Medicare and Medicaid, and I see many patients who are covered by Medicaid in particular. One significant barrier is that, at least in NC where I practice, psychology trainees (such as students in psychology Ph.D. programs who are completing practicum experiences or predoctoral psychology interns) cannot bill for services they provide to patients with Medicaid. *This is an unnecessary barrier to care for patients with Medicaid, since psychology trainees provide services under the close supervision of a licensed psychologist and can certainly provide high-quality services*."
"I am grateful for the mental health coverage my patients have with Medicare; however, with the aging population, our clinic receives more referrals than can be accommodated by licensed psychologists. The restrictions on trainees seeing government pay sources places undue barriers to care for our patients. In addition, our patients with Medicaid are unable to receive mental health services at our facility as psychologists in the state of Georgia are not reimbursed by Medicaid. We would be able to serve more patients if psychologists in the state of Georgia were reimbursed by Medicaid and *if my trainees could see patients independently*."
"It is pretty easy for me as a provider—my institution accepts versions of all 3. *The challenge is my trainees cannot see Medicare patients, nor most privately insured patients, so I don't take the patients*."
"I am a licensed clinical social worker, licensed at the highest level possible in the state. Medicare and Medicaid do not reimburse for my services or those provided by my trainees. *This is a disservice to underserved patients who need treatment*."

TABLE 4-1 Continued

"We accept Medicaid in our clinic, but it's been a challenge since unlike some other insurance companies that allow psychology doctoral trainees to bill under their licensed and credentialed supervisor (the way medical residents do), Medicaid does not. *This limits our ability to serve this population and leads to our Medicaid waitlist of over a year, probably more like two years for psychological assessment services*. In our small rural area that lacks providers, especially those who take Medicaid, this is a huge disservice."
"*There are many students/trainees who would enter this field if Medicare reimbursement rates provided a full income or at least enough of a full income to allow medical centers to easily hire them.*"

NOTE: 96318 = CPT code 96138 is used to bill for the first 30 minutes spent by a technician administering and scoring psychological or neuropsychological tests. This includes situations where at least two tests are administered, whether they are paper-based, verbal, or electronic.

Finding: While CMS allows for physicians-in-training to bill for services under the supervision and license of a preceptor, similar parity does not exist for other behavioral health professionals. This limits non-physician behavioral health trainee exposure to caring for Medicare and Medicaid beneficiaries and has a strong potential to influence which patients these health care providers serve when they finish training.

Conclusion 4-5: The lack of billing for services provided by trainees in Medicare and Medicaid is a major barrier to expanding training opportunities for behavioral health specialists more likely to participate in the Medicare and Medicaid programs.

BILLING COVERAGE OF NON-LICENSED BEHAVIORAL HEALTH PROVIDERS AND SERVICES

A substantial body of evidence, encompassing over 100 randomized, controlled trials, underscores the viability, feasibility, and clinical efficacy of behavioral health care delivery by non-specialist care providers, including CHWs, peers, lay individuals, and nurses (Barbui et al., 2020). These interventions are rooted in community contexts and require sustained collaboration, funding, training, support, and monitoring. Known throughout the literature as "task sharing," this approach entails community-driven identification and delivery of behavioral health care, also called community-initiated care (CIC). CIC involves empowering local communities to implement evidence-informed programs for behavioral health prevention and intervention. This departs significantly from the predominant focus on specialist-delivered care, acknowledging the pivotal role that caregivers and frontline workers can play in addressing community behavioral health needs.

Behavioral health support specialists, such as peer support specialists (PSSs), CHWs, and paraprofessionals, play a crucial role in bridging the gap between individuals and traditional treatment settings and improving outcomes for individuals with complex social, economic, and environmental needs. Research has shown that PSSs significantly improve the overall effectiveness of behavioral health treatment for individuals with serious mental illness by decreasing substance use, decreasing depressive and psychotic symptoms, decreasing emergency department use and admission rates, and reducing costs (Davidson et al., 2012). People living with serious mental illness also report increased self-control, increased self-esteem and confidence, and increased empowerment when working with a PSS (Davidson et al., 2012). The positive benefits of peer support are captured by the following comment from Keris Jän Myrick during the committee's webinar, Lived Experiences in Accessing Behavioral Health Care Services Through Public Insurance Programs:

> The power of peer support was super helpful for me, especially because there are not a lot of providers of color . . . (F)inding a peer who looked like me and has the same cultural background as me, also helped me on my recovery journey.

A growing body of research supports the role of CHWs in improving behavioral health outcomes for lower income and racial/ethnic minority patients across the lifespan (Barnett et al., 2018). A 2021 issue brief from the CMS Office of Minority Health highlights the roles of CHWs in improving outcomes for vulnerable populations, including those with limited English proficiency and those living in rural communities (CMS, 2021). Given the evidence supporting the role of PSSs and CHWs in improving the mental health outcomes of individuals with complex needs, expanding this workforce's reach within the Medicare and Medicaid-insured population has the potential to improve outcomes for Medicare and Medicaid beneficiaries with such needs. A 2024 SAMHSA report noted the growth in reimbursement opportunities for PSS services in public insurance programs and highlighted persistent challenges in actual use of these billable services on behalf of beneficiaries with behavioral health conditions. Specifically, the report notes that 48 out of 50 state Medicaid plans include PSS-delivered care as a reimbursable service and that the 2023 Consolidated Appropriations Act newly allows for direct reimbursement of PSS services for behavioral health conditions under Medicare (SAMHSA, 2024). Despite the broad availability for billing under Medicaid, a low proportion of Medicaid beneficiaries with behavioral health conditions were found to actually have received these services. The fee-for-service payment model was highlighted as a key barrier; other issues noted as barriers to PSS workforce expansion included low compensation, infrastructure challenges, and an absence of operational content and guidance (SAMHSA, 2024). Similarly, though interest is growing, even fewer states allow Medicaid payment

for services provided by CHWs (Haldar and Hinton, 2023), and allowable services are often limited in scope and target population (MACPAC, 2022).

SAMHSA established core competencies and a National Model Standards for PSS Certification to assist states in establishing a certification framework (SAMHSA, 2023a,b). More extensive use of PSSs and CHWs will require implementing standardized training and competencies to ensure that these important members of the team deliver care in a high-quality and effective way. A 2023 report, *Filling the Gaps in the Behavioral Health Workforce*, highlights this need and includes several policy recommendations that could support expanding the behavioral health workforce. These recommendations include creating a set of core competencies for behavioral health support specialists (BHSSs) at the federal level, creating pathways for improved coverage of BHSSs within the Medicare and Medicaid programs, and establishing a minimum federal exemption to becoming a BHSS for those convicted of nonviolent crimes (Gilbert et al., 2023). The recognition of Peer Support by Medicare could pave the way for broader adoption by Advantage Plans and other insurance companies, promising widespread integration in the future.

This report also calls for Congress to create a pipeline program to help interested BHSSs become licensed and to expand existing federal funding streams to support CIC programs (Breuer et al., 2023; Kohrt et al., 2023; Siddiqui et al., 2022). The report further called on Congress to help speed and spread the adoption of CIC programs by integrating existing federal funding streams that support CIC-related programs and those that support the work of BHSSs to help distribute the responsibility of behavioral health support into the community.

Finding: The presence of behavioral health support specialists, such as peer support specialists, community health workers, and other community-based paraprofessionals, plays a crucial role in bridging the gap between individuals and traditional treatment settings. These paraprofessionals have been shown to improve behavioral health outcomes for individuals with complex needs.

Finding: Including and using BHSSs in public insurance programs has been hampered by multiple factors, including lack of a standardized set of core competencies across the nation for certification, lack of payment structures that allow BHSSs to operate as part of a team, and federal funding streams that perpetuate the continuation of BHSS services outside of Medicare and Medicaid.

Conclusion 4-6: Expanding the delivery of behavioral health support specialist (BHSS) services in Medicare and Medicaid has the potential to significantly improve access and outcomes, especially for individuals with complex needs, while also augmenting the reach of licensed

behavioral health professionals. Federal intervention is crucial to establish BHSSs through model national certification standards and flexible payment models that facilitate the integration of these services into the full continuum of behavioral health care.

TELEHEALTH AND EXPANDED LICENSURE TO ADDRESS BEHAVIORAL HEALTH PROVIDER MALDISTRIBUTION

Expanding the delivery of behavioral health services via telehealth is one avenue for improving access to care and addressing the maldistribution of the current behavioral health workforce across areas of need (Guth, 2023). The following section considers the evidence on the role that occupational compacts play in expanding the reach of the current behavioral health workforce via telehealth, thereby addressing workforce maldistribution. Chapter 6 addresses other elements of telehealth relevant to expanding access to behavioral health services, including issues of modality, payment parity, and coverage parity.

In March 2020, during the COVID-19 public health emergency, the federal government and individual state governments provided temporary, specific telehealth flexibilities, including temporary licensure waivers to allow for clinicians to deliver telehealth services across state lines and for retired clinicians to reinstate their licenses. While some of these changes remain, much of the flexibility around licensure ended with the public health emergency.

Multiple stakeholders are encouraging states to permanently streamline licensing for all licensed care providers, in particular for licensed telehealth care providers. States approach licensing flexibility using a variety of mechanisms, including interstate compacts, licensure by endorsement or reciprocity, special-purpose telehealth registries or licenses to deliver telehealth services, and exceptions to in-state licensure requirements under certain circumstances and for telehealth services.

Thirty-nine states and the District of Columbia are now members of the Interstate Medical Licensure Compact for physicians. As the Center for Connected Health Policy explains, "When telehealth is used, it is considered to be rendered at the physical location of the patient, and therefore a care provider typically needs to be licensed in the patient's state. A few states have licenses or telehealth specific exceptions that allow an out-of-state provider to render services via telemedicine in a state where they are not physically located or allow a clinician to provide services via telehealth in a state if certain conditions are met (such as agreeing that they will not open an office in that state). Still other states have laws that do not specifically address telehealth and/or telemedicine licensing, but make allowances for practicing in contiguous states, or in certain situations where a temporary license might be issued provided the specific state's licensing conditions are met" (CCHP, 2024).

Occupational compacts are one pathway to decreasing the barriers for licensed clinical providers seeking to practice telehealth in a state other than their state of residence and are a facilitator for improving access to care across state lines for Medicare and Medicaid beneficiaries (HHS, 2024a). A license compact is an agreement to streamline the licensing process for physicians who would like to practice in multiple states. This development is a promising replacement for the relaxation of licensure laws that took place during the pandemic emergency orders. There are license compacts in place that include psychiatrists, psychologists, and nurses, but there is no compact for mental health/SUD counselors, including licensed clinical social workers, licensed clinical professional counselor, and licensed addiction counselors, Therefore, the existing licensing compacts are not as helpful as they could be when it comes to expanding the delivery of telehealth for behavioral health services (HHS, 2024a).

Medicare allows billing by health care providers in occupational compacts because the compacts meet the CMS's federal licensing requirements. Currently the Interstate Medical Licensure Compact explicitly allows for practicing telemedicine across state lines but the Counseling Compact's allotted privileges authorizing telehealth and in-person practice across state lines are expected to be open in late 2024 or early 2024 (Counseling Compact, 2024b; IMLCC, 2021). Physicians must meet the licensure requirements of the state where they are licensed and any additional licensure or practice requirements of the state where the patient is physically located at the time of the appointments. Compacts differ regarding single- versus multi-state licensing, allowance for telehealth, or exceptions to state licensure in specific circumstances to preserve continuity of care (HHS, 2024c).

There are at least nine health care occupational compacts, of which at least five are relevant to the delivery of longitudinal behavioral health services (see Table 4-2):

1. Interstate Medical Licensure Compact: 41 jurisdictions (states and territories)
2. Nursing Licensure Compact: 41 jurisdictions (states and territories)
3. Psychology Interstate Compact: 41 states
4. Counseling Compact: 33 states
5. Social Work Compact (24 states have introduced legislation, need seven states to pass legislation for an active compact)

Upon enactment, these compacts are binding agreements that expedite a state's (or territory's, used interchangeably henceforth) licensing process and require legislative authorization for an individual state's participation. A minimum number of states, often at least seven, must enact the model legislation before a compact can be implemented. Compact commissions

TABLE 4-2 Comparison of Common Compact Licenses in the United States

Name of Compact	Distribution	History	Practitioner Eligibility	Governance	Revenues
The Counseling Compact Commission (Counseling Compact Commission, 2023, 2024a,b)	36 States (effective July 1, 2024)	Funded and created by the American Counseling Association and the Council of State Governments, the Counseling Compact was finalized in December 2020.	Applications for Counseling Compact privileges to practice are expected to open in late 2024. The compact applies only to counselors licensed as licensed professional counselors, or whatever designation the state uses.	Each licensing board appoints one current member of its board to serve as a commissioner.	None yet. The American Counseling Association has agreed to cover the initial funds necessary to operationalize the Commission through September 30, 2023. Total initial proposed *expenses*: $367,500.00.
The Interstate Medical Licensure Compact (IMLCC, 2024)	40 states plus Guam and Washington, DC	In April 2017, the compact became operational.	Physician (M.D. or D.O.). Approximately 80% of U.S. physicians meet the criteria for licensure through the compact. The physician's primary residence is in the state of primary licensure. Serves as an information share/ clearinghouse among states, state license required for all physicians in the compact.	Each participating compact state sends two representatives to the Commission.	Proposed 2025 budget: $7,236,000

The Nurse Licensure Compact (NLC, 2022, 2024)	41 jurisdictions	Started in 2000. Beginning on Jan. 19, 2018, an updated version of the NLC was implemented in 26 states, replacing the original version that started in 2000.	RN or LPV/VN. Does not include APRNs. Nurses may not currently be a participant in an alternative program and are required to self-disclose current participation in an alternative program if applying.	The Interstate Commission of Nurse Licensure Compact Administrators comprises members from each of the participating NLC jurisdictions.	FY 2022: $192,000.00
The Psychology Interjurisdictional Compact Commission – PSYPACT (PSYPACT, 2024a,b)	41 states as of July 1, 2024	PSYPACT was originally created in 2019.	Must hold a full, unrestricted license to practice psychology based off a doctoral-level degree. Psychologists must identify a home state and **will be physically located in the home state while providing telepsychology**	Bylaws established 2019. Each licensing board appoints one current member or staff member of its board to serve as a commissioner.	Annual 2024 revenue is $275,000.00

NOTE: Compacts listed are those with more than 50 percent saturation across the country
SOURCES: Counseling Compact, 2023, 2024a,b; IMLCC, 2024; NLC, 2022; PSYPACT, 2024a,b.

are the governing bodies that make sure that states comport to the licensing rules and processes that are established. Compacts do not change a state's statutory authority regarding the specific scope of practice. Compacts differ regarding single- versus multi-state licensing, allowance for tele-behavioral health, or exceptions to state licensure in specific circumstances to preserve continuity of care (HHS, 2024c).

The Department of Defense has been partnering with the Council of State Governments to fund and support the development of new interstate compacts for occupational licensure. According to the National Center for Interstate Compacts, over 325 pieces of compact legislation have passed at the state and territorial level since 2016. In addition, 50 states and territories are participating in at least one occupational licensure compact, and 17 professions have occupational licensure compacts (NCIC, 2024). On April 12, 2024, Kansas became the seventh state to pass social work interstate licensing compact legislation, reaching the seven-state threshold creating a compact commission that will govern the compact and ensure coordination between the participating states (NASW, 2024).

Some states participate in only one compact, while others participate in multiple compacts. There are active advocacy efforts at both the federal and state levels to implement compacts for other professions well as to increase adoption by states and jurisdictions to join existing compacts. Despite the national footprint these compacts allow, there remains no federal government influence or oversight on specifics for licensure, standardization, or reimbursement, even though CMS pays more than any other insurer for behavioral health service delivery.

BILLING COVERAGE OF ADDITIONAL CLINICAL BEHAVIORAL HEALTH PROVIDERS AND SERVICES

Widespread shortages of behavioral health providers disproportionally affect beneficiaries and enrollees of the Medicare, Medicaid, and Marketplace plans (Counts, 2023). To mitigate this challenge, various efforts have been underway to expand the workforce pool, such as allowing insurance funding for new types of behavioral health care providers not previously eligible for reimbursement on a consistent basis (Saunders et al., 2023). This effort increasingly includes nonclinical and paraprofessional behavioral health providers and services, such as peer counselors and CHWs, as discussed previously. In addition, other allied health clinical provider types are now also being considered as a viable option to help close the gap in mental health and SUD provider shortages, especially as part of integrated, interdisciplinary health care teams. For example, there is growing evidence for the value of occupational therapy (OT) as a part of an interdisciplinary approach to the treatment of behavioral health conditions (Arbesman et al., 2013; Lannigan and Noyes, 2019) and SUDs (Stoffel and Moyers, 2004).

However, RFI data from OT responders indicated some notable differences in experiences while accessing insurance reimbursement specifically for behavioral health services depending on state of practice or practice setting. While some OT providers reported being able to bill insurance, many others reported having faced considerable difficulty obtaining reimbursement from Medicare, Medicaid, and Marketplace programs specifically for behavioral health services, thus limiting patient access to these vital services. As one OT provider stated: "Occupational therapy is not recognized as a qualified behavioral health provider in every state. This limits reimbursement from these programs." Other responders remarked on common misconceptions surrounding an OT's ability to assess and treat behavioral health concerns. For example, one OT provider said, "There seems to be a misperception that occupational therapists only work with people who have primary physical diagnoses. Payment has been denied for OT services provided to people with behavioral health conditions, requiring significant therapist time to complete appeals and payer education."

Mental health clinical pharmacy specialists are another group that fellow team members and patients are recognizing as making contributions to clinical teams, leading to increased access to care and improvements in workflows and overall quality of care (Gillespie et al., 2022). However, there is considerable variation in the ability of pharmacists to bill for their services. Pharmacists can bill Medicaid and private commercial insurance in some states but not others, depending on whether the specialists have been formally recognized under each respective state's legal designation of a health care provider (Ali et al., 2023; Hazlet et al., 2017). This group has also not been legally recognized as health care providers at the federal level, under Medicare, Part B (Terrie, 2023). As a result, pharmacists continue to face barriers to providing some important services, including behavioral health services, depending on the state in which the practice is located, the service performed, and payer type. This was exemplified in the following sample of responses from the RFI:

> "Currently due to CMS rules, pharmacists cannot bill for services. This is because they are not recognized as providers. Pharmacists have more years of education and training than many other professions who can currently bill for services. This limits our ability to provide services to those in need, especially those with behavioral health needs. This barrier delays access to care."

> "For all 3 programs, clinical pharmacists in general, including psychiatric pharmacists, are not recognized as providers. I therefore cannot submit for reimbursement of services I provide to patients, which are very similar in nature to a psych NP or APRN. I am forced to submit under my supervising psychiatrist's name to get any kind of reimbursement, and

> even then, not all of the FQHC's submitted claims for my patient visits get reimbursed."
>
> "Medicare/Medicaid does not recognize pharmacists as providers, therefore limiting reimbursement possibilities and tying pharmacists to provider-based clinics. This fact negates community pharmacists from providing reimbursable behavioral health services when patients are in their pharmacy (medication assessment, metabolic monitoring, side effect/outcome screening/assessment)."

Additional training might sometimes be needed to further support these allied health care providers as members of interdisciplinary behavioral health care teams (El-Den et al., 2021). Nonetheless, advocacy efforts have continued to result in removing or relaxing various scope-of-practice restrictions and billing limitations, which would allow these allied health care professionals to be more widely recognized as behavioral health providers (Read et al., 2024), including more consistent inclusion under definition of a behavioral health provider for all applicable state and federal laws.

> Finding: During the COVID-19 pandemic, both the federal government and states waived provisionally specific licensure requirements to maintain health care services, including behavioral health care. This flexibility included the provision of telehealth and provision of treatment across state lines. Several states have taken steps to codify this flexibility either through state policies or legislation.
>
> Finding: The licensing process for behavioral health providers is hampered by a myriad of individual state licensure and scope-of-practice laws and guidelines. Coupled with lengthy and different credentialing processes among individual insurance and managed care companies, these have served as a deterrent for some individuals to participate in or be allowed to participate into insurance networks to provide behavioral health treatment.
>
> Finding: There is evidence that state-based licensure is a barrier to portability across state lines and reciprocity across state lines.
>
> *Conclusion 4-7: Occupational licensing compacts can facilitate improved access to care and diminish the maldistribution of the current behavioral health workforce. Revising and updating the interstate licensure agreements or advocating for adjustments in the state law, policy, or regulation could bolster and expand occupational compacts to further ease the provision of telemedicine services across state lines.*

CONCLUSIONS

Conclusion 4-1: In addition to making short-term improvements in behavioral health provider participation among the existing workforce, strengthening the pipeline of federally subsidized behavioral health providers would build a workforce more likely to continue serving Medicare and Medicaid populations after completing their training. Bolstering workforce programs and policies, including successful pathway or pipeline programs, would increase the number of people who want to enter the behavioral health field and support behavioral health provider retention.

Conclusion 4-2: The behavioral health workforce does not reflect the diversity of the population it serves. Increasing historically underrepresented racial and ethnic identities, as well as language and cultural representation, in the behavioral health workforce is one mechanism to address disparities in access to care facing Medicare and Medicaid programs. Within Medicaid specifically, increased representation of historically underrepresented racial and ethnic identities in the health care workforce could expand access to care for beneficiaries more broadly, regardless of identity.

Conclusion 4-3: Recruitment barriers, particularly those affecting communities of color, may be addressed through efforts to decrease stigma, dispel historical mistrust, and provide financial incentives associated with behavioral health professions.

Conclusion 4-4: There is a demonstrated inconsistency between the primary source of GME program funding (e.g., Medicare and Medicaid) and participation in public insurance programs among behavioral health providers whose training is funded by GME. While GME program funding primarily comes from Medicare and Medicaid, many trainees do not subsequently participate in these programs.

Conclusion 4-5: The lack of billing for services provided by trainees in Medicare and Medicaid is a major barrier to expanding training opportunities for behavioral health specialists who are more likely to participate in the Medicare and Medicaid programs.

Conclusion 4-6: Expanding the delivery of behavioral health support specialist (BHSS) services in Medicare and Medicaid has the potential to significantly improve access and outcomes, especially for individuals with complex needs, while also augmenting the reach of licensed behavioral health professionals. Federal intervention is crucial to establishing BHSS through model national certification standards and flexible

payment models that facilitate the integration of these services into the full continuum of behavioral health care.

Conclusion 4-7: Occupational licensing compacts can facilitate improved access to care and diminish the maldistribution of the current behavioral health workforce. Revising and updating the interstate licensure agreements or advocating for adjustments in the state law, policy, or regulation could bolster and expand occupational compacts to further ease the provision of telemedicine services across state lines.

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5

Enhancing Workforce Retention in Medicare, Medicaid, and Marketplaces: Key Factors at Play

Amid national behavioral health provider shortages, maldistribution of care providers, and growing demand for services, a key hypothesized driver of inadequate access to care is the low rate of behavioral health provider participation in insurance plans, particularly in public payer markets (Graham, 2023). Studies estimate that psychiatrist acceptance of insurance is among the lowest across physician specialties (Bishop et al., 2014). For example, a 2014 analysis of the National Ambulatory Medical Care Survey found that in 2009–2010 only 55 percent of psychiatrists accepted private insurance, as compared with 89 percent of physicians in other specialties (Bishop et al., 2014). The proportion of psychiatrists accepting Medicaid decreased from 48 to 35 percent between 2011 and 2015, and, despite Medicaid expansion in many states in 2014, the proportion has remained low (Wen et al., 2019). While the empirical evidence on behavioral health provider participation in Medicare, Medicaid, and Marketplace plans has focused largely on psychiatrists, the grey literature and media reports suggest that psychologists and other behavioral health professionals' acceptance of insurance may be similarly low (Khazan, 2016; Petersen, 2021; Utah Medical Education Council, 2015). Although the number varies, depending on the source, it is estimated that approximately 54 percent of psychologists opt not to participate in Medicare (Graham, 2023).

Definitive evidence regarding other behavioral health specialty providers is unavailable. Research, largely focused on primary care providers, has identified important factors such as organizational mission and culture that contribute to health care providers' decisions to participate in insurance

programs (Gordon et al., 2018; Hallett et al., 2024). Health care providers working in settings with a community-oriented mission to provide access to care may be more supported to serve individuals who are under-resourced. A smaller body of work has further identified factors specific to behavioral health that may serve as barriers to retaining behavioral health providers in Medicare, Medicaid, and Marketplace plans. These factors include reimbursement rates, administrative burdens and delays associated with insurance billing, social and clinical complexities of the enrollee population, increasing patient acuity, using managed care, and work environment and lack of career progression opportunities. Behavioral health workers, when compensated fairly, exhibit a greater sense of value within their agencies and demonstrate reduced turnover rates (Mor Barak et al., 2001; Scales and Brown, 2020).

Currently, high turnover rates among behavioral health providers, ranging from 25 percent to 60 percent annually, pose a significant challenge to solving behavioral health provider shortages (Fukui et al., 2020). With 40 percent of the U.S. psychologist workforce over age 50, strategies to attract and retain younger professionals are imperative for sustaining behavioral health care services in the long term (APA, 2022). Finally, factors that may influence the geographic availability of behavioral health providers include licensure requirements, as individual state licensure requirements are sometimes in conflict with interstate care and telehealth service provision (HHS, 2024). Existing evidence identifies specific barriers to recruiting and retaining behavioral health providers in rural areas, including inadequate funding, professional and personal isolation, and difficulty obtaining the supervision required for licensure (Domino et al., 2019).

Among these factors, behavioral health care provider reimbursement has been identified consistently as among the most important factors in behavioral health provider decisions to participate in public or publicly subsidized insurance programs. Two major factors relate to behavioral health provider payment: (1) reimbursement, or the amount of financial remuneration per patient or service; and (2) the ease and speed with which reimbursement for services rendered is received (an equal component of a behavioral health care provider's financial profit and loss calculation). Additional concerns around ease of payment relate to what economists call "hassle" factors, which include requirements to enter into contracts to join private insurer and public health plan networks (i.e., credentialing) and approval to be reimbursed for specific services the care provider seeks to provide for a patient (i.e., prior authorization). At least one study concludes that the lower the favorability of the financial benefits associated with participation, the greater the influence these "hassles" have on a decision to participate (Dunn et al., 2021). Box 5-1 summarizes the committee's insights into the factors shaping behavioral health care providers' decisions.

BOX 5-1
What Influences Behavioral Health Care Provider Decision Making?

1. Financial viability—reimbursement rates minus "costs" of participation, including ease of payment
2. Work satisfaction—includes the sum-total of numerous contracting and participation hassles, along with the influence of patient and population needs
3. Incentives (covered in Chapter 4)—care providers who receive federal tuition subsidies or training reimbursement (similar to Health Resources Services Administration funding with commitment to underserved communities) may be commissioned as a source of professionals dedicated to public insurance networks
4. Team-based and integrated care, alternative payment and delivery models (covered in Chapter 6)—some care providers reap benefits from practicing in alternatives to traditional means, while others face challenges to their ability to practice in these models

REIMBURSEMENT AS A DRIVER OF BEHAVIORAL HEALTH CARE PROVIDER PARTICIPATION

Low reimbursement rates for behavioral health clinicians have been documented across multiple settings, service types, and health care provider types. Three levels of reimbursement disparities have been identified. First, there are significant disparities in reimbursement rates across payers. For example, Medicaid pays, on average, 20 to 30 percent lower rates for behavioral health services than commercial insurance or Medicare, although there is considerable variation in rates across states (Zhu et al., 2023). As one speaker told the committee, "based on data reported to DFR, reimbursement rates for behavioral health services are generally lower than those for medical-surgical services. Despite slight increases seen in reimbursement rates for both categories from 2021 to 2022, the gaps still remain. . . . [A] 30-minute behavioral health visit was reimbursed at $91.55, which is about 130 percent of the Medicare rate. In contrast, a 30-minute medical–surgical visit in the same area was reimbursed at $143.51, representing about 163 percent of the Medicare rate" (Brook Hall, webinar 3 panelist).

Behavioral health professional participation in Medicaid also appears to be among the lowest across payer types, despite Medicaid being the largest payer for behavioral health services (Modi, 2022). A 2017 study found that only 46 percent of psychiatrists were willing to accept new

patients covered by Medicaid, while 75 percent of psychiatrists were willing to accept new patients covered by Medicare, and 69 percent were willing to accept new patients covered by private coverage (National Council for Mental Wellbeing, 2022). Several studies and reports have cited low reimbursement rates as a driver of low behavioral health provider participation in insurance programs (Gordon et al., 2018; Mark and Parish, 2024).

Second, particularly for Medicare Advantage and Marketplace plans, behavioral health providers receive higher reimbursement for services delivered out of network than for those delivered in-network (Benson and Song, 2020; Pelech and Hayford, 2019). One study found that for similar behavioral health services, non-psychiatric medical doctors received 13–20 percent higher in-network reimbursement than psychiatrists. However, for services provided out of network, the median reimbursement was 6–28 percent higher for psychiatrists, creating financial incentives that discourage network participation among psychiatrists (Bishop et al., 2014). Third, reimbursement rates largely have not kept up with the cost of care provision, which continues to hurt staffing and services. Figure 5-1 shows the Medicare reimbursement rate for a set of common psychotherapy

FIGURE 5-1 Figure designed by Meghann Dugan-Haas, American Psychological Association Coding & Payment Policy Officer, using data from the CY2024 PFS Final Rule (11/02/2023), Addendum B. *CPT Copyright 2024 American Medical Association. All rights reserved. CPT® is a registered trademark of the American Medical Association.*
SOURCE: CMS, 2023b.

services over the last 5 years. This reimbursement landscape serves to disincentivize behavioral health care provider participation in insurance programs where behavioral health clinicians have the market power to decide to avoid insurance hassles and earn higher rates with direct cash or out-of-network pay. In addition, there is reimbursement disparity within the Medicare fee schedule. For example, while psychologists and psychiatrists are reimbursed at 100 percent of the Medicare physician fee schedule, the Medicare rate for licensed clinical social workers is set at 75 percent, lower than the 85 percent rate at which other nonphysician practitioners are reimbursed.

There remains a persistent lack of coverage parity for psychiatry compared with benefits covered for medical and surgical services, which tend to be notably higher. Studies have shown that psychiatrists are reimbursed about 20 percent less than primary care physicians for the same set of services (Rapfogel, 2022). While the Medicare Improvements for Patients and Providers Act of 2008[1] implemented cost-sharing parity between outpatient behavioral health services versus all other Part B services, federal parity laws such as the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)[2] apply to Medicaid Managed Care and commercial health plans but do not apply to Medicare q, 2016a). As a result, behavioral health benefits can be more restrictive in Medicare than in other services. For example, Medicare has no lifetime limits on inpatient services other than those for psychiatric hospitals (Freed et al., 2023). Similarly, there is often a lack of parity when comparing substance use disorder (SUD) with mental health treatment services. While mental health and substance use conditions are often co-occurring, services may be provided in different settings, by different care providers, using different billing codes. For example, coding for schizophrenia in an encounter could substantially increase reimbursement, even if substances were causing the psychosis (Zhu et al., 2022). There is concern that this separation creates barriers to coordinated care and contributes to continued and longstanding fragmentation of care in delivery systems.

Payment also inadvertently disadvantages health care providers who are delivering more complex or prolonged care, language translation, and care coordination. For example, translation services for a therapy appointment generally cost more than the reimbursement rate, and using a translator lengthens the appointment duration. A minority of states and territories

[1]H.R.6331—110th Congress (2007–2008): Medicare Improvements for Patients and Providers Act of 2008. July 15, 2008. https://www.congress.gov/bill/110th-congress/house-bill/6331/text.

[2]H.R.6983—110th Congress (2007–2008): Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008. September 23, 2008. https://www.congress.gov/bill/110th-congress/house-bill/6983.

cover language services for language-incongruent visits. In at least 14 states and the District of Columbia, Medicaid and the Children's Health Insurance Program (CHIP) reimburse health care providers or language service agencies for the cost of interpreter services (APA, 2020) but require care providers to enroll in these services and complete additional paperwork in Medicare and Medicaid which may not be required in commercial plans. Overall, 16 percent of nonelderly adults living in households with at least one Medicaid enrollee have limited English proficiency, compared with 7 percent of nonelderly adults in which no household member is enrolled in Medicaid (Haldar et al., 2022).

State behavioral health workforce reports have replicated these various payment disparities and the perceptions of and effect on behavioral health care providers. Key informant interviews with behavioral health providers and provider organizations in Washington, Oregon, California, Minnesota, Illinois, Texas, and other states demonstrated agreement that behavioral health provider wages and reimbursement is a key issue in the recruitment and retention of clinicians to the field of behavioral health more broadly and in driving attrition specifically from public payer systems (Department of State Health Services, 2014; Gattman et al., 2017; Mental Health Workforce Steering Committee, 2015; Post, 2019; Zhu et al., 2022). Behavioral health care providers across states perceive current reimbursement rates to be not commensurate with behavioral health providers' level of education, experience, or skillsets. Finally, wages vary widely across behavioral health occupations, as do the settings in which people are employed. Paula Stone, director of the Arkansas Department of Human Services, Office of Substance Abuse and Mental Health, reported in webinar 3:

> What we didn't have was something similar to what we saw on the commercial insurance side, which was independently licensed master's degree professionals that would be able to provide counseling services and set up pretty much more like private practice kinds of situations. So we . . . began paying them in 2018 the same rate we were paying agency providers. . . . (W)e went from about . . . less than five providers statewide to well over 400 of those providers statewide when we opened that up.
>
> One of the things we really wanted to do was to allow those kinds of professionals that had private practices out across our state is, not only would they enroll in commercial insurance networks, they would also start taking Medicaid clientele.

Others have found efforts to retain a diverse, culturally competent workforce to be challenged by payment concerns. A report from the National Council for Mental Wellbeing (2022) identified pay as the main barrier to recruitment and retention of qualified behavioral health staff. This was especially true for health care providers of racial and ethnic

minoritized groups, with concerns about race-based pay inequities further exacerbating low wages. Although it is important to have a diverse workforce with equitable pay, it is necessary to emphasize that the goal should be for all providers to be culturally competent, and not just rely on the racial and ethnic minority providers to solve the problem of health disparities.

Research eliciting behavioral health provider perspectives on reimbursement is limited, and empirical evidence regarding the effect of higher reimbursement rates on care provider participation in insurance markets is mixed (Candon et al., 2018; Saulsberry et al., 2019; Wagenschieber and Blunck, 2024; Yu et al., 2019). A recent Government Accountability Office (GAO) study noted when state Medicaid programs increased payment rates for substance use treatment, states saw a marked increase in supply (GAO, 2020b).

Other research on the effects of reimbursement increases has largely been limited to primary care or dental care. Some studies have focused on evaluating the effects of the temporary Medicaid fee bump for primary care clinicians in 2013–2014 under the Affordable Care Act (ACA). One study found that a $10 increase in Medicaid reimbursement was associated with 13 percent fewer enrollees reporting difficulty in being accepted as a new patient and a 1.4 percent increase in the probability that enrollees reported an outpatient visit in the past 2 weeks (Alexander and Schnell, 2019). However, other studies have found no significant association between primary care fee changes and Medicaid participation (Decker, 2018; Saulsberry et al., 2019). One study, using 2010–2016 data, found that a $10 increase in primary care fees reduced the probability of a positive screen behavioral illness by 2.8 percent among adults (Maclean et al., 2023).

While there is an absence of empirical evidence on the effects of reimbursement increases on behavioral health provider participation rates, there have been efforts at both the federal and state levels to increase payments. In a recent survey of state Medicaid programs, 38 of 44 responding states reported increasing reimbursement rates in 2023 or having plans to increase reimbursement in 2024, though there was wide variation in the scope and magnitude of these changes and the extent to which they applied to specific versus broader behavioral health provider groups (Saunders et al., 2023b). For example, Iowa's Medicaid program reported a 20.6 percent increase in rates for behavioral health intervention providers in fiscal year (FY) 2023 as well as a 56.6 percent increase in rates for individual mental health practitioners and a 96.5 percent increase in rates for SUD providers in FY 2024 (Hinton et al., 2023). In comparison, Vermont reported a 5 percent and 8 percent rate increase for SUD and behavioral health providers, respectively, in FY 2023, followed by another 5 percent rate increase across all behavioral health providers in FY 2024.

In addition, Medicaid managed care plans have several tools, including the use of supplemental or directed payments, to target specific behavioral health provider types or services where a lack of access violates existing network adequacy standards (Candon et al., 2018). In Medicare, CMS has recently proposed or implemented several payment-related changes for behavioral health services, including increasing rates for SUD treatment in the office setting and increasing rates for some timed services such as psychotherapy (Hinton et al., 2023; Seshamani and Jacobs, 2023). CMS will also increase reimbursement for psychotherapy for crisis services to pay 150 percent of the usual Physician Fee Schedule rate when this care is provided outside of health care settings.

In webinar 3, Sean Robbins, the executive vice president and chief corporate affairs officer at the Blue Cross Blue Shield (BCBS) Association, reported some BCBS plans for increasing reimbursement by as much as 50 percent, reporting: "We've been able to increase the Blue Cross and Blue Shield behavioral health networks by over 55 percent over the last 4 years, with coverage in all 50 states." However, Robbins also said that rate increases did not address low provider participation: "While payment is an important factor, it is not sufficient," he said. "It is not enough alone . . . it simply doesn't do enough to solve the issue of building broad networks. . . . It does not equal network participation."

However, at webinar 2, Rakhee Patel, the regional adult services clinical director at Coastal Horizons Center in North Carolina, voiced a different opinion: "Here in (our state) we have not had rate increases for behavioral health care in over 12 years for Medicaid programs. That is huge. . . . The reimbursement rates for Medicaid and even some of the private plans . . . have been really grossly inadequate for . . . what our clinical psychiatric staff do. Therefore, that really does disincentivize providers wanting to opt in to seeing these Medicaid and Medicare beneficiaries." Low in-network rates are consistently raised in the literature as an important barrier to insurance acceptance for behavioral health providers. Anecdotal and empirical evidence is inconclusive about the scope and magnitude of reimbursement increases needed to induce behavioral health provider participation in insurance programs. Further evaluation of these ongoing efforts and their effects is needed.

Committee Request for Information Responses

Many respondents to the committee's request for information (RFI) (see Chapter 4 for more information about the RFI) identified low reimbursement rates as the predominant barrier to participation and retention in insurance markets. Low reimbursement was an area of concern for behavioral health care providers across practice settings, including academic medical centers, community-based health centers, and independent

practice. Some respondents specifically highlighted Medicare and Medicaid reimbursement rates as being too low for many types of service providers, including those provided by psychiatrists, psychologists, licensed clinical social workers (LCSWs), and advanced practice registered nurses (APRNs). A psychologist practicing in a Georgia hospital reported in their response to the RFI that increased demand in higher-acuity settings occurred because of the resulting low availability of outpatient providers: "We're facing a tremendous shortage of providers willing to participate on insurance panels, creating a high burden on the hospital providers."

Among behavioral health care providers in independent practice, respondents highlighted the financial challenges of relying solely on insured populations, given reimbursement rates that did not account fully for the rising cost of practice. Because there is no requirement to review and adjust reimbursement rates for behavioral health services provided to beneficiaries with Medicare and Medicaid (Hinton and Raphael, 2023), respondents in federally qualified health centers (FQHCs), certified community behavioral health clinics (CCBHCs), and community mental health centers (CMHCs) observed that reimbursement rates have not kept up with the cost of providing care, with adverse effects on staffing and services. In community-based settings respondents indicated that many patients could not afford the co-pay where one existed, resulting in the behavioral health providers rarely being paid the full allowable Medicare amount. Some care providers noted a higher no-show rate for Medicaid patients, resulting in lost revenue. In addition, behavioral health providers reported that patients covered by Medicaid often require a higher level of care which is non-reimbursable outside of the allowable psychotherapy codes.

Several respondents to the committee's RFI commented on the lack of insurance coverage for services in the community, which leads to limited access for patients or lengthy waiting lists for inpatient providers facing high demand, or both. In other cases, respondents reported services being significantly scaled down or even discontinued in hospitals because of inadequate reimbursement, leaving vulnerable patient populations, such as older adults or those needing psychiatric medications, with limited options. One responding psychologist said:

> Several challenges (exist) related to mental health coverage, especially when receiving mental health services within specialty medical services clinics. Reimbursement for specialized health psychology services are also minimal and larger hospital systems are less inclined to negotiate contracts for mental health services for Medicaid/ Medicare programs, creating significant barriers for patients to access specialized health psychology services.
>
> —Ph.D./ Psy.D.
> Academic medical center, FL

In other cases, RFI respondents highlighted the frustrations that result from a lack of coverage and payment parity across payers. For example, behavioral health providers expressed frustration about an inability to bill for behavioral health services for their patients because of a lack of coverage across programs and states for certain provider types, including LCSWs, occupational therapists, and pharmacists who perform care management and coordination roles:

> Given shortened inpatient hospital stays (for medical or psychiatric stabilization) and limitations with resources/insurance coverage, there are few to no outpatient/community [occupational therapists] providers available to continue to address the mental/behavioral health needs of these patients after discharge from the hospital. This contributes to continued utilization of the inpatient hospital system vs. supported community programming to meet patients' needs.
>
> —Occupational therapist
> Academic medical center, OH

Some perceived differences were noted across insurance programs. Some Medicare-participating providers reported satisfaction with the program, noting higher reimbursement in Medicare than in other public or publicly subsidized insurance programs, and with reimbursement for telehealth services to support wide practice adoption during the COVID-19 public health emergency. Meanwhile, respondents noted specific challenges with Medicaid, including wide variability in Medicaid coverage and health care provider eligibility across states. For instance, in states that organize their Medicaid behavioral health services around FQHCs or CCBHCs, Medicaid does not contract with independent practitioners. In some states, Medicaid does not permit psychologists to bill for providing behavioral health services to adults. A psychologist practicing in Maryland said in their response to the RFI: "I am not permitted by state regulations to participate in Medicaid as a solo practitioner who is not an agency employee." Another psychologist practicing in Florida said: "My state prohibits psychologists (in most cases) from participating in Medicaid. At the current reimbursements rates, I may not participate if I could."

Despite the challenges noted with Medicare and Medicaid specifically, some respondents opted to participate in these programs. Some participants highlighted "goodwill" reasons to participate in these insurance programs, including a desire to improve access to health care, give back to the community, or serve specific populations such as the elderly or disabled persons. This sentiment has been reported in the literature, suggesting that some health providers already participating in publicly

funded insurance programs are mission-oriented, desire to serve enrollee populations, and may respond to retention efforts (Bunger et al., 2021; Hallett et al., 2024).

Reimbursement Setting and Criteria

Important differences exist in reimbursement for services across settings. For example, Medicaid reimbursement for telehealth services in a primary care setting differs from those in a behavioral health setting in terms of amount and qualifications, including that behavioral health providers must be on site for telehealth provision in an embedded primary care setting. Another example is an existing requirement within Medicaid to conduct comprehensive data collection, case intake paperwork, and diagnosis assessment and recommendations before care providers can deliver treatment and bill for services. This initial intake appointment has been documented to be the service delivery point with the highest rate of patient attrition, particularly for those with SUD or severe mental illness. A number of models have been implemented across states, such as New Mexico's Treat First approach, that prioritize treatment with a provisional diagnosis over a full assessment for up to four visits, with full comprehensive assessment following as needed. This model improves behavioral health provider capacity, increases access to services, improves patient satisfaction, lowers patient no-show rates, and reduces staff burnout (New Mexico Human Services Department, 2015; Treat First Talks, 2024).

Coding and Behavioral Health Provider Eligibility Concerns

Behavioral health providers' concerns regarding reimbursement are not limited to low reimbursement rates and include disparities in reimbursable services across provider types, care settings, and payers. Because reimbursable behavioral health services require a preceding diagnosis, therapeutic appointments lacking a diagnostic code for a mental health issue or SUD are ineligible for payment, compared to primary care where preventive or wellness visits are reimbursed (CMS, 2019, 2023e; Dormond and Afayee, 2016). In addition, substantial differences exist across Medicare, Medicaid, and Marketplace plans in the coverage and reimbursement of core behavioral health services, including many that add clinical value to patients and are performed within appropriate scopes of practice. These differences not only create administrative, payment, and clinical inconsistency among health care providers, adding to operational burdens, but they also directly limit access to certain types of services and health care provider types across payer populations.

Both Medicare and Medicaid recognize psychiatrists, clinical psychologists, LCSWs, and APRNs/nurse practitioners as core behavioral health professionals who can bill for common Current Procedural Terminology (CPT) codes (Dormond and Afayee, 2016). Starting January 1, 2024, marriage and family therapists (MFTs) and mental health counselors (MHCs) may independently bill Medicare for their services (CMS, 2024c). Implementing Medicare eligibility for MHCs and MFTs is estimated to increase the behavioral health workforce by about 225,000 care providers nationally and expand much-needed access to behavioral health services for Medicare beneficiaries.

Medicaid billing processes and procedures also vary from state to state, particularly in reimbursement for clinical psychologists, LCSWs, MFTs, MHCs, and peer counselors (Dormond and Afayee, 2016). Peer support services, in particular, remain an optional benefit for state Medicaid programs (GAO, 2020a), although as of 2023, 48 states covered peer support services in their Medicaid fee-for-service programs. Per a 2022 Kaiser Family Foundation report, 16 states specify service limits, such as units per day or medical necessity (KFF, 2022). Some variation in behavioral health provider billing eligibility stems from differences in scope-of-practice laws at the state level. For example, Louisiana, New Mexico, Illinois, Iowa, Idaho, Colorado, and Utah permit doctoral-level psychologists to prescribe or consult for medical doctors after receiving specialized training (DeAngelis, 2023). Thus, varying behavioral health provider roles and scopes of practice may contribute to some heterogeneity in billing eligibility and coverage. A study done by the University of Michigan's School of Public Health highlighted the challenges in meeting the demand for mental health and substance use disorder services due to a shortage of qualified professionals. The study suggests further efforts are needed in reviewing billing and reimbursement practices and the assurance of reimbursement for routine procedures within professionals' expertise. It also explored how professionals use CPT codes across Medicare, Medicaid, and private insurers, noting that while most codes are usable for authorized services, alternatives exist for restricted codes (Dormond and Afayee, 2016). Tables 5-1 and 5-2 show Medicaid program variation between states in behavioral health care provider eligibility for billing common behavioral health services. Misalignment in reimbursement can hamper coordinated care efforts, although as healthcare moves towards integrated and value-based models barriers may diminish as payers value the benefit of non-licensed professionals and team-based approaches, leading to better patient outcomes with possible savings of cost (Dormond and Afayee, 2016).

TABLE 5-1 Medicaid Reimbursement Eligibility for 90791: Psychiatric Diagnosis Evaluation without Medical Services, by State and Occupation

State	Psychiatrist	Clinical Psychologist	Licensed Clinical Social Worker	Licensed Professional Counselor	Licensed Marriage and Family Therapist
Alabama	B	B	B	B	B
Alaska	X				
Arizona	X	X	X	X	X
Arkansas	X	X	X	X	X
California	X				
Colorado	X	B	B	B	B
Connecticut	X	X	X	X	X
D.C.	A	A	A		
Delaware	X	A	A		
Florida	X	A	A		
Georgia	X	X	X		
Hawaii	X				
Idaho	X	X	X	X	X
Illinois	X	X			
Indiana	X	X	X	X	
Iowa	B				
*Kansas—Sunflower	X	A	A		
Kentucky	B	B	B	B	B
Louisiana	X	X	X		
Maine	B	B	B		
Maryland	B	X	X	B	
Massachusetts	X				
Michigan	X				
Minnesota	X	B	B	B	B
Mississippi	X	X	X		
Missouri	X	X	X	B	B
Montana	X	B	B	B	
Nebraska	X	X			
Nevada	X	X	X		
New Hampshire	B				

continued

TABLE 5-1 Continued

State	Psychiatrist	Clinical Psychologist	Licensed Clinical Social Worker	Licensed Professional Counselor	Licensed Marriage and Family Therapist
New Jersey	X	A	A	A	
New Mexico	X	X	B		
New York	X	A	A		
North Carolina	X	B	B	B	B
North Dakota	X		B		
Ohio	X				
Oklahoma	X	X	X	B	
Oregon	X	B	B	B	
Pennsylvania	X	B			
Rhode Island	B				
South Carolina	B	B	B	B	
South Dakota	X	A	A		
Tennessee	X				
Texas	X	B	B	B	
Utah	X	X			
Vermont	X				
Virginia	X				
Washington	X	X	A		
West Virginia	B	B			
Wisconsin	X	B	B	B	
Wyoming	X	B	B		

NOTES: *Kansas Medicaid is divided among several managed care organizations (MCOs). Sunflower is one MCO that served as a proxy for Medicaid information. A = only community health; B = only community behavioral health; X = both community health and community behavioral health. Data are unavailable for community health for: Kentucky, Maine, Rhode Island, South Carolina. Data unavailable for community behavioral health: Washington, D.C. Not covered for community health: New Hampshire, West Virginia.
SOURCE: Dormond and Afayee, 2016.

TABLE 5-2 Medicaid Reimbursement Eligibility for 90846: Family or Couples Psychotherapy with Patient, by State and Occupation

State	Psychiatrist	Clinical Psychologist	Licensed Clinical Social Worker	Licensed Professional Counselor	Licensed Marriage and Family Therapist
Alabama	X	X	X	X	X
Alaska	X	X	X	X	X
Arizona	X	X	X	X	X
Arkansas	X	X	X	X	X
California					
Colorado	X	X	X		
Connecticut	X	X	X	X	X
Delaware		X	X	X	X
Florida	X	X	X	X	X
Georgia	X	X	X	X	X
Hawaii	X	X	X	X	X
Idaho	X	X	X	X	X
Illinois					
Indiana	X	X	X	X	X
Iowa	X	X	X	X	X
*Kansas—Sunflower	X	X	X	X	X
Kentucky	X	X	X	X	X
Louisiana	X	X	X	X	X
Maine	X	X	X	X	X
Maryland	X	X	X	X	X
Massachusetts					
Michigan	X	X	X	X	X
Minnesota	X	X	X	X	X
Mississippi	X	X	X	X	X
Missouri	X	X	X	X-under 21 only	
Montana	X	X	X	X	
Nebraska	X	X	X	X	X
Nevada	X	X	X	X	X
New Hampshire	X	X	X	X	X

continued

TABLE 5-2 Continued

State	Psychiatrist	Clinical Psychologist	Licensed Clinical Social Worker	Licensed Professional Counselor	Licensed Marriage and Family Therapist
New Jersey	X	X	X	X	X
New Mexico	X	X	X	X	X
New York	X	X	X	X	X
North Carolina	X	X	X	X	X
North Dakota	X	X	X	X	X
Ohio	X	X	X	X	X
Oklahoma	X	X	X	X	X
Oregon	X	X	X	X	X
Pennsylvania	X	X	X	X	X
Rhode Island			X	X	X
South Carolina	X		X		
South Dakota					
Tennessee	X	X	X	X	X
Texas					
Utah	X	X	X	X	X
Vermont	X	X	X	X	X
Virginia	X	X	X	X	X
Washington	X	X	X	X	X
West Virginia	X	X	X	X	X
Wisconsin	X	X	X	X	X
Wyoming	X	X		X	

NOTES: *Kansas Medicaid is divided among several managed care organizations (MCOs). Sunflower is one MCO that served as a proxy for Medicaid information. Data unavailable for: Washington, D.C.
SOURCE: Dormond and Afayee, 2016.

Service Types

There are significant disparities in covered services within payer systems. Historically, Medicare did not cover SUD outpatient services, and enrollees had to rely on private pay or state indigent funds. While Medicare now covers an array of SUD treatment services, special rules limit coverage and reimbursement, including a 190-day lifetime limit on coverage of psychiatric inpatient hospitalization this is a statute, and is not up to Medicare's regulatory

discretion (Medicare.gov, 2024). This coverage cannot be renewed once it has been used, though individuals requiring inpatient treatment for a behavioral health condition may receive relevant treatment at a general hospital under Medicare Part A benefits. Beginning January 1, 2024, Medicare expanded an existing partial hospitalization benefit and now covers intensive outpatient (IOP) services in a variety of settings, including Community Mental Health Centers (CMHCs), hospital outpatient departments, and Federally Qualified Health Centers FQHCs (Freed et al., 2023b). Medicare also pays for IOP in Opioid Treatment Providers (OTPs) and also Rural Health Clinics (RHCs) (CMS, 2023c). However, Medicare still does not cover treatment at free-standing substance use disorder (SUD) facilities, a setting in which most individuals with SUD conditions receive IOP and partial hospitalization services. Congress has not established a provider type for freestanding SUD facilities through legislation, preventing them from billing Medicare directly—an issue that falls outside CMS' regulatory authority and requires legislative change for resolution (CMS, 2023e; Steinberg, 2023).

Finally, there are persistent concerns that existing billing codes and modifiers inadequately cover the full scope of services provided by behavioral health professionals, including health-related social needs and care coordination activities. For example, the Interactive Complexity Component Code (Code 90785) performed with psychotherapy is an add-on code that allows some behavioral health providers to increase reimbursement for complex patients, but this code is generally reimbursed at less than $20 per visit and relates only to the increased work intensity of the psychotherapy service (CMS, 2019). In addition, while a preponderance of evidence supports the role of care coordination in supporting health behaviors and improved health outcomes in adults and children with behavioral health needs, behavioral health integration codes are underused (Albertson et al., 2022; Daumit et al., 2019). Medicare began making payments for behavioral health integration services in 2018 to accelerate the adoption of behavioral health integration (BHI) models more widely, but evidence suggests that in the first 2 years of adoption, BHI codes represented just 0.1 percent of beneficiaries with a relevant behavioral health diagnosis (Cross et al., 2020). Similarly, the use of BHI codes in Medicaid has also stalled (McConnell et al., 2023). Early adopters of BHI codes have struggled to implement sustainable billing and care delivery practices, suggesting a concurrent need for structural and process-related investments (Carlo et al., 2019).

While behavioral health services rely on numerous collateral activities, including treatment planning, team-based collaboration, care navigation and coordination, and addressing the social determinants of health, non-encounter services remain time- and labor-intensive but unbillable for care providers. The committee heard from behavioral health providers that inadequate payment for supervisory roles—a key component of workforce development and retention—was unsustainable, as supervision, training,

and education activities often translated into fewer billable hours. This misalignment between activities delivered and activities paid for reinforces longstanding concerns about the opportunity costs of practicing in an underpaid, overworked public payer system.

Finding: Data show that payment for behavioral health care has been stagnant and not kept pace with either inflation or the costs of care provision, which generates financial pressures for behavioral health practices and adverse impacts on staffing and services.

Finding: There is a persistent lack of behavioral health coverage and payment parity, particularly in Medicare, compared with benefits covered for medical and surgical services.

Finding: Evidence on the effects of reimbursement increases on behavioral health provider participation has largely been limited to primary care and dental care, and more evidence is needed to demonstrate the magnitude and scope of the rate changes that can induce changes in health care provider behavior. Based on existing empirical and anecdotal evidence, rate changes are likely necessary but insufficient on their own to increase access to behavioral health services in Medicare, Medicaid, and Marketplace plans.

Finding: Reimbursement models are generally not designed to adequately compensate and incentivize collaborative, team-based care. Similarly, uptake of integrated care codes has been slow and limited.

Conclusion 5-1: Insufficient and often unstable reimbursement has been identified as a key factor driving low behavioral health provider participation in public insurance programs. Low reimbursement is particularly stark when compared with higher out-of-network rates paid in commercial insurance markets and higher cash-pay rates. Across payers, there is often a lack of transparency on how rates for behavioral health services are currently set, with consistent undervaluation of work efforts for behavioral health care providers and inadequate accounting for the costs of care provision.

Conclusion 5-2: There is limited and mixed evidence about the effects of reimbursement rate increases on behavioral health provider participation in insurance programs, and existing evidence is lacking on the magnitude and scope of reimbursement required to increase access to behavioral health providers in Medicare and Medicaid. Recent state efforts to modify behavioral health payments, particularly in Medicaid, should be evaluated and monitored closely.

RISING COSTS MAY RESTRICT NEEDED INVESTMENT IN WORKFORCE: THE ROLE OF COST CONTAINMENT

With ensuring patient access to quality care as the overall goal, there are numerous competing focuses that deserve attention within Medicare, Medicaid, and Marketplace plans. Focus on rising costs and potential service delivery efficiencies while improving outcomes, demands serious policymaker attention on reasonable and evidence-based cost containment measures. It cannot be understated that cost containment measures are simultaneously (a) critically important to the fiscal sustainability of Medicare, Medicaid, and Marketplace plans and (b) having a dramatic adverse impact on the provider experience in the provision of care. As this report discusses "Administrative Barriers" and "burdens" throughout its chapters and recommendations, the Committee recognizes that cost containment tools (such as prior authorization) are fiscally necessary, and to a large extent will continue to be applied. However, the Committee also identified the often-excessively time consuming and ineffective application of these cost containment tools. The need to reform current cost control mechanisms to ensure their most effective, accountable, and targeted application is identified as an area of immediate action.

ADMINISTRATIVE BARRIERS

> As a child and adolescent psychiatrist, when there had been stimulant shortages in the past year . . . covered by Medicaid and CHIP . . . I needed to get a prior authorization for another medication; by the time I got the prior authorization, the medication was already out. I had to pursue another prior authorization . . . spending the valuable time as a provider trying to take care of people and kids. It delayed actually access to care, but it also increased the level of stress and additional work and burden on the psychiatrist if you do not have a practice management system that takes care of all of those things.
>
> —Warren Ng, webinar 2 panelist
> Experiences of Behavioral Health Care Providers with
> Public Insurance Programs

Health care provider administrative burden consists of an array of time-consuming requirements, including prior authorization, payment denials and associated appeals, and other added costs of doing business. A large body of work has shown that the time and expense associated with these paperwork and negotiation activities influences the decision of health providers to participate in insurance plans, particularly Medicaid. There is also concern that administrative processes, including prior authorization, may be one way that health plans may limit access to behavioral health services in particular.

While behavioral health providers face many of the same administrative burdens as medical and surgical providers, there are also administrative burdens unique to behavioral health. For example, behavioral health providers remain more likely than medical and surgical providers to work in small-group or solo practices, with limited capacity and support for billing, claims processing, network contracting and credentialing, and other administrative activities across the modern clinical practice continuum. In addition, the organization of behavioral health service delivery may impose unique burdens on the workforce. For example, 43 percent of psychologists outside of urban areas operate in solo practices, and 11 percent work in independent group practices and 43 percent in individual solo practices (Hamp et al., 2016). As such, behavioral health providers often lack the administrative staff needed for administrative and operational tasks, including paperwork required to enroll in provider networks, maintain credentialing, coding, reimbursement, and appeals processes.

Supporting this evidence, behavioral health providers responding to the committee's RFI said they perceived several administrative processes to be overly burdensome, including prior authorization processes for medication and service coverage; addressing claim rejections; lengthy and document-heavy credentialing processes; and documentation burden to comply with audits, including the real or perceived threat of insurance clawbacks (Pollitz et al., 2023c). Other data drawn from the multi-specialty physician members of a large academic medical center found administrative burden to negatively affect the behavioral health care provider experience in an academic setting. Physicians in this sample said that they spent nearly a quarter of their working hours spent on administrative tasks, and higher administrative burden was associated with higher burnout and lower career satisfaction. The administrative tasks identified as most burdensome included prior authorizations and ambulatory clinical documentation (Rao et al., 2017).

> Primary issues with these insurances are generally related to coverage and pre-authorizations . . . . I am paneled with some Medicare and Medical plans that are easy to work with and others we struggle to obtain authorization for services even with providing solid clinical evidence and support.
>
> —Ph.D./ Psy.D.
> Private medical clinic, UT

Billing and Coding Barriers

Delayed and denied payment is a key factor influencing behavioral health provider participation, particularly in managed Medicaid and Medicare Advantage. Beyond reimbursement rates, payment-related administrative barriers may include paper-based billing, processing errors, payment denials, and

time-consuming negotiation and appeals processes. Evidence demonstrates that physicians report payment delays and other administrative burdens associated with Medicaid in particular and that delays in reimbursement can offset the effects of rate increases (Cunningham and O'Malley, 2008). Along these lines, there are several major effects of administrative barriers on behavioral health care providers' willingness to accept insurance.

- **Care providers respond to billing problems by refusing to accept Medicaid patients.** Empirical evidence suggests that payment hurdles appear to be as important quantitatively as payment rates in explaining the variation in physicians' willingness to treat Medicaid patients. Health care provider reluctance to accept Medicaid is acute in states with more billing challenges (Dunn et al., 2021). A 2024 analysis of national remittance data found that care providers lose 18 percent of Medicaid revenue to billing barriers, compared with 4.7 percent for Medicare and less than 2.4 percent for commercial insurers (Dunn et al., 2021). The same study found that increases in incomplete billing reduced the probability of physicians' acceptance of Medicaid to a larger effect than a comparable increase in Medicaid reimbursement rates, suggesting the importance of administrative hassles in influencing willingness to participate in Medicaid (Gottlieb et al., 2018).
- **Lag times in reimbursement generate financial uncertainty.** Payment for services through Medicare and Medicaid may occur several months or more after the clinical encounter. The numerous, complicated, and highly specific steps in the revenue cycle increase the likelihood of errors, both by payers and care providers (Burks et al., 2022). For example, an incorrectly entered initial or digit may often result in a denial. Once corrected, re-submission of the claim may yield yet another denial, this time for timely filing. The delays and lack of predictability in cash flow represent a significant source of financial uncertainty for care providers and provider organizations (LaPointe, 2016). In Medicare Advantage the Department of Health and Human Services (HHS) Office of the Inspector General (OIG) has found evidence of inappropriate payment denials that exacerbate health care provider cash-flow challenges. Medicare Advantage plans were found to deny payments to health care providers for services they had delivered to patients, even though the requests met Medicare coverage rules and Medicare Advantage organization billing rules. Physicians were more likely to fight a denial when the reimbursement rates and the likelihood to collect payment are higher, but this effort is time and labor-intensive, which could adversely affect behavioral health providers practicing in smaller and independent settings.

Respondents to the committee's RFI noted the effect of such administrative burdens. For example, once a care provider had been admitted to insurer panels, documentation expectations were reported to be "very rules-heavy" and administratively complex with limited assistance in navigating or understanding policies, procedures, and processes. Some health care providers reported that after a prolonged waiting period, claims could be denied if even a small detail was missing or erroneous. Many reported they needed to hire a full-time administrative staff to manage authorization and billing processes, especially in Medicaid, and that the process was such that the costs exceeded the generated revenue. Some respondents felt they were paying to provide the service instead of being paid. Finally, several health care providers expressed concerns that if they were treating a higher-than-average number of Medicare and Medicaid patients, they would be flagged as being potentially fraudulent and risk being audited, a process that was both time consuming and financially draining.

Given that delays in Medicaid payments reduce care provider participation, some Medicaid agencies have adopted prompt payment policies (Cunningham and O'Malley, 2008). Box 5-2 highlights the rules for prompt payment. The GAO's examination of Medicaid program integrity found that collaboration between CMS and state auditors engaged in Medicaid oversight could help target oversight to areas of greatest risk for noncompliance such as lags in prompt payment (GAO, 2023). In addition, some Medicaid agencies are incentivizing behavioral health providers to participate in integrated physical and behavioral health systems (Saunders et al., 2023a). Similar policies exist across commercial and Medicare Advantage plans, but there is evidence that inconsistent or non-specific definitions allow insurers wide latitude in interpreting what constitutes a "clean claim" and make it possible for them to reject claims for minor mistakes or to use other tactics to dictate the payment timeframe. Additional reasons for insurers to deny a submitted claim, such as not a covered benefit or enrollee, no prior authorization approval or referral, or a medical necessity concern, also contribute to delays. To a health care provider, these denials could lead to the same time-consuming, back-and-forth negotiations and appeals that effectively constitute a payment delay (Pollitz et al., 2023a).

Prior authorization and related usage review tools such as concurrent review are management tools that insurers use to determine what behavioral health care provider-recommended services or medications for a particular patient they will approve for payment. Most prior authorizations are typically done either by telephone or via electronic web portals (ACMA, 2021). After submitting the required information, the payer may approve the prior authorization, approve it with revisions or limitations, or deny it. Health care providers and patients may appeal denials through an established review process involving the submission of

BOX 5-2
Prompt-Pay Rules

Medicaid: As of 2022, The federal "Timely Claims Payment" rules require states to pay 90 percent of all clean claims within 30 days of receipt; and 99 percent of all clean claims within 90 days of receipt, with some waivers and exceptions allowed. All clean claims must be paid within 12 months of receipt with some waivers and exceptions allowed (42 CFR § 447.45).

ACA Marketplace Plans: All states require commercial insurers to pay or deny claims within a set time, usually 30, 45, or 60 days after receipt of a "clean claim." These state "prompt pay" laws do not apply to Medicare and Medicaid. Prompt-pay laws are intended to address issues related to delayed care provider payments for services rendered, often requiring insurers to pay electronic claims faster than paper claims, pay interest on late payments, and risk being fined by the state's Department of Insurance (APA Services, 2005).

Medicare Advantage: Federal rules also govern Medicare Advantage Plans via the contracts between CMS and the Medicare Advantage organizations, such that: the Medicare Advantage organizations must pay 95 percent of the "clean claims" within 30 days of receipt if they are submitted by, or on behalf of, an enrollee of a Medicare Advantage private fee-for-service plan. For noncompliance, Medicare Advantage plans will pay interest to the health care providers or may have funds deducted from their contract with Medicare (CMS, HHS § 422.520).

further documentation. These processes are ubiquitous. In 2024, Medicare Advantage plans required prior authorization for up to 21 percent of all clinical services, including 93 percent of all Part B medication spending and 74 percent of all medication use (Gupta et al., 2024). An OIG report reviewing 115 Medicaid managed care plans found that in 2019 one out of every eight prior authorization requests were denied (OIG, 2023). A 2018 study showed that 85 percent of Medicare Advantage plans imposed prior authorization processes on psychiatric services, compared with 60 percent for other physician specialty services (Hodgkin et al., 2018).

There is ongoing debate about the role and efficacy of the prior authorization process. Insurers maintain that prior authorization is a necessary cost control mechanism to address inefficient or unnecessary spending, low value or harmful care, and misalignment of health care resources. According to an April 2023 analysis, inefficient clinical spending costs an estimated

$345 billion a year (Peter G. Peterson Foundation, 2023). The pressure to reduce the costs of inefficient or ineffective care compels insurers to weigh the savings associated with decreasing inefficiencies with the cost of doing usage review or management. These usage review practices generally consist of reviewing a practitioner's clinical judgment and clinical plans to determine if services should be reimbursed. Some evidence suggests that prior authorization processes may reduce costs. For example, a 2023 study examining prior authorization restrictions in relation to prescription drug use and spending in Medicare Part D found that the use of prior authorized drugs declined by 25 percent and overall Part D spending fell by 3 percent, translating into savings that exceeded the overhead costs of administration by a factor of 10 (Wallace, 2023).

In behavioral health, prior authorization is used to manage the array of SUD inpatient and outpatient treatment services. Some insurers focus prior authorization only on residential SUD treatment out of a concern for cost and quality (Tufts Health Plan, 2024). However, for individuals in crisis and for those who are committed to seeking treatment, a delay in care can be catastrophic and can contribute to missed opportunities for early treatment, poorer outcomes, or foregone care. Other common applications of prior authorization in behavioral health care include mental health partial hospitalization programs, inpatient detoxification admissions, mental health inpatient admissions, neuropsychological testing, psychological testing, behavioral health day treatment, residential treatment, and electroconvulsive therapy, though these applications vary widely across plans and markets.

Health care providers note that significant time and labor demands are required to comply with prior authorization processes (AMA, 2022b). A 2009 study estimated that physician practices spent, on average, 20.4 hours per physician per week to respond to authorization requests, the second greatest administrative burden after billing. These prior authorization processes are viewed as having a cost-shifting effect onto the health care provider, by demanding additional provider time and staff resources to comply with them. In response to a 2017 American Medical Association survey, 34 percent of physicians reported having at least one staff member working exclusively on prior authorization requests, representing a substantial added cost to each practice that is not calculated into estimates of the cost–benefit of prior authorizations (AMA, 2018; Casalino et al., 2009).

Thus, the potential benefit of prior authorization processes in reducing unnecessary or wasteful spending is offset by the significant associated administrative burdens and costs to the insurer and provider of conducting prior authorization processes and is offset by the costs to the patients of dealing with the effects of delayed patient care. More recent evidence

suggests that prior authorization processes play an important role in insurance participation decisions. Reducing provider hassles could promote greater provider participation, which may be as important as containing unnecessary spending. One study found that when administrative burdens are disproportionately greater in Medicaid programs, relative to other payers, providers are more likely not to accept Medicaid insurance (Dunn et al., 2021). These findings have been replicated in other settings. For example, a 2011 survey of Washington State primary care physicians found that a quarter of physicians already seeing Medicaid patients considered administrative paperwork in Medicaid to be a major problem. Consistent with other studies, these researchers concluded that there is a care provider financial calculation related to the practice costs of participation in Medicaid (Long, 2013). Another study showed that the requirement of prior authorization for certain medications has been cited as a top reason by psychiatrists to decline participation in Medicare and Medicaid provider networks (Shim et al., 2014).

Evidence suggests that prior authorization processes may prevent individuals with behavioral health needs from obtaining needed services because of delay or coverage uncertainty, sometimes leading to untreated disorders. A 2022 survey of physicians by the American Medical Association found that 94 percent of physicians reported care delays arising from prior authorization requests and 80 percent reported that prior authorization processes sometimes led to the abandonment of the care plan (AMA, 2022a). A 2023 Kaiser Family Foundation consumer survey found that more than a quarter of those seeking treatment for behavioral health conditions had experienced prior authorization problems in the previous year, compared with 13 percent of insured adults who did not seek behavioral health treatment (Pollitz et al., 2023b).

Similarly, a GAO report found that prior authorization is less likely to be granted for mental health inpatient hospitalizations than for medical and surgical hospitalizations, creating further access challenges for patients who need acute and higher levels of service (GAO, 2022). Evidence also suggests prior authorization policies, as well as step therapy and other use management requirements, measurably affect behavioral health medication choices as well as medication continuity (Zhang et al., 2009). Research has also shown that increased hospital and other health care service use is linked to delaying or switching psychiatric medications due to prior authorization and other medication management tools (Lu et al., 2011; West et al., 2010).

Removing prior authorization for certain behavioral health services has been shown to promote access to evidence-based treatment and improved outcomes, while significantly decreasing adverse outcomes such as related hospital use. A notable share of policies to remove prior authorization in behavioral health have been part of a bundle of state policies designed to

expand the use of medication-assisted treatment (MAT) for opioid use disorders (OUDs). For example, removing prior authorization for MAT among Medicare patients with OUD was associated with a decrease in opioid use, an increase in MAT initiation, a significant decline in relapse rates, and decreases in SUD-related inpatient admissions and emergency department visits (Mark et al., 2020). Studies of Medicaid-funded OUD care found that prior authorization was linked to lower use of buprenorphine prescription, an evidence-based MAT option, in addiction treatment programs (Andrews et al., 2019). Finally, the effects of prior authorization removal may differ in different contexts, an area needing further study. An analysis of Medicaid beneficiaries found that states with low baseline MAT use had significant increases in usage associated with the removal of prior authorization processes, but that this effect did not exist in states with already high baseline MAT use (Christine et al., 2023).

Studies of insurer application and government regulation of prior authorization activities suggest a need for enhanced regulatory oversight. The HHS OIG found that Medicare Advantage plans improperly denied 13 percent of prior authorizations for services that Medicare should have covered (OIG, 2022). The same review found extensive use of prior authorization in Medicare Advantage plans, including prior authorization for 99 percent of Part B drugs, versus traditional Medicare, which generally does not use either prior authorization or step therapy for Part B drugs. OIG also noted excessive documentation requirements and clinical ambiguity. Among Medicaid managed care organizations, OIG found high rates of denied prior authorization requests, insufficient oversight by most states of prior authorization denials, and limited access to external medical reviews to expertly determine care approvals.

While offering consumer choice and potentially competition among plans, state contracting with multiple Medicaid managed care organizations appears to increase provider administrative burden. Unless a state requires standardization, health care providers contracting with multiple Medicaid managed care organizations encounter duplicative administrative burdens which could challenge smaller behavioral health organizations in particular. When a state contracts with multiple MCOs healthcare providers need to sign agreements with each one to join their networks. This requires managing several contracts, adhering to diverse administrative rules, and adjusting to different reimbursement rates. These complexities can challenge care coordination among the various MCOs leading to increased administrative burdens and potentially affecting the efficiency of healthcare delivery. In addition, OIG found that managed care organizations in many markets violate federal MHPAEA requirement that insurers' prior authorization requirements and medical necessity standards for behavioral health services must be comparable to, or "no less restrictive"

than, those for medical and surgical health services (OIG, 2023). Finally, as with Medicaid managed care organization markets, state insurance regulator, CMS, and Department of Labor reviews have found commercial plans, including Marketplace plans, with MHPAEA parity and other violations resulting from impermissible preauthorization requirements and improperly denied claims.

Based upon patient and behavioral health provider pressure, negative feedback, and state 699 legislative and regulatory actions, efforts are underway to streamline prior authorization 700 processes. In 2024, CMS issued a final rule aimed at expediting and automating prior authorization processes for medical items and services (other than drugs) in Medicare Advantage (MA), Medicaid, Children's Health Insurance Program (CHIP), Medicaid and CHIP managed care organizations, and Qualified Health Plans (QHP) offered through the Federally-facilitated Marketplace. These final rule provisions, largely beginning in 2026, also include requirements to publicly report prior authorization metrics, such as approval rates and median length of time to make a decision. In addition, state Medicaid programs are working to address "administrative burdens to reduce time associated with unbillable (sic) behavioral health provider time and resources and potentially result in higher rates of Medicaid acceptance" (Saunders et al., 2023a). Box 5-3 highlights a recent Kaiser Family Fund study on what some state Medicaid programs are doing to increase participation of behavioral health care providers.

Although progress to address commercial insurance, including Marketplace plans, has been slow, a January 2018 agreement among national insurance and behavioral health provider associations resulted in a "Consensus Statement on Improving the Prior Authorization Process," which highlighted the need for various approaches, including:

- Selectively applying prior authorization requirements, exempting certain care providers based on their quality performance (called "gold carding") (AMA, 2024).
- Using data analytics and clinical criteria to reduce the list of services subject to prior authorization.
- Communicating prior authorization requirements, criteria, and rationales to care providers and patients.
- Using electronic health records or other automated systems for electronic prior authorization versus phone and fax processes.
- Ensuring continuity of care for patients undergoing active treatment with change of coverage.
- Enacting laws limiting prior authorization from public and private insurers on SUD services or medications, something that 21 states and the District of Columbia have done since 2020 (Partnership to End Addiction, 2020).

BOX 5-3
Review of State Innovations Aiming to Increase Behavioral Health Provider Participation in Medicaid

A recent Kaiser Family Foundation study of state Medicaid programs offered the following findings:

Strategies to extend the existing behavioral health workforce include reimbursing for new behavioral health provider types, adding behavioral health provider types who can bill without a supervising practitioner, loosening in-person requirements for telehealth or interprofessional consultation codes, and reimbursing trainees or the license-eligible workforce. Nearly all responding states (33 out of 38) had at least one strategy in place to extend the existing workforce. Most states with managed care organizations reported that the new strategies adopted were also applied to managed care organizations. Adding peer support counselors or marriage and family counselors was the most commonly reported change. Interprofessional consultation can extend the workforce under recent CMS guidance—for instance, allowing a primary care physician to be reimbursed for a consultation with a psychiatrist to discuss medication management.

Lengthy forms and documentation; unclear, duplicative processes; lengthy credentialing processes; and unclear reasons for claim denials or auditing result in administrative and financial burdens that many behavioral health providers are unwilling to accept. Unnecessary, duplicative administrative processes are time consuming and uncompensated and may cause payment delays. These factors discourage behavioral health providers from participating in Medicaid and managed care organizations. Adding to those complications, managed care organizations in the same state may have different administrative requirements.

About three-fourths of responding states (24 out of 31) adopted at least one strategy to reduce administrative burden in 2022 or 2023. The most common strategies were seeking provider feedback on administrative processes and standardized credentialing (15 states).

Medicaid programs and managed care organizations can incentivize behavioral health provider participation by adopting prompt-pay policies and reducing delays in reimbursement. Other types of behavioral health provider incentives include providing additional funding for integrated physical and behavioral health, increasing internships and other training opportunities, and student loan repayment programs.

SOURCE: Saunders et al., 2023a.

Pathways to Enrollment in Medicare, Medicare Advantage, Medicare Marketplace, and Medicaid Plans

Providers who wish to participate in Medicare, Medicare Advantage, Medicaid, and Marketplace plans must become acutely familiar with the requirements and steps involved with each specific plan. CMS offers two options for enrollment – one for individual providers and one for organizations. Regardless of option, enrollment for Medicare, Medicare Advantage, and Marketplace plans typically follows three main steps to becoming a Medicare Provider: (1) Obtain a National Provider Identifier (NPI), (2) Complete the Medicare Enrollment Application, and (3) Work with regional Medicare Administrative Contractor (MAC). Individuals must complete the enrollment steps on their own, whereas organizations typically have enrollment and credentialing staff who manage applications. The enrollment process typically takes 60–90 days. CMS offers multiple resources, including videos, on how to enroll in Medicare (CMS, 2023a). Figure 5-2 shows a summary of the enrollment process for Medicare providers and suppliers.

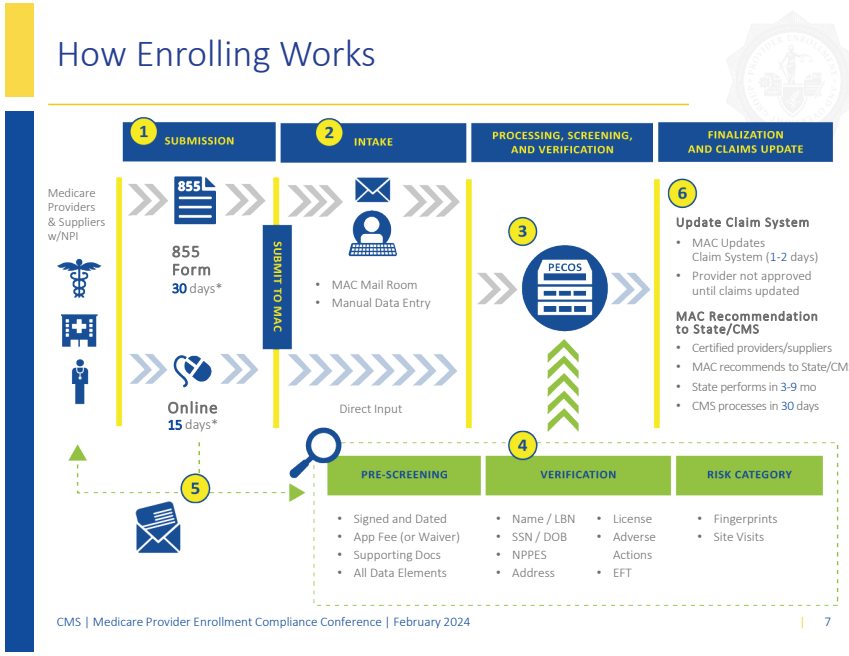

FIGURE 5-2 Enrollment process for Medicare providers and suppliers.
SOURCE: Schalm and Chong, 2024.

Provider participation in specific Medicare Advantage and Medicare Marketplace plans will have to complete additional application steps for each plan (Freed et al., 2024).

In contrast to Medicare, Medicaid programs are state based and fall under the purview of individual state Medicaid agencies (CMS, 2016; Medicaid.gov, 2024). As such, each state has its own application procedures. In general, any provider seeking to participate in a state Medicaid program must submit demographic information (including social security number), licensure, National Provider Identifier (NPI), and any criminal convictions related to Medicare, Medicaid, or CHIP (CMS, 2024a). If the provider practices in one of the 41 states that has Medicaid Managed Care (Hinton and Raphael, 2023), they must also complete additional applications to each Medicaid Managed Care entity. For some providers, this could result in as few as two additional applications (e.g. As noted previously, the majority of behavioral health providers in independent practice do not have the infrastructure to absorb the administrative demands of the application process (Bishop et al., 2014).

The credentialing process as briefly outlined above can be slow, burdensome, difficult navigate, and unsustainable for solo providers or small provider practices and groups that do not have adequate resources (such as time, staffing, or additional funding). Please refer to Table 5-3 for selected RFI quotes about provider experiences and perceptions with enrollment and credentialing for Medicaid, Medicare, and Marketplace plans:

Credentialing

To receive the accreditation that they need to conduct business and for legal liability reasons, payers must credential all health care providers in their network. A health care organization, third-party organization, or payer can complete the credentialing process, which involves assessing and verifying the education, training, registrations, licensing, certifications, and medical practice history of individual providers, including provider-related disciplinary actions and malpractice allegations. Even health care providers who have completed a credentialing process with another organization must request participation with each payer as a prerequisite to filing any claims. In general, each payer has its own health care provider enrollment process with requirements that often duplicate what the care provider supplied during the initial credentialing process. Payer enrollment includes negotiating the behavioral health care provider contract and other information the payer needs to process claims from that provider (Medallion, 2023). In addition, many plans require separate enrollment for behavioral health and other clinical services, creating additional burdens for providers that operate in an integrated practice, as network access is not granted simultaneously for behavioral health and medical services.

TABLE 5-3 Selected RFI Quotes about Provider Experiences and Perceptions with Enrollment and Credentialing for Medicare, Medicaid, and Marketplace Plans

The paneling for Medicare was confusing and time consuming and since it did not fit the population, I specialize in for the small caseload I carry I stopped bothering with the process. Medicaid: I paid a credentialing company to get me paneled (. . .). Marketplace or private insurance: I also paid to get credentialed.
I have not had the most positive experience working with Medicare so far. It took about 10 months for the credentialing process to go through which impacted my ability to serve those I work with (I work primarily with older adults and disabled people). Navigating their system has been incredibly difficult, though they are good on the phone, their online system is rather rudimentary and not easy to navigate. And even though I have been on their panel for months, I still have not seen a single payment/reimbursement. I can see why so many providers in my area do not accept Medicare. Medicaid has been a similar but slightly less frustrating experience, as these plans are managed by local CCOs in my state.
Credentialing is a hassle as the CMS system and Pecos systems are complicated and not intuitive.
I am not currently a provider of any program. When I was a provider, I found the Medicare and Medicaid systems to be very time consuming to set up for each client and for my credentialing. Once set up I was paid in a timely predictable manner. Rates were way too low, however.
I no longer participate in Medicare. It became too confusing to enroll with the subcontractors.
Medicaid - Was happy to be a provider and had good experiences with patients and proud of the ability to provide services. Reimbursement was well below average. I would have stayed a provider, but our states portal is so dysfunctional that I was unable to re-validate my enrollment, despite several attempts, contacting the organization for assistance. if it is this difficult for providers, I cannot imagine what it is like for beneficiaries.
I only recently have attempted to work with Medicare and Medicaid in Alaska. Cost/Benefit gap between what they reimburse and their requirements for enrollment/documentation/ continued participation does not make business sense - it costs me money to participate in these programs. I am participating as a service to my community.
We are contracted with all three. Medicare has become more complex to contract with and our latest contracting took several months. In our area some of our Medicaid MCOs are likewise complicated and unresponsive leading to months of follow-up with them to finalize contracting and credentialing. We accept some Marketplace plans, but do not follow all the companies offering plans on the marketplace in our area. There are far too many health insurance companies for a clinic to keep track of, contract with, and keep up with.
For Medicaid, the enrollment application was only on paper and required mailing through the USPS and it took me 4 attempts to enroll. On one occasion, my application was rejected because I wrote "N/A" in the questions that did not apply to me instead of writing "None." I had no ability to negotiate my rate and the rate for my state is 20% of my usual fee. If I am going to be paid so little, I might as well just slide my fee and avoid all the wasted time dealing with this hostile bureaucracy. For Medicare, I began to explore how to enroll and the required rules, but I became overwhelmed when colleagues recommended I hire an attorney to help make sure my system is in compliance. There is really no way to participate in this program if you only have solo practice and no full-time administrative team who understands all the regulations and rules.

continued

TABLE 5-3 Continued

Approximately 3-4 yrs. ago, I decided that I wanted to work with older adults having Medicare insurance. As I am a psychologist in that age group myself, it was my hope to help expand access to high quality services to the broader population. I attempted not once, but FOUR times, to use Medicare's online enrollment form and was never able to complete it due to extraordinarily burdensome documentation requirements, lack of adequate instructions, and redundant verification processes. Had Medicare simply accessed the CAQH verification process, the enrollment process could have been streamlined and more successful. Each time I left the enrollment form, the data I had entered was lost, vanished, never saved so each time I returned to the form, I lost all my work and had to start all over from scratch. This was so infuriating, that I gave up becoming a Medicare provider. Frankly, I don't regret the decision because all I can imagine is ongoing headaches with not a single person available to discuss the onboarding process with. I simply gave up. Though it is important to mention, I probably invested 6 to 8 hours of time trying to complete the enrollment form. CAQH asks for many of the very same verification questions and there is no reason Medicare couldn't simply use the CAQH resources to verify licensed professional's credentials.
When a longtime client became Medicare eligible, I began the process to become a network provider. After 6 weeks of back and forth paperwork, calls, and extreme frustration at requests to redo paperwork already submitted and other directives, I threw hands and refused to continue. Understand that I had been a Medicare provider 15 years earlier during my psychology residency in Community mental health so all I had to do was change TIN, and address, and add a few company specifics.
I have tried to get on Medicaid panels as a pediatric neuropsychologist and have been denied due to limited network provider availability despite the enormous need in our community.

The credentialing and provider enrollment process is unavoidable and burdensome, especially for many behavioral health providers in independent practices who lack administrative support and staffing. Figure 5-3 depicts the credentialing workflow, showing the typical credentialing process to participate in Medicaid managed care.

Several credentialing burdens exist. First, it is estimated that the current credentialing process, which is sometimes manual and paper-based, contributes to substantial administrative waste (Health Affairs, 2022). For example, payers may use a paper-based data exchange that may take 90 to 180 days, and they must credential all new health care providers and repeat the process every 1 to 3 years after that ("recredentialing"). Rosters of credentialed providers must be updated and sent to individual payers monthly or quarterly, including specific practice locations. Health care providers are not typically informed if they are dropped from the credentialed list, which can occur because of a typo or minor data entry error. Instead, a care provider who is no longer credentialed may learn of his or her status when a subsequent claim for reimbursement is denied.

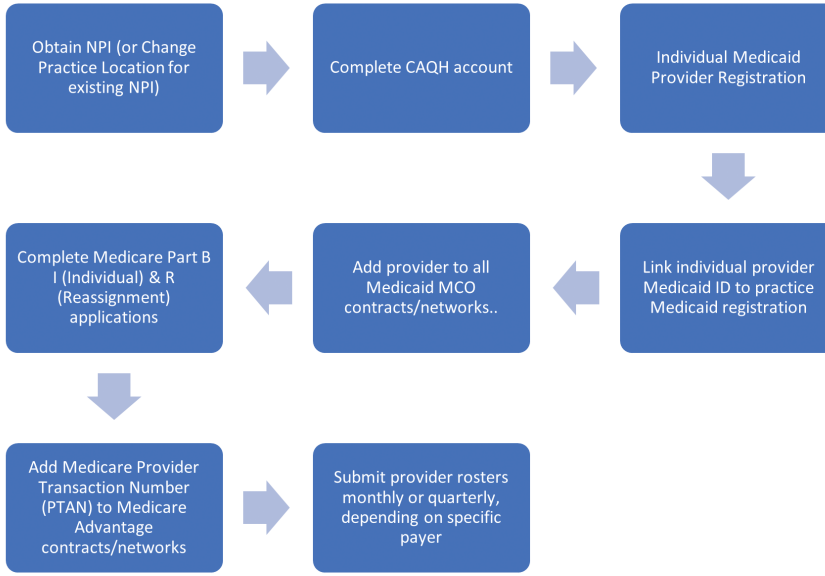

FIGURE 5-3 Typical credentialing process to participate in Medicaid managed care.

Second, payers may each have their own rules and processes for behavioral health care provider enrollment. Multiple credentialing processes for each payer are time consuming and expensive, as each process may involve multiple follow-up phone calls or emails, especially if there are errors or missing information in the original application. This lack of consistency—with different documentation requirements, processes, and timelines, results in significant complexity for behavioral health providers. Third, health care providers cannot submit a bill to a payer until they are enrolled with that payer, which translates into payment delays and potential financial hardship, especially for small practices or independent practitioners (Hansen et al., 2015; Mullangi et al., 2021). Finally, evidence suggests that care providers who accept insurance often contract with multiple plans, amplifying the complexity of credentialing and enrollment processes (CAQH, 2019). For example, while data on behavioral health providers is limited, one study from 2019 showed that the average primary care practice contracted with 12 managed care plans, and 12 percent of practices contracted with 20 or more plans (Ly and Glied, 2014).

Respondents to the committee's RFI similarly identified credentialing as a challenge to participation, along with low reimbursement. Some respondents characterized the paperwork required to participate in programs, especially with Medicare and Medicaid, as "excessive." Several respondents

commented on a prolonged and cumbersome credentialing application process that could take several months for them to get admitted as in-network providers. If a care provider had a change of address, even relatively minor suite or street number revision, formal documentation had to be provided to make this request, during which time reimbursement would be held. Finally, respondents stated that the recredentialing process, which occurred as frequently as annually for some plans, was time consuming and cumbersome, particularly for Medicaid.

> (W)e lifted certification requirements, allowing co-location in different places has been a key. . . . So then private practitioners don't have to go out and open up their own clinics, (N)ow that we've really decreased that certification piece of this, the credentialing, as far as Medicaid enrollment, we want to make as easy as possible.
>
> Paula Stone, webinar 3 panelist
> Innovations to Improve Mental Health and Substance Use Disorder Access in Medicare, Medicaid, and Marketplace Insurance Plans

States have recognized credentialing processes as a challenge to behavioral health provider participation in Medicaid. Over half of states report moving to centralize or standardize credentialing for fee-for-service providers or requiring Medicaid managed care organizations to do so (Saunders et al., 2023a). Paula Stone, an Arkansas Medicaid administrator who spoke in webinar 3, reported a similar effort: "We're looking at some programs that allow us to have a single platform where we can credential and then our . . . provider organizations . . . (will) not have to do . . . recredentialing with every different managed care organization."

> I would like to accept Medicaid for children in my state. The process of applying has been arduous and complicated. I got accepted for state Medicaid, however, most children in the state use an MCO after multiple confusing emails, attempting to get credentialed with the most common MCO Highmark, Blue Cross Blue Shield, I was told it will take over six months for them to consider my application. The process is too complex and burdensome. It takes too long and I understand why more providers in private practice do not take Medicaid. So many of the questions were things I had to Google in order to understand what they were asking. There should be a streamlined way to apply and get credentialed. The MCO explained the delay in that they don't have enough people processing credentials. That means that they are using money they collect for other things, then to quickly get people through this process.
>
> —RFI respondent, PhD./Psy.D.
> Private practice, DE

Setting-Specific Administrative Barriers

Several RFI respondents shared a perception that the administrative burden from Medicare and Medicaid is lighter in academic and other hospital settings than in independent practice, the result of academic medical centers and hospitals having dedicated billing staff. However, respondents in academic settings frequently stated that administrative burden would deter them from accepting these public insurances in an independent practice environment. In fact, RFI respondents in academic medical centers and other hospitals who felt they could comment on insurance-related matters highlighted administrative burdens in their responses, including high demands for prior authorizations and credentialing timelines, as lengthy and inefficient. Behavioral health care providers noted concerns for vulnerable patient groups on public insurance programs and administrative burdens that can take precedence over patient care. As a licensed alcohol and drug counselor and licensed mental health practitioner noted, "The amount of paperwork and documentation required takes away from patient care time."

Similar to the hospital-based care provider input received, behavioral health care providers working in community-based health entities typically reported that they relied on internal administrative staff to fulfill administrative tasks such as credentialing and billing. Such infrastructure seems to insulate the care team from the burdens associated with these administrative tasks. Table 5-4 shows additional selected quotes from RFI participants about their experiences working in Medicare, Medicaid, and Marketplace.

Facilitators of Insurance Participation

In addition to the barriers described above, several additional factors have also been identified as key facilitators of behavioral health provider acceptance of public and publicly subsidized insurance. These factors include pathways to career progression; the availability of compensated and well resourced supervisory roles; participation in team-based care, integrated health records, and enhanced flexibility in clinical practice (e.g., telehealth, expanded medication formularies); and access to additional supports to address health-related social needs (Beck et al., 2018; CHCS, 2019; Horstman et al., 2022; OIG, 2024; Parker et al., 2023).

Infrastructure Support

Community-based health entities typically have internal administrative staff to fulfill administrative tasks such as credentialing and billing. Health centers, CMHCs, and CCBHCs also employ a multidisciplinary team of

TABLE 5-4 Selected Quotes from the Committee's RFI on Behavioral Health Workforce Experience by Setting

Behavioral Health Care Provider Setting	Comment or Critique
Academic medical setting	"Medicare and Medicaid are huge barriers in the ability to provide the necessary services needed for those with severe mental illnesses—it does not allow for the reimbursement of occupational therapy services within a mental health space, even though the foundations of the profession are in mental health." "I do take Medicaid, but most of my colleagues do not because the reimbursement is SO low and the patient needs SO high."
Academic medical school	"Insurance providers do not adequately recognize and reimburse for services provided by licensed marriage and family therapists (LMFTs) and associate or provisionally licensed LMFTs. This inhibits growth of the mental health workforce and patient/client access to care." "There is significant variability in rates, especially for behavioral health. Insurance pays significantly less than private pay clients and often does not reimburse out of network for people who are desperate to be seen. The paperwork is significant and a drawback."
Community center	"Although I have years of experience in inpatient psychiatric facilities, currently the work I do is community-based and pro bono or grant funded." "Medicare, Medicaid, and private insurance was used for inpatient acute crises but is not widely available to help folks in the community avoid costly hospitalization." "My experience is with Medicaid, but it starts with the social workers. They are so behind on assessments and therefore delays the coverage of services. If and when the client/patient calls 211, the hold to get assistance in your case is overwhelming."
Community mental health center	"While recognizing the roles of accountability of providers, some requirements are onerous and distract provider time and effort away from direct care." "I have experience with Medicaid (state-level government-sponsored insurance). It is frequently needlessly bureaucratic, wildly inefficient, and confusing both to providers and consumers."
Group practice	"I have had a few problems with Medicare processing claims correctly. It is challenging and time consuming to get claims that were processed incorrectly fixed. Medicaid reimburses poorly. Marketplace insurance programs vary on reliability of claim processing and often reimburse poorly. I have considered numerous times getting off these panels."

TABLE 5-4 Continued

Behavioral Health Care Provider Setting	Comment or Critique
Hospital	"As a psychologist in a large health care system, I do not have direct engagement in billing or accounts receivable, but I do hear constant challenges of extremely high co-pays for private insurance, the complete lack of affordability for Marketplace insurance, and high demand for prior authorization for treatments, both procedural and prescription, covered by Medicare and Medicaid, which leads to dangerous delays in care and creates a backlog in patient access, as providers are forced to step away from direct patient care and instead engage with insurance panels to argue the necessity of their treatment plans."
	"Within the hospital our reimbursements for these payers are so low that we take a loss providing the services. That's really 100 percent of the story to be honest."

professionals and clinical support staff to address social drivers of health, care coordination, and task demands often associated with individuals with Medicare and Medicaid coverage.

Enhanced and Flexible Payment Models

Community-based health entities, such as FQHCs and Certified Community Behavioral Health Clinics (CCBHCs) in some states, benefit from enhanced payment models. Medicare and Medicaid each pay FQHCs through prospective payment systems (PPS) (CMS, 2023d). The PPS is a method of reimbursement in which the Medicare and Medicaid payment is made based on a predetermined, fixed amount based on a per visit rate and accounting for the cost of services, for CCBHCs the rate can be daily or monthly. The payment rate is typically higher than usual and customary reimbursement and is designed to cover a broader, more flexible range of clinical services. While these rates are updated annually to reflect inflation and cost of new services, the payment amounts have fallen behind the cost of providing care reflected in the National Association of Community Health Centers (NACHC) Chartbook 2023. The PPS payment for FQHCs—and some CCBHCs—offers enhanced reimbursement and flexibility in service provision (Counts and Nuzum, 2024; Rosenbaum et al., 2023). In addition, some state Medicaid programs do implement alternate payment/value-based payment mechanisms that provide additional reimbursement for quality, efficiency, and access to behavioral health services. Together, these efforts may buffer community-based behavioral health centers from greater financial uncertainty while simplifying some administrative processes associated with billing.

Finding: Largely because of billing codes and their remuneration values, there is often a lack of parity when comparing treatment services for SUD and for mental health, even though these conditions are often co-occurring and merit coordinated care.

Finding: Delayed and denied behavioral health provider payment may be as important as reimbursement in influencing behavioral health care provider participation, particularly in managed Medicare and Medicaid.

Finding: While usage management tools including prior authorization decrease costs for wasteful or ineffective care, they are not exclusively focused on the care and behavioral health providers where the cost savings are most substantial. These applications of prior authorization result in additive costs associated with significant administrative burdens to the insurer and behavioral health provider, while frequently producing delayed care impacts on patients. In addition, these management tools have focused disproportionately on behavioral health services, where the applied review criteria have been shown to lack a basis in evidence.

Finding: It is estimated that insurer credentialing processes, which are sometimes manual and paper-based, contribute to substantial administrative waste, disproportionate burdens on smaller behavioral health care provider practices, and delays in care providers billing for services.

Conclusion 5-3: Evidence suggests that the behavioral health rates for behavioral health providers, particularly for the Medicaid and Medicare Advantage plans, have been inadequate to attract and retain care providers in the plan's networks. In addition, rates do not have parity for the same services with other health care providers. Furthermore, the evidence suggests that because of billing codes, there is a lack of parity between services for substance use disorder and for mental health conditions. As a result, the rationale for the existing reimbursement structures must be re-evaluated, revised, and subsequently and regularly updated to reflect the full cost of care, including ancillary service provision, administrative requirements, and parity among behavioral health care providers.

Conclusion 5-4: Evidence suggests that administrative burdens, particularly around delayed and denied payments, are at least as important as inadequate rates in disincentivizing behavioral health providers from participating in Medicaid, and that similar disincentives exist in Medicare Advantage where inappropriate payment denials have been demonstrated. Given that behavioral health providers are more likely to practice independently and lack administrative support, efforts are needed to simplify and streamline credentialing, billing, and claims processes.

Conclusion 5-5: Research, regulatory actions, and reported care provider experience provide compelling evidence that current prior authorization activities demand reform. The time, expense, and patient care delays associated with insurer-applied usage management tools factor into behavioral health provider participation decisions and decrease care access for patients. Policies recently adopted by some states, CMS, and the broad-based participants in the "Consensus Statement" (referred to above) provide guidance for reform.

OTHER BURDENS AND STRESS FACTORS THAT LEAD TO ATTRITION, BURNOUT, OR DISSATISFACTION

Additional burdens may affect care delivery processes daily, driving increased turnover and exacerbating behavioral health care provider participation shortages in public insurance programs (Figure 5-4). Evidence suggests that the combined allosteric load of these daily burdens contributes to cynicism, depersonalization, exhaustion, and ultimately, burnout and workforce attrition (Hallett et al., 2024). There is modest empirical evidence regarding the relative role these burdens play on behavioral health providers who serve enrollees in public or publicly subsidized insurance programs, particularly regarding their retention within the existing workforce. Contributing factors that elevate the daily burdens of delivering behavioral health services may include: the complexity of patient needs and the inability to meet these needs; fragmentation of data, data flows, and documentation burden; and additional workplace burdens (Counts, 2022; Satcher, 2000).

Fragmentation of Data, Data Flows, and Documentation Burden

Behavioral health documentation and data sharing have often been inadequate, with minimal and inconsistent access to behavioral health data in particular. Timely, accurate, accessible, and relevant clinical, financial, and usage data are not readily available for clinicians to support the care coordination needs of individuals covered by Medicare, Medicaid, and Marketplace plans. Clinicians may be held accountable for outcomes without full access to actionable data. Each payer may have a different online portal for accessing data, which is usually based on aggregate claims and less useful for individual clinical practice.

Electronic health records (EHRs) have improved communication among health care providers, facilitating care coordination between physical and mental health care and among different settings of health care, such as between outpatient and inpatient settings and primary and specialty care practices (Gedikci Ondogan et al., 2023). However, despite their widespread adoption, EHRs remain fragmented and underused in the behavioral health delivery system. In 2017–2018, only 6 percent of non-federally owned

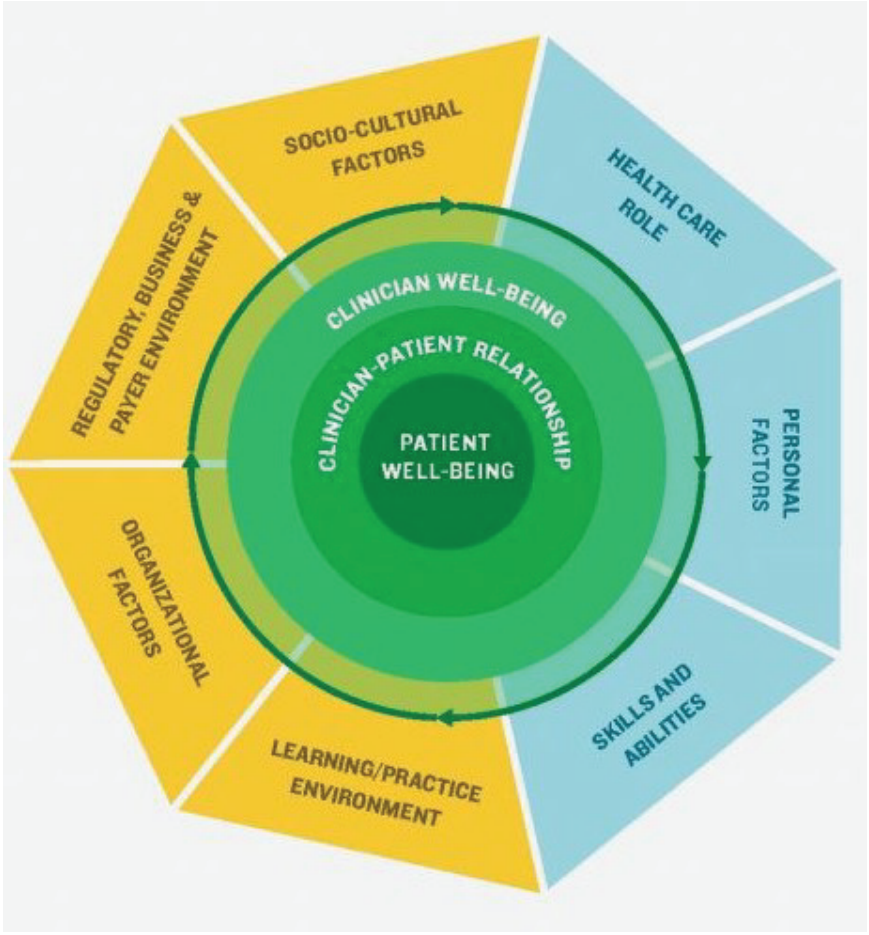

FIGURE 5-4 Factors affecting clinician well-being and resilience.
SOURCE: Brigham et al., 2018.

mental health facilities and 29 percent of non-federally owned substance use treatment facilities used an EHR, compared with more than 80 percent of hospitals (MACPAC, 2022). As a result, behavioral health providers may forego communication or coordination with physical health providers or exchange information via older communication modalities such as telephone or fax (Brown, 2021).

Low rates of EHR use in behavioral health settings result from several factors. First, there has been a lack of federal and state incentives to promote and facilitate adoption. For instance, the Health Information

Technology for Economic and Clinical Health Act of 2009[3] introduced financial incentives for medical practices to adopt EHRs. However, the act excluded behavioral health providers because eligibility for funding depends on meeting requirements that the majority of the behavioral health workforce does not meet. These include "hospital facility" status, having a prescriber on staff, and a patient panel consisting of at least 30 percent Medicaid patients (Cohen, 2015). The Coronavirus Aid, Relief, and Economic Security Act of 2020[4] is addressing the accessibility gap for behavioral health providers treating SUD, but there continue to be challenges for behavioral health providers concerning data protection, cost, and significant user education (MACPAC, 2022).

Second, the financial costs of implementing and establishing EHR systems have been challenging, particularly for smaller behavioral health provider organizations and solo or small group practitioners (Miller et al., 2005). A recent study estimated that for a typical five-physician primary care practice, the cost of establishing an EHR was roughly $162,000, with $85,000 going towards first-year maintenance costs alone. In addition, the use of EHR systems also requires additional information technology tools, including practice management software, email servers, staffing support, and training resources, which may be cost-prohibitive for behavioral health providers. Third, mental health clinicians have expressed concerns over privacy issues within EHRs, with 83 percent of participants in a 2010 study desiring additional modifications to limit access to psychiatric records (McGregor et al., 2015; Salomon et al., 2010). While psychotherapy and substance use treatment documentation is subject to additional federal protections, smaller EHR systems may not have accessible mechanisms for restricting access to sensitive records.

Despite these barriers, the potential is high for EHR acceptance among behavioral health providers. In one study, interviewed physicians, nurses, pharmacists, mental health clinicians, and administrative professionals said they expected to enhance their work productivity and interprofessional collaboration by introducing a behavioral health EHR (Jung et al., 2021). Another study examining examined EHR use indicated that 81 percent of behavioral health providers expressed overall positive support for behavioral EHRs (Shank et al., 2012).

However, evidence is lacking regarding the extent to which EHR implementation in behavioral health settings has the potential to reduce

[3]The American Recovery & Reinvestment Act of 2009 established the Health Information Technology for Economic Clinical Health Act, which requires that CMS provide incentive payments under Medicare and Medicaid to "meaningful users" of electronic health records, H.R.1—111th Congress (2009–2010).

[4]Coronavirus Aid, Relief, and Economic Security Act, S.3548—116th Congress (2019–2020).

fragmentation and administrative burden, improve quality, lessen provider frustration, and lead to improved medical and behavioral integration. Evidence from other specialties has demonstrated that EHR use has been a prominent contributor to care provider burnout, particularly in the context of additional documentation requirements, electronic messaging and inbox, cognitive load, and time demands (Budd, 2023; Tai-Seale et al., 2023; Tajirian et al., 2020).

> Finding: Several additional clinical and organizational factors, including expense of EHR adoption, insufficient support for patients' complex clinical and social needs, and inadequate pathways for advancement, contribute to behavioral health clinicians' attrition and burnout in public behavioral health systems.

Complexity of Patient Needs

Public or publicly subsidized insurance covers a large proportion of those with behavioral health needs, with a high prevalence of comorbid medical conditions, including SUD. Nearly 70 percent of those with mental disorders have comorbid medical conditions (Druss and Walker, 2011; Rosenfeld et al., 2022). As of 2021, over one-third of adults with mental illness also had an SUD in the past year, and about one in five adolescents with a major depressive episode had a co-occurring SUD (SAMHSA, 2023). As a result, behavioral health needs are often accompanied by greater needs for care coordination, targeted case management, chronic disease management, and the addressing of health-related social needs. This complexity of management may affect behavioral health providers' sense of efficacy or control (Dora-Laskey et al., 2022) and play a contributing role in care providers' willingness to participate in insurance programs.

Compared with adults with private insurance, Medicaid beneficiaries experience higher rates of SUD and mental health conditions and are more likely to have chronic health conditions, report fair or poor health, and experience more contributing social determinants of health (CMS, 2024b). Clinical complexity has been documented as one reason that physicians decline to accept Medicaid insurance in particular. In a 2019 survey study of Michigan primary care providers, 46 percent cited the illness burden of Medicaid enrollees as a barrier to accepting Medicaid (Tipirneni et al., 2019). Health care providers who did accept Medicaid tended to be female, minoritized, nonphysician providers; specialize in internal medicine; and be paid by salary or be working in practices with Medicaid-predominant payer mixes, suggesting that this population was most likely to be served by specific types of behavioral health care providers and facilities. Other research has replicated these findings across settings, suggesting that behavioral

health care providers who care for medically and socially complex patient populations view this care as mission-oriented but struggle to balance practice costs with financial viability (Decker, 2013; Hsiang et al., 2019).

Medically and socially complex patients may also be more likely to schedule and miss appointments because of transportation, job, or life events. A meta-analysis of 34 audit studies found that Medicaid enrollment is associated with a 3.3-fold lower likelihood of successfully scheduling a specialty care appointment compared with those covered by private insurance (Hsiang et al., 2019). In one sample of patients with behavioral health diagnoses, no-show rates in an outpatient setting were 13 percent for in-person appointments and 17 percent for telehealth appointments (Bhatta et al., 2023). Other studies estimate no-show rates to be as high as 30 percent for behavioral health appointments (Long et al., 2016; Muppavarapu et al., 2022). For independent practitioners, in particular, lost revenue resulting from missed appointments can amount to significant lost revenue, care discontinuity, and poorer quality of care.

> I am an internist. I am working with my patients on their chronic medical conditions and comorbid mental health conditions or newly identified (mental health conditions) and how they impact their medical care and our team's work to connect them with additional services when we are not able to do this in-house. I will break it down into two groups. There is counseling work, and then there is psychiatry. . . . When we talk about counseling in the community, the largest barrier that we face is the lack of behavioral health counselors in our community who . . . accept Medicare. The largest reason people are not accepting it is reimbursement rates. And those that are able to accept Medicare based on their licensure, Medicare presently has some restrictions on who they will reimburse for doing counseling work. . . . Options for patients who needed the service was either wait to be seen, that six-month wait list; do not be seen at all, a common occurrence; pay out of pocket to see a private psychiatrist and very few if any of our patients have the resources to do that; or wait until people decompensate and get hospitalized. That is the state of what we have access to.
>
> —Margaret Adam, webinar 2 panelist
> Experiences of Behavioral Health Care Providers with
> Public Insurance Programs

Workplace Burdens

Behavioral health providers may also experience significant workplace burdens, including staffing shortages and high rates of turnover which increase demands on the remaining workforce. As a 2022 SAHMSA report notes, the behavioral health workforce is engaged in work that is often physically and emotionally taxing (SAMHSA, 2022). Estimates for average

turnover rates in the behavioral health workforce are around 30 to 50 percent annually—more than three times higher than the approximately 8 percent for teachers and physicians, and three times higher than what is considered a "healthy" organizational turnover rate of 10 percent. Some studies estimate the turnover rate for behavioral health care workers is as high as 70 percent annually (Brabson et al., 2020).

Clinicians who stay face the consequences of these workforce and staffing pressures, including increased caseloads, establishing disrupted connections with patients for whom new care provider relationships may require re-raising past traumas, and increased paperwork. For patients, these frequent behavioral health provider changes may lead to discontinuity of care, delayed care, and loss of a trusted care provider relationship. Studies of the behavioral health workforce in the publicly funded settings where many Medicare and Medicaid patients receive care have found that younger, master's level clinicians were more likely to experience increased turnover (Beidas et al., 2016). Just over half of staff who left their organization stayed in the public mental health sector, with the remainder choosing other career paths for higher pay or improved work–life balance (Zhu et al., 2022).

Research also suggests that organizational and workplace culture factors contribute to turnover. In the community setting, larger agencies had higher turnover rates, while smaller agencies had lower turnover because of stronger relationships with their workforce (Bukach et al., 2017). Many studies found that negative organizational cultures in terms of shared beliefs and expectations about day-to-day functions and negative climates based on staff perceptions of the work environment are also associated with higher turnover rates (Hallett et al., 2024; Herschell et al., 2020).

In many public mental health care settings, clinicians receive loan repayment in some form. These programs may require recipients to work in health profession shortage areas where patients have a higher burden of medical and psychiatric complexity and higher social determinant burden. Usually, these clinicians are recent graduates and lack professional experience, wisdom, and learned expertise, creating a scenario where the most junior and inexperienced clinicians, though well-intentioned and socially committed, are providing care for the most complex patients. There is no federal program that rewards organizational retention, longevity of service, reduced organizational turnover, or seniority at an organization.

Taken together, the day-to-day clinical and workplace burden of behavioral health providers, particularly in community settings and in service of public or publicly subsidized insurance programs, create additional factors that contribute to burnout and attrition of an already strained workforce. This turnover exacerbates workforce shortages and delivery of care that further reduce the longevity of a workforce that is mission-oriented to serve

the Medicare, Medicaid, and Marketplace populations. Evidence suggests that several potential models and clinical programs may help to ameliorate the day-to-day workplace burdens and strongly support a work environment that fosters behavioral health provider efficacy and more optimal clinical care.

INTEGRATING CARE TO IMPROVE BEHAVIORAL HEALTH CARE PROVIDER SATISFACTION

Providing care in integrated settings can reduce the challenges that care providers experience treating clients with complex conditions. Research has shown that integrating medical, mental health, and SUD treatment benefits patients, payers, and health care providers. Multiple studies have found that integrated behavioral health treatment reduces treatment times, improves patient outcomes, and is more cost-effective than segregated care for different conditions (Kroenke and Unützer, 2017). Other benefits include increased health care provider satisfaction, improved patient treatment plans, increased patient satisfaction, increased engagement and adherence to treatment plans, and reduced system barriers (Heath et al., 2013).

A broad spectrum of innovative behavioral health care models are evolving across the United States (Heath et al., 2013). Primary care is an entrance point for most patients, since 90 percent of patients with mental health disorders are seen in the medical sector (Kroenke and Unützer, 2017). Recent data show that the share of adult primary care visits addressing mental health concerns increased by over 50 percent between 2006–2007 and 2016–2018, underlining the importance of this health care provider group in providing behavioral health care (Rotenstein et al., 2023). Studies have shown that consultative models support medical practitioners and improve patient outcomes and that co-located models, in which a licensed behavioral health practitioner integrates into the core primary care team, improve the behavioral health provider experience by helping behavioral health providers care for more complex patients (Funderburk et al., 2012; Torrence et al., 2014), leading to higher provider satisfaction (Angantyr et al., 2015; Serrano and Monden, 2011; Torrence et al., 2014). Examples include the Primary Care Behavioral Health model, which has grown over the past two decades (Reiter et al., 2018), and the Patient-Centered Medical Home (PCMH) model, for which approximately 13,000 practices are recognized by the National Committee for Quality Assurance PCMH recognition model (NCQA, 2023).

The more team-based collaborative care model of treatment by behavioral health and medical professionals is distinguished by a behavioral health care manager serving as the bridge between professionals and the patient. There is strong evidence that the collaborative care model for

mental health treatment is effective across multiple comorbid conditions, including pregnancy, neurology, oncology, chronic pain, diabetes, and other medical disorders among adolescents and older adults (Kroenke and Unützer, 2017; Reist et al., 2022).

A fully merged medical/behavioral health practice is the highest level of integration. Few of these exist, limiting evidence of their effectiveness (Heath et al., 2013). Developing integrated models is particularly challenging in rural areas, where behavioral health care providers are more limited. Vermont originally designed a hub-and-spokes model built on medical home payments to increase rural access to treatment for opioid use disorder. Hubs facilitated intensive outpatient care to stabilize patients; spokes were usually primary care practices that served as medical homes and provided office-based opioid treatment to patients, receiving consultative expertise and screening support from the hub. Other states followed Vermont's lead and implemented hub-and-spokes models for MAT, with varying levels of success (Green et al., 2021). Similarly, the Veterans Administration is implementing a telehealth hub-and-spokes model for chronic pain treatment to augment services in rural and under-resourced areas by providing expertise and support to local practitioners. The hub-and-spokes model has promise for integrating care in rural areas through the use of teleservices aligned with local practitioners (Heath et al., 2013; Huffman et al., 2014; Katon et al., 2001; Kroenke and Unützer, 2017; Reist et al., 2022; Solberg et al., 2015; Unützer et al., 2001, 2020).

Despite the potential for increased behavioral health care provider satisfaction, significant savings, better patient outcomes, and improved access to services, effective integrated care remains the exception and not the norm in treatment. Integrating care across medical, mental health, and substance use treatment silos continues to face many obstacles, arising from decades of treating these three practice areas as distinct, separate, and unrelated forms of care. To integrate care so that the whole person is treated requires integrating or sharing information, a team approach to treatment plans and services, and financial payment models that adequately cover the complexity of integrated care. All must be addressed for integrated care to become the standard for treating a patient with comorbid behavioral health and medical conditions (Petts et al., 2022).

Real-world data suggest that average treatment response to integrated care for depression across a large sample of clinics was substantially lower than response rates reported in randomized clinical trials, with patient factors and clinic factors, including the level of collaborative care experience and implementation support, contributing heavily. Other research has shown that financial integration alone is less effective without clinical transformation efforts (Kroenke and Unützer, 2017).

Widespread adoption of integrated care lags far behind the evidence of its effectiveness. To incentivize the adoption of integrated care,

reimbursement models should be designed to adequately compensate and incentivize collaborative care, but several barriers make this difficult:

- Current payment systems are structured to separate behavioral health and medical treatment rather than compensate for team-based care.
- Bundled payments, such as for pregnancy, preclude additional reimbursement for behavioral health comorbidities.
- Differing reimbursement structures among commercial, Medicare, and Medicaid create a barrier to implementing collaborative care across all comorbid patients in a practice.
- EHR limitations in many behavioral health practices, particularly smaller practices, make it difficult to join a collaborative care arrangement.

Addressing these barriers requires:

- Care management and coordination between medical and behavioral health treatment must be included in compensation.
- Additional time for collaboration and team-based communication/planning is needed.
- Reimbursement and accountable care organization payments should be designed to recognize all team members in a collaborative care arrangement.
- Technical assistance is needed for smooth practice transformation to implement collaborative care.

These challenges are evident in the recent Kaiser Family Foundation survey of actions that states are taking to support the behavioral health workforce. While the majority of states reported addressing reimbursement, prompt payment, credentialing and prior authorization challenges, only a few indicated they were putting in place incentives to drive integrated care (Saunders et al., 2023a).

Finding: Evidence suggests that several clinical program models (including integrated and collaborative care arrangements) can help to ameliorate the day-to-day behavioral health provider workplace burdens, fostering provider satisfaction and more optimal patient care.

Conclusion 5-6: A key barrier for behavioral health provider retention and satisfaction in Medicaid and Medicare, in particular, is the inability to meet patient needs, driven in part by the complexity and fragmentation of the care delivery system and patient navigation challenges. While building behavioral provider participation in Medicare, Medicaid, and Marketplace programs is important, it is not sufficient to ensure that patients are matched to the right behavioral health providers according to their clinical, cultural and language needs, at the right time and right place.

CONCLUSIONS

Conclusion 5-1: Insufficient and often unstable reimbursement has been identified as a key factor driving low care provider participation in public insurance programs. Low reimbursement is particularly stark when compared to the higher out-of-network rates paid in commercial insurance markets and higher cash-pay rates. Across payers, there is often a lack of transparency on how rates for behavioral health services are currently set, with consistent undervaluation of work efforts for behavioral health care providers and inadequate accounting for the costs of care provision.

Conclusion 5-2: There is limited and mixed evidence about the effects of reimbursement rate increases on care provider participation in insurance programs, and existing evidence is lacking on the magnitude and scope of reimbursement required to increase access to behavioral health providers in Medicaid and Medicare. Recent state efforts to modify behavioral health payments, particularly in Medicaid, should be evaluated and monitored closely.

Conclusion 5-3: Evidence suggests that the behavioral health rates for care providers, particularly for the Medicaid and Medicare Advantage plans, have been inadequate to attract and retain behavioral providers in the plan's networks. In addition, rates do not have parity for the same services with other behavioral health providers. Furthermore, the evidence suggests that because of billing codes, there is a lack of parity between services for substance use disorder and mental health conditions. As a result, the rationale for the existing reimbursement structures must be re-evaluated, revised, and subsequently and regularly updated to reflect the full cost of care, including ancillary service provision, administrative requirements, and parity among care providers.

Conclusion 5-4: Evidence suggests that administrative burdens, particularly concerning delayed and denied payments, audits and the real and perceived threat of clawbacks, are at least as important as inadequate rates in disincentivizing behavioral health providers from participating in Medicaid and that similar disincentives exist in Medicare Advantage where inappropriate payment denials have been demonstrated. Given that behavioral health providers are more likely to practice independently and lack administrative support, efforts are needed to simplify and streamline administrative processes including credentialing, billing, and claims processes.

Conclusion 5-5: Research, regulatory actions, and reported behavioral health provider experience provide compelling evidence that current prior authorization activities demand reform. The time, expense, and patient care delays associated with insurer-applied usage management tools factor into behavioral health provider participation decisions and decrease care access for patients. Policies recently adopted by some states, CMS, and the broad-based participants in the "Consensus Statement" (referred to above) provide guidance for reform.

Conclusion 5-6: A key barrier for behavioral health provider retention and satisfaction in Medicaid and Medicare, in particular, is the inability to meet patient needs, driven in part by the complexity and fragmentation of the care delivery system and patient navigation challenges. While building behavioral health provider participation in Medicare, Medicaid, and Marketplace programs is important, it is not sufficient to ensure that patients are matched to the right health care providers according to their clinical, cultural and language needs, at the right time and right place.

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6

Innovative Infrastructure: Balancing Support and Challenges for the Behavioral Health Workforce in Medicare, Medicaid, and Marketplace

As discussed in the previous chapter, administrative processes can create burdens and barriers that reduce the incentives for behavioral health providers to participate in Medicare, Medicaid, and Marketplace plans. As behavioral health providers are rational actors that respond to system incentives, policies that align these incentives in the service of both providers and beneficiaries are critical to health care provider participation. This chapter examines various systems-level levers, including payment systems, health plan regulation, technology platforms, and delivery models that might increase participation in Medicare, Medicaid, and Marketplace among the behavioral health workforce and promote meaningful access to care amid increased demand for behavioral health services across public and publicly subsidized payers.

Importantly, the program structures and enrollment patterns in Medicare, Medicaid, and individual insurance markets have changed dramatically over the past two decades. Managed care arrangements have become the payment and delivery structures that serve most people enrolled in those insurance programs. In 2023, the Medicare Advantage program has enrolled 31.6 million people, or 52 percent of all Medicare beneficiaries, with a projected increase to 33.8 million people in 2024. (CMS, 2023c; MedPAC, 2024). In addition, care providers participating in the Medicare Shared Savings Program (MSSP) now serve a notable segment of traditional Medicare beneficiaries. The Medicaid program has expanded and now serves about 74 percent of recipients, or approximately 60 million people, through Medicaid managed care organizations (MCOs) (Hinton and Raphael, 2023a). The individual market is now largely

government-supported and regulated through the ACA Marketplaces that started in 2014. The Centers for Medicare & Medicaid Services (CMS) reported that 21.3 million people were enrolled in Marketplace plans in January 2024 (CMS, 2024e). The implication is that for the nearly 113 million Americans who participate in these three public insurance programs, health care provider payment, health care provider availability, and access arrangements have become the domains of MCOs. The government's involvement as both purchaser and regulator in the insurance market has grown at both the federal and state levels, yet the performance of these programs results from the complex interplay between federal and state agencies and their laws and regulations. This is especially the case for Marketplace and Medicaid plans. Thus, the discussion that follows is organized to reflect the modern configuration of health care payment and resource allocation.

PAYMENT SYSTEM INCENTIVES THAT AFFECT WORKFORCE PARTICIPATION

Incentives embedded within the structure of Medicare, Medicaid, and the Marketplace may present challenges for behavioral health professionals participating in these plans. The committee considers three payment pathways for behavioral health care providers in Medicare: Medicare Advantage (MA); traditional Medicare, a fee-for-service (FFS) payment system; and the MSSP, which combines FFS with value-based payments. The committee also considers Medicaid managed care and Marketplace plans. In all these cases the most common way of paying individual clinicians remains FFS even as payment methods continue to evolve. In managed care arrangements, where almost all beneficiaries are enrolled, the payment system for the insurer plays a crucial role in shaping the payer–provider relationship. This relationship, in turn, affects the various ways in which patients access behavioral health providers.

Payment Rates Create Access Challenges

The Government Accountability Office recently examined whether people with behavioral health coverage could access services easily. The answer was that people may have difficulty finding in-network behavioral health care providers that accept new patients, with low care provider reimbursement rates contributing to this problem (GAO, 2022). For example, while a 1-hour initial appointment with a psychiatrist can cost over $500, Medicare would pay $216.44 and Medicaid would pay $177.44 for a similar visit (Gilberti, 2023). What this disparity leads to is individuals who need mental health or substance use disorder (SUD) services end up

using out-of-network health care providers. In effect, individuals with lower incomes who cannot afford out-of-network costs may be unable to access needed care.

One study, for example, found that 17.2 percent of behavioral office visits in 2017 were to an out-of-network behavioral health care provider, compared with 3.2 percent for primary care and 4.3 percent of medical and surgical specialists (Melek et al., 2019). The same study found that the average in-network reimbursement rates for behavioral health office visits were lower than for medical and surgical office visits as a percentage of Medicare-allowed amounts. Another study, using non-self-employed clinical, counseling, and school psychologists as a proxy, found that behavioral health care providers concentrate in metropolitan areas where reimbursement is higher compared with locations associated with lower pay (Mauri et al., 2019).

Traditional Medicare Payments and Incentives

Individuals with traditional Medicare face no administrative barriers, such as prior authorization, to access care. In traditional Medicare, reimbursement for all covered services delivered by behavioral health providers is based on the Medicare physician fee schedule under Medicare Part B, which means traditional Medicare pays clinicians more for doing more. CMS constructs the fee schedules based on the Relative Value Scale for each provided procedure, such as a psychotherapy visit, as well as the clinician type. The relative value depends on the time and effort required to deliver a specific procedure, with CMS and other experts evaluating the time and effort across procedures. In the 2024 Physician Fee Schedule, the proposal to adjust the work RVUs for psychotherapy codes payable under the PFS has been finalized for implementation over a four-year transition period. In response to public comments, the adjustment has also been extended to psychotherapy codes billed alongside an E/M visit and to the HBAI codes. These changes are intended to address longstanding distortions in the valuation of time-based behavioral health services. Consequently, these adjustments represent a significant 20% increase in the fee schedule valuation for these essential behavioral health services (CMS, 2023b). Psychiatrists and psychologists, for example, receive 100 percent of the fee established under the Medicare fee schedule for procedures they supply. The resulting rate of accepting new patients in traditional Medicare is 60 percent for psychiatrists and about 50 percent for psychologists, by far the lowest for any medical specialties (Freed et al., 2023). While new patient acceptance rates are not estimated, in comparison, clinical social workers, marriage and family therapists, and behavioral health counselors are paid at roughly 60 percent of the psychologists' rate under the Medicare fee schedule, and

nurse practitioners, clinical nurse specialists, and physician assistants are paid at roughly 70 percent of the psychiatrists' rate under the Medicare fee schedule.

Studies have shown that the process of establishing the Relative Value Scale disadvantages psychiatrists and thus all other behavioral health providers, because work values associated with psychiatric services are undervalued. For instance, the median reimbursement for psychiatrists versus nonpsychiatric medical doctors performing the same services in network was 13 to 20 percent lower for psychiatrists (Mark et al., 2018). In response, CMS has recently proposed to increase this component by 19 percent over 4 years (Moran, 2023). In addition, CMS has agreed with an additional concern that the practice cost component of the Relative Value Scale has been underestimated, requesting information to improve the methodology of estimating practice costs (CMS, 2023c).

Medicare Shared Savings Program Incentives

MSSP enrolls a relatively small share of traditional Medicare beneficiaries, and is based on accountable care organization (ACO) models. ACOs are grounded in traditional Medicare but create incentives for the ACO to manage care efficiently and reduce spending. Successful management of savings that adhere to quality standards allows the ACO to share in realized savings, though behavioral health quality metrics are limited and have relatively little weight in the assessments of quality. In addition, ACOs have a financial incentive to use clinicians affiliated with their organization, which may create some access frictions. Thus, there is little financial incentive to ensure adequate access to behavioral health services in the MSSP. To date, the degree to which behavioral health providers are part of ACOs is variable (Busch et al., 2022). Moreover, the evidence suggests there is essentially no impact on behavioral health outcomes resulting from implementing MSSP (Hockenberry et al., 2023). For example, people with depression associated with an ACO were 24 percent less likely to get treatment than those in the simple traditional Medicare program (Hockenberry et al., 2023).

Medicare Advantage Incentives and Administrative Processes

The MA program covers 52 percent of Medicare beneficiaries (Ochieng et al., 2023). MA plans receive a fixed per-beneficiary, per-month payment, creating a strong incentive to control the use of services and costs. Specifically, MA plans receive risk-adjusted capitation rates based on bids the plan submits against a benchmark payment defined by the average Part A and Part B spending by traditional Medicare in each county.

The risk adjustment mechanism represents an effort to ensure that payments adequately offset the incentives that discourage plans from enrolling of the sickest and highest-cost individuals from the eligible population. If the conditions used for risk adjustment in MA and in the Marketplace plans fail to adequately account for differences in health spending for particular health conditions, health plans would find it profitable to discourage the enrollment of people with those conditions.

At least one study determined that behavioral health conditions have inadequate risk adjustment arrangements (Montz et al., 2016). As such, health plan strategies may discourage enrollment by individuals with behavioral health conditions or limit access to treatment. For example, health plans may pay low rates to discourage behavioral health providers from participating in their networks, thereby limiting the supply of clinicians who treat behavioral health conditions. This limited supply may discourage enrollment by people likely to seek behavioral health care and may result in lower plan spending among those enrolled based on selection efforts rather than on effective care management. Another example of strategies aimed at affecting enrollment by those with mental illnesses and SUDs is through administrative processes such as prior authorization that impede care for particular types of treatment, such as intensive outpatient care. Recent evidence shows that 85 percent of MA plans impose prior authorization on psychiatric services compared with 60 percent for other physician specialty services (Freed et al., 2023). The Star Ratings bonus structure also provides substantial financial incentives to plans and is a critical vehicle for benchmark setting, capitated rates, and rebates in the form of benefits provided back to members. Box 6-1 shows the billing complexity that health care providers must navigate when diagnosing an individual, which may be a source of inadequate risk adjustment in behavioral health.

Inadequate risk adjustments for behavioral health conditions are not the only challenge to increasing access to care for MA beneficiaries. Certain MA plans have profited significantly by focusing on specific clinical diagnoses and enhancing coding practices to boost their risk adjustment factors (Adler, 2018; Mandal et al., 2017). These issues are multiplied for beneficiaries with social needs, which are also captured poorly in risk adjustment and which can drive health spending. Thus, health plan incentives lead MA plans to avoid enrolling people with mental illnesses and SUDs through limiting the supply of care, which may help explain the greater supply limitations in areas with greater social needs.

Regulation might partially offset the incentive to restrict the supply of behavioral health care. For example, quality metrics in a plan that create an offsetting incentive to provide access to care, evidence-based treatment, and adequate levels of follow-up might increase the supply of behavioral health care. However, policies such as the MA Quality Bonus Program do

BOX 6-1
Two Separate Diagnostic Classification Systems

Billing and coding for behavioral health services present a unique challenge for behavioral health care providers, in part because of the existence of two diagnostic classification systems. This feature may be one source of inadequate risk adjustment for behavioral health. The Diagnostic and Statistical Manual of Mental Disorders (DSM), produced by the American Psychiatric Association, is the primary reference for diagnoses for U.S. behavioral health care providers. However, the International Statistical Classification of Diseases and Health Related Problems (ICD), produced by the World Health Organization, is the primary mechanism for billing and coding in the United States. While the two classification systems have become increasingly aligned over the years, discrepancies remain (Cerbo, 2021; Gomez et al., 2023; McCabe and Widiger, 2020), and behavioral health care providers must reconcile and convert DSM (now in the 5th text revision, DSM 5 TR) codes into ICD codes for billing. The diagnostic thresholds and symptom criteria can vary between DSM and ICD for certain disorders, such as attention-deficit/hyperactivity disorder and mood disorders. There are also codes for clinical conditions other than behavioral health disorders, such as V codes for DSM and Z codes for ICD, that behavioral health care providers treat.

Currently, there is no common set of diagnostic codes that qualify for payment, making precision in coding a challenge. Insurers also have different diagnostic requirements for the same underlying behavioral health issue. Consequently, managing the denials for claims based on diagnostic codes in behavioral health places a significant administrative burden and can lead to lower overall revenue for health care providers.

Call out example: A therapist may evaluate a child who is not performing well in school, and code Z55.3 (Underachievement in School). However, this service is not reimbursed because it is not a mental health disorder.

Call out example: The DSM 5 TR diagnosis "Other Specified Anxiety Disorders" can be coded in ICD 10 as F41.8 "Other Specified Anxiety Disorders" or F41.9 "Unspecified Anxiety Disorder." One payer may deny a F41.8, stating that it is too vague, while another payer may pay for this diagnostic code, yet deny F41.9.

not include payments based on any behavioral health care quality metrics. Likewise, the regulation of networks may be an important mechanism to offset the incentives to be overly restrictive of the supply of behavioral health care providers, but outcomes from network adequacy regulations have failed to improve access for behavioral health. The details of these regulations are addressed later in this chapter.

The willingness of health plans to expand behavioral health services depends in part on whether the risk adjustment prevents significant payoffs from avoiding the enrollment of people with behavioral health conditions. MedPAC recently reported evidence of significant problems with biased selection in the MA program, with MA plans enrolling healthier people who yield a payment advantage of 6 percent to 13 percent (Serna, 2023). Thus, there is a meaningful payoff to engaging in actions that affect risk selection, which historically have targeted people with mental illnesses and SUDs (Frank and Glied, 2006). Moreover, CMS has not deployed regulatory strategies that could attenuate incentives for restricting supply and therefore promote access to behavioral health care.

Medicaid Managed Care Incentives

Medicaid MCOs serve over 70 percent of Medicaid enrollees (GAO, 2024). Medicaid MCOs operate in an environment with incentives similar to those found in MA, where Medicaid MCOs receive capitated payments based on a combination of the design of each state's Medicaid plan and negotiations with the state Medicaid agency. For behavioral health, some states carve out specialized behavioral Medicaid MCOs from a full-service Medicaid MCO to provide behavioral health services. In most states, however, full-service Medicaid MCOs provide care for the behavioral health population, so while all care is combined, the behavioral health population is targeted, with risk adjustment based on acuity.

As in the case of MA, capitation creates incentives to enroll less costly people into the plan. Since people with mental illnesses and SUDs are more costly in terms of both their behavioral health and their general medical care, plans have long taken measures to avoid such groups. In the case of states with behavioral Medicaid MCOs, the specialized and expensive behavioral health services are covered elsewhere, diminishing the incentive to avoid beneficiaries with the behavioral health conditions, though the general incentives that limit clinician availability for Medicaid MCO beneficiaries remain. For example, the median state Medicaid program paid psychiatrists 81 percent of the Medicare fee schedule for psychiatrists (Zhu et al., 2023). In Medicaid, capitation rates are based on historical FFS Medicaid spending levels that typically occurred under a benefit structure that frequently imposed strict limits on behavioral health services.

Therefore, the capitation rates are inconsistent with the benefit designs that define the responsibilities of the Medicaid MCOs.

Such payment arrangements are at odds with efforts to achieve parity and broaden behavioral health coverage within Medicaid MCOs. This is in part because FFS Medicaid is not subject to parity regulations under the Mental Health Parity and Addiction Equity Act (MHPAEA). Together, these features, along with health care provider opportunities to earn more for commercial or cash-pay clients, contribute to the low participation rates of behavioral health providers. The result is that only between 30-40 percent of psychiatrists accepted new Medicaid patients in 2015 (MACPAC, 2021; Wen et al., 2019). Most states have some network adequacy requirements, but they usually count the number of in-network health care providers and time and distance in establishing standards (Hinton and Raphael, 2023b). Finally, Medicaid risk adjustment efforts vary widely across states, from minimal age and sex adjustment to the use of well-known risk adjustment systems. As with MA adjusters, these systems are quite imperfect.

Marketplace Incentives

The Marketplaces, with 100 percent of beneficiaries in private plans, are largely subject to the same incentives as MA and Medicaid MCOs. Evidence shows that the risk adjustment shows that the system used in the Marketplaces is weaker than that used in the MA program. One study from 2016 showed that the Marketplace risk adjuster for behavioral health is weak and could be improved with some simple modifications to the diagnoses used to characterize mental illnesses (Montz et al., 2016). However, far fewer data are available for these insurance plans, with a small body of evidence showing that Marketplace plans have especially narrow networks for behavioral health providers (Zhu et al., 2017). Rates of participation for psychiatrists in Marketplace plan networks were lower than for Medicare—nearly 43 percent versus 60 percent, respectively. The consistency of low network breadth for psychiatrists across MA, Medicaid MCOs, and the Marketplace suggests that higher earnings and lower administrative burden from delivering care out of network is an external challenge for constructing robust behavioral health care provider networks.

> Finding: The responsibility for health care provider payment structures, health care provider networks, and assorted access arrangements that affect health care provider participation has increasingly fallen on MCOs, which cover the vast majority of the nearly 113 million Americans who participate in Medicare, Medicaid, or the individual market. Behavioral health care provider participation is affected by the incentives created by a per-member, per-month payment system to plans to

pay for the care of beneficiaries enrolled in their plans. These payments are frequently risk-adjusted in an attempt to minimize the strong incentive of plans to take measures to avoid the beneficiaries who likely have the highest costs of care.

Conclusion 6-1: Insufficient risk adjustment for those with mental illnesses and SUDs contributes to MA, Medicaid MCO, and Marketplace plan strategies that limit access to behavioral health services. These strategies include creating restrictive behavioral health care provider networks and using administrative mechanisms such as prior authorization. Risk adjustment, oversight of availability of clinicians, and limits on administrative processes such as prior authorization can attenuate such behavior. Improving access to behavioral health care providers and services through managed care could occur through improvements in behavioral health risk adjustment, regulation of access to care, and thoughtful limits on prior authorization.

REGULATING HEALTH CARE PROVIDER NETWORKS IN MEDICARE, MEDICAID, AND MARKETPLACE

With over 52 percent of Medicare enrollees, over 70 percent of Medicaid enrollees, and 100 percent of Marketplace enrollees in managed care or other network-based health plans, health care provider participation in these plan networks is critical if enrollees are to have timely access to the covered services they need. Effective health care provider networks requires that health care providers have a contract to be allowed to be paid by a beneficiary's insurance plan, an issue that centers on the potential availability of services in a plan's health care provider network. It is equally important for the in-network health care providers to have sufficient accessibility to ensure timely treatment.

An important tool that health plans can use to reduce costs and increase profitability is limiting the network of behavioral health care providers that a plan enrollee can see. Contracting with a narrow selection of health care providers may have several benefits, because plans can:

1. Negotiate lower rates by offering volume discounts and driving more volume to fewer health care providers, demonstrating a more credible threat to exclude a health care provider from the plan's network.
2. Offer a distinctive product with a curated and more highly managed group of health care providers to offer a higher value product (e.g. higher quality at a lower cost).
3. Limit high-cost services if health care provider availability for those services is limited.

However, a narrow network can create challenges for enrollees if they cannot get timely appointments with high-quality behavioral health care providers. These enrollees may be forced to go out-of-network, increasing their share of the costs. For Medicare and Marketplace enrollees, increased out-of-pocket expenses may make services unaffordable, leading them to forego care. Consistent with this, evidence suggests that those with behavioral health conditions are far more likely to experience barriers to care (Busch and Kyanko, 2024), are more likely to seek care out-of-network (Kyanko et al., 2013), and have significantly higher cost-sharing compared with those with physical health conditions (Xu et al., 2019). For the beneficiaries in Medicaid, out-of-network treatment may not be affordable.

The responsibility to ensure that beneficiaries have an adequate health care provider network is delegated to the plan with the government using contract or regulatory authority to enforce plan compliance. Health care provider networks for many types of health plans are subject to network adequacy regulations which establish minimum standards to measure and track the accessibility and availability of medical services. There are two approaches to regulating network adequacy: qualitative and quantitative. "Qualitative standards" describe the network as "adequate" or "sufficient" to provide services in a "timely manner" and within a "reasonable distance." Quantitative standards include (1) time and distance between enrollees and health care providers in a specific geographic area; (2) minimum health care provider-to-enrollee ratios for specific health care provider types; and (3) appointment wait times, among other metrics (Weber, 2020).

Network adequacy requirements vary among the three programs and across the states, as do current enforcement mechanisms across all three programs. Despite this regulatory framework, the behavioral health care provider supply shortfalls in public insurance programs persist across the country (Zhu et al., 2021), and surveys show that enrollees are still experiencing great difficulty in accessing in-network behavioral health care (Silliman et al., 2023).

Marketplace Plans

Enrollees in Marketplace plans are growing at a rapid pace, with signups increasing by 30 percent from 2023 to 2024 (CMS, 2024d). With one-fifth of 2024 Marketplace enrollees having household incomes under 250 percent of federal poverty level, ensuring adequate networks to prevent the need for out-of-network care is important. A 2017 study found that mental health networks in Marketplace plans were narrow compared with primary care networks, with only 42.7 percent of psychiatrists and 19.3 percent of nonphysician behavioral health care providers participating in any Marketplace network in 2015. The study noted that Marketplace

plan networks included only 11.3 percent of all behavioral health care providers practicing in a given state-level market (Zhu et al., 2017).

The CMS regulations for Marketplace plans in 2024 require that qualified health plans "must ensure a sufficient choice of care providers," including behavioral health care providers. By 2022, 30 states had adopted at least one quantitative metric to enforce this regulation. (Giovannelli, 2022). Time and distance criteria apply in 29 states (Giovannelli, 2022; Weber, 2020), wait time standards exist in at least 15 states (Giovannelli, 2022), and some states also have criteria for health care provider–enrollee ratios (Bradley et al., 2021). As a quantitative metric, wait times for new patient appointments focus more on the patient experience of timely access to care than existing time and distance standards. Health care provider-to-enrollee ratios are easier to measure than wait times and attempt to capture a similar concept. Some states have recently adopted quantitative standards that may be more effective at capturing the number of health care providers in a specific geographic area who are willing to contract and who are available to see new patients. For instance, the New Hampshire Insurance Department determines the number of all available health care providers in a county by analyzing claims from the state's all-payer claims database and then counting the share of available health care providers in each plan's network. Marketplace consumers can compare qualified health plan hospital networks on the New Hampshire Insurance Department website. This method captures the number of health care providers who are contracting with an insurer, seeing patients, and submitting claims (Bradley et al., 2021; Pollitz, 2022).

In another state example, webinar 3 panelist Cara Cheevers, the behavioral health program director at the Colorado Division of Insurance, explained her agency's approach:

> (Colorado) Insurance Regulation 4-2-53 also sets standards related to network adequacy, and the idea here is really to understand how hard or how easy it is for a consumer to be able to get the care that they need. This regulation in particular pertains to behavioral health because we set standards in data around both mental health and substance use disorder treatment separately. While we understand integrated care is incredibly important, we also understand that somebody with generalized anxiety disorder has a different set of needs as someone with opioid use disorder. And while those two might combine and those two might pertain or be relevant to one consumer, we want to make sure that when we're counting and measuring access, we're doing so almost by condition. And that requirement also indicates that a consumer must be able to get care within 7 calendar days from the moment they attempt to make an appointment to actually being seen. So those time and distance standards in that regulation are really important.

Evaluations of the effectiveness of these various network adequacy regulation approaches are limited, but multiple years of trial and error in practice has shown that network adequacy policies have generally failed to realize their goals. The current time and distance measures used most frequently to assess network adequacy may be ineffective if they do not account for telehealth availability and its use in treating behavioral health conditions. Other measures such as appointment wait times may be more patient-centered and capture access more effectively. In addition, the effectiveness of how well network adequacy regulation works in one state might not apply in a different context.

> Our network adequacy statute currently prohibits the use of telehealth for network adequacy purposes, so while we do understand the crucial role that telehealth plays in behavioral health services and medical-surgical services, insurers are actually not allowed to use telehealth as a way to meet network adequacy requirements currently. And so we are looking at whether or not we should be utilizing telehealth for network adequacy purposes, but in general we do like to see primarily in-person, person-centered care and so that's what our statute reflects.
>
> —Brooke Hall, webinar 3 panelist
> Innovations to Improve Mental Health and Substance Use Disorder Access in Medicare, Medicaid, and Marketplace Insurance Plans

Regulatory approaches will continue to evolve. In 2023 the Department of Labor and CMS proposed new MHPAEA rules that require plans to take affirmative steps to collect, evaluate, and analyze specific types of outcome data. In this context, several state insurance departments have begun to review reimbursement parity data from insurers in their state to assess MHPAEA compliance and to assist with enforcing network adequacy standards. New Hampshire, Massachusetts, Maryland, Oregon, New Mexico, and other states are beginning to scrutinize insurers' approaches to setting reimbursement rates for behavioral health care providers (Volk, 2023). The "data outcome" approach outlined in the proposed MHPAEA regulations may hold promise, but evaluations are needed to identify and understand best practices in this important area of regulation which is intended to ensure sufficient behavioral health care provider networks. Separate from network adequacy regulation, improving network transparency for consumers may be another approach to hold plans accountable for the adequacy of their networks.

State Medicaid and Medicaid Managed Care

Federal law requires Medicaid managed care plans to have the capacity to serve the expected enrollment in their service area and to maintain a

sufficient number, mix, and geographic distribution of health care providers. These plans must make covered services accessible to their enrollees to the same extent that such services are accessible to other state residents with Medicaid who are not enrolled in a managed care plan. MHPAEA applies to Medicaid managed care and Children's Health Insurance Program (CHIP), and about 72 percent of all Medicaid enrollees are covered by those programs (Hinton and Raphael, 2023b).

The 2020 CMS Medicaid managed care final rule removed the requirement that states use time and distance standards to ensure health care provider network adequacy and instead lets states choose any quantitative standard, such as minimum health care provider-to-enrollee ratios, maximum travel time or distance to health care providers, minimum percentage of contracting health care providers accepting new patients, maximum wait times for an appointment, or hours of operation requirements (Hinton and Raphael, 2023b). The 2024 CMS Ensuring Access to Medicaid Services Final Rule, effective as of April 2024, further strengthens network adequacy regulations through the establishment of appointment wait time standards and enforcement through secret shopper surveys and audits (Federal Register, 2023a).

There may, however, be a tension between allowing greater flexibility on network adequacy standards and increasing plan accountability for developing an adequate behavioral health network. Moreover, existing standards have not been associated with improved access to behavioral health care providers (Hu et al., 2023; Ndumele et al., 2017; Zhu et al., 2021). Given that these standards in Medicaid are relatively new and rapidly evolving, there is scant evidence on the degree to which adopting these standards increases beneficiary access to behavioral health care providers. The committee expects challenges to increasing access to behavioral health care that are similar to those described above for the Marketplace (Hinton and Raphael, 2023b; Zhu et al., 2021) and encourages assessment of these regulatory changes and their effects.

Medicare and Medicare Advantage

The traditional Medicare program, based on FFS, does not manage a health care provider network. Physicians, nonphysician practitioners, and other health care suppliers must enroll in the Medicare program to be eligible to receive Medicare payment for covered services provided to Medicare beneficiaries. CMS regulates MA plans that use health care provider networks, and therefore they are subject to federal network adequacy regulations. These regulations are quantitative. Plans must maintain a network of appropriate health care providers that is sufficient to provide adequate access to covered services to meet the needs of the population

served. However, in 2022 and 2023, CMS finalized regulations that added requirements for maximum time and distance standards in rural areas and rules governing the use of telehealth. Beginning in 2023, for contract years 2024, CMS may deny an application for a new or expanding service area based on an evaluation of the applicant's network (CMS, 2023d).

The non-interference provision in section 1854(a)(6) of the Social Security Act[1] prohibits CMS from requiring MA plans to contract with specific health care providers or require a specific reimbursement for contracted services. However, CMS can enforce the network adequacy regulations that apply to MA plans and may refuse to approve MA plans that do not meet those requirements. The MA plans themselves can decide what strategies are successful in attracting more behavioral health and SUD care providers to join their networks, allowing the plan to comply with network adequacy standards (CMS, 2023d). In 2024, CMS finalized new Medicare Advantage rules, establishing enhanced network adequacy standards for outpatient behavioral health, including diverse providers like MFTs, MHCs, OTPS, addiction medicine physicians, and other behavioral health care providers who provide addiction medicine and counseling (CMS, 2024c). New categories for LCSWs and clinical psychologists were introduced, alongside wait time standards for primary care and behavioral health services (CMS, 2023a).

Finding: Past experience demonstrates that "qualitative" network adequacy regulations do not improve access to behavioral health care.

Finding: Over the past few years, CMS and many states have adopted quantitative approaches to network adequacy regulation and guidelines, such as those based on time and distance network parameters, in efforts to strengthen networks and improve access to behavioral health care providers. Some of these metrics are inconsistent with advances in telehealth approaches to treatment. For metrics such as waiting times, which may better reflect patient experience, there is insufficient evidence to demonstrate whether they motivate plans to ensure adequate supply or offer guidance on best practices.

Conclusion 6-2: Various approaches to network adequacy regulations have not been shown to be effective in expanding behavioral health care provider participation or patient access. Nevertheless, these adequacy regulations are tools that regulators currently rely on to prevent insurers from selling health plans that are overly restrictive in the supply

[1]Social Security Act §1854, Sec. 1854. [42 U.S.C. 1395w–24] (a) Submission of Proposed Premiums, Bid Amounts, and Related Information.

of behavioral health services offered. Thus, while network adequacy regulation remains a key tool for regulators, current approaches are unlikely to be the avenue for improving health care provider participation in Medicare, Medicaid, and the Marketplace. Strengthening plan accountability for providing adequate supply of behavioral health services based on outcome data would improve regulatory oversight.

Conclusion 6-3: Studies should explore the role of outcome-based approaches for expanding health care provider participation, the results of which may lead to a recommended regulatory approach.

Conclusion 6-4: Approaches to measuring access for the purposes of regulating plan networks have largely been health care provider–focused, measuring the availability of health care providers. Patient-focused measures, including ease of finding and receiving quality treatment from a culturally appropriate health care provider, are likely to require investments in new and alternative data sources, including patient surveys.

TELEHEALTH: AN INFRASTRUCTURE FOR ADVANCING OR LIMITING HEALTH CARE PROVIDER PARTICIPATION

As described in Chapter 3, telehealth use for behavioral health concerns expanded rapidly during the COVID-19 pandemic (Cantor et al., 2023) and has largely sustained over time. Before the COVID-19 pandemic, only 5 percent of behavioral health care providers participating in Medicaid had provided at least one telemedicine visit (Uscher-Pines et al., 2020). In comparison, as of 2022, up to 40 percent of all behavioral health encounters continued to be telehealth visits. Similarly, in 2022, 13 percent of behavioral health specialists serving commercially insured or MA enrollees had shifted entirely to telehealth, with these health care providers more likely to be female and working in densely populated counties (Hailu et al., 2024). It is likely that this shift because telehealth is widely viewed as a feasible, acceptable, and effective approach to providing behavioral health treatment across the lifespan and for a range of disorders. Telehealth has the potential to directly address existing barriers to care, including alleviating geographic maldistribution of behavioral health providers, circumventing transportation barriers for patients and providers, and reducing practice overhead expense and increasing quality of life for providers who work from home. At the same time, there are unknowns about the clinical applications of telehealth, as well as important effects on the provider workforce, including whether telehealth flexibilities can directly improve provider capacity and enhance participation in Medicaid, Medicare, and the ACA Marketplace.

Coverage and Payment Policies that Facilitate Telehealth Uptake

A number of state and federal policies around telehealth coverage and payment have facilitated its uptake in behavioral health (CCHP, 2024b; Chu et al., 2021; McBain et al., 2023). In March 2020, during the COVID-19 public health emergency, the federal government and individual state governments provided temporary, specific telehealth flexibilities for coverage and reimbursement to meet the demand for virtual care. These temporary flexibilities included payment parity for specific telehealth clinical services such as behavioral health and expanded the definition of telehealth to include audio only (AMA, 2023). While some of these changes remain, many of the flexibilities concerning licensure are gone.

Coverage parity requires payers to cover a telehealth service if it is also covered in person and can be delivered remotely while meeting the standard of care. *Payment parity* requires payers to reimburse for telehealth visits at the same rate as the equivalent in-person visit. States and payer program have adopted coverage parity more widely than payment parity. In states with payment parity for commercial plans, for example, there may exist caveats such as a sunset date or only being available for specific services, such as behavioral health. The statutory language of these provisions in the various states is not uniform, which makes practicing across state lines more difficult (AMA, 2023; Augenstein and Marks Smith, 2024).

Telehealth is included within the scope of Medicaid, where it is considered a mode of service delivery rather than a distinct service under federal law (Medicaid.gov, 2024). States have broad authority to design their own Medicaid telehealth policies, including which health care provider and service types may use telehealth, the mode of telehealth delivery, such as audio only or audio–visual, and reimbursement. As a result, there is wide variation regarding telehealth coverage and payment parity, although most states are allowing telehealth services for behavioral health, home as the originating site for telehealth, and both synchronous and asynchronous services (Telehealth.HHS.gov, 2023b). As of 2023, 24 state Medicaid programs offered payment parity for telehealth, including for behavioral health services (CCHP, 2023). Figure 6-1 shows some of the variations states can have in their telehealth policies. Box 6-2 highlights the specifics of coverage for audio-only payments.

For Medicare, the Consolidated Appropriations Act of 2023[2] and the 2024 Physician Fee Schedule extended many of the COVID-19 public health emergency telehealth flexibilities through December 31, 2024. As of this writing, Medicare telehealth flexibilities include permanent coverage of both audio and visual visits for a broad swath of behavioral health

[2]H.R.2617—117th Congress (2021-2022); Consolidated Appropriations Act, 2023.

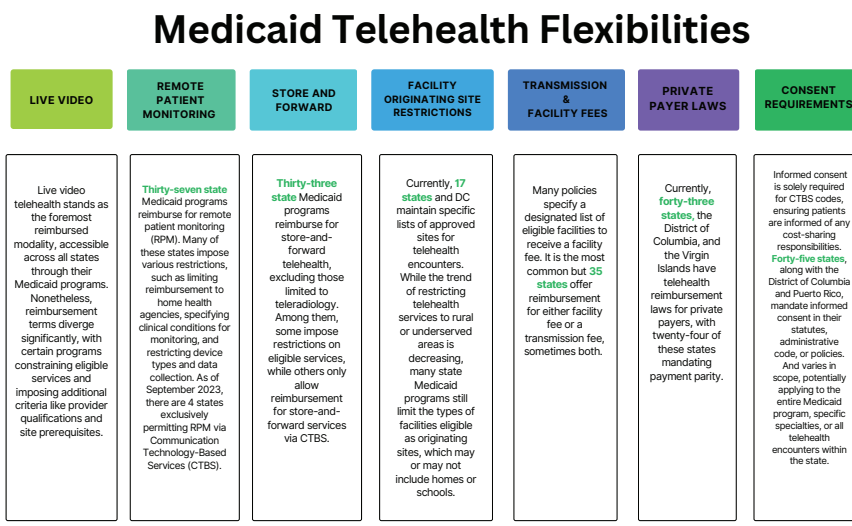

FIGURE 6-1 Medicaid telehealth flexibilities.
SOURCE: Committee generated using data from CCHP, 2024a.

services, as well as broad health care provider eligibility for telehealth billing (Telehealth.HHS.gov, 2023a). In addition, there are no geographic restrictions for the originating site for behavioral telehealth services, and federally qualified health centers, rural health centers, and rural emergency hospitals are all permanently eligible originating sites for telehealth services (Telehealth.HHS.gov, 2023c). For commercially insured populations, including by MA and Marketplace plans, 43 states and the District of Columbia have enacted legislation requiring insurers to reimburse for telehealth services. Of these states, 24 have additional requirements for payment parity.

Telehealth Uptake in Behavioral Health Care

Telehealth is one tool that can leverage existing health care provider supply to address access needs for diverse populations, including those in rural areas. Telehealth modalities have several potential advantages over in-person care for those living in areas with few available behavioral health providers, including connecting patients with specialized providers who may not be available locally; eliminating the need for and hassle of travel; offering flexible scheduling and allowing patients to receive care from the comfort of their own homes; reducing stigma; integrating with other digital tools like electronic health records to facilitate care coordination and treatment planning; and facilitating real-time interventions in a timely manner.

BOX 6-2
Audio-Only Coverage and Payment

Prior to the COVID-19 public health emergency, audio-only telehealth visits were typically not covered and were often excluded from the definition of telehealth. During the federal public health emergency, all states and the District of Columbia took advantage of CMS's Medicaid telehealth flexibilities and allowed for audio-only telehealth visits. Regulators found that the audio-only option was especially important for older patients, those unfamiliar with audio-visual technology, and individuals with behavioral health conditions who found audio-only visits more comfortable. For example, California safety net organizations reported that during the COVID-19 pandemic, 23 percent of visits were in person, 63 percent via phone calls, and 14 percent via video (Uscher-Pines et al., 2021).

A key reason for the need for audio-only visits is that some people do not have access to broadband internet in their homes. As of January 2024, between 73 and 86 percent of adults, depending on where they lived, had broadband access at home computer (Gelles-Watnick, 2024). Individuals aged 65 and older and people experiencing poverty were less likely to own a smartphone or to have broadband internet access. In addition, only 58 percent of Black individuals and 57 percent of Hispanic individuals owned a computer. Because of this variation, many states made their coverage of audio-only visits permanent.

Since the public health emergency ended, at least 20 states have acted to allow or require insurers to cover telephone visits, sometimes with limitations (Volk et al., 2022). For now, telephone visits may be needed to reach the millions of people who lack broadband, and Medicaid programs in 43 states and the District of Columbia will reimburse for audio-only telehealth visits, with some caveats and restrictions. Fourteen states introduced legislation pertaining to audio-only coverage in 2023, and some of those proposals were aimed at establishing reimbursement rates for audio-only services (AMA, 2023). However, Medicare will not reimburse for audio-only visits after 2024, except for behavioral health visits (South Central Telehealth Resource Center, 2023).

There is still a lack of evidence on differences in care quality and outcomes for telephone versus video visits. Understanding these differences, if any exist, will be important for guiding policy and balancing the need for access to care and quality of care.

However, there has been differential uptake of telehealth for behavioral health services across modalities, population, and geographies. A 2020 national survey examining trends in telehealth found significant disparities among subgroups in terms of audio versus video telehealth use, with video telehealth rates lowest among those without a high school diploma, older adults, and people of color (Karimi et al., 2022). Another study found that people of color had substantially fewer telemedicine visits for behavioral health conditions than White individuals (Marcondes et al., 2024). Thus, while telehealth has had widespread and sustained uptake, less clear is whether telehealth has reduced pre-existing disparities in access. These gaps in telehealth use may be driven in part by structural issues like broadband internet access; rural areas often have significantly less access to broadband internet at FCC minimum broadband speeds than urban areas (Kohli et al., 2024). Disparities in digital literacy have also affected adoption of and access to telehealth services, as patients need digital skills to work with the technology needed to engage in telehealth.

> We . . . need access to digital literacy and training and support that is funded or reimbursable because sometimes people may not have access to the technology and when they get it, they don't know how to use it.
>
> —Keris Myrick, webinar 1 panelist Lived Experiences in Accessing Behavioral Health Care Services through Public Insurance Programs

Telehealth uptake also has been lower in the public sector than in the private sector, with recent data suggesting that even states with the largest uptake of telehealth did not increase access to behavioral health services more than states with lower telehealth uptake (Cantor et al., 2024). Many questions also remain about the quality of telehealth care, the best applications for video versus phone-based telehealth, appropriate payment models, and the role of new asynchronous models of telehealth using, for example, smartphone apps (Bartelt et al., 2023; Samson et al., 2021), all of which are widely applicable to behavioral health.

Unknowns about Telehealth's Effects on Clinicians

Due to its rapid and relatively recent rise, it is still unknown the extent to which telehealth modalities may help or hinder behavioral health clinicians' ability to care for enrollees in Medicare, Medicaid, and ACA Marketplaces. There have been few studies to date that examine the net effects of telehealth delivery on behavioral health provider satisfaction, capacity, and retention.

On the one hand, telehealth may help to alleviate care burdens among clinicians, for instance, by reducing existing geographic barriers in care delivery. Proponents argue that the convenience and flexibility of telehealth can be a protective tool that can streamline clerical tasks, improve workplace autonomy, introduce greater flexibility in work schedules, reduce time constraints, and improve job satisfaction. On the other hand, while the digital delivery of care has many potential advantages for access to care, workplace flexibility, and clinician capacity, it may also increase clinician burden and burnout. At least one study has shown that health care providers with higher telehealth use have more after-hours EHR-based work, which could lead to higher levels of burnout (Lawrence et al., 2022). Telehealth may also increase depersonalization and dissatisfaction among clinicians by increasing required documentation, duplicating or slowing work processes because of interoperability, and increasing total work time through greater asynchronous patient messaging in EHR systems. One study, for example, found that clinician time spent in the EHR increased during 2020, with asynchronous messaging from patients increasing to 157 percent of the pre-pandemic average. Each additional patient message was associated with a more than 2-minute increase in EHR time per day (Holmgren et al., 2022).

Other workforce effects are likely to be seen over time and across markets, as telehealth delivery organizations rise in prominence. An increasing number of retail chains now offer telehealth offerings, including via behavioral health–specific companies as well as tele-mental health programs or partnerships with primary care–focused retail companies (Ashwood et al., 2017). While there are limited studies on the effects of telehealth retail companies on care access and quality, early evidence suggests that digital health and retail companies have attracted patients with lower-acuity behavioral health needs, opening new avenues for access that may be less stigmatized than traditional behavioral health delivery settings. Interim COVID-19-era flexibilities that allowed patients with opiate use disorder (OUD) to initiate or continue receiving buprenorphine treatment via audio or video telehealth have also ushered in many retail telehealth companies focused on telehealth-based OUD treatment, though there is uncertainty whether this flexibility will be extended after November 2024 (Federal Register, 2023b).

While there is optimism about retail telehealth improving access to services for some populations, there are also concerns that retail telehealth may shift resources, including the behavioral health workforce, away from community-based health settings that disproportionately care for Medicare and Medicaid populations. It is also important to consider whether retail telehealth may target less acute populations, shifting more complex patients to community health settings. Finally, there are also concerns that telehealth companies may be disconnected from traditional delivery systems, requiring

individuals to re-establish care and creating care navigation challenges should more acute or complex behavioral health needs arise. In the absence of evidence about the potential effects of these alternative delivery models, more evaluation is needed as alternative behavioral health delivery systems emerge out of telehealth platforms.

Recent Innovations in Telehealth

In addition, recent innovations, including the use of asynchronous telehealth, where communication between the individual and health care provider is not live, may help with both with patient care and clinician satisfaction. For example, new digital innovations around chatbots and behavioral health apps are not reaching Medicare and Medicaid populations (Miller-Rosales et al., 2023) and are largely untested, but some of these applications may increase access to care by offering wellness and non-clinical support to people with lower-acuity needs. Technological tools may also make clinicians more efficient by offering this augmented support to more complex patients.

Asynchronous tools such as apps, virtual reality, and self-help computer programs are important to explore but are not yet ready for routine clinical payment. However, there is a need to support rigorous research to understand their true role and value in care. These assessments need to be conducted in a real-world clinical setting, with diverse patients, and by objective teams without a conflict of interest regarding the outcome. Recent reports indicate that actionable use cases are emerging but still limited and that the technology solutions are unstable (SAMHSA, 2023).

The uptake of any digital tools into care requires a concomitant focus on patients as the recipients of these tools' actions. Tasking clinicians with digital literacy, education, and support regarding these new tools will quickly nullify any promised efficiencies. Therefore, it will be important to support a new workforce of digital navigators who help both patients and clinicians with digital literacy, digital tool selection, patient engagement, and clinical workflow in order to realize the potential of these tools (Perret et al., 2023). This new role must be considered in the costs and savings associated with technology.

Studying hybrid care or blended models of care that combine synchronous and asynchronous telehealth offers the potential to discover where actual efficiencies in telehealth lie. The industry is already actively experimenting, but the results are not public or shared on how this new model of care could best serve Medicare and Medicaid patients.

> Finding: Telehealth is a feasible, acceptable, and effective modality for providing behavioral health treatment across the lifespan and for a range of disorders. The COVID-19 pandemic-associated jump in

telehealth use has been unique for behavioral health, given the sustained share of visits conducted via telehealth following the pandemic.

Finding: The telehealth flexibilities introduced during the COVID-19 public health emergency, particularly the expanded coverage and payment policies for telehealth services, enabled expanded adoption of telehealth and have supported the sustained use of telehealth for behavioral health. Coverage and payment for telehealth varies across Medicare, Medicaid, and Marketplace plans, with uncertainty as to how it will change following the expiration of the extended public health emergency flexibilities.

Finding: There has been differential uptake of telehealth across modalities, populations, and geographies. Research has found that variations in broadband access and digital skills are among the most critical barriers to equitable access to telehealth services.

Finding: Audio-only telehealth increases access to behavioral health services, decreases health inequities, and expands access to underserved communities with inadequate access to broadband internet services at adequate speeds. However, it may also carry some disadvantages for the clinician–patient interactions for some behavioral health conditions.

Finding: The net effect of telehealth on the behavioral health workforce, and particularly on recruitment, retention, and insurance participation, is yet unknown. On the one hand, telehealth may help to alleviate care burdens for providers by introducing new workplace flexibilities, and on the other hand, new technologies may increase depersonalization and burnout among providers. Other new trends, including the rise of commercial telemental health companies, may have additional workforce effects that should be monitored.

Conclusion 6-5: To maintain health care equity, audio-only behavioral health and SUD telehealth services are essential for serving individuals without adequate internet video access. There is not enough evidence on the relative effectiveness of audio-only telehealth, but until the digital divide is addressed, the access to audio-only telehealth for those facing disparities in access may outweigh the uncertainly regarding its relative effectiveness compared with video telehealth for behavioral health services.

Conclusion 6-6: Telehealth is innovating rapidly with many new models coming on board with little evidence concerning the quality of care

across these new modalities. This uncertainly makes it unclear whether future modalities within existing regulatory and payment frameworks will be effective in promoting health care provider access in Medicare, Medicaid, and Marketplace plans. Developing agile and flexible payment and regulatory structures may be needed. For example, hybrid care models that blend synchronous and asynchronous telehealth may increase access to care, but developing best practices and regulations to protect consumers and ensure integrity of clinical services would be necessary. In addition, payment for these models must balance access with the potential for overuse of low-value care. It is important to explore new regulatory pathways for novel asynchronous telehealth tools that can quickly assess value, build public trust, and increase transparency.

Conclusion 6-7: To improve access to behavioral health care amidst broadband gaps, targeted efforts should identify regions needing both services and broadband. Collaborating with federal agencies such as the Department of Commerce, Treasury, Agriculture, and the Federal Communications Commission can strategically allocate broadband funds. Effective distribution of these resources to underserved areas is crucial for enhancing connectivity and equitable access to essential behavioral health services nationwide.

PAYMENT MODELS: BARRIERS AND FACILITATORS FOR HEALTH CARE PROVIDER PARTICIPATION

Concerns persist that existing health care provider billing codes and modifiers inadequately cover the full scope of services provided by behavioral health care providers. Existing billing codes and modifiers also limit innovation in developing alternative approaches to meeting care needs. As a result, certain types of evidenced-based services, such as care coordination activities, are a underused tool in behavioral health care delivery. For example, while a preponderance of evidence supports the role of care coordination in supporting health behaviors and improving health outcomes in adults and children with behavioral health needs, behavioral health integration codes are underused (McConnell et al., 2023). Medicare began making payments for behavioral health integration services in 2018 to accelerate the adoption of behavioral health integration (BHI) models more widely. Similarly, the use of BHI codes in Medicaid has also stalled. Early adopters of BHI codes have struggled to implement sustainable billing and care delivery practices, suggesting a concurrent need for structural and process-related investments.

Similarly, while behavioral health services rely on a slew of additional activities, including treatment planning, team-based collaboration, care

navigation and coordination, and addressing social drivers of health, nonencounter services remain time- and labor-intensive but unbillable for health care providers. The committee heard from behavioral health care providers that inadequate payment for supervisory roles—a key component of workforce retention and development—was unsustainable, as supervision, training, and education activities often translate into fewer billable hours.

Medicare's Merit-Based Incentive Payment System (MIPS) affects participation by psychiatrists and addiction medicine specialists. This mandatory outpatient, value-based payment program ties reimbursement in Medicare to performance on cost and quality measures. A cross-sectional study comparing psychiatrists with other outpatient physicians found that psychiatrists had significantly lower 2020 MIPS performance scores, were penalized more frequently, and received fewer bonuses (Qi et al., 2022). In particular, psychiatrists had poorer performance compared with other outpatient physicians on technology-dependent measures, including participation in health information exchanges; care coordination measures, such as documentation of patient medications in medical records; and preventive care measures unrelated to psychiatry, such as cancer screening. The authors of this study asserted that psychiatrists likely were not as well prepared as other outpatient physicians for the reporting and performance requirements of the MIPS program, which resulted in financial penalties. The authors recommended that policy makers evaluate whether the current MIPS performance measures appropriately assess the performance of psychiatrists.

Quality Measurement Infrastructure to Support Value-Based Payment and Quality Improvement

A measurement of performance linked to a system's consequences for strong and weak performance lies at the core of accountability systems. Quality measurement has become widely established in medical care and increasingly includes more behavioral health measures. A broad range of state and federal programs include quality measures, with about a third of Medicare core quality measures specific to behavioral health (CMS, 2024a,b). These measures can facilitate quality improvement by tracking trends over time and providing a basis for comparison across health care providers. However, the effort required to collect and report these measures when participating in federal programs may reduce health care provider participation. The National Committee for Quality Assurance (NCQA) reports that federal programs use over 100 behavioral health performance measures, yet only four are commonly used, with most measures used by only one federal program. This puts an undue burden on health care providers participating in federal programs to adhere to the varied measurement requirements (NCQA, 2021).

Tying measures to payment is critical if these measures are to ultimately play a role in improving the quality of care. The mantra of "what gets measured, gets done" is particularly true when those measures are tied to payment, yet few, if any, behavioral health quality measures are tied to payment. For payment models to produce true benefit to society, CMS needs to ensure that payment incentivizes "value" in ways that drive behavioral health access and the outcomes that are important to the people who experience illness. They must also carry sufficient revenue effects to reward health care providers that excel and penalize those that provide sub-par care.

In considering value-based payment and alternative payment models as an opportunity for addressing health care provider participation and meaningful beneficiary access in Medicare, Medicaid, and the Marketplace, the committee considers the following opportunities and challenges for quality measurement in behavioral health:

Consistency

It is common for innovative quality measures that address deficiencies tied to data availability and the lack of outcomes measurement to lack consistency across payers and treatment sites (Gaynes et al., 2015). This lack of consistency creates burdens on health care providers that may further limit health care provider participation, particularly in the least resourced settings most critical to access for beneficiaries in Medicaid, Marketplace, and Medicare. There is a consensus that consistency is supported by the validation of performance metrics and coordination across payers and health care providers and settings that can be facilitated by a trusted steward (Brown et al., 2018).

Value

The highest-value quality measures require health care providers to devote resources to collect data linked to a substantial share of practice revenue (HHS, 2022). Having a large number of quality measures reduces the marginal value of any additional measure. Thus, an emphasis on fewer measures adds value to measurement for health care providers and facilitates health care provider participation.

Data Availability

Behavioral health outcome reporting has been limited historically by data availability. Most measures used in payment programs to assess behavioral health quality rely exclusively on administrative

data. However, administrative claims data do not capture important elements of evidence-based behavioral health care performance, such as results from a commonly used screening instrument for depression or other patient-reported outcomes such as functional impairments that are affected by the quality of behavioral health services. NCQA's Electronic Clinical Data Systems (ECDS) reporting method requires health plans to use structured electronic clinical data to report measures, and it does have six behavioral health measures among the 16 ECDS-reported Healthcare Effectiveness Data and Information Set measures.

However, the feasibility of collecting the necessary data is a persistent challenge affecting various levels of the delivery system. At the practice level, for example, inadequate practice capabilities, limited data sharing—including regulatory obstacles such as regulations pertaining to the confidentiality of SUD-related patient records—and weak data standards have created barriers to the feasibility and utility of reporting behavioral health quality measures (Morden et al., 2022).

Data needed to measure access from the patient's perspective are also limited. Common access measurements are physician- and clinician-focused, rather than focused on the patient's experience of access. While "secret shopper" surveys have some value for determining timely appointment availability, other aspects of the patient's access experience, including ease of navigating the system; finding appropriate care for racially, ethnically, culturally and linguistically diverse care for all individuals; or easing barriers that inhibit patients from receiving or fully benefitting from care, may require organizing existing data sources, including all-payer claims databases, to look at patterns of use and effectiveness of care. It may also be necessary to develop new data sources, such as an annual national survey of Medicaid beneficiaries, similar to the one conducted in 2015 (Sommers and Tipirneni, 2024). Moreover, there are few data available that capture downstream person-centered benefits of behavioral health care, such as alleviating loneliness or mitigating trauma. (Counts et al., 2021).

Outdated EHRs and Data Systems

EHRs and data systems that lack interoperability across practices are a major source of challenges to reporting behavioral health care quality measures. This technology gap contributes to inadequate practice-level resources and insufficient standardized health data exchange, particularly between behavioral health care and physical health care providers. Primary care and behavioral health providers must be able to access and use up-to-date EHRs and data systems to mitigate underreporting for behavioral health care quality measures.

Practice Organization

Behavioral health care providers are more likely than medical and surgical providers to work in small group or solo practices, with limited capacity and support for adapting to the requirements for value-based models.

Conclusion 6-8: Quality measurement that can provide more meaningful guidance on the value of care provided and can overcome reporting challenges will better support meaningful improvements in the quality of behavioral health care. It will also enable payment schemes that incentivize investment in behavioral health care by generating new, value-based revenue streams that better support quality care delivery and health care provider recruitment.

Conclusion 6-9: Quality measurement aimed at ultimately improving the accountability of health plans and practices can have the effect of raising costs for both plans and practices. Moreover, behavioral health care providers have frequently opposed performance measurement as an intrusion on professional autonomy. Thus, efforts to bolster accountability may also serve to make clinicians balk at participating in health plan networks that are required to report on sophisticated quality metrics.

Conclusion 6-10: Addressing the technology gap with investments in lower-cost, interoperable EHR systems appropriate for behavioral health and connecting behavioral health records through health information exchanges or other mechanisms is critical for advancing value-based care payments and integrated care models. Managed care tools that allow supplemental or directed payments could provide a mechanism for closing the gap.

BI-DIRECTIONAL INTEGRATION OF BEHAVIORAL HEALTH, PRIMARY CARE, AND GENERAL HEALTH

Virtually all primary care providers participate in Medicare, and a substantial segment also serve Medicaid beneficiaries and individuals enrolled in Marketplace plans. The evidence-based approach known as bi-directional integration of primary care and specialty behavioral health care[3] offers one approach for taking advantage of the existing supply of health care providers in a way that can compensate for payer-specific and geographic shortages of behavioral health care providers and address a

[3]The committee uses the term bi-directional integration to capture the concept that has many other names, including integrated primary care, integrated care, collaborative care, comprehensive person-centered care, or whole-person care.

range of needs of people with behavioral health care needs. The evidence supporting the notion of integrated health is generally optimistic (AHRQ, 2023 (unpublished); Ross et al., 2019). Box 6-3 highlights the benefits of bi-directional integration.

After numerous false starts, it is clear that realizing the benefits of bi-directional integrated behavioral health care is complex and remains a somewhat elusive goal (Frank and Wachino, 2022). Specifically, integrating care within primary care or behavioral health care settings can represent a comprehensive and intricate organizational change. Bringing together services that have historically been separated usually requires a fundamental shift in workflows, care transitions, and training. This transformation to becoming an integrated practice encompasses various components, such as systematic case identification and diagnosis, patient involvement and education, treatment methodologies informed by emerging research, and incorporating clinicians from diverse backgrounds and a range of professionals (e.g., peers) who may be geographically dispersed yet collaborate throughout treatment and follow-up phases, including the adjustment of care plans to secure ongoing progress. Realizing these changes will require adaptations to practice operational procedures and workflows, enhancements in documentation and information exchange practices, and improved communication strategies. Furthermore, concerted efforts to engage leadership and multidisciplinary teams will be vital in ensuring that the implemented changes are sustainable.

There are numerous approaches to integrating behavioral health and primary care, which is an asset when envisioning a bi-directional integrated health care system. This array of choices can also be beneficial when states are looking to see the best fit and encounter issues with one model, for they can then pick facets from other models to create an individualized approach that works in their state to pay health care providers and payers and broaden the reach of care to patients using Medicare, Medicaid, or Marketplace plans. A handful of states lowered their medical costs with BHI through their Medicaid programs, in Medicaid MCO contracts, through Medicaid health home programs, and accountable care organizations. These states also saw savings across payers that were often accompanied by improved patient outcomes (Bipartisan Policy Center, 2021).

Noteworthy models designed to achieve BHI include the Patient-Centered Medical Home, Collaborative Care Model, Primary Care Behavioral Health Co-Location of Services Model, and Health Homes model. In addition, there are multiple grant programs, such as the Substance Abuse and Mental Health Services Administration's Primary and Behavioral Health Care Integration program, that have the goal of improving the health of people with co-occurring health issues by including preventive physical health services into the behavioral health care they were receiving in certified community behavioral health clinics (Breslau et al., 2021).

BOX 6-3
Benefits of Bi-Directional Integration

Bi-directional integration can, in theory, increase behavioral care access and improve the patient experience of behavioral health care. One visit providing an array of care to the patient provides the opportunity to approach the patient's treatment plan more holistically, allowing the health care provider to see the layers of concerns surrounding the patient's current state of health. Time is an immeasurable resource for everyone, but for those who lack strong support systems or who live paycheck to paycheck, time is their livelihood (Tai-Seale et al., 2007). People in more disadvantaged positions can take less time and energy to meet multiple appointments on different days and locations if their primary and behavioral care visits are integrated into one or by having a plan set up on the same day as care was given. Increasing the accessibility of both primary and behavioral health care providers achieve greater health equity by removing time and coordination as a barrier.

Voices from the committee's webinar support integration:

[T]he first time that I had even heard of integration was in Dubuque, Iowa. I thought that that was a great concept because it cuts down on me having to tell my story to so many people consistently. Like I'm explaining the same thing and it's like, are you all not talking to each other.

–Eboni S. Dabney, webinar 1 panelist
Lived Experiences in Accessing Behavioral Health Care Services through Public Insurance Programs

I was at that time discharged from a locked psychiatric unit in which I had been in for quite some time, and I was on my own to navigate the Medicaid insurance. . . . [I]magine now just your plain old person trying to figure it out, especially a person who wasn't doing all that well at the time. . . .

People are not segregated into these separate parts and pieces, but the way that we have to receive our services are because there's not sort of one central place in which the information can exist and be shared in order to ensure that people don't fall through the cracks.

—Keris Myrick, webinar 1 panelist
Lived Experiences in Accessing Behavioral Health Care Services through Public Insurance Programs

Barriers and Facilitators to BHI

The Agency for Healthcare Research and Quality found that the organizational culture and the professional culture in which clinicians provide care were the biggest barriers and facilitators to BHI. Staffing, training, and group attitude, along with sustainable regulations and contracts, proved to be the most common roadblocks to integrating care, but the biggest barriers were the restrictions for licensing and coding relevant for behavioral health and the lack of a coordinated policy approach to achieve integrated care goals.

A lack of coverage for the bi-directional BHI model was a consistently cited barrier in our committee's request for information (RFI). In particular, the barriers that respondents to the RFI noted included a lack of coverage for Collaborative Care Model codes and limited coverage for intermediate levels of care, such as partial hospitalization programs and intensive outpatient programs, that typically serve people with serious mental illness and are delivered in specialty settings. The *Bipartisan Policy Center Task Force Recommendations Report on Mental Health and Primary Care Integration* provides a detailed overview of the steps that CMS, the Department of Health and Human Services, and individual states should take to move toward a bi-directional health integration system. The list is extensive, focuses on the needs for BHI to function, and includes payment reforms mentioned in this chapter. The report notes the need for payment mechanisms that incentivize collaboration and coordination between both primary care and behavioral health care providers, such as such as billing for collaborative care services or reimbursing for telehealth visits. States can also use Medicaid waivers to advance integrated care goals and improve behavioral health services (Bipartisan Policy Center, 2021).

BHI and Care Provider Participation in Public Insurance Programs

BHI creates the opportunity for enhanced collaboration and communication that can promote the adoption of integrated care practices by primary care providers, knowing they have support from behavioral health specialists (Rybak et al., 2023). Some integrated care models offer opportunities for enhanced reimbursements, usually involving value-based payment arrangements that encourage investing time and resources in delivering comprehensive care to patients. BHI can enhance professional satisfaction for care providers' holistic health needs and allow them to see the effects of their care more directly. By sharing the workload with behavioral health professionals, primary care physicians may experience reduced burnout as well, making them more likely to participate in these kinds of models.

Finding: A broad collection of bi-directional integrated care models have been tested and found to be cost-effective in care for some behavioral health conditions. These models can reduce treatment times and improve patient outcomes compared with usual care.

Finding: The biggest barriers to integrated care are organizational and cultural, including restrictions on licensing and coding.

Finding: Although successful models of integrated care exist, the development of payment, coverage, and infrastructure investments that promote the widespread adoption of such models in Medicare, Medicaid, and the Marketplace environments remains elusive.

ADDRESSING COMPLEX NEEDS

People with complex needs, such as individuals with severe and persistent mental illnesses, often need services that fall outside of the traditional bounds of what health insurance covers. Medicaid covers some "non-medical services" aimed at people with functional impairments and a need for long-term services and supports, but, typically, those services are not mandatory in the way that most medical services are within Medicaid. In addition, these individuals may transition over their life course between coverage within and between Medicare, Medicaid, and the Marketplace and even leave these programs and return to public insurance.

In this section, the committee illustrates the specific challenges for persons with complex needs having their care needs met by the system currently in place. Themes throughout this section reinforce the challenges beneficiaries face in a delivery system that is focused on a narrow set of services from a narrow set of health care providers; is organized around the services covered by insurance, which frequently omit key services needed to improve behavioral health outcomes; and has trouble addressing the heterogeneity of behavioral health care needs.

Persons with Behavioral Health Conditions and Complex Social Risk Factors

For individuals with serious mental illnesses, dual diagnoses, or intricate behavioral health issues, addressing social and economic factors alongside health behaviors is critical in determining overall health. For instance, research has shown that individuals with higher levels of education and social support experience better health outcomes (Magnan, 2017).

Consequently, addressing these wide-ranging drivers of health requires involving professionals with diverse expertise, particularly those skilled in engagement strategies. Medicaid has recognized the new opportunities for states to address social drivers, and CMS recently issued guidance aimed at expanding state capabilities to use Medicaid in tackling issues such as housing and food insecurity (HHS, 2023).

One innovative pathway that CMS outlined uses managed care to address social drivers of health. In early 2023, CMS introduced guidance that enables states to permit Medicaid managed care plans to offer "in lieu of" services and "value-added benefits," such as housing, transportation, and nutrition supports, as alternatives to standard Medicaid benefits (Hinton and Diana, 2024). These services must be medically appropriate, cost-effective, and voluntary for both the Medicaid MCOs to offer and the beneficiaries to receive. Ensuring the supply of the "right services" to people with severe illnesses and complex needs is part and parcel of promoting traditional clinician participation in Medicare, Medicaid, and the Marketplaces.

In the longer term, adopting value-based payment models or alternative payment models may present an important opportunity for the flexibility to address the range of needs of people with mental illnesses and SUDs. These models encourage a shift from a rigid, prescriptive approach to a more dynamic, outcome-focused system that would enable health care providers to develop and implement care models that are tailored to the unique needs of beneficiaries (Johnson and Rittenhouse, 2023). However, as discussed above, the success of alternative payment models and value-based payment models hinges on implementing robust performance measures. In particular, it will be important for these measures to capture the degree to which health plans and care providers are addressing these social needs by measuring social outcomes and improving beneficiaries' lived experiences in terms of quality of life, loneliness, and related patient-reported outcomes.

Effectively addressing the social factors that influence care and improve health outcomes among those with complex behavioral health needs will require new approaches that expand the set of health care providers supporting behavioral health needs. For example, community health workers have emerged as a critical bridge between health care systems and marginalized communities, demonstrating their value in improving population health and reducing health disparities (Phillips et al., 2023). Their roles, which vary from case managers to health navigators, were particularly highlighted during the COVID-19 pandemic, where they played a vital role in facilitating access to testing, vaccination, and treatment for marginalized groups.

Dual-Eligible Beneficiaries with Severe Mental Illness

Individuals with serious mental illness typically present with complex needs which often require a more comprehensive and multifaceted approach to treatment and support. Both Medicare and Medicaid disproportionately and simultaneously serve people with serious mental illness. The preponderance of so-called dual-eligible beneficiaries in the populations of those with serious mental illness highlights the need for effective inter-program coordination and alignment to allow for sufficient access to health care providers and services that meet the psychiatric care, medication management, primary care, and social service needs of these individuals.

While the complexity of coordinating between Medicare and Medicaid for dual-eligibles who have a serious mental illness may present challenges in accessing needed behavioral health care providers, Medicaid increasingly offers home- and community-based services and supports that may be available to individuals with serious mental illness. This benefit can include functional services, such as supported employment or respite, that allow an individual to remain in his or her home or in the community while undergoing treatment and recovery. These services, often provided by paraprofessionals, are critical to providing the continuum of services that allows individuals to access and benefit from behavioral health treatment without institutionalization or out-of-home or community placement. States are innovating with approaches to home and community-based services through waivers that increase care coordination to help beneficiaries navigate the system. States are also using managed care tools to develop a more robust and highly trained health care provider network. In the committee's webinar with state officials, the Medicaid official overseeing behavioral health and home- and community-based services for individuals with serious mental illness said:

> So we really started looking at how do we better support care providers in starting up. Because it's one thing to be able to hang a shingle as a private practice and get your caseload going, but when you're talking about serving a higher-need population, startup is really important. So we've been able to work with . . . our managed care organizations and use (their) community investment funding . . . to bring new care providers into our state, as well as pay care providers for pilot projects. . . . Because what we found is . . . if we can give people startup money and . . . we come in with a policy and the payment then care providers engage.
>
> —Paula Stone, webinar 3 panelist
> Innovations to Improve Mental Health and Substance Use Disorder Access in Medicare, Medicaid, and Marketplace Insurance Plans

There are successful care models that research has shown to improve outcomes and reduce costs for people with serious mental health needs. For example, clubhouses are an evidence-based form of community-based psychosocial rehabilitation that use intentional community to assist people with serious mental illness in recovery. Research demonstrates that clubhouses significantly improve quality of life (Chen et al., 2020; McKay et al., 2018), promote greater recovery experiences (Pernice et al., 2017), and substantially reduce hospitalizations (Di Masso et al., 2001) and Medicaid costs (Solís-Román and Knickman, 2017). Furthermore, economic modeling suggests the combined effect of clubhouse engagement for an average person with serious mental illness is $11,000 annually when factoring in behavioral health, physical health, disability, criminal justice, and employment and opportunity costs (Usman and Seidman, 2024). However, Medicare does not pay for clubhouse services, and many states do not pay for clubhouses through their Medicaid programs even though they have the authority to do so as a form of Medicaid psychosocial rehabilitation.

Another evidence-based, holistic care model is assertive community treatment (ACT). ACT supports people with serious mental illness with a multidisciplinary team in community settings, providing intensive, timely, and personalized services facilitated through frequent team meetings to review treatment plans and services (OIG, 2024). ACT offers a more community-based approach to behavioral health care by providing interdisciplinary, patient-centered support directly in communities. ACT teams include professionals from various fields who offer personalized interventions tailored to individual needs and goals. Research has consistently shown ACT's effectiveness in reducing hospitalizations, emergency department visits, and criminal justice involvement while improving housing stability, employment, and overall quality of life for individuals with severe mental illness. Furthermore, ACT's cost-effectiveness, driven by decreased crisis service use and institutional care, underscores its value as a pivotal component of behavioral health service delivery.

Persons with Co-Occurring Mental Health Issues and SUD

Co-occurrence of a mental illness and SUD is prevalent among those presenting with either condition. In 2021, over one-third of adults aged 18 or older who had any mental illness also had an SUD in the past year. Approximately 20 percent of adolescents aged 12 to 17 had a major depressive episode in the past year and 20 percent of adolescents with a major depressive episode had a co-occurring SUD (SAMHSA, 2022). Around 25 percent of individuals with a serious mental illness also had an SUD (SAMHSA, 2024). Treating two or more co-occurring conditions effectively requires coordination, collaboration, and integrated treatment by multiple

health professionals. Multiple barriers exist to developing an adequate network for integrated treatment for co-occurring mental illness and SUD.

The lack of specialized services and integrated treatment settings for adults and youth, including residential or rehabilitation programs and intensive inpatient care, presents a barrier to integration (Priester et al., 2016). Only slightly over half of U.S. substance abuse treatment facilities report offering programs for clients with co-occurring mental illness and SUD (SAMHSA, 2020).

Another barrier cited by both mental health and SUD clinicians is the need for additional training and for staff that specialize in co-occurring disorders within both systems, as well as staffing and technology to facilitate coordination among health care providers (Priester et al., 2016). There are limited staff and faculty with expertise in integrated treatment, increasing the difficulty of improving access through education and training (Yule, 2019).

Coverage and reimbursement are identified repeatedly as barriers to integrating behavioral health and SUD treatment (Yule, 2019). Inconsistent coverage of services in Medicare, Medicaid, and Marketplace plans creates a checkerboard of service availability for those with co-occurring disorders. Services may not be covered, may be covered through FFS, or may be covered through an alternative payment mechanism (Priester et al., 2016). In some states, payment for integrated treatment delivery is limited by diagnostic and billing criteria that do not recognize the need for treatment of two or more disorders, the clinical complexity added when a co-occurring condition is present, or the additional time and staffing needed to coordinate care among practitioners. Reimbursement inequities for each type of care can also disincentivize integrated care. Historically, insurance benefits for behavioral health treatment have been greater than the benefits for substance use treatment (Yule, 2019).

Statewide efforts to implement integrated behavioral health, SUD, and physical health with Medicaid as the cornerstone payer are showing results but require an intentional focus to address multiple barriers. Washington State's multi-year plan and implementation effort is an example of a systematic effort to identify and address barriers in order to ensure an adequate network for integrated behavioral health and physical care (CHCS, 2020).

Box 6-4 illustrates the complexity of treating behavioral health conditions for specialized populations by focusing on the particular case of women who experience a behavioral health issue during or after pregnancy.

Individuals with Intellectual and Developmental Disabilities

Medicare and Medicaid are critical programs for individuals with intellectual and developmental disabilities. These individuals usually have higher incidences of behavioral health conditions than the general population

BOX 6-4
Pregnancy and Postpartum Care

Medicaid is the largest payer for maternity and postpartum care in the United States. Medicaid covers 42 percent of all births, and in many states Medicaid pays for more than half of all births (ASPE, 2023). Co-occurring mental health and SUDs are common among pregnant and postpartum women, complicating the pregnancy and postpartum period. Between 10 and 20 percent of women experience perinatal depression, 9.5 percent report alcohol use during pregnancy, and over 5 percent report drug use. Women hospitalized for delivery who have a behavioral health condition are more likely to have an SUD as well. Pregnant and postpartum women who have a behavioral health condition are less likely to be receiving adequate care compared with women who are not pregnant (AHRQ, n.d.).

The primary connection to the medical system for a pregnant or postpartum woman is through her obstetrician/gynecologist, pediatrician, family physician, or other primary care providers. Integrating behavioral health care into these settings where the woman has relationships and feels comfortable reduces barriers to treatment and improves health outcomes. Models for integrated perinatal and behavioral health care in various settings have shown success (AHRQ, n.d.; ASPE, 2022; Lomonaco-Haycraft et al., 2019; Miller et al., 2021).

Integrating behavioral health care into maternity and infant treatment requires reimbursement models to incentivize integrated perinatal behavioral health care, addressing network deficiencies in settings for pregnant and postpartum women, and addressing complexities concerning state child welfare laws and practices.

Coverage limitations in Medicaid can restrict access to perinatal behavioral health services, and limited reimbursement in Medicaid is repeatedly identified as a key barrier to implementing and expanding integrated models of mental health and SUD care in obstetrician/gynecologist practices. Over the last several years, most states have expanded access to postpartum coverage for up to a year after the birth of a child for low-income women; as of January of 2024, only four states were not covering or planning to cover postpartum health services for a year after birth. In Medicaid, maternity is often covered through a bundled payment, which may not include reimbursement for screening, referral, and coordinating care with a behavioral health practitioner.

Several successful models for integrated maternity and behavioral health care have developed outside the Medicaid program, using either state-only dollars or other federal grant programs. For example, state funding and a surcharge on commercial health plans supports the Massachusetts Child Psychiatry Access Program. New Jersey's Maternal Wraparound Program, another coordinated care model, receives both state and federal funding, the latter from the federal block grant

BOX 6-4 Continued

women's set-aside. Ohio has used State Opioid Response and State Targeted Response to the Opioid Crisis funding to support integrated care by covering care coordination, childcare, and transportation and providing gap funding for services postpartum.

Innovative models have also been developed in Medicaid. Colorado, for example, uses a prenatal engagement billing code to support integrated services and offers services through a 1915(b) Medicaid Waiver. Expanding access to integrated behavioral health care models for pregnant and postpartum women will require states to adopt payment models in their Medicaid programs that incentivize health care providers to screen and coordinate care (ASPE, 2022).

A lack of specialized behavioral health care settings for pregnant and postpartum women complicates treatment and integration of care for women who require a higher level of services. Inpatient and residential settings that can provide appropriate medical as well as behavioral health services are limited. For postpartum women or women who already have children, an inpatient or residential setting that accepts the child may be needed to prevent separation. Child welfare funding is usually used to reimburse for services in these settings where Medicaid reimbursement is not available.

Health care providers treating pregnant or postpartum women with SUD may also face difficult issues related to child welfare laws and practices in their state. State laws differ concerning the mandated reporting of known or suspected substance abuse among pregnant patients, but health care providers with an obligation to report a pregnant woman with SUD may be disincentivized to implement integrated care (Geiderman and Marco, 2020). Even when the health care provider is not required to report, however, women are often reluctant to initiate SUD treatment for fear that the treatment could be used as evidence against them in a child welfare or other custody setting. Women with SUD may also be reluctant to receive adequate prenatal and postpartum care because of state laws and policies. One recent study of over 4,000 women who engaged in substance use during their pregnancy found that they began prenatal care later and were less likely to have adequate prenatal and postpartum care if they lived in a state with mandated reporting and child abuse SUD policies (Austin et al., 2022). The passage of the Families First Prevention Services Act,[4] which shifts the focus of child welfare towards prevention and safely maintaining the family structure, should have a positive impact over time, but state differences will have an effect on successfully integrating behavioral health treatment.

[4]Public Law (P.L.) 115–123.

(Lineberry et al., 2023; Munir, 2016). The prevalence of intellectual and developmental disabilities is around 1 to 3 percent, and co-occurring mental ill-health is around 40 percent, with persistent mental ill-health around 30 percent. Currently, only one in 10 youth with an intellectual and developmental disability receives specialized behavioral health services (Munir, 2016). Despite the prevalence of co-occurring disorders in this population, intellectual and developmental disability services in Medicare and Medicaid are often not designed to recognize and integrate behavioral health treatment.

Individuals and families seeking treatment for someone with an intellectual and developmental disability and mental health or SUD needs and intellectual and developmental disability as well as behavioral health practitioners report significant barriers to integrated treatment. Barriers include the need for research and training on evidence-based behavioral health treatments for this population, the need for training on intellectual and developmental disabilities, the need for training behavioral health and other medical practitioners to recognize the co-occurrence of intellectual and developmental disabilities and behavioral health issues so that there is no "wrong door" for an individual to access the system, and the complexity of payment for intellectual and developmental disabilities and behavioral health services. People with intellectual and developmental disabilities and behavioral health needs and their families often struggle to identify resources or services in each system, whether they are eligible, and whether their coverage will pay for the services (The Arc, 2019). States often organize their health infrastructure with behavioral health and intellectual and developmental disabilities as separate entities, sometimes outside the Medicaid agency, making development and navigation of programs to serve the intellectual and developmental disability population with co-occurring disorders more difficult.

Several states are using home and community-based service waivers to strengthen the networks serving individuals with co-occurring intellectual and developmental disabilities and behavioral health needs. In Arkansas, Medicaid enrollees with high functional needs and an intellectual and developmental disability or serious mental illness diagnosis are served through a health care provider–led managed care model that encourages behavioral health and intellectual and developmental disability care providers to develop the capability to serve individuals with both diagnoses. The state incentivizes the plans to develop and train health care providers to fill gaps in the continuum of services and provides ongoing care coordination to help the beneficiary and their family navigate the network and services (DHS, 2024).

The need to integrate services available through public insurance, train health care providers to treat co-occurring intellectual and developmental disabilities and behavioral health conditions, and assist individuals with

co-occurring intellectual and developmental disabilities and behavioral health in navigating the health system has also been recognized by other federal agencies. The Administration for Community Living, for example, has created the Link Center to provide training and technical assistance to state agencies and health care providers and assist policy makers in advancing systems change that will increase access to effective services and supports for people with co-occurring conditions.

Finding: There continues to be a lack of specialized settings and services for people with significant functional impairments and complex needs, such as individuals with co-occurring MI/SUD, co-occurring mental illness and SUDs, and severe and persistent mental illnesses.

Finding: Although behavioral health challenges often occur among pregnant and postpartum women, complicating the pregnancy and postpartum period, these women are less likely to receive appropriate behavioral health care than women who are not pregnant.

Finding: There is evidence that integrating behavioral health care with maternity and postpartum care can improve health outcomes. Widespread adoption of payment models that reimburse for integrated perinatal care has not occurred in Medicaid, the largest payer of maternity/postpartum services, disincentivizing the development of integrated services and settings.

Conclusion 6-11: The fragmented organization of publicly supported coverage within and between Medicare, Medicaid, and the Marketplace exacerbates the challenges that beneficiaries have in identifying an available behavioral health care provider that can meet behavioral health needs in a timely way. These challenges are heightened for individuals with behavioral health conditions with complex needs. Even if health care provider participation were to improve, the patient experience related to locating suitable services would remain. Addressing care navigation difficulties is a necessary complement to addressing health care provider participation.

CONCLUSIONS

Conclusion 6-1: Insufficient risk adjustment for those with mental illnesses and substance use disorders contributes to MA, Medicaid MCO, and Marketplace plan strategies that limit access to behavioral health services. These strategies include creating restrictive health care provider networks and using administrative mechanisms such as prior authorization.

Risk adjustment, oversight of availability of clinicians, and limits on administrative processes such as prior authorization can attenuate such behavior. Improving access to behavioral health care providers and services through managed care could occur through improvements in behavioral health risk adjustment, regulation of access to care, and thoughtful limits on prior authorization.

Conclusion 6-2: Various approaches to network adequacy regulations have not been shown to be effective in expanding behavioral health care provider participation or patient access. Nevertheless, these adequacy regulations are tools that regulators currently rely on to prevent insurers from selling health plans that are overly restrictive in the supply of behavioral health services offered. Thus, while network adequacy regulation remains a key tool for regulators, current approaches are unlikely to be the avenue for improving health care provider participation in Medicare, Medicaid, and the Marketplace. Strengthening plan accountability for providing adequate supply of behavioral health services based on outcome data would improve regulatory oversight.

Conclusion 6-3: Studies should explore the role of outcome-based approaches for expanding health care provider participation, the results of which may lead to a recommended regulatory approach.

Conclusion 6-4: Approaches to measuring access for the purposes of regulating plan networks have largely been health care provider–focused, measuring the availability of health care providers. Patient-focused measures, including ease of finding and receiving quality treatment from a culturally appropriate health care provider, are likely to require investments in new and alternative data sources, including patient surveys.

Conclusion 6-5: To maintain health care equity, audio-only behavioral health and SUD telehealth services are essential for serving individuals without adequate internet video access. There is not enough evidence on the relative effectiveness of audio-only telehealth, but until the digital divide is addressed, the access to audio-only telehealth for those facing disparities in access may outweigh the uncertainly regarding its relative effectiveness compared with video telehealth for behavioral health services.

Conclusion 6-6: Telehealth is innovating rapidly with many new models coming on board with little evidence concerning the quality of care across these new modalities. This uncertainly makes it unclear whether future modalities within existing regulatory and payment frameworks will be effective in promoting health care provider access in Medicare,

Medicaid, and Marketplace plans. Developing agile and flexible payment and regulatory structures may be needed. For example, hybrid care models that blend synchronous and asynchronous telehealth may increase access to care, but developing best practices and regulations to protect consumers and ensure integrity of clinical services would be necessary. In addition, payment for these models must balance access with the potential for overuse of low-value care. It is important to explore new regulatory pathways for novel asynchronous telehealth tools that can quickly assess value, build public trust, and increase transparency.

Conclusion 6-7: To improve access to behavioral health care amidst broadband gaps, targeted efforts should identify regions needing both services and broadband. Collaborating with federal agencies such as the Department of Commerce, Treasury, Agriculture, and the Federal Communications Commission can strategically allocate broadband funds. Effective distribution of these resources to underserved areas is crucial for enhancing connectivity and equitable access to essential behavioral health services nationwide.

Conclusion 6-8: Quality measurement that can provide more meaningful guidance on the value of care provided and can overcome reporting challenges will better support meaningful improvements in the quality of behavioral health care. It will also enable payment schemes that incentivize investment in behavioral health care by generating new, value-based revenue streams that better support quality care delivery and health care provider recruitment.

Conclusion 6-9: Quality measurement aimed at ultimately improving the accountability of health plans and practices can have the effect of raising costs for both plans and practices. Moreover, behavioral health care providers have frequently opposed performance measurement as an intrusion on professional autonomy. Thus, efforts to bolster accountability may also serve to make clinician balk at participating in health plan networks that are required to report on sophisticated quality metrics.

Conclusion 6-10: Addressing the technology gap with investments in lower-cost, interoperable EHR systems appropriate for behavioral health and connecting behavioral health records through health information exchanges or other mechanisms is critical for advancing value-based care payments and integrated care models. Managed care tools that allow supplemental or directed payments could provide a mechanism for closing the gap.

Conclusion 6-11: The fragmented organization of publicly supported coverage within and between Medicare, Medicaid, and the Marketplace exacerbates the challenge that beneficiaries have in identifying an available behavioral health care provider that can meet behavioral health needs in a timely way. These challenges are heightened for individuals with behavioral health conditions with complex needs. Even if health care provider participation were to improve, the patient experience related to locating suitable services would remain. Addressing care navigation difficulties is a necessary complement to addressing health care provider participation.

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7

Recommendations

This committee developed its findings, conclusions, and recommendations with a recognition that the nation's current behavioral health system is fragmented, overly complex, and difficult to navigate for behavioral health providers and for patients. Historically, behavioral health services have not been uniformly covered through insurance, public or private. Because of the parallel and separate evolution of these delivery systems, the behavioral health provider infrastructure differs significantly from that for physical health. This legacy continues to disrupt effective person-centered care and affect behavioral health provider and patient satisfaction and system costs. Moreover, the organization of behavioral health care is unique, as a significant portion of the behavioral health workforce works in small, independent practices, often treating patients who self-pay. The challenge in attracting these care providers, therefore, is two-fold: what would it take to participate in insurance, and are there different or additional barriers to participating in publicly subsidized health insurance programs? While a portion of the behavioral health workforce is likely to remain outside insurance networks, the committee examines below some of the unique complexities care providers face in Medicare, Medicaid, and Marketplace plans that, if addressed, could induce greater participation and retention among some care providers. The evidence the committee reviewed demonstrates there is no single "silver bullet" that will improve behavioral health provider participation in these programs. Instead, a multi-faceted effort is

required across all three programs to address the intersecting issues affecting behavioral health provider participation.

- These three programs differ vastly in their coverage of behavioral health services, the providers who are eligible to serve patients in the programs, reimbursement, and administrative operations. As individuals transition among insurance plans, including Medicare, Medicaid, and Marketplace plans, throughout the lifespan, access to behavioral health providers and services may face disruptions and access to particular care providers can vary substantially depending on insurance coverage.
- The financial support provided by both the Centers for Medicare & Medicaid Services (CMS) and the Substance Abuse and Mental Health Services Administration (SAMHSA) to train the behavioral health workforce is substantial, yet the training programs that benefit from these taxpayer dollars are not held accountable to ensure that behavioral health providers participate in taxpayer-funded insurance programs. Moreover, these dollars are not targeted towards training environments that are more likely to support career choices that will more directly affect care for Medicare and Medicaid beneficiaries. In contrast, several Health Resources and Services Administration (HRSA) programs have a proven track record of growing the behavioral health workforce in under-resourced areas.
- Telehealth offers promise and pitfalls for addressing access to behavioral health services in Medicare, Medicaid, and Marketplace plans. Behavioral health has the largest sustained use of telehealth, and innovation in this space continues to accelerate. There are opportunities to use telehealth as one tool to improve access to behavioral health services, particularly in addressing the maldistribution of behavioral health providers across geographies and populations. These opportunities must be taken advantage of without compromising quality, value, and equity in behavioral health service delivery.
- Participating in Medicare, Medicaid, and Marketplace plans usually requires a care provider to accept lower reimbursement than is otherwise available in self-pay markets, creates more complexity and uncertainty in the provider's revenue cycle, beings in more complex patients, and requires adhering to restrictive administrative guidelines. In addition, the iterative, recurrent processes of enrollment and credentialing with contracted networks may be disproportionately burdensome for smaller behavioral health practices without administrative staffing and resources.
- Much of the population covered under Medicare or Medicaid receives services under third-party contracts administered by managed care organizations. Managed care plans have several tools that serve to

restrict access to behavioral health services, including prior authorization and other usage management processes. Conversely, managed care plans also have levers with which to improve behavioral health provider participation, including changing payment structures, adopting prompt payment policies, reducing claims denials and delays, and implementing less clinically restrictive usage management policies.

- In recognition of widening access gaps in behavioral health, state and federal regulators have attempted to monitor and measure access to behavioral health care. However, current approaches have not yet moved the needle on access to care. Network adequacy regulations based solely on "time and distance" standards are insufficient to hold managed care plans accountable for inadequate care provider availability which in turn fail to meet patient needs.
- While primary care is the point of entry for most individuals into the health system, integration between primary care and behavioral health is still lacking. Movement towards bi-directional integration between behavioral and physical health, which has been shown to improve outcomes for patients with behavioral health conditions, has been glacial, as integrating clinical delivery also relies on changing payment structures, promoting behavioral health provider training, updating information systems, and overcoming the complexity of delivery systems transformation.
- In addition to the underlying low rates of behavioral health provider acceptance of insurance, beneficiaries with insurance coverage in Medicare, Medicaid, and Marketplace struggle to access behavioral health services for other reasons, including the complexity of identifying appropriate care providers for the services they need. A diverse behavioral health care provider workforce is important in behavioral health, with patients often preferring to work with a care provider who shares their culture, race, ethnicity, or other identifiers. Other resources available in physical health systems are unavailable in behavioral health; for example, no widespread "navigator" structure is available for beneficiaries needing behavioral health services.
- A portion of the Medicaid and Medicare population requires more intensive services delivered primarily by specialized behavioral health providers to address co-occurring disorders or social needs. Individuals with complex and comorbid conditions are confronted with fragmented behavioral health, medical, and social service delivery systems which make it more difficult to meet their whole-person needs. Given that payment structures, data exchange, and community and social service systems are neither designed nor organized to support behavioral health providers treating these complexities, significant obstacles in serving these individuals effectively may contribute to care provider burnout and attrition.

The committee's recommendations center on key levers within the limitations of this currently complex and fragmented behavioral health delivery system. In line with the scope of this consensus committee study, the committee focuses on targeted, evidence-based recommendations that are most likely to increase the availability of behavioral health providers in public and publicly subsidized insurance programs. Throughout this report where specific delivery system or government initiatives are mentioned or listed, it is not to be assumed that the lists are exhaustive, as they are often used simply to provide one or more examples of promising practices. Appendix F contains a crosswalk between the recommendations and supporting conclusions.

It is critical to acknowledge that advancing behavioral health care access and delivery may require a broader vision for transforming behavioral health care delivery, one beyond the scope of this report. The landscape of behavioral health care delivery is undergoing a profound evolution, propelled by unprecedented demand, advances in technology, shifting societal norms, and changing patient preferences. As transformations progresses, traditional clinical settings alone may be insufficient to meet the diverse needs of individuals seeking behavioral health treatment and support. In addition, the current structures of care reinforce a fragmented approach to behavioral health, in which the ways in which care is measured, paid for, and delivered are separate and often isolated from a broader vision of health care.

Facilitating novel ways to deliver care, whether through telehealth platforms, community-based interventions, or digital therapeutics, is essential for ensuring greater and more equitable access to behavioral health services across diverse populations and needs. Similarly, there may be untapped potential within communities, peer support networks, and allied professions that may expand the current workforce and more deeply integrate behavioral health into current understandings of health and health care. While the committee's recommendations focus on one specific and important challenge—enhancing behavioral health provider participation in Medicare, Medicaid, and Marketplace insurance programs—broader, long-term, and transformative strategies are needed to change the structures of how behavioral health care is financed, organized, and delivered.

Based on the findings and conclusions identified throughout chapters 4, 5, and 6, the committee developed three overarching goals, presented in Box 7-1, under which the committee has proposed specific recommendations for policy changes to help achieve these goals.

These recommendations are situated in the context of a well-documented geographic maldistribution of behavioral health providers as well as a large share of care providers who practice in a private, self-pay market. While the committee's recommendations could assist with this

BOX 7-1
Goals

Through its work, the committee developed three overarching goals to guide its recommendations on strategies that can improve behavioral health provider participation in Medicare, Medicaid, and Marketplace plans:

1. *Grow the pie*: Bolster state and federal efforts to promote and ease entry into Medicare and Medicaid along the behavioral health care workforce continuum by reducing credentialling, enrollment, and licensing barriers and by focusing training programs and telehealth support where Medicare, Medicaid, and Marketplace beneficiary access gaps are greatest.
2. *Make participation worthwhile*: Strengthen support structures for behavioral health care providers and alleviate administrative and financial impediments to participation.
3. *Optimize performance and accountability*: Improve opportunities for behavioral health care providers to increase care delivery capacity and to provide more person-centered care, while strengthening managed care organization accountability for access and care delivery and provide accountability for performance.

maldistribution of behavioral health providers, it recognizes that for some smaller, independent practices sustained by a self-pay model, transitioning to insurance, whether public or private, may not be feasible. Therefore, the committee's recommendations focus more heavily on building the supply and increasing the diversity of a behavioral health care workforce that is more likely to serve public programs; increasing workforce capacity to better meet the needs of publicly insured populations; supporting and sustaining care providers currently participating in Medicare, Medicaid, and Marketplace plans; and developing innovative payment and clinical care models that optimize behavioral health provider retention, satisfaction, and efficacy in fully serving their clients.

While each of these recommendations can have an impact, significant change will require overcoming a common perception that accepting public or publicly subsidized insurance is costly or burdensome relative to alternative opportunities. The committee members believe that these recommendations can help change these perceptions and alleviate some of the challenges facing behavioral health care providers as they make practice decisions. As the committee learned in webinars and through its request for information,

many care providers who currently serve or hope to serve the Medicare, Medicaid, and Marketplace populations are mission-oriented, community-engaged, and patient-centered. Ensuring these programs sustain and support them is one important component to developing a comprehensive behavioral health workforce strategy in the service of patients. Quotations from webinar speakers have been presented throughout this chapter to exemplify situations in which the committee heard of challenges and barriers faced that the recommendations would move toward alleviating.

RECOMMENDATIONS

Goal 1: *Grow the pie*. Bolster state and federal efforts to promote and ease entry into Medicare and Medicaid along the behavioral health care workforce continuum by reducing credentialling, enrollment, and licensing barriers and by focusing training programs and telehealth support where Medicare, Medicaid, and Marketplace beneficiary access gaps are greatest.

The workforce and funding for training from both CMS and SAMHSA presently support care delivery sites or institutions (examples: CMS: graduate medical education (GME) funding; SAMHSA: certified community behavioral health centers). This funding is ongoing, year-after-year, and dependable. However, there are no requirements for institutional recipients of funds to report on workforce pathways after training is completed, so it is not possible to assess either the positive or negative effects of a training environment on long-term career choice. Psychiatrist training, like other physician training, is supported by CMS GME funding, but psychiatrists are the physician specialty least likely to accept patients with Medicare and Medicaid plans. In this context, CMS should predicate ongoing funding of workforce training with consistent reporting of post-trainee career trajectories to facilitate institutional comparisons among grantees. SAMHSA has similar opportunities with its grants that support environments where training occurs, largely supporting the non-physician behavioral health care workforce. Programs can then be developed to support training environments in which more trainees care for populations covered by Medicare, Medicaid, and Marketplace plans.

CMS could pilot alternative GME payment methods, award new Medicare-funded GME training positions in priority disciplines and geographic areas and develop models within the CMS Center for Medicare and Medicaid Innovation to add other behavioral health care professions to the educational funding aspects of these programs that increase access to care. Medically underserved areas and underrepresented and minoritized communities should be prioritized, with strong consideration

given to modeling these CMS and SAMHSA pilots after existing HRSA programs with this focus, such as the National Health Service Corps, Behavioral Health Workforce and Education Training Program, Graduate Psychology Education Program, Health Careers Opportunity Program, and Nursing Workforce Diversity Program. These HRSA programs have a proven track record of increasing the supply of behavioral health care providers in underserved areas and diversifying the behavioral health care workforce to better reflect the communities served, including under-resourced populations, based on patient needs, race, ethnicity, and lived experience. This approach has been shown to increase access to care for all Medicaid beneficiaries.

Much of the funding for training presently supports care delivery sites or institutions rather than directly supporting the workforce required to care for beneficiaries and individuals in these funded settings. This creates a more extreme challenge in behavioral health care because while CMS allows for physicians in training to bill for services under the supervision and license of a preceptor, similar parity does not exist for other behavioral health care professionals. This limits non-physician behavioral health trainee exposure to caring for Medicare and Medicaid beneficiaries and has a strong potential to influence which patients these care providers serve when they finish training.

RECOMMENDATION 1: CMS and SAMHSA should restructure current workforce and training mechanisms and their funding to better incentivize robust training environments that support career choices that will more directly impact care for Medicare and Medicaid beneficiaries.

- **1-1 The CMS and SAMHSA restructuring of the current workforce and training mechanisms should have two interrelated priorities: first, a focus on the providers serving populations with the highest need for greater access to behavioral health provision in Medicaid, such as rural, child/adolescent, and racial/ethnic minoritized populations; second, a focus on workforce demographic diversity, modeled after and aligned with existing HRSA programs that have successfully grown and diversified the behavioral health care workforce in underserved areas.**
- **1-2 CMS should predicate ongoing funding of the workforce training with consistent reporting of post-trainee career trajectories to facilitate institutional comparisons among grantees and ultimately provide a mechanism for greater accountability between CMS funding of training and the rate at which trained providers serve Medicare and Medicaid beneficiaries.**

1-3 CMS should allow for behavioral health care trainees to bill for services under the supervision of a licensed care provider, as already exists for physician trainees.

> (T)here is a whole provider enrollment and credentialing process. That is also an additional barrier and burden. And sometimes we will hire someone, but their Medicaid enrollment is several months delayed because it takes time to be able to get them enrolled. . . . (W)e do not actually have them start work until . . . (we) get all that paperwork done.
>
> —Warren Ng, webinar 2 panelist
> Experiences of Behavioral Health Care Providers with
> Public Insurance Programs

A lengthy, repetitive, and burdensome credentialing process discourages behavioral health care providers from enrolling with multiple payers. Credentialing delays also delay the ability to bill and receive payments. Behavioral health care providers are less likely than other care providers to have an administrative support system that enables them to navigate unnecessary complexities. Adopting certain technological and administrative tools would eliminate many of these difficulties.

RECOMMENDATION 2: CMS should use its regulatory authorities over Medicare (including Medicare Advantage) and provide assistance to state Medicaid programs and Marketplaces plans to streamline behavioral health provider credentialing and enrollment processes.

2-1 CMS should develop guidance for states on funding mechanisms and provide models for developing, implementing, and operating a single state-wide platform for care provider credentialing and enrollment. For instance, states could use available funding mechanisms to upgrade their Medicaid Management Information System provider enrollment modules, creating a single, state-wide platform for Medicaid, its managed care organizations (MCOs), or other Medicaid payers to use for credentialing, enrollment, renewals, and licensure checks.

2-2 CMS should allow states to include connectivity to state and federal licensing entities as part of the allowable costs of implementing the system.

2-3 CMS should encourage states to accept Medicare credentialing and enrollment for Medicaid purposes, and Medicare should reciprocate.

2-4 CMS should work with states to modify Medicare's and Medicaid's enrollment systems and processes to check ex parte information sources before requiring additional information from behavioral health care providers for initial enrollment or renewal as a care provider. This would allow behavioral health care providers to keep their enrollment information current in either a state Medicaid or a state Medicare system, and it would facilitate more rapid initial enrollment.

2-5 Whenever possible, CMS should impose time limits on the credentialing process, or support enforcement if there are existing time limits, employing a centralized database to streamline this process. CMS should encourage state regulators to do the same.

> We need regulations, but having that balance is really important. (H)ow do we ensure individuals . . . are getting seen, and this redundancy (and licensing and regulations) is not going to get in the way of more providers doing the work (because that is what we really need)[?] We need more providers working with the underserved populations that we see nationwide.
>
> —Rakhee Patel, webinar 2 panelist
> Experiences of Behavioral Health Care Providers with
> Public Insurance Programs

As a field, behavioral health has had the largest sustained use of telehealth and continues to drive innovation in telehealth for all of health care. In this context, CMS has a key opportunity to use telehealth as one tool to improve access to behavioral health care services in Medicare, Medicaid, and Marketplace as it offers a mechanism to address the documented maldistribution of behavioral health providers across geographies and populations. In addition, the rapidly evolving nature of telehealth applications in behavioral health, recommendations to support the next generation of telehealth applications are also critical. While 90 percent of Americans today already have access to a smartphone or computer able to connect to audio or video telehealth (synchronous telehealth), inequities in broadband access and digital literacy limit the applicability and reach of telehealth. In addition, the effects of telehealth and new technology-powered tools on clinicians are unknown. The recommendation seeks to balance the opportunity for telehealth to address geographic maldistribution of behavioral health care providers with the considerations that support equitable access to high-quality behavioral health care services.

RECOMMENDATION 3: CMS should develop an agile and flexible interagency strategy to set guidelines for coverage and payment for telehealth for behavioral health needs across settings, modalities, and care providers. This strategy should include:

- **3-1 Efforts to establish coverage consistency of telehealth across states in order to simplify cross-state telehealth health care provider engagement.**
- **3-2 Development of processes to reimburse telehealth based on a thoughtful consideration of the value provided and the cost of delivery—as is done with in-person care. Flexibility on the use and reimbursement of these services will be essential to maximizing the benefit to patients and the system at large. Given the rapid changes in modalities for telehealth, these policies should be evaluated regularly.**
- **3-3 Establishing skill needs and promoting digital skills training for clinicians and digital health literacy skills for patients that will increase equitable adoption.**

> I rode a bicycle to the community mental health center to get my services, which back then were medication management until I could get housing and leave the shelter. So there were gaps around security, ability to have safe housing. The environment I lived in played a big role in the pace of recovery.
>
> —Laura Van Tosh, webinar 1 participant
> Lived Experiences in Accessing Behavioral Health Care Services through Public Insurance Programs

Expediting the process of cross-state and cross-territory professional licensure will increase the number of behavioral health care professionals who practice across jurisdictional boundaries and provide services in underserved communities across the lifespan. Occupational interstate compacts should be developed and adopted for *all* behavioral health professions across all states and territories.

RECOMMENDATION 4: The Department of Health and Human Services (HHS) and its agencies should develop a uniform strategy to promote and adopt evidence-based approaches to reduce multi-state licensure barriers as a mechanism to expand access to behavioral health providers in Medicare, Medicaid, and the Marketplace.

- **4-1 HHS should actively collaborate with organizations such as the Department of Defense, the Council of State Governments, and its National Center for Interstate Compacts; the relevant**

national professional associations; and states to create and adopt interstate compacts for those behavioral health care professions not currently covered in an occupational interstate compact. Provisions for telehealth across state and jurisdictional lines should be included.

4-2 HHS should actively collaborate with organizations such as the Department of Defense, the Council of State Governments, and its National Center for Interstate Compacts; the relevant national professional associations; and states to ensure that states join existing occupational interstate compacts.

4-3 HRSA should incentivize states by including language in its request for proposals grantmaking process to join existing occupational licensure interstate compacts.

4-4 HHS should encourage states to review existing occupational professional interstate compacts to allow for the provision of telehealth across state and jurisdictional lines.

Goal 2: *Make participation worthwhile.* Strengthen support structures for behavioral health care providers and alleviate administrative and financial impediments to participation.

> There are a lot of challenges and barriers that we are facing day to day . . . there are prior authorizations and reauthorization requests. Care providers of course are taking into consideration the time it takes to complete these sorts of documentations to get approval for the services for the clients that they see. And oftentimes there is lag time here too. We submit the prior authorizations, or the reauthorizations, and it takes a couple of weeks or so if not longer to get approvals. That again can be really cumbersome and oftentimes sometimes frustrating for health care providers who really want to continue to see individuals get the ongoing services that they need.
>
> —Rakhee Patel, webinar 2 panelist
> Experiences of Behavioral Health Care Providers with Public Insurance Programs

Based upon patient and care provider pressure, negative feedback, and state legislative and regulatory actions, gradual and fragmented efforts are underway to streamline health plan prior authorization processes. To accomplish Recommendation 5, a coordinated, comprehensive, and expeditious effort is called for, including the active participation of stakeholders, particularly states since Medicaid is a joint federal/state program. There is likely sufficient interest in this topic to attract private grant support for the data analysis and convening of stakeholders, which will be prerequisites for the CMS rulemaking on this topic.

A critical focus on cost-containment necessitates MCO and health plan use of prior authorization and other cost management tools. Data exist on the substantial cost savings associated with applying prior authorization for specific services and medications. Likewise, there are some services and treatments where data shows that imposition of prior authorization is of little cost-saving value. These data should be used to identify the low-cost-savings ("low-value prior authorization") applications. Policies recently adopted by some states and CMS and voiced by the broad-based participants in the January 2018 "Consensus Statement on Improving the Prior Authorization Process" provide guidance for achieving reform. Implementing these policies expeditiously will take a concerted effort by CMS and states, given the changes each payer will need to make to data analytics, clinical criteria reviews, process automation, and other medical care coordination and processes. A process for ongoing monitoring of prior authorization reforms will be needed to respond to evolving consequences. This process should require continual data analysis and periodic assessments of whether revisions are needed.

RECOMMENDATION 5: CMS should use its authority to adopt policies and issue rules and guidance, and to monitor managed care plan access standards to quickly reduce provider administrative burdens and related adverse patient impacts associated with low-value prior authorization and other medical usage review instruments applied to behavioral health care services.

- **5-1 CMS should use its authority to identify and, to the fullest extent possible, disallow low-value prior authorization practices within Medicare plans. CMS should provide states with technical assistance to similarly eliminate and monitor for low-value prior authorization practices within Medicaid managed care.**
- **5-2 CMS should adopt policies and the standards that require or incentivize insurers to focus behavioral health prior authorization only where high-cost waste and misuse are evident. These policies and rules should articulate clear responsibilities and guidelines for the mechanisms of rigorous regulatory oversight of insurer prior authorization review activities by state and federal agencies.**

> (A)t one point, (I) had a therapist that had to leave because he couldn't support his family. So he went to work for a bank to pay the bills. And then worked as a CLS worker in the evenings and weekends to kind of fill that personal need he had.
>
> —Laura Marshal, webinar 1 panelist,
> Lived Experiences in Accessing Behavioral Health Care Services
> through Public Insurance Programs

Inadequate reimbursement negatively affects care provider participation in insurance plans, particularly in public and publicly subsidized payer markets. This, in turn, affects access to behavioral health care for vulnerable populations, including older adults, persons with disabilities, the rural population, and racial and ethnic minoritized individuals. CMS is well positioned to be a federal leader on reimbursement policies across public and publicly subsidized insurance markets and can play a critical role in guiding behavioral health reimbursement and coverage policies. CMS has recently proposed a 19 percent increase over 4 years in the "work value" component of the resource-based relative value scale (RBRVS). While this is a positive start, CMS has not yet addressed the practice cost component of the RBRVS.

CMS has several potential avenues to ensure that reimbursement rates and coverage of services are sufficient to support behavioral health care providers across a range of core behavioral health services and health care provider types and are, where appropriate, in accordance with the Mental Health Parity and Addiction Equity Act.

RECOMMENDATION 6: CMS should provide guidance on setting Medicare and Medicaid fee-for-service reimbursement rates to ensure adequate access to a full continuum of behavioral health care services, which includes accounting for the actual costs of care and adjusting for past and current undervaluation of work efforts of behavioral health care providers. To address this undervaluation, CMS should continue to revisit and revise the RBRVS.

- **6-1 CMS should conduct an updated cost study to remedy the acknowledged bias in the current RBRVS formulation. Improving the formulation of the Medicare fee schedule may also help to influence Medicaid fee-for-service rates.**
- **6-2 Within Medicaid fee-for-service, CMS should encourage state Medicaid agencies to adopt regular rate reviews to adjust for inflation and account for market forces that could be discouraging behavioral health providers from enrolling in Medicaid fee-for-service. CMS should encourage consideration of rate differentials in underserved areas where there is an inadequate workforce within Medicaid and ensure proposed rates are sufficient to support access to behavioral health providers consistent with the general population. CMS should provide comparison rate and provider access information to states for Medicare, Medicare Advantage, Marketplace, and private plans to assist states in developing access monitoring review plans (AMRP) for behavioral health services that better determine whether state payment rates are sufficient to ensure access to care for beneficiaries at least comparable to the general population.**

> I think the other piece is around some of the prompt pay policies that we've seen in Medicaid programs . . . . (T)hat's probably a more commonly used strategy . . . . [The Medicaid programs are] setting expectations and requirements with the managed care plans to conduct prompt payment to the behavioral health providers who may need that cash flow, [that] may not have a lot of reserves.
>
> —Lindsey Browning, webinar 3 panelist
> Innovations to Improve Mental Health and Substance Use Disorder Access in Medicare, Medicaid, and Marketplace Insurance Plans

A concerted effort to improve the cash flow for behavioral health care providers through an efficient revenue cycle infrastructure, including prompt payment and claims management, by all parties should result in marked improvement in the participation of behavioral health providers in these plans. A broad-based approach will have a greater effect than individual insurance plans making their own adjustments, which could add complexity and confusion. Developing effective billing and payment processes will take collaboration and cooperation across all payers and regulators, including CMS, state Medicaid agencies, state insurance commissioners, and managed care organizations serving Medicare, Medicaid, and Marketplace beneficiaries. By prioritizing prompt pay and charging the oversight to state Medicaid programs and insurance regulators, CMS will be able to help reduce financial strain on behavioral health providers who participate in Medicare, Medicaid, and Marketplace plans.

RECOMMENDATION 7: CMS should use its regulatory and incentive structures to ensure prompt payment and eliminate inappropriate claims denials of behavioral health care services.

- **7-1 To adequately enforce prompt pay laws and regulations, CMS should use its monitoring authority over state Medicaid programs and state Marketplace plans to ensure that plans are in compliance with prompt pay laws. Specifically, state Medicaid agency single audits should include monitoring of prompt payment of Medicaid managed care plan behavioral health claims. State insurance regulators should include similar monitoring of prompt payment in Marketplace plans.**
- **7-2 CMS, in consultation with state Medicaid officials, should ensure that Medicare and Medicaid provider claims are not rejected or denied for non-substantive reasons (such as using Dr. instead of Drive in an address). This may necessitate updating claims payment systems, manuals, managed care contracts, or other actions to ensure that payments are received in a timely manner following claims submission. Medicare and**

Medicaid payers should be required to provide regular training opportunities for behavioral health care providers on billing and claims submission and clear, accurate, and up-to-date instructions to participating care providers.

7-3 CMS should develop a common set of behavioral health diagnostic codes that qualify for reimbursement. CMS, through its federal authority, and Medicaid and insurance regulators, through their state authority, would hold responsibility for enforcing compliance.

7-4 CMS should develop policies that address the findings of the HHS Office of Inspector General report related to Medicare Advantage plans' inappropriate payment denials for services provided that meet Medicare coverage rules and medical assistance organizations' billing rules.

Goal 3: *Optimize performance and accountability.* Improve opportunities for care providers to increase care delivery capacity and to provide more person-centered care, while strengthening MCO accountability for access and care delivery and provider accountability for performance.

> [M]y pie in the sky dream is that . . . every child, youth and family navigating the . . . system would have . . . [a] family support specialist to accompany them through finding providers. . . . We never just call and somebody says, oh, hello, thank you for calling our office, how can we help you?
>
> —Lisa Butler, webinar 1 panelist
> Lived Experiences in Accessing Behavioral Health Care Services through Public Insurance Programs

Managed care organizations have the responsibility to deliver a care provider network sufficient to ensure access to beneficiaries. Managed care organizations have greater flexibility to address barriers to care provider participation and improve behavioral health care access among their beneficiaries compared with traditional Medicare and Medicaid. Beneficiary access entails more than an adequate network of available behavioral health providers. Plans are not financially accountable for beneficiaries accessing the services they need when they need them. Access to care is affected by payment arrangements, hassle factors, and the quality of care providers. That is, access requires that the individual receive timely behavioral health services to achieve the best possible outcome. The following recommendation is designed to maximize the flexibilities that managed care plans have to address market forces and barriers inhibiting behavioral health care provider availability as well as barriers to beneficiary access such that timely, appropriate behavioral health services are made available to beneficiaries.

RECOMMENDATION 8: CMS should develop behavioral health care access outcome standards, along with significant financial penalties and bonuses, for managed care organizations participating in Medicare. CMS should work with states to develop similar standards and financial models to incentivize behavioral health care access in Medicaid managed care.

- **8-1 Both Medicare and Medicaid increasingly rely on third-party managed care organizations to deliver health care services to beneficiaries. CMS should work with states to establish an outcome-based behavioral health care access standard for payment, which can be adopted widely in a contract model.**
- **8-2 CMS should convene Medicare and state Medicaid leadership to develop a model managed care contract for behavioral health services that establishes quality metrics for access, measuring the managed care organization's delivery of timely, appropriate behavioral health care services to enrollees, and that is enforced through financial incentives (e.g., penalties and bonuses). In establishing quality metrics, CMS and states should recognize that meeting access outcome standards will require managed care organizations to build a full continuum of behavioral health providers and services, culturally aligned with the beneficiary population, and establish bi-directional integration of behavioral and physical health. It will also require addressing beneficiary barriers to seeking, receiving, and benefiting from services.**
- **8-3 CMS and SAMHSA should implement a technical assistance function to support states and managed care organizations (Medicare Advantage and Medicaid MCOs) in implementing these access measures and to help plans adopt additional efforts to support and build the behavioral health workforce and improve beneficiary access to care.**
- **8-4 SAMHSA should work with states to align state grant funds to supplement managed care investments in building the continuum of care providers and services needed for MCOs to meet quality metrics for access.**

I was very keen on moving forward in my education and employment, but I was told no, those aren't the things you're going to do. . . . They pushed those aside rather than looking at things like supported employment and supported education.

—Keris Myrick, webinar 1 panelist
Lived Experiences in Accessing Behavioral Health Care Services through Public Insurance Programs

Value-based payment and alternative payment models in Medicare, Medicaid, and Marketplace plans are increasingly prevalent and represent the direction that an evolving health care delivery system is taking in the U.S. One implication of this trend is that health care professional will be delivering care under arrangements that measure performance and demand accountability. At the core of accountability for value is the measurement of performance towards desired goals of care and tying these measures to payment. Those measures need to be accompanied by consequences related to performance. Unfortunately, the current set of measures in behavioral health are inadequate in that they do not fully capture the desired goals and can be burdensome. Even coding for the behavioral health risk is inadequate, as it misaligns rewards for the managed care plans that embrace care for behavioral health because they are paid risk-adjusted per-member, per-month rates for beneficiaries. As a result, value-based arrangements for behavioral health care do not create incentives for health plans to ensure access to appropriate-high quality care. As a result, too often the supply of professionals that can address the needs of people covered by Medicare, Medicaid and Marketplace plans is insufficient.

RECOMMENDATION 9: CMS should invest in the development of improved quality and risk adjustment measures for behavioral health care. These measures should improve the measurement of performance of care toward desired goals of care and be linked to payment. These measures should carefully consider the administrative measurement burden that would fall on care providers.

9-1 CMS should lead in the development of new performance metrics. CMS should coordinate with states and MCOs to agree on a limited set of measures that apply across Medicare, Medicaid, and the Marketplace. Measures should offer insight into whole-person health by considering social (e.g., educational attainment, employment levels, housing stability) and emotional (e.g., quality of life, loneliness, self-efficacy) needs. Without this emphasis, value-based models in behavioral health run the risk of perpetuating disparities and leaving vulnerable populations behind.

9-2 CMS and states should work with MCOs and CMS-supported, value-based payment programs to incentivize care providers based on these newly developed measures. These efforts should include sunsetting legacy measures and aligning measures across insurance segments to reduce the burden to care providers participating in these programs.

9-3 CMS should create targeted financial support for practice transformation costs, recognizing that behavioral health care providers need technical assistance for developing new operations, reporting, billing, and health record systems.

9-4 In its development of new measures, CMS should also consider modifying the existing measures for behavioral health risk adjustment.

This report is based on the best available scientific evidence and input from individuals with firsthand experience trying to provide or access behavioral health services. As such, the urgency with which the nation must move to take action may not be apparent on every page of the report. However, the committee cannot understate the importance of seeing these recommendations as requiring immediate attention to stop the problems that people enrolled in Medicare, Medicaid, and Marketplace plans face daily in accessing even the most basic behavioral health care.

Outside of uncertainties from the recent Supreme Court decision in the Loper Bright Enterprises v. Raimondo case, which overturned the longstanding "Chevron deference" that allowed agencies to interpret ambiguous language applicable to their work, statutory authorities are likely sufficient for these recommendations (Turrentine, 2024)[1,2]. Some recommendations can be implemented in the short term and put into action within a year or two, especially those that apply to existing systems. These focus on immediate actions within current frameworks. The recommendations that can be implemented in the short term are Recommendation 1-3; Recommendations 2-1, 2-2, and 2-3; Recommendation 3; Recommendation 4; Recommendation 5; Recommendation 6-1; Recommendations 7-1 and 7-4; Recommendations 8-1 and 8-2; and Recommendation 9-3. All recommendations have at least one aspect that can be implemented in the short term. The remaining recommendations primarily address systemic changes, which may take longer to fully implement.

Regardless of the timeframes for full implementation, these recommendations provide specific actions that should be set in motion with a sense of urgency. This work is not intended to be a plan that "sits on a shelf," but rather a guide to how Medicare, Medicaid, and Marketplace programs can improve behavioral health provider participation in the context of the current dysfunctional, inequitable, under-resourced, and stigmatized disarray of policies and structures which have lost sight of the individuals, children, and families unable to get the health care they need and deserve.

REFERENCE

Turrentine, J. 2024. *The Supreme Court ends Chevron deference—What now?* https://www.nrdc.org/stories/what-happens-if-supreme-court-ends-chevron-deference (accessed June 18, 2024).

[1]Chevron USA Inc. V. NRDC. 1984. 467 U.S. 837.

[2]Loper Bright Enterprises v. Raimondo, 603 U.S. ___ (2024).

Appendix A

Committee and Staff Biographies

COMMITTEE

Daniel Polsky, Ph.D. (*Chair*), is the Bloomberg Distinguished Professor of Health Economics and Policy at Johns Hopkins University. He holds primary appointments in both the Department of Health Policy and Management, Johns Hopkins Bloomberg School of Public Health, and the Carey Business School. He was the Robert D. Eilers Professor at the Wharton School and the Perelman School of Medicine, University of Pennsylvania, where he was faculty from 1996 to 2019. As the current director of the Hopkins Business of Health Initiative and former executive director of the Leonard Davis Institute for Health Economics, Dr. Polsky has extensive experience in leading interdisciplinary teams advancing research to inform U.S. health policy to address challenges of access, affordability, value, and equity. He is a member of the National Academy of Medicine. He was the senior economist on health issues at the President's Council of Economic Advisers. He received a Master of Public Policy degree from the University of Michigan in 1989 and a Ph.D. in economics from the University of Pennsylvania in 1996.

London Breedlove, Psy.D., (they/them) is a licensed psychologist with over a decade of experience practicing, teaching, and doing program development with integrated behavioral health. Dr. Breedlove is the director of integrated behavioral health and a clinical associate professor in the Family Medicine Department (DFM) at University of Washington in Seattle, Washington. They serve as the co-director of education for the

Osher Center of Integrative Health. They are a past board of trustees president for the Washington State Psychological Association (2019) and serve as the Washington's Council representative to the American Psychological Association (2021–present). Prior to joining the DFM, Dr. Breedlove was the director of clinical training for doctoral internship and postdoctoral fellowship programs at Columbia Valley Community Health, a patient-centered medical home and federally qualified health center in Wenatchee, Washington, for 7 years. Dr. Breedlove currently co-chairs a task force for the Washington State Psychological Association to address psychology trainee reimbursement in Washington as an avenue to fund psychology training and address behavioral health workforce shortages in the state.

Richard G. Frank, Ph.D., is the Margaret T. Morris Professor of Health Economics emeritus at Harvard Medical School. He is a senior fellow in economic studies and the director of the Schaeffer Initiative on Health Policy at the Brookings Institution. From 2009 to 2011, he served as the deputy assistant secretary for planning and evaluation at the U.S. Department of Health and Human Services (HHS) directing the Office of Disability, Aging and Long-Term Care Policy. From 2014 to 2016 he served as assistant secretary for planning and evaluation in the HHS. His research is focused on the economics of mental health and substance abuse care, long-term care financing policy, prescription drug markets, and disability policy. He was elected to the National Academy of Medicine in 1997. He is co-author with Sherry Glied of the book *Better but Not Well* (Johns Hopkins Press). Dr. Frank received his Ph.D. in economics from Boston University.

Marie Ganim, Ph.D., is semi-retired, teaching health policy at Brown University and Northeastern University. She has over 35 years of experience leading health care reform initiatives at various levels and branches of government. The focus of her career and academic study has been on health care policy analysis, legislation, and implementation. For more than 20 years as a top advisor to the Rhode Island State Legislature, she participated in crafting most of the state's health-related laws and policies during that era. She later served (from 2017 to 2021) as the nation's only state health insurance commissioner, a Governor's Cabinet role that is unique to the State of Rhode Island, combining both health regulation and policy authorities. She chaired the National Association of Insurance Commissioners' (NAIC) Working Group on Health Care Innovation from 2018 to 2021 and was a co-founder of the NAIC Behavioral Health Parity Working Group. During the crisis response to the COVID-19 pandemic, Dr. Ganim was actively engaged in eliminating state regulatory and payment

constraints on tele-health and facilitating increased private funding for Rhode Island's substance use and mental health clinicians and services to maintain access to care throughout 2020. She holds a master's degree in public administration from Syracuse University and a Ph.D. in public affairs from Northeastern University.

Cynthia Gillespie, M.A., retired from her position as secretary of the Arkansas Department of Human Services in November of 2022. Prior to her appointment in 2016, Ms. Gillespie served as a principal in the Washington, D.C., office of Dentons' Public Policy and Regulation practice and a leader of the firm's health policy and health insurance exchange teams. Earlier in her career, she served as a senior advisor to then-Massachusetts Governor Mitt Romney, where she oversaw the Romney Administration's executive branch initiatives and helped develop the state's health reforms. She has served on boards overseeing state government employee health plans, a health insurance marketplace, and the National Academies of Sciences, Engineering, and Medicine Board on Health Care Services. For the past 20 years, Ms. Gillespie has focused on health policy and innovations in coverage and insurance models, particularly for lower-income and special populations. As secretary in Arkansas, she oversaw a significant state-wide expansion of mental health services provided through Medicaid, with the goal of ensuring access to a robust continuum of services in both rural and urban settings. Ms. Gillespie is a graduate of Auburn University with an M.A. in organizational communication.

Christina L. Goe, J.D., is an attorney with extensive experience in health insurance regulation and health care law. She is a member of the bar in California (1980–present [inactive]) and Montana (1995–present). Ms. Goe worked as chief legal counsel and general counsel for the Montana Department of Securities and Insurance from 1999 to 2017. She was also active on several committees at the National Association of Insurance Commissioners, including as chair of the ERISA Working Group and vice-chair of the Regulatory Framework Task Force. Beginning in 2010, she worked exclusively on implementing state and federal health insurance laws, including HIPAA, the Affordable Care Act, and the Mental Health Parity and Addiction Equity Act. In 2017, Ms. Goe established a solo law practice, focusing on state and federal health insurance law and other issues relating to health care delivery reform. She has consulted on or co-authored issue briefs and articles relating to mental health parity enforcement.

She was the recipient of the Montana Governor's Award for Excellence in 2014 and 2016. She has a B.A. in history from Stanford University and a J.D. from Santa Clara University Law School.

Jennifer Kelly, Ph.D., is the 2021 past president of the American Psychological Association (APA). She is board certified in clinical health psychology and is the director of the Atlanta Center for Behavioral Medicine in Atlanta, Georgia. Her primary APA presidential initiative focused on psychology's role in achieving health equity. In 2019, she served as a co-chair of the Advocacy Coordinating Committee of the American Psychological Association Services, Inc. She served on the board of directors as recording secretary for APA from 2013 to 2018. Prior to that, she served on the board as a member-at-large. A past president of the Georgia Psychological Association, Dr. Kelly has served as the federal advocacy coordinator of the association for 24 years.

Dr. Kelly has been recognized for her advocacy on behalf of psychology, including recognition by the APA Services, Inc., Practice Leadership Conference in 2019, for her leadership in advancing the profession of psychology through federal advocacy, Legislative Award of the Georgia Psychological Association in 2000, the 2011 State Leadership Award, Karl F. Heiser Advocacy Award, and the Federal Advocacy Award by the APA Practice Organization in 2004. She was the 2012 recipient of the APA Division of Health Psychology/American Psychological Foundation Timothy B. Jeffrey Award for Outstanding Contributions to Clinical Health Psychology. Dr. Kelly received her Ph.D. in clinical psychology from Florida State University.

Parinda Khatri, Ph.D., is the chief executive officer at Cherokee Health Systems (CHS). Dr. Khatri is a licensed clinical psychologist with over 25 years of experience in clinical practice, training and education, research, and administrative leadership in behavioral health. Prior to her role as CEO, she was the chief clinical officer at the organization, where she provided guidance on clinical quality, program development and management, workforce development, clinical research and operations for blended primary care, and behavioral health services.

Dr. Khatri is on the advisory council for the National Integration Academy for the Agency for Healthcare Research and Quality (AHRQ) as well as the clinical advisory committees for Amerigroup and BlueCare of Tennessee. She is also on the National FQHC Advisory Board for United Healthcare, board of directors for Advocates for Community Health (ACH), board of directors of the Tennessee Association of Mental Health Organizations, and the board of directors for Clinicians for the Underserved. Dr. Khatri was recognized with the Don Bloch Award in 2020 by the Collaborative Family Healthcare Association, the Cynthia Belar Award for Excellence for Education and Teaching by the Society of Health Psychology, and the Susan P. Smith Award of Excellence by the Tennessee Primary Care Association. Dr. Khatri received her Ph.D. in clinical psychology at the University of North Carolina at Chapel Hill.

Benjamin F. Miller, Psy.D., is the past president of Well Being Trust, a national foundation dedicated to advancing the mental, social, and spiritual health of the nation. Over the last two decades, Dr. Miller has worked tirelessly to prioritize mental health in our policies, programs, and investments. A clinical psychologist by training, Dr. Miller works at the intersection of policy and practice, ensuring that mental health and addiction treatment are prioritized across America. His primary professional and research experience has been on the integration of mental health into both community and health care settings. He has published prolifically on the topic of mental health and primary care integration and is seen as subject matter expert for mental health. Dr. Miller has participated in several National Academies of Sciences, Engineering, and Medicine (National Academies) efforts, including as a member of the Forum on Mental Health and Substance Use Disorders and a co-chair for the National Academies' workshop on Innovative Data Science Approaches to Assess Suicide Risk in Individuals, Populations & Communities: Current Practices, Opportunities, and Risks. Dr. Miller received his doctorate in clinical psychology at Spalding University.

Douglas P. Olson, M.D., is an internal medicine and addiction medicine physician. Dr. Olson most recently served as the chief medical officer for the country's Medicaid program at The Center for Medicaid & Medicaid Services (CMS) in Washington, D.C. While at CMS, he worked primarily on mental health and substance use treatment initiatives. He is the medical director of HAVEN, Connecticut's Physician Health Program; remains clinically active working at a community health center; and is president of the board of directors of the Association of Clinicians for the Underserved. He was a National Health Service Corps scholar, is a fellow of the American College of Physicians and the American Society of Addiction Medicine, and is an American Academy of HIV Medicine Specialist. As an administrator and clinician, his career has been dedicated to improving the health of our country's workforce and that of underserved populations. Dr. Olson graduated from George Washington University School of Medicine and completed his residency and chief residency in internal medicine at Yale.

Sally Raphel, M.S., APRN-PMH, FAAN, has been a practicing nurse for 62 years and retired from teaching in 2016 from Johns Hopkins School of Nursing. She is presently the associate editor for *Archives Journal of Psychiatric Nursing*. Ms. Raphel started the child sexual abuse clinic at the University of Maryland in the 1980s and served as the director of the American Nurses Association Policy, Practice and Economics Department for 11 years. Ms. Raphel ran the World Health Organization Collaborating Center for Mental Health Nursing at the University of Maryland School of Nursing and worked with countries in South and Central America.

She served as the president of the Baltimore Mental Health Leadership Institute and served on the Board of ISPN. She has numerous national and international publications, presentations, and blogs and has held national elected and appointed positions on groups working to advance mental health for persons of all ages. Ms. Raphel graduated from Mercy Hospital Nurses School and holds a masters in psychiatric nursing from the University of Maryland. She is a fellow in the American Academy of Nurses and was named a Living Legend in Psychiatric Nursing by the International Society of Psychiatric Nurses.

E. Clarke Ross, D.P.A., has been the public policy director for the American Association on Health and Disability (AAHD) since December 2010. Since 2014 Dr. Clarke and AAHD have served as the Washington Representative of the Lakeshore Foundation. Dr. Clarke's 52 years of work history includes serving as the chief executive officer of CHADD (Children and Adults with Attention-Deficit/Hyperactivity Disorder); the deputy executive director for public policy at the National Alliance on Mental Illness; the executive director of the American Managed Behavioral Healthcare Association; the assistant executive director for federal relations and then deputy executive director of the National Association of State Mental Health Program Directors; and director of governmental activities at United Cerebral Palsy.

Dr. Clarke served on the National Quality Forum (NQF) Measure Applications Partnership coordinating committee (July 2021–March 2023) and between July 2012 and March 2023 served on several NQF committees. Dr. Clarke was a member of the Office of the National Coordinator for Health Information Technology's Health IT Policy Committee, Consumer Workgroup, from March 2013 to November 2015; of the Consumer Task Force, November 2015–April 2016; and of the Substance Abuse and Mental Health Services Administration's Wellness Campaign National Steering Committee from January 2011 to September 2014. Dr. Clarke received his doctorate in public administration from George Washington University.

Joshua Jacob Seidman, Ph.D., is the chief research and knowledge officer at Fountain House, a national mental health not-for-profit organization fighting to improve health, increase opportunity, and end social and economic isolation for people living with serious mental illness. He is trained academically as a health services researcher and strongly believes in complementing that with human-centered design approach in advancing new models of care. Dr. Seidman previously launched and led Avalere's Center for Payment & Delivery Innovation. Dr. Seidman oversaw quality and performance improvement at Evolent Health. He served as director of meaningful use for the U.S. Department of Health and Human Services where he was responsible for the Office of the National Coordinator for

Health IT's policy development around the meaningful use of electronic health records and e-quality measures. Previously, Dr. Seidman was the founding president of the Center for Information Therapy, which advanced the practice and science of using health information technology (IT) to deliver tailored information to consumers to help them make better health decisions. Dr. Seidman also served as the director of measure development at the National Committee for Quality Assurance (NCQA). Dr. Seidman received his Ph.D. and M.H.S. from Johns Hopkins Bloomberg School of Public Health and his B.A. from Brown University.

Marylou Sudders, M.S.W., is currently a senior policy advisor at Smith, Costello & Crawford, a premier public policy law firm and a trustee of a charitable fund that invests in children's mental health in Massachusetts. In 2023 she stepped down after serving the full 8-year term in Massachusetts Governor Charlie Baker's administration as secretary of health and human services. She oversaw 12 agencies, including the MassHealth program, and chaired the state's insurance marketplace and numerous commissions. During that time she also led the state's response to COVID-19. As secretary, she invested heavily in improving access for behavioral health care, advocating for stronger consumer insurance protections, implementing telehealth, and developing strategies to address current work force challenges. An expert in behavioral health, she has worked to pass significant legislation on behavioral health care and insurance coverage, child welfare reform, and gun safety. She has worked in both the public and private sectors, including serving as commissioner of mental health in Massachusetts, associate professor and department chair at Boston College School of Social Work, a nonprofit chief executive officer, and a consultant with the U.S. Department of Justice. Ms. Sudders received her M.S.W. from Boston University and holds three honorary doctorates, plus is the recipient of numerous civic, social work and professional honors, including the Knee/Wittman Outstanding Achievement Award from the NASW Foundation.

Rachel Talley, M.D., is an assistant professor of clinical psychiatry in the Department of Psychiatry at the University of Pennsylvania. She is the director of the department's fellowship in community psychiatry and the associate program director for the department's adult psychiatry residency program. Dr. Talley serves on the board of the American Association for Community Psychiatry and is a member of the National Council for Mental Wellbeing's Medical Director Institute. She works clinically in community-based settings providing care to publicly insured patients with severe mental illness. She has contributed to several nationally disseminated quality-improvement frameworks to advance the integration of physical and behavioral health services, including co-authorship and participation

on expert panels. She has been recognized for her teaching and leadership in community mental health, including receipt of the University of Pennsylvania Department of Psychiatry's Albert Stunkard Faculty Recognition Award for the past three consecutive years (2021, 2022, 2023) and receipt of the 2021 Larry A. Real Award from the Montgomery County, Pennsylvania, chapter of the National Alliance on Mental Illness.

Dr. Talley received her B.A. from Harvard University and her M.D. from the Stanford University School of Medicine. She completed both her residency training in adult psychiatry and her public psychiatry fellowship at Columbia University/New York State Psychiatric Institute.

John Torous, M.D., M.B.I., is the director of the digital psychiatry division in the Department of Psychiatry at Beth Israel Deaconess Medical Center (BDIMC), a Harvard Medical School–affiliated teaching hospital, where he also serves as a staff psychiatrist and assistant professor. At a system level, Dr. Torous is the medical director of behavioral health informatics for Beth Israel Lahey Health. Dr. Torous is active in investigating the potential of mobile mental health technologies for psychiatry and has published over 250 peer-reviewed articles and five book chapters on the topic. He directs the digital psychiatry clinic at BIDMC, which seeks to improve access to and quality of mental health care through augmenting treatment with digital innovations. Dr. Torous serves as editor-in-chief for the journal *JMIR Mental Health* and as web editor for *JAMA Psychiatry*, and he is the immediate past chair of the American Psychiatric Association's health information technology committee. He has served on National Research Council panels on veterans' health in the past year.

He has a background in electrical engineering and computer sciences and received an undergraduate degree in the field from the University of California, Berkeley, before attending medical school at the University of California, San Diego. He completed his psychiatry residency, fellowship in clinical informatics, and master's degree in biomedical informatics at Harvard University.

Jane Zhu, M.D., M.P.P., M.S.H.P., is a primary care physician and associate professor of medicine in the Division of General Internal Medicine at Oregon Health & Science University. Dr. Zhu's broad research interests relate to access to care as well as the role of provider incentives and organization of care on health care delivery. Her research program has focused extensively on mental and behavioral health services, including (1) how mental health provider networks (the sets of providers with which managed care insurers contract to deliver services) affect access to care and clinical outcomes; (2) how to measure and monitor network adequacy; and (3) understanding levers that improve mental health workforce

participation and patient access in public insurance programs. Funded by foundation grants and the National Institutes of Health, her work has been published in high-impact journals, including the *New England Journal of Medicine*, *JAMA*, and *Health Affairs*; cited in government and legislative reports; and widely reported in the media.

Dr. Zhu received her B.S. from Duke University, where she was named a Fulbright Scholar, and her M.D. and M.P.P. from Harvard. She completed internal medicine residency training at the University of California, San Francisco, and completed fellowship at the University of Pennsylvania as a National Clinician Scholar.

STAFF

Udara Perera, M.P.H., is a senior program officer on the Board on Health Care Services at the National Academies of Sciences, Engineering, and Medicine (National Academies). She is the study director for this project, Strategies to Improve Access to Behavioral Health Care Services through Medicare and Medicaid. Prior to joining the National Academies, she was a director in quality measurement at the National Quality Forum in Washington, D.C., where she led the consensus development process committees on cardiovascular diseases, all-cause admissions and readmissions, surgery, primary care and chronic illness, geriatrics and palliative care, and cost and efficiency. She also worked on the Measure Applications Partnership and led the Post-Acute Care/Long-Term Care Workgroup and Health Equity Advisory Group, and she has worked on the development of several recommendations reports on topics that include maternal morbidity and mortality measurement, electronic health record care communication and care coordination, and attribution for critical illness and injury. She completed her postdoctoral research training in maternal and child health at the Harvard T.H. Chan School of Public Health. She holds an M.P.H. in Global and Community Health and graduate certificate in public health leadership and management from George Mason University, and a B.S. in biological sciences, a B.S. in interdisciplinary studies: public and community health, and a minor in psychology from the University of Maryland, Baltimore County. She is completing her Dr.P.H. in community health and prevention at Drexel University.

Abigail Godwin, M.P.H., is a dedicated public health professional specializing in policy analysis, legislative research, and executive administration. Currently, she serves as a research associate at the National Academies of Science, Engineering, and Medicine working on enhancing provider participation in Medicare, Medicaid, and Marketplace insurance plans. She holds a master of public health from Boston University and a bachelor of science

in public health from Sam Houston State University. Before her role at the National Academies of Sciences, Engineering, and Medicine, Ms. Godwin worked on campaign efforts to expand long-term services and supports coverage with the Massachusetts Senior Action Council, served as a policy intern for Massachusetts State Senator John F. Keenan, and worked as a special assistant at the Brennan Center for Justice. Alongside her professional and academic milestones, Ms. Godwin is dedicated to community service, with volunteer experience at United Ways Workplace Wellness, Be The Match, and Bridge Over Troubled Water.

Elizabeth Ferré, M.P.H., is a research associate with the Board on Health Care Services. She is currently working on the project Long-Term Health Effects of COVID-19: Disability and Function Following SARS-CoV-2 Infection and assisting with a second project, Strategies to Improve Access to Behavioral Health Care Services through Medicare and Medicaid. Previously, she has worked on the Board on Global Health on the Analysis to Enhance the Effectiveness of the Federal Quarantine Station Network Based on Lessons from the COVID-19 Pandemic consensus study. Her primary interests include anticipation, prevention, detection, and response to infectious diseases; emerging disease threats; global health security; pandemic preparedness; and achievement of health equity. She is originally from Boston, Massachusetts, and attended James Madison University for a Bachelor of Science in public health. She holds a Master of Public Health with a concentration in global health from the University of Maryland School of Medicine.

Marc Meisnere, M.H.S., is a senior program officer on the National Academies of Sciences, Engineering, and Medicine's (National Academies) Board on Health Care Services and is director of the Standing Committee on Primary Care. Since 2010, Mr. Meisnere has worked on a variety of National Academies consensus studies and other activities that have focused on mental health services for service members and veterans, suicide prevention, primary care, and clinician well-being. Most recently, he was the study director for the 2021 National Academies report *Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care* and the 2023 report *Achieving Whole Health: A New Approach for Veterans and the Nation*. Before joining the National Academies, Mr. Meisnere worked on a family planning media project in northern Nigeria with the Johns Hopkins Center for Communication Programs and on a variety of international health policy issues at the Population Reference Bureau. He is a graduate of Colorado College and the Johns Hopkins University Bloomberg School of Public Health.

Joseph Goodman, B.S., is a senior program assistant at the National Academies of Sciences, Engineering, and Medicine (National Academies). Having been with the Academies since 2007, Mr. Goodman has extensive experience with working on several studies and workshops. Some of his recent work at the National Academies has included workshop series such as *Accelerating the Use of Findings from Patient-Centered Outcomes Research in Clinical Practice to Improve Health and Health Care*. He earned his Bachelor of Science in music education from Frostburg State University.

Sharyl J. Nass, Ph.D., serves as senior director of the Board on Health Care Services and director of the National Cancer Policy Forum at the National Academies of Sciences, Engineering, and Medicine (National Academies). To enable the best possible care for all patients, the board undertakes scholarly analysis of the organization, financing, effectiveness, workforce, and delivery of health care, with an emphasis on quality, cost, and accessibility. The forum examines policy issues pertaining to the entire continuum of cancer research and care. For more than two decades, Dr. Nass has worked on a broad range of health and science policy topics that includes the quality, safety, and equity of health care and clinical trials; developing technologies for precision medicine; and strategies to support clinician well-being. She has a Ph.D. from Georgetown University, and she undertook postdoctoral training at the Johns Hopkins University School of Medicine as well as a research fellowship at the Max Planck Institute in Germany. She also holds a B.S. and an M.S. from the University of Wisconsin–Madison. She has been the recipient of the Cecil Medal for Excellence in Health Policy Research, a Distinguished Service Award from the National Academies, and the Institute of Medicine staff team achievement award (as team leader).

Appendix B

Disclosure of Unavoidable Conflict of Interest

The conflict-of-interest policy of the National Academies of Sciences, Engineering, and Medicine (http://www.nationalacademies.org/coi) prohibits the appointment of an individual to a committee authoring a Consensus Study Report if the individual has a conflict of interest that is relevant to the task to be performed. An exception to this prohibition is permitted if the National Academies determines that the conflict is unavoidable and the conflict is publicly disclosed. A determination of a conflict of interest for an individual is not an assessment of that individual's actual behavior or character or ability to act objectively despite the conflicting interest.

Parinda Khatri has a conflict of interest in relation to service on the Committee on Strategies to Improve Access to Behavioral Health Care Services through Medicare and Medicaid because she is the chief executive officer of Cherokee Health Systems, a federally qualified health center that serves as a community mental health center that receives reimbursement from Medicare and Medicaid.

The National Academies has concluded that for this committee to accomplish the tasks for which it was established, its membership must include at least one person who has substantial current experience in managing a federally qualified health center that serves as a community mental health center for an underserved population that has a high burden of behavioral health needs. As described in her biographical summary, Dr. Khatri has extensive experience in leadership roles at Cherokee Health Systems working directly on the challenges that community mental health centers face providing behavioral health services for underserved populations.

Dr. Khatri also has extensive experience in working to blend primary care and behavioral health services.

The National Academies has determined that the experience and expertise of Dr. Khatri is needed for the committee to accomplish the task for which it has been established. The National Academies could not find another available individual with the equivalent experience and expertise who does not have a conflict of interest. Therefore, the National Academies has concluded that the conflict is unavoidable.

The National Academies believes that Dr. Khatri can serve effectively as a member of the committee and that the committee can produce an objective report, taking into account the composition of the committee, the work to be performed, and the procedures to be followed in completing the study.

Appendix C

Chapter 3 Tables

TABLE C-1 Medicaid Eligibility and Benefits by Type of Dual-Eligible Beneficiary

Type	Full or partial Medicaid benefits	Federal income and asset (individual/couple) limits for eligibility in 2021	Benefits
Medicare Savings Program (MSP) beneficiaries			
Qualified Medicare beneficiary (QMB)	Partial: QMB only	• At or below 100% FPL • $7,970 / $11,960	Entitled to Medicare Part A, eligible for Medicaid only under MSP, and qualify for Medicaid payment of: • Medicare Part A premiums (if needed) • Medicare Part B premiums • At state option, certain premiums charged by Medicare Advantage plans • Medicare deductibles, coinsurance, and copayments (except for nominal copayments in Part D, the Medicare drug program)

continued

TABLE C-1 Continued

Type	Full or partial Medicaid benefits	Federal income and asset (individual/couple) limits for eligibility in 2021	Benefits
	Full: QMB plus	• At or below 100% FPL • $2,000 / $3,000	Entitled to Medicare Part A, eligible for Medicaid under a mandatory or optional pathway in addition to MSP, and qualify for Medicaid payment of: • Medicare Part A premiums (if needed) • Medicare Part B premiums • At state option, certain premiums charged by Medicare Advantage plans • Medicare deductibles, coinsurance, and copayments (except for nominal copayments in Part D) • All Medicaid-covered services
Specified low-income Medicare beneficiary (SLMB)	Partial: SLMB only	• 101%–120% FPL • $7,970 / $11,960	Entitled to Medicare Part A, eligible for Medicaid only under MSP, and qualify for Medicaid payment of: • Medicare Part B premiums
	Full: SLMB plus	• 101%–120% FPL • $2,000 / $3,000	Entitled to Medicare Part A, eligible for Medicaid under a mandatory or optional pathway in addition to MSP, and qualify for Medicaid payment of: • Medicare Part B premiums • At state option, certain premiums charged by Medicare Advantage plans • Medicare deductibles, coinsurance, and copayments (except nominal copayments in Part D); state may elect to pay only for Medicare services covered by Medicaid • All Medicaid-covered services

TABLE C-1 Continued

Type	Full or partial Medicaid benefits	Federal income and asset (individual/couple) limits for eligibility in 2021	Benefits
Qualifying individual (QI)	Partial	• 121%–135% FPL • $7,970 / $11,960	Entitled to Medicare Part A, eligible for Medicaid only under MSP, and qualify for Medicaid payment of: • Medicare Part B premiums
Qualified disabled and working individuals (QDWI)	Partial	• At or below 200% FPL • $4,000 / $6,000[2]	Lost Medicare Part A benefits because of their return to work but eligible to purchase Medicare Part A, eligible for Medicaid only under MSP, and qualify for Medicaid payment of: • Medicare Part A premiums
Non-MSP beneficiaries			
Other full-benefit dual-eligible beneficiaries	Full	• Income limit varies, but generally at or below 300% of the federal Supplemental Security Income benefit rate (about 225% FPL for an individual) • $2,000 / $3,000	Eligible under a mandatory or optional Medicaid pathway, not eligible for MSP, and qualify for Medicaid payment of: • At state option. certain premiums charged by Medicare Advantage plans • Medicare deductibles, coinsurance, and copayments (except for nominal copayments in Part D); state may elect to pay only for Medicare services covered by Medicaid • All Medicaid-covered services

SOURCE: MedPAC, 2022.

TABLE C-2 Range of Behavioral Health and Wellness Services Covered by Medicare

The range of behavioral health and wellness services covered by Medicare varies depending on the care setting and profession but includes:
Alcohol misuse screening and up to four brief, face-to-face counseling sessions per year for adults who use alcohol but are not dependent
Annual wellness visits to develop or update a personalized prevention plan, including health risk assessment and depression screening
Behavioral health integration by clinical staff to assess, monitor, and plan care
Bundled opioid use disorder payments for management and counseling and in-office services such as overall case management, care coordination, individual and group psychotherapy, and substance use counseling
Caregiver-focused behavioral health risk assessment of their own behavior and health risks, which benefits the patient
Cognitive assessment and care planning
Depression screening up to 15 minutes annually when staff-assisted depression care supports can assure accurate diagnosis, effective treatment, and follow-up
Diagnostic psychological and neuropsychological tests
Electroconvulsive therapy
Family psychotherapy
Health and behavioral assessment and intervention identifying or treating psychological, behavioral, emotional, cognitive, and social factors important to prevent, treat, or manage physical health issues
Individual and group psychotherapy • Hypnotherapy • Medication-assisted treatment for SUDs • Psychoanalysis
Psychiatric evaluation that systematically evaluates a psychiatric disorder's causes, symptoms, and course and consequences

SOURCE: CMS, 2023.

REFERENCES

CMS (Centers for Medicare and Medicaid Services). 2023. *Medicare & mental health coverage.* Baltimore, MD: Centers for Medicare and Medicaid Services Medicare Learning Network. https://www.cms.gov/files/document/mln1986542-medicare-mental-health-coverage.pdf (accessed June 13, 2024).

MedPAC. 2022. *Data book: Beneficiaries dually eligible for Medicare and Medicaid.* Washington, DC: Medicare Payment Advisory Commission and the Medicaid and CHIP Payment and Access Commission. https://www.macpac.gov/publication/data-book-beneficiaries-dually-eligible-for-medicare-and-medicaid-3/ (accessed June 13, 2024).

Appendix D

Public Meeting Agendas

WEBINAR 1: LIVED EXPERIENCES IN ACCESSING BEHAVIORAL HEALTH CARE SERVICES THROUGH PUBLIC INSURANCE PROGRAMS

NOVEMBER 9, 2023

12:00 p.m.	**Welcome and Introduction to the Study** Daniel E. Polsky, Committee Chair
12:05 p.m.	**Panel 1: Adults with Lived Experience Using Public Insurance Programs** Keris Jän Myrick, Inseparable Audrey Levine, Fountain House Laura Van Tosh, Mental Health Policy Roundtable
12:35 p.m.	**Panel 1 Discussion** Moderator: Joshua Jacob Seidman, Committee Member
1:00 p.m.	**Panel 2: Caregivers to Children with Experience Using Public Insurance Programs** Lisa Butler, Oregon Family Support Network Laura Marshal, Advocates for Mental Health of Michigan Youth Eboni S. Dabney, A Mom Like Me Inc.

1:30 p.m. **Panel 2 Discussion**
Moderator: Sally Raphel, Committee Member

2:00 p.m. **Closing Remarks**
Adjourn

WEBINAR 2: EXPERIENCES OF BEHAVIORAL HEALTH CARE PROVIDERS WITH PUBLIC INSURANCE PROGRAMS

JANUARY 10, 2023

2:00 p.m. **Welcome and Introduction to the Study**
Daniel E. Polsky, Committee Chair

2:05 p.m. **Panel 1 Presentation**
Warren Ng, Columbia University
Karin Jeffers, Clinical & Support Options Inc.
Margaret Adam, Iora/One Medical

2:35 p.m. **Panel 1 Discussion**
Moderator: London Breedlove, Committee Member

3:00 p.m. **Panel 2 Presentation**
Rakhee Patel, Coastal Horizons Center
Tyler Vermillion, Ideal Option
Heather Jefferies, Oregon Council for Behavioral Health

3:30 p.m. **Panel 2 Discussion**
Moderator: Rachel Talley, Committee Member

3:55 p.m. **Closing Remarks**
Adjourn

WEBINAR 3: INNOVATIONS TO IMPROVE MENTAL HEALTH AND SUBSTANCE USE DISORDER ACCESS IN MEDICARE, MEDICAID, AND MARKETPLACE INSURANCE PLANS

JANUARY 11, 2023

2:00 p.m. **Welcome and Introduction to the Study**
Daniel E. Polsky, Committee Chair

2:05 p.m. **Panel 1 Presentation**
Cara Cheevers, Colorado Division of Insurance
Brook Hall, Oregon Department of Insurance
Paula Stone, Arkansas Substance Abuse and Mental Health Services Administration and Medicaid

2:35 p.m.	**Panel 1 Discussion** Moderator: Christina Goe, Committee Member
3:00 p.m.	**Panel 2 Presentation** Sean M. Robbins, BCBS Association Lindsey Browning, National Association of Medicaid Directors Douglas Jacobs, Centers for Medicare & Medicaid Services
3:30 p.m.	**Panel 2 Discussion** Moderator: Marie Ganim, Committee Member
3:55 p.m.	**Closing Remarks** **Adjourn**

Appendix E

Exploring Strategies to Improve Access to Behavioral Health Care Services Through Medicare and Medicaid: Proceedings of a Workshop—in Brief

NATIONAL ACADEMIES Sciences Engineering Medicine

Proceedings of a Workshop—in Brief

Exploring Strategies to Improve Access to Behavioral Health Care Services Through Medicare and Medicaid

Proceedings of a Workshop—in Brief

The United States is experiencing challenges in ensuring broad access to behavioral health care services, presenting a serious obstacle for Americans seeking behavioral health care. In 2021, 22.8 percent of U.S. adults experienced a behavioral health problem, though only 47.2 percent of them accessed mental health services (SAMHSA, 2021). Medicaid and Medicare account for 58 percent of U.S. behavioral health care expenditures, with Medicaid being the largest payer of behavioral health services. However, low reimbursement rates and an insufficient behavioral health workforce leave many beneficiaries without timely access to care (Bureau of Health Workforce, 2023; Guth, 2023).

As part of its charge to examine the current challenges in ensuring broad access to high-quality behavioral health care services through the Medicare, Medicaid, and Marketplace programs through a consensus study, the Committee on Strategies to Improve Access to Behavioral Health Care Services through Medicare and Medicaid will publish a report with recommendations to increase behavioral health care workforce participation in these programs. The committee convened three virtual public webinars on November 9, 2023, and January 10–11, 2024, to help inform the consensus study. The topics for the three webinars were perspectives from adults and caregivers to children with lived experience using behavioral health care services through public insurance programs, behavioral health care provider experiences with public insurance programs, and innovations to improve behavioral health care access at the state and national level. This Proceedings of a Workshop—In Brief summarizes the presentations and discussions and the broad range of views and ideas the speakers, panelists, and webinar participants expressed at the three webinars.

ADULTS WITH LIVED EXPERIENCE USING PUBLIC INSURANCE PROGRAMS

To better understand the experience of individuals who are past or present beneficiaries of public insurance programs, the webinar heard from three individuals who summarized their experiences and perspectives. Keris Jän Myrick, the vice president of partnerships at Inseparable, said not having a navigator at the beginning of her mental health troubles was a huge challenge when she was a Medicaid beneficiary. When discharged from a locked psychiatric unit after being diagnosed with schizophrenia, she was left to navigate Medicaid benefits on her own. She floundered and had no idea what to do, how to do it, or even how to find a provider who accepted Medi-Cal[1] and specialized in treating individuals with schizophrenia without first having to go through the community mental health system. Today, she said, Medicaid

[1] Medi-Cal is California's Medicaid program.

beneficiaries receive a welcome letter with the name of a navigator they can contact who can help the individual use and maximize their Medicaid benefits.

The community health system, Myrick said, focused on medication and professional care, but not on providing services such as the supported employment and supported education she wanted to pursue. There was also no emphasis on prevention or early intervention, which would have kept her from deteriorating to where she required hospitalization.

Myrick's family was not aware that they were eligible to receive support themselves. Myrick explained that families of beneficiaries can receive family support services (family or parent peer support/psychoeducation, etc.) as collateral to the member and paid for by Medicaid. Peer support was important for her, given the shortage of providers of color, but only 18 states' Medicaid programs allow for billing youth peer support services for members under the age of 18. Though many state Medicaid programs now allow billing for telehealth services, Myrick raised questions about access to digital therapeutics, apps, and evidence-based digital tools. She said there is a need to include digital literacy training and support for beneficiaries as a billable service.

Advocating for a holistic approach to health, Myrick said mental health should not exist in isolation but should be part of achieving complete physical, mental, and social well-being. For her, the four pillars of recovery are health, home, purpose, and community, many of which happen in systems that do not communicate with mental health. For example, the housing system may not be aware that the Medicaid beneficiary it serves is receiving services in the public mental health system. This can lead to individuals not getting the integrated support they need. "As a Medicaid beneficiary, I did not want my mental illness to exist in a silo," she said. "I wanted to be seen as a whole person."

Myrick spoke of the challenge of facing society's perceived low expectations for people with a severe mental illness on public assistance and Medicaid. The treatment and support an individual receives can align with low expectations, affecting the individual's belief in his or her own capabilities. She pointed out how valuable the therapeutic alliance with one's provider can be, so picking a provider cannot be a "willy-nilly thing."

Audrey Levine, a faculty member at Fountain House, said that being eligible for both Medicaid and Medicare came with the stigma of being both a "dual eligible" and having a dual diagnosis. In New York, she said, she perceives that people with dual diagnoses receive less attention from the mental health system and are often relegated to "young and inexperienced clinicians" or clinicians who are "burned out and about to retire." Levine expressed a desire to find a provider with whom she can grow.

Laura Van Tosh, a convener for the Mental Health Policy Roundtable, said that when she moved to Washington to be with her family until she was well enough to live on her own, she was put on a 2-month waitlist to see a specialist at Kaiser Permanente who treats patients with her disorder. Until there was an opening, she saw an out-of-network psychiatrist to manage her medications, which at the time were causing intense side effects. She also hired an out-of-network case manager to help with her care while she reintegrated into society. During this time, she paid out of pocket for both psychiatric and community-based services, along with medication co-payments.

Today, Van Tosh's Medicare Advantage program pays for her medication and psychiatric services, though she pays for her out-of-network psychotherapy. She has qualified and is grateful for medical financial assistance through Kaiser that has kept her from being financially vulnerable, as well as for the integrated care Kaiser provides that has made a huge difference in her health and quality of life. "Services integration is paramount and matters more than I ever imagined," she said.

In 2022, Van Tosh had a mental health crisis and used publicly funded crisis services, inpatient care, and peer support services which enabled her to seek recovery-oriented care. While insurance covered the majority of her inpatient care, there were still unexpected expenses. She now lives independently and has enrolled with Seattle Club house, a Medicaid-reimbursable, psychosocial rehabilitation, community support program. She said that peer support has played a large role in helping her avoid repeated hospitalizations.

CAREGIVERS TO CHILDREN WITH EXPERIENCE USING PUBLIC INSURANCE PROGRAMS

In 2010, Lisa Butler, who today is director of family support services at the Oregon Family Support Network, and her husband were suffering from substance use disorder and had their three children (while pregnant with their fourth child) placed in foster care. Both adults recovered and reunited with their children. At the time, Butler said, she was a scared parent navigating a system that considered her a problem parent. The family engaged in wraparound services[2] for her older son, but she was overwhelmed by the many services and supports the program imposed on her without asking for her input. At one point, the family was dealing with eight providers, and she did not feel the system was welcoming or supportive.

Butler said there needs to be a paradigm shift in thinking about how providers view families and that families need to be approached with some humility. It is easy to find someone to blame for an issue, she said, but her family takes the attitude that nothing is wrong and that something that needs to change will emerge. This attitude, she said, is destigmatizing and reframes challenges as opportunities for growth rather than as inherently negative. She wondered what the mental health system would look like if it viewed families in that way and if there was a better balance between professional outcome-based therapies and engaging with a family and getting to know it better before trying to address needs and problems.

When her younger son was diagnosed with bipolar disorder with psychosis, the family entered the system again. The local youth and family crisis center handed her a long list of providers, but she could not find one with the capacity to accept another client. Instead, the family used the crisis center often. Her son could call any time of day, and someone from the crisis center would be there for him. After her son was seen at the crisis center, the provider who saw her son would call to check in on both her and her son. "That was the first time I had ever had a provider call and check on me as the parent caregiver rather than the identified youth," Butler said. "That was probably the most beneficial and supportive thing that could have happened for me."

When Butler's daughter had a suicide attempt, the safety plan the crisis center gave her was like nothing she had ever seen. "It was something I could follow," she said. She commented that the system does a good job once a family gets connected with professional services and supports, and she noted that what families often need at first is help meeting basic needs such as sleep, food, and financial support. Providing those basic needs can set a family in crisis up to do the work that lies ahead to support their child. She added she wants every family navigating the youth and family mental health system to have family peer support to help them find a provider. A family peer support partner could walk alongside the parents, empower them, offer them hope, normalize their situation, and reduce the isolation the family may experience.

Laura Marshall, co-founder of Advocates for Mental Health of Michigan Youth, spoke about her family's challenges navigating the mental health system as it sought mental health treatment for her son. Adopted at age 14 months, her son began showing signs of significant mental health challenges almost immediately and was diagnosed with reactive attachment disorder, attention deficit hyperactivity disorder, oppositional defiant disorder, and pediatric bipolar disorder. By the time her son was 6 years old, the family was involved with community mental health. Though Marshall was employed and had private health insurance, the few times she tried to use her insurance to access any service or assistance, the claim was denied.

When the family first sought help from community mental health, they had a "phenomenal" therapist who tried to understand the challenges Marshall's son was facing. Despite trying many therapeutic approaches, none seemed to help her son overcome his anger and aggression issues. When this "experienced, knowledgeable" therapist moved on to work with adults, her son had a succession of therapists "who always assumed that she and her husband must be doing something wrong as parents rather than looking for the root cause of her son's problems."

[2] Wraparound is a collaborative approach where young people and their families work together with a team to create personalized plans for community-based support services. The goal is to help youth with emotional and behavioral challenges stay at home and avoid institutionalization whenever feasible. See https://ojjdp.ojp.gov/model-programs-guide/literature-reviews/wraparound_process.pdf (accessed March 26, 2024).

Marshall's son did qualify for a serious emotional disturbance waiver, which meant his behavioral and mental health challenges were severe enough that he could qualify for hospitalization. The waiver also made him and his family eligible to receive a variety of services and supports that would enable him to stay at home and in his community. Marshall said that studies show this had the best chance of producing a good outcome for him. The family tried working with these services, but with unsatisfactory results. For example, the family was promised respite care, but all they were offered was group respite that required driving an hour into town for 2 hours of care for their son. Marshall said her experience differed from what the Medicaid provider manual promised.

By the time Marshall's son was 12, his aggression and destructive behavior had reached a point where he was causing thousands of dollars of damage to the family's home and car. The crisis line did not meet the family's needs, leaving the family no choice but to call the police regularly. This resulted in him being placed in the juvenile detention system. There, he sat for 6 months until a judge ordered him released to a residential program in Wyoming, far from his family in Michigan.

Marshall said she wants to emphasize the value the services that experienced social workers can provide and added there are so few psychiatrists left who accept Medicaid that often the only option for seeing a psychiatrist is via telehealth, and, while it is better than nothing, telehealth is not for everyone. She said that her family has struggled finding a therapist who was culturally competent. For example, her Black teenage son is more comfortable sharing his story and challenges with someone who looks like him, rather than young White females assigned to him. Even when he was matched with a Black therapist born in Kenya, the fit was poor because he did not have the lived experience to understand the challenges her son was having.

Eboni Dabney, founder of A Mom Like Me, discussed the challenges she faced accessing behavioral health services for both her and her son. One challenge was finding a provider who would accept Medicaid or Blue Cross Blue Shield when it became a Medicaid add on. Despite having a list of providers who reportedly accepted Medicaid, none she called actually did. She said that when she and her son lived in Iowa, she could call the mobile crisis support hotline during a crisis, but in Chicago, where they now live, accessing crisis support involves calling 911, potentially leading to police involvement.

Dabney recalled that as a Black woman living in Iowa, she never had an established relationship with a therapist, in part because no one she saw looked like her. Since moving to Chicago, the only services she has accessed are through an organization for at-risk boys that also offers services to their parents. When her son was 10, he told Dabney he wanted to speak with a behavioral health professional. The list of providers for children was scant, and finding one who had the cultural background and experience to relate to her son was challenging. Eventually, she found a therapist who was a good fit for her son.

Dabney expressed frustration with the process of navigating through various providers, especially during a crisis when urgent assistance is needed. However, her navigator had no better luck than she did finding a provider who would accept Medicaid. A simple place to start, she said, would be for Medicaid to keep the provider list updated. She has heard from providers that they are choosing not to deal with Medicaid because of the difficulty of getting paid. She also learned that Medicaid does not cover things such as cognitive or neurodivergent tests in Illinois.

She also voiced frustration with the overemphasis on medication as a first solution for her own mental health challenges. At one point, Dabney was placed on a 72-hour hold at a behavioral health facility, and when discharged she was told to learn her triggers and stay away from them, with no follow up. She supported the idea that addressing basic needs should be included as a component of behavioral health services and that focusing on root causes can contribute to more effective and holistic support for individuals and families.

EXPERIENCES OF BEHAVIORAL HEALTH CARE PROVIDERS WITH PUBLIC INSURANCE PROGRAMS

Warren Ng, the medical director of outpatient behavioral health at New York-Presbyterian/Columbia University Irving Medical Center, said that the perception among psychiatrists is that lower payment and reimbursement rates often affect how systems of care invest in mental

services and are barriers to addressing the nation's mental health crisis, particularly in under-resourced communities and communities of color. Without addressing these barriers, the limited number of mission-minded psychiatrists will continue going instead to places with fewer barriers and administrative burdens. Moreover, trainees working in this setting see the difficulties in managing care for Medicare and Medicaid beneficiaries, a disincentive to work in public health. Ng said that without a value-based payment system that reimburses for this work, this will continue to be a problem.

Ng said that many psychiatrists are interested in providing psychotherapy and other interventions beyond prescribing medications, but the current payment structure and prior authorization requirements make that difficult. He said the medication shortage of attention-deficit/hyperactivity disorder medications during and after the COVID-19 pandemic was challenging because of the difficulties in securing prior authorization for alternative medicines from Medicaid and the Children's Health Insurance Program. By the time Medicaid authorized one medication, it was often unavailable, requiring him to seek prior authorization for another drug. This took away from the time he could provide care and delayed access to care. While some organizations have a practice management system that handles prior authorization and reimbursement issues, public health settings lack such administrative support.

Another challenge is that the individuals seeking mental health care in the public health setting tend to present with more complex and more acute cases. Often, Ng said, obtaining prior authorization for intensive outpatient treatment can be a burden. Processing claim denials in the different reimbursement systems creates a significant administrative burden that has some health systems considering whether providing mental health services is too much trouble, he added.

The variability in reimbursement policies across Medicaid, Medicare, Marketplace, and managed care settings creates another challenge, Ng said. For example, there is a difference between the Medicare and Medicaid reimbursement for telehealth services in primary care setting and the reimbursement in a mental health setting which results in telehealth services being reimbursed when delivered in an outpatient setting but not when delivered in a primary care setting. Consistency in Medicaid and Medicare rates is important for the sustainability within the public health care system, Ng said.

These challenges create recruitment and retention issues, Ng continued. The new requirement for individuals to renew their Medicaid status annually creates an administrative burden resulting from the need to check each individual's status before providing care. It also creates a burden for Medicaid beneficiaries, particularly those with cultural or linguistic needs. Medicaid also requires new clinicians to go through a laborious enrollment and credentialing process before they provide services, which can delay when a clinician can start work.

New York's Medicaid program recently approved reimbursements for its school-based mental health programming at 125 percent of the normal Medicaid rate, though this positive development came only after the billing and collection structure was changed for this one service in this one setting. The state did not raise the reimbursement rate for the same services delivered in its primary care settings. In Ng's imagined ideal world, Medicare, Medicaid, and Marketplace plans would all cover a full menu of options that would provide clinicians with the flexibility to treat their patients without today's administrative burdens, and behavioral care would be integrated into primary care.

Margaret Adam, the medical director at Iora/One Medical, said that her organization works with seniors and accepts original Medicare, some Medicare Advantage managed care plans, and dual-eligible individuals, though not Medicaid alone. The largest barrier her team faces in providing counseling services is the lack of behavioral health counselors who accept Medicare, particularly those who accept Medicare and have experience in geriatric psychiatry, comorbid conditions, and the complicated medication interacts that can occur. Poor reimbursement rates are to blame for this shortage, she said. In one New York county, only four psychiatrists accept Medicare, most of whom work part time. Options for patients who need services are to join a wait list, skip therapy altogether and wait until they deteriorate to where they require hospitalization, or pay out of pocket to see a private psychiatrist. Few if any of her patients have the resources to take the third course.

This problem is compounded by the fact that Medicare restricts reimbursement for counseling services to those who have the proper licensure. Adam said that there are many licensed mental health counselors who could work with patients, but Medicare does not recognize that licensure. Medicare has acknowledged this problem and is considering some policy changes, but the current policy limits access to care and can delay a patient connecting with services for as much as 6 months.[3]

Often, patients struggling with severe, chronic mental illness who cannot get care immediately will appear at her office pleading for a prescription for a medication that has benefited them previously, Adam said. If the drug requires prior authorization, the amount of information required about past treatments can be almost impossible to provide, making the odds of getting prior authorization "slim to none," she added.

In her organization's integrated behavioral health model, the financial limitations have restricted the organization's ability to staff according to need, resulting in the limited number of behavioral health providers handling large panels. In an ideal world, if Adam was seeing a patient for high blood pressure and realized that depression was the major barrier to the patient taking the medication as prescribed, she would introduce her patient to a behavioral health provider in a warm handoff.[4] If treated effectively, the patient would have his or her depression under control, take the prescribed high blood pressure medication, and avoid having a stroke and being hospitalized. However, the current reimbursement structure makes the ideal situation difficult to achieve, even though it could reduce expenses overall.

One significant administrative burden, Adam said, is the need to negotiate rates with each individual Medicare Advantage plan and then determine if a patient is eligible for care given the patient's specific plan. In addition, this situation makes it difficult to tell a patient ahead of time how much care will cost. For many seniors, this uncertainty is not acceptable, and it increases the likelihood that they will forgo treatment.

Step one to address this situation is to increase reimbursement rates, Adam said. Step two is establishing more community health clinics that accept Medicare and Medicaid beneficiaries. Step three is getting more behavioral health providers into the field and having both Medicare and Medicaid recognize a broader range of licensures[5]. Step four, a larger issue, is changing society's perspective about the importance of behavioral health care. "It impacts everything we do, and yet we continue to pigeonhole it," she said. "It is a carve-out on insurance and does not get covered when it is integral to health."

Rakhee Patel, the clinical director for regional adult services at Coastal Horizons Center, said that there is a shortage of providers in her region of North Carolina who will accept Medicare and Medicaid beneficiaries. Perceived administrative burden, the need for additional training and having the right credentials to be Medicaid or Medicare certified, challenges with prior authorizations, and low reimbursement rates that have not changed in over 12 years are largely to blame for this shortage, even in the private practice community. In North Carolina, Patel added, clinicians need to get reauthorization for their Medicaid beneficiaries after every eighth session.

In addiction counseling, the regulatory burdens are significant and usually involve dealing with multiple federal and state-level regulations, Patel said. She acknowledged the need for regulation but said there could be a better balance that ensures there are enough clinicians to provide the care individuals dealing with an addiction treatment need. She wants the Centers for Medicare & Medicaid Services (CMS) to communicate better before changing a clinical coverage policy.

Tyler Vermillion, the community outreach coordinator at Ideal Option, said that dealing with the administrative and regulatory burdens associated with addiction treatment requires at least two full-time employees at his

[3] Effective January 1, 2024, licensed mental health counselors and licensed marriage and family therapists can bill Medicare for their services. See https://www.cms.gov/medicare/payment/fee-schedules/physician-fee-schedule/marriage-and-family-therapists-mental-health-counselors (accessed April 5, 2024).

[4] A warm handoff refers to the transfer of care between two members of a health care team and occurs in front of the patient (and family if present). See https://www.ahrq.gov/patient-safety/reports/engage/interventions/warmhandoff.html (accessed April 5, 2024).

[5] As previously mentioned, for Medicare, licensed mental health counselors and licensed marriage and family therapists are covered. See https://www.cms.gov/medicare/payment/fee-schedules/physician-fee-schedule/marriage-and-family-therapists-mental-health-counselors (accessed April 5, 2024).

organization. The documentation required for an individual to gain admission to care for a behavioral health and substance use disorder poses a significant challenge. The mandate to adopt a certified electronic health record (EHR) incurred exorbitant costs and has been problematic because most EHRs are not tailored for behavioral health. Integrating a behavioral health module into an EHR represents an additional and ongoing expense and administrative burden, he added.

Vermillion said that managed care organizations wield excessive power to dictate with which providers they will contract. Opening a new facility and commencing the contracting process requires an agency to be fully operational, including facilities and staff. His organization endured 18 months of employing staff despite not yet being eligible for reimbursement, and it recently had to remove behavioral health care from 90 percent of its addiction treatment clinics because of contracting issues. Medicare, he added, requires more highly credentialed providers to cater to enrollees in an outpatient setting, but it can cost twice as much to employ such a provider. This is not feasible for many stand-alone agencies.

Vermillion wants Medicare to allow for a provisional diagnosis and level of care that meets the American Society of Addiction Medicine (ASAM) recommendations so that an individual could access needed services quickly. New Mexico's Treat First model does just that.[6] Instead of prioritizing extensive diagnostic exploration before even establishing rapport with a client, Treat First provides a mechanism to form a relationship with an individual within four visits. The idea is to help people first and then conduct the full assessment required for Medicare and Medicaid reimbursement.

Heather Jefferies, the executive director of the Oregon Council for Behavioral Health, said Oregon launched 17 community-governed managed care organizations (CCOs) in 2012, which, along with commercial insurance, has created a complicated system that providers must deal with for prior authorizations. The CCO model increased immunization rates and improved access to chronic disease care. However, behavioral health is lagging, in part because obtaining reimbursement for behavioral health services delivered outside of the physical health benefit is hampered by a failure to adjust historical payment schedules which disadvantages community-based providers. There is more emphasis at the federal level on achieving parity with physical health, but progress has been slow. One problem stemming from having 17 CCOs is that behavioral health clinics must endure 7 to 12 audits a year. An ongoing problem in Oregon is that addiction treatment services delivered before a provider performs a full assessment with the patient/client (Oregon uses ASAM) are not reimbursable, leaving early engagement services and other services rendered unfunded while still critical to engaging individuals in care, particularly those with barriers such as houselessness. Workforce shortages have placed Oregon among the worst states for providing behavioral health services. Without the ability to pay a living wage, organizations in Oregon have difficulty recruiting employees, particularly persons of color. "We do not want to continue unintentional institutional racism by offering poor wages," Jefferies said. Yes, she added, individuals drawn to work in community-based behavioral health and substance use treatment are mission driven, but it is wrong to have them bear the burden of delivering care without providing them with a respectable salary. The problem is that addiction treatment services in Oregon are not reimbursable unless a provider has undergone an extensive ASAM assessment.

Going forward, Jefferies would like to see parity between mental health and substance use disorder services and physical health care. She said community-based behavioral health systems cannot take financial risks because revenues have been so lean for too many years. A recent modest increase in Oregon health plan reimbursement rates, averaged at 30 percent, gave the resources needed for provider organizations to increase available behavioral health provider wages in Oregon. This was demonstrated in reducing the number of empty job positions reported within these organizations from 40–65 percent to 18–25 percent. This was a significant and immediate improvement occurring within 7 months after providers were able to increase wages. She wants CMS to modernize its rules to reflect current behavioral health care practices and interventions, to offer guidance to help states streamline and improve their operations, and to

[6] Additional information is available at http://treatfirst.org.

provide states with the resources needed to collect and report data on compliance. She would also have CMS work with Marketplace and commercial plans to standardize coverage requirements for behavioral health and addiction treatment.

STATE-LEVEL INNOVATIONS TO IMPROVE MENTAL HEALTH AND SUBSTANCE USE DISORDER ACCESS IN MEDICARE, MEDICAID, AND MARKETPLACE INSURANCE PLANS

Cara Cheevers, the director of behavioral health programs at the Colorado Division of Insurance, said there are several approaches that her office takes to enforce parity in behavioral health coverage, starting with rule making. Colorado's regulation about mental health parity mandates annual reporting requirements regarding quantitative treatment limitations such as financial requirements and cost-sharing for behavioral health services compared with physical health services. It also includes nonquantitative treatment limitations such as prior authorization, step therapy, and other usage-management requirements. The latter includes network adequacy and how a plan develops and retains provider networks. A second regulation details similar reporting requirements for medication-assisted treatment (MAT) for substance use disorders coverage, addressing opioid use, opioid overdose, nicotine dependence, and alcohol dependence.

A third regulation sets standards related to network adequacy. Cheevers said that these reporting requirements aim to assess how hard or easy it is for a consumer to get the behavioral health care and substance use disorder treatment they need. This regulation also mandates that individuals must be able to get care within seven calendar days from when they first attempt to make an appointment. Cheevers office also examines mental health parity from the perspective of rates and forms, which provides information on what insurers say they do, as well as market regulation and conduct, which provides information on how insurers cover care in practice.

Cheevers said that Colorado has different robust and dynamic processes to collect complaints from consumers and providers. Hearing directly from consumers and providers about what is working and what is not helps her office adjust its policy approaches to parity and behavioral health coverage in general. From the consumer experience, her office gains insights into how easy or hard it is to get medication prescribed by their providers, how much it will cost to receive care, how clients find a provider who accepts their insurance, how far they have to travel to get to that provider, and if the provider directory is accurate.

Colorado's usage-management protocols dictate that insurers may not require prior authorization or step therapy for MAT and that they place at least one covered Food and Drug Administration-approved drug for MAT on the lowest drug formulary tier. The protocols also mandate that insurers comply with Mental Health Parity and Addiction Equity Act cost-sharing financial requirements. Recent enforcement actions found that many insurance companies were overcharging for their copays and coinsurance for behavioral health coverage and were out of compliance compared with their coverage of physical health care. Cheevers said her office checks to ensure that the cost share of any plan sold in Colorado is appropriate and complies with state and federal law prior to annual rate approval. It has also created resources to help consumers with complaint navigation and insurance literacy.

As part of its efforts to protect consumers, Cheevers's office works to ensure that there are adequate provider networks. It cannot require that providers accept commercial insurance, but it tries to mitigate the challenges that it hears about and to understand what it can fix. This work includes making sure that the credentialing process and timeline are clear and transparent, understanding how carriers set their reimbursement rate, and ensuring that the steps a provider must take to be admitted to a network are clear. There are also several statutes and requirements about claim handling, post-payment audits, and delays in paying claims. Cheevers noted that while telehealth is a valuable modality for patients, Colorado states that telehealth cannot supplant in-person requirements for network adequacy.

Brooke Hall, a senior health care policy analyst for the Oregon Department of Consumer and Business Services (DCBS), said that Oregon's behavioral health parity law requires every insurer offering plans providing behavioral health benefits to report to DCBS annually on nonquantitative treatment limitations (NQTLs) for behavioral

health benefits. NQTLs include medical management standards that limit or exclude benefits based on whether a treatment is considered experimental formulary design and any other criteria that may limit the scope or duration of benefits. The law also requires DCBS to evaluate and report on whether insurers are treating behavioral health services at parity with medical services.

The DCBS reports show that there were similar denial rates for behavioral health and medical-surgical services, Hall said, but that notable variation among insurance carriers indicates potential biases. The reports also revealed inconsistences in the application of NQTLs and more claims from out-of-network behavioral health providers. The latter suggests there are access challenges or patient preference for out-of-network care. However, in-network claims for behavioral health have increased, suggesting improved availability of in-network services or increased consumer confidence in in-network providers.

Hall said that the DCBS reports indicate that reimbursement rates for behavioral health services are generally lower than for medical-surgical services and that reimbursement rates for out-of-network services are lower than for in-network rates. They also detail significant geographic variations in reimbursement rates for behavioral health services that may affect consumer access.

Responding to these findings, DCBS has developed comprehensive templates and guidance for insurers to streamline reporting—focusing on quantitative data and NQTLs—and improve the quality and consistency of insurer-provided data, Hall said. It has also refined its data collection process to more accurately assess mental health parity. Going forward, Oregon is considering adding quantitative standards around time and distance to providers and appointment wait times. It is also looking to streamline the credentialing process to enable more providers to enter the state's networks. Hall noted that, as in Colorado, Oregon's network adequacy statute prohibits the use of telehealth to meet network adequacy requirements.

Paula Stone, the director of the Arkansas Department of Human Services' Office of Substance Abuse and Mental Health, noted that Medicaid provides 65 percent of all mental health services in Arkansas, with much of the remaining funded through Substance and Mental Health Services Administration block grants. She explained that Arkansas handled Medicaid expansion by making premium payments for Marketplace plans rather than by adding more people to its Medicaid roles. This allowed the state to get a new provider group to provide behavioral health services and to increase reimbursements for and access to substance user disorder services.

When Stone's office looked at its traditional Medicaid population, it found that the office was paying for more services than commercial insurers were, particularly for home and community-based services to address functional deficits related to mental health conditions. While Medicaid pays for some of those services for children, it does not for adults. Rather than have Medicaid managed care plans provide care, Arkansas developed a new type of organized care model that requires Medicaid-enrolled providers to own at least 51 percent of the service provider. This program targets individuals ages 4 and up with significant intellectual and developmental disabilities or behavioral health conditions.

To get enough providers in place to meet the behavioral health care needs of its traditional Medicaid population, Stone said that Arkansas began paying independent, licensed, master's degree therapists in addition to those employed by health care agencies. By paying them the same rate as agency providers, the state enticed independent therapists to provide services to lower-needs Medicaid beneficiaries. In addition, the state lifted requirements for prior authorization for its lower-needs population. This could have made the program unsustainable financially, but when people could access services quickly, they would use services for a shorter time. The state has since eliminated its requirement for a primary care referral, too. Arkansas has also lifted its certification requirements and allowed behavioral health care to be co-located in new places so that private practitioners need not open their own clinics and primary care physicians can hire their own behavioral health care providers and bill for their services. In addition, it changed its credentialing rules so that providers need not be recredentialed when joining a new organization.

NATIONAL PERSPECTIVE ON INNOVATIONS TO IMPROVE MENTAL HEALTH AND SUBSTANCE USE DISORDER ACCESS IN MEDICARE, MEDICAID, AND MARKETPLACE INSURANCE PLANS

Sean Robbins, the executive vice president and chief corporate affairs officer at the Blue Cross Blue Shield (BCBS) Association, said that in BCBS's experience, raising Medicaid payment rates is not a silver bullet for getting more behavioral health care providers to accept Medicaid beneficiaries. While payment policy is important, it does not do enough to build the broad networks that can deliver mental health services where they are most needed. One issue is that many providers already have a full roster of clients. Another issue is the perception that participating in a network comes with an administrative burden.

That said, BCBS has expanded its behavioral health networks by over 55 percent over the past 4 years and provides coverage in all 50 states. It did this, Robbins explained, by forming partnerships with management services organizations to identify gaps, fill the gaps based on geography, and contract with new providers in those areas. BCBS has also increased the number of primary care providers in networks, given that primary care may deliver as much as 25 percent of outpatient behavioral health care. Another tactic to entice providers has been to speed and even automate credentialing processes and automate prior authorization.

Robbins said that BCBS has increased access to care by establishing over 250 community-based behavioral health programs across the nation. BCBS also launched a $10 million, 4-year effort to partner with Boys and Girls Clubs in some 5,000 locations nationwide. This program will provide training on trauma-informed care for all 48,000 of the organization's frontline staff to enable them to identify, triage, and potentially direct youth who need care to the appropriate place in the health care system. BCBS of Rhode Island has been testing the idea that eliminating prior authorization for both in-network and out-of-network behavioral health services will increase access.

A third focus for BCBS is public policy regarding workforce development, diversity in the workforce pipeline, and telehealth. Telehealth, Robbins said, is an important link for providing behavioral health services, particularly in rural communities that cannot build large provider networks. Building a diverse behavioral health workforce is important to meeting the needs of the different populations needing care.

Lindsey Browning, the director of Medicaid programming at the National Association of Medicaid Directors, noted that Medicaid pays for 24 percent of all spending on behavioral health and substance use treatment, with 40 percent of Medicaid enrollees living with a mental health or substance use disorder. Medicaid is the only insurer for children with complex medical health needs, and at least some states are developing innovative programs to expand residential youth services and expand access to other services for children and adolescents. She said there are four levers that Medicaid programs have to address behavioral health provider supply: network adequacy and access standards, payment policies, reducing administrative burden, and expanding and extending the workforce.

Browning said that nearly 75 percent of Medicaid beneficiaries are in risk-based managed care plans accountable for ensuring that there are sufficient provider networks to meet the demand for services. States have leverage here because they include network adequacy and access standards in Medicaid contracts. For many Medicaid leaders, a big question is whether their increased investment in certified community behavioral health clinics is improving care delivery and access.

To reduce administrative burden, states are aligning or centralizing certain processes such as credentialing, prior authorization, and processing claims rather than having a separate process for each managed care plan. Some states are processing claims more promptly to help providers who may have cash flow issues. Telehealth has been an important method for extending the behavioral care workforce, and Medicaid has been a leader in employing peer supporters and community health workers to augment the traditional workforce. Reiterating Robbins's comment that payment is but one lever to increase provider participation, Browning said that state and federal partnerships are essential because the states are not well positioned to address some of the underlying infrastructure gaps.

Douglas Jacobs, the chief transformation officer for the Center for Medicare at CMS, said that CMS's behavioral

health goals focus on coverage and access to care, quality of care, equity and engagement, and data analytics for action and impact. He said that, over time, more psychiatrists have been dropping their Medicare participation. This is one reason Medicare has expanded network adequacy requirements to include marriage and family therapists and has recently proposed including mental health counselors, clinical psychologists, and licensed clinical social workers.

He then discussed some changes in traditional Medicare and Medicare Advantage that focus on expanding access to behavioral health. These changes include:

- allowing a physician or nurse practitioner to provide general rather than direct supervision of behavioral health providers.
- creating new billing codes to support integrating behavioral health into primary care; providing bundled services for individuals with chronic pain and substance use disorder; allowing social workers, marriage and family therapists, and mental health counselors to bill for health behavior assessment and intervention; enabling reimbursement for services delivered by community health workers, peer support workers, and care navigators; and addressing social determinants of health risk assessment.
- implementing a new benefit category for marriage and family therapists, mental health counselors, and intensive outpatient program services in settings such as federally qualified health centers, community mental health centers, and regional health centers.
- allowing addiction counselors to enroll in Medicare, paying for crisis psychotherapy outside of clinical settings.
- allowing upfront funding for new accountable care organizations in underserved areas and allowing them to invest in new staff, including behavioral health providers.
- requiring Medicare Advantage organizations to establish care coordination programs.
- making the telehealth benefit permanent for behavioral health services.

Box 1 summarizes suggestions to improve access to behavioral health care services that were made by speakers at the three webinars.

BOX 1

Suggestions from Individual Webinar Participants to Improve Access to Behavioral Health Care

Navigation and Support

- Provide a navigator/case manager for all Medicaid beneficiaries at the beginning of a beneficiary's mental health journey to help them understand the services they can receive (Dabney, Myrick, Van Tosh).
- Establish care coordination programs in Medicare Advantage organizations (Jacobs).

Emphasizing Whole-Person Care

- Mental health should not exist in isolation but should be part of achieving complete physical, mental, and social well-being (Myrick, Van Tosh).
- Integrate behavioral health care into primary care (Adam, Jacobs, Ng, Robbins, Van Tosh).

continued

BOX 1 CONTINUED

Increasing and Supporting the Workforce

- Expand the use of peers (including Family and Parent Peers), social workers, community health workers, marriage and family counselors, and mental health counselors (Browning, Butler, Jacobs, Marshall, Van Tosh).
- Remove or reduce licensure and credentialing restrictions for behavioral health workers (Adam, Vermillion).
- Reduce administrative burdens by improving the prior authorization, claim denial appeals, credentialing, and enrollment processes; eliminate the need to renew client Medicaid status; and cover a full menu of options that would provide clinicians with the flexibility to treat their patients (Adam, Browning, Cheevers, Ng, Patel, Stone).
- Establish more community health clinics that accept Medicare and Medicaid beneficiaries (Adam, Robbins).
- Expand the use of telehealth (Jacobs, Robbins).

Payment Policies

- Address the need to negotiate rates with each individual Medicare Advantage plan and then determine if a patient is eligible for care given his or her specific plan (Adam).
- Increase reimbursement rates and harmonize reimbursement policies across Medicare, Medicaid, Marketplace, and managed care settings (Adam, Jefferies, Ng, Patel, Stone).
- Establish payment parity for mental health and substance use services and physical health care (Cheevers, Hall, Jefferies).

Providing Addiction Treatment

- Establish a better balance between regulation and flexibility to ensure there are enough clinicians to provide the care that individuals dealing with an addiction treatment need (Patel, Vermillion).
- Medicare should allow for a provisional diagnosis and level of care that meets the American Society of Addiction Medicine recommendations so that an individual could access needed services quickly (Vermillion).
- Promulgate standardized coverage requirements for addiction treatment (Jefferies).
- Eliminate prior authorization requirements for medication-assisted therapy for substance use disorders (Cheevers).
- Allow addiction counselors to enroll as Medicare providers (Jacobs).

DISCLAIMER: This list is the rapporteurs' summary of points made by the individual speakers identified, and the statements have not been endorsed or verified by the National Academies of Sciences, Engineering, and Medicine. They are not intended to reflect a consensus among webinar participants.

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DISCLAIMER This Proceedings of a Workshop—in Brief has been prepared by Udara Perera and Joe Alper as a factual summary of what occurred at the meetings. The statements made are those of the rapporteurs or individual webinar participants and do not necessarily represent the views of all webinar participants; the planning committee; or the National Academies of Sciences, Engineering, and Medicine.

*The National Academies of Sciences, Engineering, and Medicine's consensus study committee on Strategies to Improve Access to Behavioral Health Care Services through Medicare and Medicaid is solely responsible for organizing these webinars, identifying topics, and choosing speakers. The responsibility for the published Proceedings of a Workshop—in Brief rests with the institution. **Daniel Polsky** (*Chair*), Johns Hopkins University; **London Breedlove,** University of Washington; **Richard G. Frank,** Brookings Institution; **Marie Ganim,** Brown University and Northeastern University School of Public Policy and Urban Affairs; **Cynthia Gillespie,** Arkansas Department of Human Services (former); **Christina L. Goe,** Attorney, PLLC; **Jennifer Kelly,** Atlanta Center for Behavioral Medicine; **Parinda Khatri,** Cherokee Health Systems; **Benjamin F. Miller,** Stanford School of Medicine; **Douglas P. Olson,** Connecticut Physician Health Program and Optimus Healthcare; **Sally Raphel,** International Society of Psychiatric Nurses; **Clarke E. Ross,** American Association of Health and Disability; **Joshua Jacob Seidman,** Fountain House; **Marylou Sudders,** Massachusetts Department of Health & Human Services (former); **Rachel Talley,** University of Pennsylvania Perelman School of Medicine; **John Torous,** Beth Israel Deaconess Medical Center and Harvard Medical School; and **Jane Zhu,** Oregon Health & Science University.

REVIEWERS To ensure that it meets institutional standards for quality and objectivity, this Proceedings of a Workshop—in Brief was reviewed by **Karin Jeffers,** Clinical & Support Options; and **Warren Y. K. Ng,** Columbia University Medical Center. **Leslie Sim,** National Academies of Sciences, Engineering, and Medicine, served as the review coordinator.

SPONSORS These webinars were supported by the Centers for Medicare & Medicaid Services and the Substance Abuse and Mental Health Services Administration.

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For additional information regarding the webinars, visit https://www.nationalacademies.org/our-work/strategies-to-improve-access-to-behavioral-health-care-services-through-medicare-and-medicaid#section.

SUGGESTED CITATION National Academies of Sciences, Engineering, and Medicine. 2024. ***Exploring strategies to improve access to behavioral health care services through Medicare and Medicaid: Proceedings of a workshop—in brief***. Washington, DC: The National Academies Press. https://doi.org/10.17226/27788.

Health and Medicine Division

Appendix F

Recommendations and Conclusions Matrix

Recommendations	Conclusions
RECOMMENDATION 1: CMS and SAMHSA should restructure current workforce and training mechanisms and their funding to better incentivize robust training environments that support career choices that will more directly impact care for Medicare and Medicaid beneficiaries. **1-1 The CMS and SAMHSA restructuring of the current workforce and training mechanisms should have two interrelated priorities: first, a focus on the providers serving populations with the highest need for greater access to behavioral health provision in Medicaid, such as rural, child/adolescent, and racial/ethnic minoritized populations; second, a focus on workforce demographic diversity, modeled after and aligned with existing HRSA programs that have successfully grown and diversified the behavioral health care workforce in underserved areas.**	*4-1: In addition to short-term improvements in behavioral health care provider participation among the existing workforce, strengthening the pipeline of federally subsidized behavioral health providers would build a workforce more likely to continue serving Medicare and Medicaid populations after the end of their training. Bolstering workforce programs and policies, including successful pathway or pipeline programs, would increase the number of people who want to enter the behavioral health field and support care provider retention over time.* *4-2: The behavioral health workforce does not reflect the diversity of the population it serves. Increasing historically underrepresented racial and ethnic identities, as well as language and cultural representation, in the behavioral health workforce, is one mechanism to address disparities in access to care facing Medicaid and Medicare programs. Within Medicaid specifically, increased representation of historically underrepresented racial and ethnic identities in the health care workforce could expand access to care for beneficiaries more broadly, regardless of identity.*

continued

Recommendations	Conclusions
1-2 CMS should predicate ongoing funding of the workforce training with consistent reporting of post-trainee career trajectories to facilitate institutional comparisons among grantees and ultimately provide a mechanism for greater accountability between CMS funding of training and the rate at which trained providers serve Medicare and Medicaid beneficiaries. **1-3 CMS should allow for behavioral health care trainees to bill for services under the supervision of a licensed care provider, as already exists for physician trainees.**	*4-3: Efforts to decrease stigma, dispel historical mistrust, and provide financial incentives associated with behavioral health professions may address recruitment barriers, particularly those affecting communities of color.* *4-4: There is a demonstrated inconsistency between the primary source of GME program funding (e.g., Medicare and Medicaid) and participation in public insurance programs among behavioral health providers whose training is funded by GME. While GME program funding primarily comes from Medicare and Medicaid, many trainees do not subsequently participate in these programs.*
RECOMMENDATION 2: CMS should use its regulatory authorities over Medicare (including Medicare Advantage) and provide assistance to state Medicaid programs and Marketplaces plans to streamline behavioral health provider credentialing and enrollment processes **2-1 CMS should develop guidance for states on funding mechanisms and provide models for developing, implementing, and operating a single state-wide platform for care provider credentialing and enrollment. For instance, states could use available funding mechanisms to upgrade their Medicaid Management Information System provider enrollment modules, creating a single, state-wide platform for Medicaid, its managed care organizations (MCOs), or other Medicaid payers to use for credentialing, enrollment, renewals, and licensure checks.** **2-2 CMS should allow states to include connectivity to state and federal licensing entities as part of the allowable costs of implementing the system.** **2-3 CMS should encourage states to accept Medicare credentialing and enrollment for Medicaid purposes, and Medicare should reciprocate.**	*4-6: Expanding the delivery of behavioral health support specialist (BHSS) services in Medicare and Medicaid has the potential to significantly improve access and outcomes, especially for individuals with complex needs, while also augmenting the reach of licensed behavioral health professionals. Federal intervention is crucial to establish BHSS through model national certification standards and flexible payment models that facilitate the integration of these services into the full continuum of behavioral health care.* *5-4: Evidence suggests that administrative burdens, particularly around delayed and denied payments, are at least as important in disincentivizing behavioral health providers from participating in Medicaid, and that similar disincentives exist in Medicare Advantage where inappropriate payment denials have been demonstrated. Given that behavioral health providers are more likely to practice independently and lack administrative support, efforts are needed to simplify and streamline credentialing, billing, and claims processes.*

Recommendations	Conclusions
2-4 CMS should work with states to modify Medicare's and Medicaid's enrollment systems and processes to check ex parte information sources before requiring additional information from behavioral health care providers for initial enrollment or renewal as a care provider. This would allow behavioral health care providers to keep their enrollment information current in either a state Medicaid or a state Medicare system, and it would facilitate more rapid initial enrollment.	
2-5 Whenever possible, CMS should impose time limits on the credentialing process, or support enforcement if there are existing time limits, employing a centralized database to streamline this process. CMS should encourage state regulators to do the same.	
RECOMMENDATION 3: CMS should develop an agile and flexible interagency strategy to set guidelines for coverage and payment for telehealth for behavioral health needs across settings, modalities, and care providers. This strategy should include:	*6-5: To maintain health care equity, audio-only behavioral health and SUD telehealth services are essential for serving individuals without adequate internet video access. There is not enough evidence on the relative effectiveness of audio only telehealth, but until the digital divide is addressed, the access to audio-only telehealth for those facing disparities in access may outweigh the uncertainly regarding its relative effectiveness compared to video telehealth for behavioral health services.*
3-1 Efforts to establish coverage consistency of telehealth across states in order to simplify cross-state telehealth health care provider engagement.	
3-2 Development of processes to reimburse telehealth based on a thoughtful consideration of the value provided and the cost of delivery—as is done with in-person care. Flexibility on the use and reimbursement of these services will be essential to maximizing the benefit to patients and the system at large. Given the rapid changes in modalities for telehealth, these policies should be evaluated regularly.	

continued

Recommendations	Conclusions
3-3 Establishing skill needs and promoting digital skills training for clinicians and digital health literacy skills for patients that will increase equitable adoption.	*6-6: Telehealth is innovating rapidly with many new models coming on board with little evidence on the quality of care across these new modalities. This uncertainly makes it unclear whether future modalities within existing regulatory and payment frameworks will be effective in promoting health care provider access in Medicare, Medicaid, and Marketplace plans. Developing agile and flexible payment and regulatory structures may be needed. For example, hybrid care models that blend synchronous and asynchronous telehealth may increase access to care, but best practices and regulations to protect consumers and ensure integrity of clinical services would be necessary. In addition, payment for these models must balance access with the potential for overuse of low-value care. It is important to explore new regulatory pathways for novel asynchronous telehealth tools that can quickly assess value, build public trust, and increase transparency.* *6-7: To improve access to behavioral health care amidst broadband gaps, targeted efforts should identify regions needing both services and broadband. Collaborating with federal agencies such as the Department of Commerce, Treasury, Agriculture, and the Federal Communications Commission can strategically allocate broadband funds. Effective distribution of these resources to underserved areas is crucial for enhancing connectivity and equitable access to essential behavioral health services nationwide.*

Recommendations	Conclusions
RECOMMENDATION 4: The Department of Health and Human Services (HHS) and its agencies should develop a uniform strategy to promote and adopt evidence-based approaches to reduce multi-state licensure barriers as a mechanism to expand access to behavioral health providers in Medicare, Medicaid, and the Marketplace. **4-1 HHS should actively collaborate with organizations such as the Department of Defense, the Council of State Governments, and its National Center for Interstate Compacts; the relevant national professional associations; and states to create and adopt interstate compacts for those behavioral health care professions not currently covered in an occupational interstate compact. Provisions for telehealth across state and jurisdictional lines should be included.** **4-2 HHS should actively collaborate with organizations such as the Department of Defense, the Council of State Governments, and its National Center for Interstate Compacts; the relevant national professional associations; and states to ensure that states join existing occupational interstate compacts.** **4-3 HRSA should incentivize states by including language in its request for proposals grantmaking process to join existing occupational licensure interstate compacts.** **4-4 HHS should encourage states to review existing occupational professional interstate compacts to allow for the provision of telehealth across state and jurisdictional lines.**	*4-7: Occupational licensing compacts can facilitate improved access to care and diminish the maldistribution of the current behavioral health workforce. Revising and updating the interstate licensure agreements or advocating for adjustments in the state law, policy, or regulation could bolster and expand occupational compacts to further ease the provision of telemedicine services across state lines.*

continued

Recommendations	Conclusions
RECOMMENDATION 5: CMS should use its authority to adopt policies and issue rules and guidance, and to monitor managed care plan access standards to quickly reduce provider administrative burdens and related adverse patient impacts associated with low-value prior authorization and other medical usage review instruments applied to behavioral health care services. **5-1 CMS should use its authority to identify and, to the fullest extent possible, disallow low-value prior authorization practices within Medicare plans. CMS should provide states with technical assistance to similarly eliminate and monitor for low-value prior authorization practices within Medicaid managed care.** **5-2 CMS should adopt policies and the standards that require or incentivize insurers to focus behavioral health prior authorization only where high-cost waste and misuse are evident. These policies and rules should articulate clear responsibilities and guidelines for the mechanisms of rigorous regulatory oversight of insurer prior authorization review activities by state and federal agencies.**	*5-5: Research, regulatory actions, and reported behavioral health provider experience provide compelling evidence that current prior authorization activities demand reform. The time, expense, and patient care delays associated with insurer-applied utilization management tools factor into behavioral health provider participation decisions and decrease care access for patients. Policies recently adopted by some states, CMS, and the broad-based participants in the "Consensus Statement" (referred to above) provide guidance for reform.*
RECOMMENDATION 6: CMS should provide guidance on setting Medicare and Medicaid fee-for-service reimbursement rates to ensure adequate access to a full continuum of behavioral health care services, which includes accounting for the actual costs of care and adjusting for past and current undervaluation of work efforts of behavioral health care providers. To address this undervaluation, CMS should continue to revisit and revise the RBRVS. **6-1 CMS should conduct an updated cost study to remedy the acknowledged bias in the current RBRVS formulation. Improving the formulation of the Medicare fee schedule may also help to influence Medicaid fee-for-service rates.**	*5-1: Insufficient and often unstable reimbursement has been identified as a key factor driving low care provider participation in public insurance programs. Low reimbursement is particularly stark when compared to higher out-of-network rates paid in commercial insurance markets and higher cash-pay rates. Across payers, there is often a lack of transparency on how rates for behavioral health services are currently set, with consistent undervaluation of work efforts for behavioral health care providers and inadequate accounting for the costs of care provision.*

Recommendations	Conclusions
6-2 Within Medicaid fee-for-service, CMS should encourage state Medicaid agencies to adopt regular rate reviews to adjust for inflation and account for market forces that could be discouraging behavioral health providers from enrolling in Medicaid fee-for-service. CMS should encourage consideration of rate differentials in underserved areas where there is an inadequate workforce within Medicaid and ensure proposed rates are sufficient to support access to behavioral health providers consistent with the general population. CMS should provide comparison rate and provider access information to states for Medicare, Medicare Advantage, Marketplace, and private plans to assist states in developing access monitoring review plans (AMRP) for behavioral health services that better determine whether state payment rates are sufficient to ensure access to care for beneficiaries at least comparable to the general population.	*5-2: There is limited and mixed evidence about the effects of reimbursement rate increases on care provider participation in insurance programs, and existing evidence is lacking on the magnitude and scope of reimbursement required to increase access to behavioral health providers in Medicaid and Medicare. Recent state efforts to modify behavioral health payment, particularly in Medicaid, should be evaluated and monitored closely.* *5-3: Evidence suggests that the behavioral health rates for care providers, particularly for the Medicaid and Medicare Advantage plans, have been inadequate to attract and retain behavioral providers in the plan's networks. In addition, rates do not have parity for the same services with other behavioral health providers. Furthermore, the evidence suggests that because of billing codes, there is a lack of parity between services for substance use disorder and mental health conditions. As a result, the rationale for the existing reimbursement structures must be re-evaluated, revised and subsequently and regularly updated to reflect the full cost of care, including ancillary service provision, administrative requirements, and parity among care providers.* *6-3: Studies should explore the role of outcome-based approaches for expanding health care provider participation, results of which may lead to a recommended regulatory approach.*

continued

Recommendations	Conclusions
RECOMMENDATION 7: CMS should use its regulatory and incentive structures to ensure prompt payment and eliminate inappropriate claims denials of behavioral health care services. **7-1 To adequately enforce prompt pay laws and regulations, CMS should use its monitoring authority over state Medicaid programs and state Marketplace plans to ensure that plans are in compliance with prompt pay laws. Specifically, state Medicaid agency single audits should include monitoring of prompt payment of Medicaid managed care plan behavioral health claims. State insurance regulators should include similar monitoring of prompt payment in Marketplace plans.** **7-2 CMS, in consultation with state Medicaid officials, should ensure that Medicare and Medicaid provider claims are not rejected or denied for non-substantive reasons (such as using Dr. instead of Drive in an address). This may necessitate updating claims payment systems, manuals, managed care contracts, or other actions to ensure that payments are received in a timely manner following claims submission. Medicare and Medicaid payers should be required to provide regular training opportunities for behavioral health care providers on billing and claims submission and clear, accurate, and up-to-date instructions to participating care providers.** **7-3 CMS should develop a common set of behavioral health diagnostic codes that qualify for reimbursement. CMS, through its federal authority, and Medicaid and insurance regulators, through their state authority, would hold responsibility for enforcing compliance.**	*4-5: The lack of billing for services provided by trainees in Medicare and Medicaid is a major barrier to expanding training opportunities for behavioral health specialists more likely to participate in the Medicare and Medicaid programs.*

Recommendations	Conclusions
7-4 CMS should develop policies that address the findings of the HHS Office of Inspector General report related to Medicare Advantage plans' inappropriate payment denials for services provided that meet Medicare coverage rules and medical assistance organizations' billing rules.	
RECOMMENDATION 8: CMS should develop behavioral health care access outcome standards, along with significant financial penalties and bonuses, for managed care organizations participating in Medicare. CMS should work with states to develop similar standards and financial models to incentivize behavioral health care access in Medicaid managed care.	*6-2: Various approaches to network adequacy regulations have not been shown to be effective in expanding behavioral health care provider participation or patient access. Nevertheless, they are tools that regulators currently rely on to prevent insurers from selling health plans that are overly restrictive in the supply of behavioral health services offered. Thus, while network adequacy regulation remains a key tool for regulators, current approaches are unlikely to be the avenue for improving health care provider participation in Medicare, Medicaid, and the Marketplace. Strengthening plan accountability for providing adequate supply of behavioral health services based on outcome data would improve regulatory oversight.*
8-1 Both Medicare and Medicaid increasingly rely on third-party managed care organizations to deliver health care services to beneficiaries. CMS should work with states to establish an outcome-based behavioral health care access standard for payment, which can be adopted widely in a contract model.	
8-2 CMS should convene Medicare and state Medicaid leadership to develop a model managed care contract for behavioral health services that establishes quality metrics for access, measuring the managed care organization's delivery of timely, appropriate behavioral health care services to enrollees, and that is enforced through financial incentives (e.g., penalties and bonuses). In establishing quality metrics, CMS and states should recognize that meeting access outcome standards will require managed care organizations to build a full continuum of behavioral health providers and services, culturally aligned with the beneficiary population, and establish bi-directional integration of behavioral and physical health. It will also require addressing beneficiary barriers to seeking, receiving, and benefiting from services.	*6-4: Approaches to measuring access for the purposes of regulating plan networks have largely been health care provider-focused, measuring availability of health care providers. Patient-focused measures, including ease of finding and receiving quality treatment from a culturally appropriate health care provider, are likely to require investments in new and alternative data sources, including patient surveys.* *6-8: Quality measurement that can provide more meaningful guidance on the value of care provided and can overcome reporting challenges will better support meaningful improvements in the quality of behavioral health care. It will also enable payment schemes that incentivize investment in behavioral health care by generating new, value-based revenue streams that better support quality care delivery and health care provider recruitment.*

continued

Recommendations	Conclusions
8-3 CMS and SAMHSA should implement a technical assistance function to support states and managed care organizations (Medicare Advantage and Medicaid MCOs) in implementing these access measures and to help plans adopt additional efforts to support and build the behavioral health workforce and improve beneficiary access to care. **8-4 SAMHSA should work with states to align state grant funds to supplement managed care investments in building the continuum of care providers and services needed for MCOs to meet quality metrics for access.**	*6-9: Quality measurement aimed at ultimately improving the accountability of health plans and practices can have the effect of raising costs to both plans and practices. Moreover, behavioral health care providers have frequently opposed performance measurement as an intrusion on professional autonomy. Thus, efforts to bolster accountability may also serve to make clinician balk at participating in health plan networks that are required to report on sophisticated quality metrics.*
RECOMMENDATION 9: CMS should invest in the development of improved quality and risk adjustment measures for behavioral health care. These measures should improve the measurement of performance of care toward desired goals of care and be linked to payment. These measures should carefully consider the administrative measurement burden that would fall on care providers. **9-1 CMS should lead in the development of new performance metrics. CMS should coordinate with states and MCOs to agree on a limited set of measures that apply across Medicare, Medicaid, and the Marketplace. Measures should offer insight into whole-person health by considering social (e.g., educational attainment, employment levels, housing stability) and emotional (e.g., quality of life, loneliness, self-efficacy) needs. Without this emphasis, value-based models in behavioral health run the risk of perpetuating disparities and leaving vulnerable populations behind.**	*6-1 Insufficient risk adjustment for those with mental illnesses and substance use disorders contributes to MA, Medicaid MCO, and Marketplace plan strategies that limit access to behavioral health services. These strategies include creating restrictive health care provider networks and using administrative mechanisms such as prior authorization. Risk adjustment, oversight of availability of clinicians, and limits on administrative processes such as prior authorization can attenuate such behavior. Improving access to behavioral health care providers and services through managed care could occur through improvements in behavioral health risk adjustment, regulation of access to care, and thoughtful limits on prior authorization.* *5-6: A key barrier for behavioral health provider retention and satisfaction in Medicaid and Medicare, in particular, is the inability to meet patient needs, driven in part by the complexity and fragmentation of the care delivery system and patient navigation challenges. While building behavioral health provider participation in Medicare, Medicaid, and Marketplace programs is important, it is not sufficient to ensure that patients are matched to the right health care providers, according to their clinical, cultural and language needs, at the right time and right place.*

Recommendations	Conclusions
9-2 CMS and states should work with MCOs and CMS-supported, value-based payment programs to incentivize care providers based on these newly developed measures. These efforts should include sunsetting legacy measures and aligning measures across insurance segments to reduce the burden to care providers participating in these programs. **9-3 CMS should create targeted financial support for practice transformation costs, recognizing that behavioral health care providers need technical assistance for developing new operations, reporting, billing, and health record systems.** **9-4 In its development of new measures, CMS should also consider modifying the existing measures for behavioral health risk adjustment.**	*6-10 Addressing the technology gap with investments in lower-cost, interoperable EHR systems appropriate for behavioral health and connecting behavioral health records through health information exchanges or other mechanisms is critical for advancing value-based care payments and integrated care models. Managed care tools that allow supplemental or directed payments could provide a mechanism for closing the gap.* *6-11: The fragmented organization of publicly supported coverage within and between Medicare, Medicaid, and the Marketplace exacerbates the challenge beneficiaries have in identifying an available behavioral health care provider that can meet behavioral health needs in a timely way. These challenges are heightened for individuals with behavioral health conditions with complex needs. Even if health care provider participation were to improve, the patient experience related to locating suitable services would remain. Addressing care navigation difficulties is a necessary complement to addressing health care provider participation.*