## USC Schaeffer
## BROOKINGS

# THE BEHAVIORAL HEALTH WORKFORCE SHORTAGE:
## CAN WE MAKE BETTER USE OF THE PROVIDERS WE HAVE?

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## Introduction

Rates of serious consequences associated with mental illnesses – suicides, overdoses, and emergency department visits for behavioral health emergencies – are high and have been rising in the U.S. (Theriault et al., 2020; Garnett et al., 2022). Many of these consequences can be ameliorated through mental health treatment, but roughly half of people who meet criteria for a diagnosable mental illness do not receive behavioral health care, and lack of access is particularly a problem for people from racial and ethnic minority groups (SAMHSA, 2015; Cook et al., 2017; SAMHSA, 2021). This shortfall in access to (effective) services is an important policy target.

Prior policy has helped – expansions of the extent and breadth of health insurance coverage through the Affordable Care Act (ACA), the Mental Health Parity and Addiction Equity Act (MHPAEA), and the Medicare Improvements for Patients and Providers Act of 2008 have improved financial access to services, but even those with coverage often report that needed services are not available. This has led to a renewed focus on the supply side of the mental health sector and specifically on the lack of access due to workforce shortages. The Health Resources and Services Administration (HRSA) classifies certain areas as mental health provider shortage areas (MHPSAs); in 2022, 2774 of the 3144 counties in the U.S. had been designated as shortage areas.[1] The workforce shortage framing has led those concerned about workforce, including HRSA, to focus on interventions that strive to increase the number of providers, especially in MHPSAs, through funding for education and incentives to work in these areas.

While the goal of expanding supply in this way is compelling, its strategy rests on several concepts and assumptions whose validity are uncertain. First, it is not clear whether there is an aggregate shortage of mental health providers in the U.S., especially considering the possibilities for substitution among providers discussed below, and the logic used in defining local shortages leads to a classification of MHPSAs that is insufficiently targeted (Gilbert et al., 2023). Second, these interventions are predicated on a belief that modest incentives will induce substantial changes in location choice, but such policy efforts have, to date, been largely ineffective. Third, even if these policy efforts did function successfully, it would take many years to substantially increase the behavioral health professional workforce in MHPSAs. Addressing

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[1] Authors' analysis of data retrieved from RHIhub based on HRSA designations in 2022.

supply-side access challenges in the near term requires a better understanding of the problem of low access to mental health services and how it is related to the size, composition, location, and utilization of the mental health workforce.

Below, we show that geographic maldistributions of mental health providers, limited access to quality services for specific, underserved communities, and a misallocation of treatment resources by illness severity are important factors in the problem of low access to mental health services. These factors suggest a new set of policy responses that focus on improving the utilization of the existing workforce to address these maldistributions and misallocations. Our recommendations, described in detail at the end of this brief, fall into the following categories:

*Make it easier for people to receive care through telemedicine.* There is substantial variation in the distribution of mental health providers across the country. One way to address this maldistribution is by making it easier for practitioners in areas with more supply to provide care in areas with limited supply. As the COVID-19 experience has taught us, many behavioral health services can be provided using telemedicine. However, existing state licensure and coverage regulations limit the ability to use telemedicine to address this uneven distribution. Reducing barriers to telemedicine access, through changes in credentialing, reimbursement, and licensure rules could help, though such changes will need to be designed carefully to avoid fraud and overuse. The Centers for Medicare and Medicaid Services (CMS) is well-situated to lead in the development of reimbursement rules to address these problems, so that other regulatory authorities have a starting point.

*Set up regulatory rules to encourage appropriate utilization and allocation of services.* The behavioral health workforce is highly varied. It includes psychiatrists and psychologists with many years of post-graduate education, behavioral health nurse practitioners, social workers, counselors and therapists with more limited specialized training, primary care physicians and nurse practitioners who have general training and can prescribe psychotropic medications, and peers and community health workers and other paraprofessionals, who may be able to provide valuable care in part because of their lived experience (Gilbert et al., 2023). Improving access in the short run will require taking steps to utilize the entire range of provider types more effectively, through team-based models and consultation arrangements, and by matching patients with the most appropriate providers for their conditions. Reimbursement and regulatory

policy should facilitate efforts to use team-based care, including the use of teams with non-professional team members, and appropriately match patients to care.

*Improve measurement of the adequacy of access to care.* Addressing the shortfall in access to care depends on measurement of the adequacy of access to behavioral health services. Current network adequacy standards are often based on counts of providers per population. These measures are frequently inaccurate. Even when accurate, they do not effectively reflect the experience of access to services for beneficiaries, so they give a misleading sense of adequacy. Instead, CMS, working with HRSA, should reorient its efforts toward developing network adequacy markers that measure the quality and continuity of care patients with needs are receiving, using existing routinely collected administrative data. One further consequence of improving the measurement of network adequacy may be that plans increase payment rates for selected behavioral health provider groups to meet requirements.

*Addressing the needs of underserved groups.* Prior research has found that disparities in access to behavioral health care across sociodemographic groups are greater than for many other types of care (Cook et al., 2017; National Survey on Drug Use and Health, 2021a). In an analysis of National Ambulatory Medical Care Survey (NAMCS) data from 2007-2016, we similarly find that disparities in the rate of visits to psychiatrists and other physicians offering psychiatric services for racial/ethnic minority groups are greater than for many other forms of physician care (Cai et al., 2021).[2] Disparities in access exist for patients from other minoritized groups such as LGBTQ individuals as well (Godfrey et al., 2022; Williams et al., 2021). Increasing diversity across the entire behavioral health workforce (encompassing professionals and peer support) is one critical step in this direction, but it will take time. The policies we describe above can be tailored to very deliberately address these disparities.

Telemedicine access can help provide access to underserved groups, though it is not yet clear whether that access is as useful for all groups as in-person access. One concern about policies to expand telemedicine use is that they exacerbate the "digital divide" that exists because people with lower income or education or who live in rural areas have less access to technology than do others. In considering this concern, it is important to recognize that expanded use of telemedicine can also reduce non-price barriers such as limited transportation, child care costs,

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[2] Authors' analyses of NAMCS 2007-2016.

and lack of paid time off, which also disproportionately affect the same populations. Expansions of telemedicine access should be accompanied by efforts to reduce barriers due to the digital divide, should ensure that telemedicine expands access for all populations, and should be accompanied by robust evaluation efforts. Better measurement of access to care, including measuring access for members of specific underserved groups, is a key step in ensuring that providers are available. Finally, to the extent that training in cultural competence and humility help improve the therapeutic alliance between providers and patients, such efforts should be enhanced.

## Characterizing the problem

### Contextualizing workforce and access

Counting the behavioral health workforce is challenging because it includes such a diverse web of provider types with overlapping capacities. Some providers, including psychiatrists, nurse practitioners, and primary care physicians, can prescribe medications. Some of these providers, such as psychiatrists, may also offer psychotherapy, often in combination with medication. Psychologists and other types of counselors provide therapy, either in addition to medication being managed by a physician or other prescriber or as a stand-alone treatment. The composition of providers offering each type of service has varied over time. For example, from 2011 to 2019, a period during which, despite reductions in cost-sharing, the rate of Medicare beneficiaries receiving mental health services from either a psychiatrist or a psychiatric nurse practitioner declined by 11%, the rate of such visits to psychiatrists decreased by 29% while the rate of such visits to psychiatric mental health nurse practitioners (PMHNPs) increased by 111% (Cai et al., 2022).

An additional factor that complicates the relationship between supply of providers and adequate access to resources is the concept of matching. The matching of a mental health provider to a patient depends on many factors including the type and severity of illness; the class of indicated treatments; the providers available geographically, financially, and based on coverage; and (especially for psychotherapy) the therapeutic alliance between the provider and patient, which may be related to the cultural match between therapist and patient.

Individuals face many barriers to accessing mental health care beyond the availability of providers. Results from the National Comorbidity Survey in 2001 and 2003 indicated that, among respondents with past-year DSM-IV disorders who did not seek treatment, only 13% of

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respondents reported lack of availability of care (Mojtabai et al., 2011). Among adults with Any Mental Illness (AMI) who self-reported unmet need for mental health services on the NSDUH in 2021, the most commonly reported barrier to receiving care was cost (National Survey on Drug Use and Health, 2021b). Attitudinal or knowledge-based barriers, such as wanting to handle the problem on their own or not knowing where to go for treatment, were also frequently cited. The NSDUH does not currently ask about lack of availability of providers as a reason for not using care.

## Aggregate shortage

### *HRSA estimates*

The National Center for Health Workforce Analysis at HRSA has several models to project the supply and demand of behavioral health providers. The baseline model relies on an assumption that the supply of providers was equal to demand at some point in the past (National Center for Health Workforce Analysis, 2020). A report assuming that the baseline date was 2017 estimated that there would be shortages of only adult psychiatrists and addiction counselors by 2030. A problem with this approach is that there is no reason to believe that there was an adequate supply of or appropriate use of services from behavioral health providers in 2017.

An unmet need model takes a different approach. Based on self-reports, it is estimated that approximately 20% of those with AMI have a perceived unmet need for mental health services (SAMHSA, 2021). Using unmet need in this context is difficult. Self-reported unmet need does not necessarily translate to clinical need for treatment. Surprisingly, unmet need does not actually correspond with lack of receiving services. In 2019, of adults with AMI who reported unmet need, about 55% had received some mental health services in the past year; of adults with AMI who did not report unmet need, only 40% had received services.[3] Nonetheless, the sum of all provider shortages estimated by 2025 using this unmet need model, totaling 250,000 additional full-time providers needed to fill projected shortages, has frequently been cited in relevant literature and as a rationale for legislative action in Congress (National Center for Health Workforce Analysis, 2016; Office of Senator Angus King, 2022; Office of Senator Tina Smith, 2021; Office of Representative John Katko, 2021; Beck et al., 2018).

A third model of reduced barriers adjusts the level of service use of underserved populations (nonmetropolitan, racial and ethnic minority, and uninsured) up to equal the service use of

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[3] Authors' analysis of NSDUH 2019 data.

populations with fewer barriers (metropolitan, non-Hispanic white, and insured). This model was added in 2022 and predicted shortages among psychiatrists and addiction counselors by 2035.

There are several overarching issues with these estimates. First, given the diverse pool of mental health provider types, estimating demand for services based on past patterns of usage fails to consider the overlap or malleability of provider capacities. Second, these estimates fail to adequately account for other barriers to care. Two of the aforementioned models fill unmet need and disparities with greater supply, but a larger number of providers may still fail to meet these needs in the face of other barriers such as cost, coverage, geography, and quality.

### Supply responses

Another way to look for evidence of a shortage of mental health providers is evidence of supply-side tightening (Veneri,1999). If shortages exist, we would expect to see trends in measures of constrained supply such as shorter visits with patients, fewer providers accepting new patients, and longer hours worked. Supply-side signal-based measures account for patients moving to other provider types and facing other barriers to access by looking at real instead of estimated demand over time. To assess supply-side signals, we evaluated trends in practice characteristics for psychiatrists using data from the National Ambulatory Medical Care Survey (NAMCS) and, to a limited extent, for psychologists using data from the American Community Survey (ACS).[4]

*Time with physician.* As shown in Figure 1, the average time a physician spent with a patient trended down for visits to psychiatrists over the last few decades, by on average 1-minute every 2 years. This contrasts with the upward trend in time with physician for primary care physicians or non-psychiatric specialists. Notably, most of this trend is explained by changes in the types of services provided at visits to psychiatrists. Psychotherapy generally takes much longer to provide than medication. Over time, psychiatrists have been doing less psychotherapy and more medication prescribing in visits. From 1995-1999 on average, psychotherapy and medication together were provided in 43% of visits to psychiatrists, medication alone in 33%, and psychotherapy alone in 18%. From 2012-2016 on average, psychotherapy and medication together were provided in only 30% of visits, medication alone in 55%, and psychotherapy alone in 7%. When broken down in this way, the average times a psychiatrist spent with a patient receiving a given service have not exhibited any obvious trends (Figure 2).

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[4] Only psychiatrists were evaluated due to data availability.

It is unclear whether such changes in the makeup of psychiatrist provided services indicates workforce shortage. Considering the decline of psychiatrists providing psychotherapy, Tadmon et al. suggest that psychiatrists may have incentives to provide medication over therapy due to higher reimbursement rates, unrelated to signs of shortages. Alternatively, facing overwhelming demand, psychiatrists may prioritize medication and leave psychotherapy to other, non-prescribing mental health providers (2022). The expansion of provider types able to prescribe medications, notably primary care physicians and nurse practitioners, may be altering this dynamic, as these prescribers could alleviate shortages of medication-prescribing psychiatrists. Overall, looking at time with psychiatrists in patient visits, there are some signs that could be indicative of shortages but seem more likely related to changing common practices related to reimbursement incentives.

***Accepting new patients.*** The percent of psychiatrists accepting new patients oscillated around 90% from 2006 to 2016, with no clear trend. The average percent of psychiatrists accepting new patients is consistently lower than that of primary care physicians, at 92%, and non-psychiatric specialists, at 98%.[5] A consistent undersupply of psychiatrists could correspond with this lower rate of accepting new patients compared to other specialists, though accepting patients remains high in all categories (and the data do not break out sub-groups such as child psychiatrists). However, a growing shortage of psychiatrists is not indicated by this marker.

***Hours worked.*** With a shortage of providers, existing workers may work greater hours to meet demand. From 2005 to 2017, the average hours worked for psychologists was 37 hours a week, following a slight downward trend.[6] This was consistently lower than comparable positions such as physicians, social workers, or physical therapists. The percent of psychologists working 40-hour-plus weeks remained consistent (63% on average) and was also lower than that of physicians, social workers, or physical therapists.

In addition, shortages among mental health providers could correspond to more primary care physicians providing mental health services to meet excess demand. The percent of primary care visits where psychotropic medication was prescribed trended up slightly from 2006 to 2016, increasing on average 0.3-percentage-points per year to nearly 20% in 2016.

Overall, there are no clear signs of a growing shortage of psychiatrists based on internal indicators of tightening national supply through 2016. While this in no way dismisses the

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[5] Authors' analysis of NAMCS data
[6] Authors' analysis of ACS data retrieved from IPUMS

possibility of future supply shortages, it clearly indicates the need to further investigate how other workforce-related factors may play a role.

**Geographic maldistribution**

The distribution of mental health providers varies greatly geographically. In 2015, 51% of U.S. counties had no psychiatrists and 37% had no psychologists; 30% had no MDs who were actively prescribing behavioral health medications (psychiatrists, addiction medicine physicians, primary care physicians); and 8% had no psychologists, counselors, or therapists (Andrilla et al., 2018; George Washington University, 2023). In 2015, the rate of psychiatrists per 100,000 people in metropolitan areas was 17.5, while the rate in non-metropolitan areas was 5.8. In New England, the rate of psychiatrists was 34.1 per 100,000 people; only 6% of counties lacked a psychiatrist and only 1% lacked a psychologist. In contrast, in the West South Central region which consists of Arkansas, Louisiana, Oklahoma, and Texas, the rate of psychiatrists was 9.8 per 100,000 people; 64% of counties lacked a psychiatrist and 49% lacked a psychologist (Andrilla et al., 2022).

### *Mapping provider supply and AMI/SMI*

We have more limited geographic data on the distribution of need for mental health services. We use the NSDUH to measure the proportion of the adult population with AMI or a serious mental illness (SMI). Comparing the distribution of illness and the distribution of mental health providers suggests considerable maldistribution (Figure 6 and 7). Areas in red (seen most notably in Appalachia and parts of the Midwest and Northwest) show counties with relatively high rates of AMI or SMI, but low rates of behavioral health providers. In contrast, areas in green (seen most notably on the East Coast and in California) show counties with relatively low rates of AMI or SMI but high rates of providers.

Alternative measures of mental health need show similar geographic patterns of need.  For example, Figure 8 shows the rates of suicide and overdose deaths by county. Areas of high concentration around Appalachia and in western states bordering California seem to track with areas of high-need and low-services from the previous two graphics.

### *Mental health provider shortage areas*

Mental health provider shortage areas (MHPSAs) are designated geographic areas (individual counties or groups of counties), facilities, or population groups (such as homeless, low-income, and migrant farmworker populations) within the U.S. that experience a shortage of mental health providers. HPSA facilities include state hospitals, federally-qualified health centers (FQHC), and correctional facilities. According to HRSA, there are currently 6,495 MHPSAs across the

country, made up of 1,218 geographic areas, 4,469 facilities, and 808 population groups (HRSA, 2023). Designations of shortage are computed using an equation incorporating population to provider ratio, percent of population in poverty, and travel time to the nearest source of care, as well as other factors (HRSA, 2022). While these designations bring important focus to the problem of maldistributed and inequitable access to mental health care resources, they lack clarity or specificity. In 2022, for 88% of counties, the entire county was designated as a MHPSA.[7] For many states, every county was designated a MHPSA. Targeting is not a meaningful concept if the vast majority of counties are included.

**Inequitable access by sociodemographic factors**

In addition to variation in access across geographies, there are substantial variations in access to care related to income, insurance coverage, and racial and ethnic minority status.

### *Income and insurance*

Cost remains the most important reported barrier to use of mental health services among those with AMI. In 2021, among those with AMI who did not receive any services and reported unmet need: 47.8% reported cost as a barrier and 16% reported that their insurance does not pay enough (National Survey on Drug Use and Health, 2021b). It is not clear from these questions and responses whether the cost problem reflects high deductibles and coinsurance, or inadequate out-of-network payment combined with inadequate in-network access. One possible reason for these high levels is that most psychiatrists and other behavioral health professionals do not accept all forms of insurance and many do not accept any, so that privately-insured patients receive only limited reimbursement for out-of-network care.

While 90% of psychiatrists were accepting new patients from some source in 2007-2016, only 39% were accepting new Medicaid-insured patients.[8] In contrast, 85% were accepting new self-pay patients and 59% were accepting new privately insured patients (note that some psychiatrists may participate in only one or another of these programs, while some may participate in many). From 2007 to 2016, 21% of visits to psychiatrists were self-pay patients, compared to only 4% of visits to primary care physicians and non-psychiatric specialists.[9] A consequence of these differences in acceptance of insurance mean that people with private

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[7] Authors' analysis of data retrieved from RHIhub based on HRSA designations in 2022.
[8] Authors' analysis of NAMCS data.
[9] Authors' analysis of NAMCS data.

insurance, who generally have lower rates of illness, comprise a disproportionate share of those receiving services compared to their share of those with AMI.[10]

### *Race and ethnicity*

Access to mental health services is consistently lower for racial and ethnic minorities than for other groups. In 2021, 52% of White adults with AMI received services. In contrast, of Black, Latinx, and Asian adults with AMI, only 39%, 36%, and 25% received services (National Survey of Drug Use and Health, 2021a). From 2004 to 2012, the disparities in rates of receiving services among White people compared to Black and Hispanic people increased (Cook et al., 2016). Racial and ethnic disparities in receipt of physician services for mental health care are greater than those for non-mental health care. In office visits to MDs from 2007-2016, White patients made up 71% of the patient population at all visits, but nearly 80% of visits to psychiatrists and visits where any psychiatric services were provided.[11] When individuals from racial and ethnic minority groups do receive mental health care, compared to White counterparts, they are more likely to receive services in emergency settings, to be hospitalized, to disengage with treatment, and to have poorer outcomes (Maura and de Mamani, 2017).

One reason for these disparities in access may be that the mental health workforce is overwhelming made up of non-Latinx White providers (Lin et al. 2018). The lack of racial and ethnic concordance for racial and ethnic minority patients with their mental health providers may contribute to non-continuous or low-quality care. However, evidence on the effects of racial and ethnic concordance on treatment continuity or outcomes has shown varied effects (Takeshita et al., 2020; Alsan, 2023); evidence specific to mental health care is even more limited (Alegriá et al., 2014; Mujica et al., 2020).

**Misallocation by illness severity**

There is great heterogeneity in how mental health services are used. As the data above suggest, a considerable share of care from psychiatrists is provided to self-pay patients, who are mainly relatively high-income people without severe functional impairments. Among adults under 65 initiating an episode of mental health treatment (a first visit after 3 months without any visits), many have no second visit. The median number of visits (including the initial visit) over

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[10] Authors' analysis of data from the NSDUH 2020 detailed tables. Privately insured beneficiaries make up 57% of those with AMI and 63% of those receiving services.
[11] Authors' analysis of NAMCS data 2007-2016.

the subsequent 6 months was 4.[12] Only 25% of patients who used services account for 73% of visits; in this group, the average number of annual visits is 26. Among those with 26 or more visits over 6 months, about 20% report that they filled zero prescriptions for psychotropic medications (a pattern of care that may or may not be appropriate).

Outside some very specific collaborative care models (that have not been widely implemented), there is no consensus about which kind of professional should treat which kind of patient, how medication management and psychotherapy should be co-managed across providers, and only limited guidance on how non-professional providers should be incorporated in care (Hoeft, 2017). Many studies of appropriateness of care combine within the category "specialty care" psychiatrists, psychologists, as well as social workers and counselors in specialty mental health settings (Jacob et al., 2012; Zorrilla et al., 2019). Studies of mental health literacy find that most patients do not distinguish among types of mental health professionals (Zorrilla et al., 2019). Neither the patterns of service use described above, nor the existing literature, provide a good guide as to how well those services in scarcest supply are currently allocated.

## Policy recommendations

The data above suggest an approach to expanding access to care that focuses on making better use of the resources we already have.

### Providing care across geographies

The COVID pandemic has illustrated the viability and acceptability of providing behavioral health services through telemedicine. Two kinds of policies need to be modified to make best use of this modality. First, there needs to be adequate reimbursement for telemedicine services. Recently, Medicare has made access to telehealth mental health services more readily available (Telehealth.HHS.Gov, 2023). In-person requirements associated with these benefits, such as a requirement for at least one in-person visit within six months, have been delayed until January 1, 2025. Medicare Advantage plans may also include telehealth medicine costs in their bids (though it is not clear that they will do so). It is critical that the use of tele-behavioral health services under these provisions be evaluated, to ensure that tele-behavioral health is expanding access to populations in need while not generating excess use, fraud, or threatening data privacy. Medicaid has historically allowed telemedicine to a greater extent than Medicare has,

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[12] Authors' analysis of Medical Expenditure Panel Survey 2016-2020.

and states' uptake of those flexibilities and COVID-specific policies broadened during the pandemic.  States may reimburse for telehealth in the same way they do for face-to-face encounters without seeking permission from CMS (Medicaid.GOV, n.d.). States may also submit state plan amendments to allow alternative reimbursement for telehealth, which may be appropriate.

Reimbursement policy can encourage the use of telehealth within a state.  However, because behavioral health professionals are concentrated in a small number of states and areas, it may also be necessary to encourage states to allow behavioral health practitioners to provide care across state lines (Harris et al., 2021). The Veterans Administration has allowed professionals to bypass state licensure within its facilities, leading to a substantial increase in tele-mental health visits. During the pandemic, state-specific licensure requirements were suspended. Extending these flexibilities into a post-pandemic world has the potential to significantly improve supply for both underserved areas and populations.

One way to achieve cross-state licensure flexibilities is through cross-state compacts. Many states currently participate in these compacts – but New York and California, home to a disproportionate share of mental health providers, do not. While cross-border licensure of physicians is politically very thorny, there is increasing interest in encouraging interstate license reciprocity in other fields. Medicare now recognizes non-physician compacts (such as PSYPACT) in lieu of separate state licenses (Telehealth.HHS.Gov, 2023). There are many opportunities for federal policy to further encourage such compacts. Medicaid could offer incentives to states that participate in such compacts, perhaps by clarifying that in states participating in compacts, out of state providers will be considered in computing network adequacy and quality measures. CMS is considering issuing such guidance. Further afield, the U.S. military now considers the availability of interstate portability of licensure in its military basing decisions (Harris et al., 2021).

**Utilize and allocate provider types appropriately**
The first step in encouraging the utilization of the broad array of mental health providers is to extend reimbursement to these groups. Over time, insurers have expanded the array of providers who can be reimbursed for services. Most recently, beginning in 2023, Medicare will reimburse services provided by counselors, marriage and family therapists, and other practitioners under the general supervision of a billing physician or non-physician provider. To

the extent that such providers are available in underserved areas, Medicare reimbursement may expand access to care. Medicaid plans have also expanded the range of providers reimbursed over time, including, in some instances, providing reimbursement for peers, community health workers, and other paraprofessionals who meet state-developed competency requirements (Gilbert et al., 2023). In addition to reimbursing specific services, plans should consider models, including capitated models, that provide incentives for team-based care, coordination among providers, or consultation and supervision across team members, consistent with a recent CMS clarification letter (CMS, 2023).

Expanding reimbursement can extend supply, but it does not directly address the problem of appropriate matching of patients by severity. Managed care plans are best suited to doing this kind of allocation through their utilization review programs. Utilization review is heavily used in behavioral health (Freed et al., 2023). However, excessive use of this tool can lead to significantly restricted access to services (Pestaina and Politz, 2022). Medicare has recently issued proposed rules that would speed up prior authorizations in Medicare Advantage plans and clarify the rules that plans can use in making these decisions. More generally, utilization review and other non-quantitative strategies to limit care should be subject to the same parity rules that apply to other aspects of mental health care. The tensions between program cost and integrity on the one hand and expanded scope of practice, greater telehealth reimbursement, more covered services, and limitations on utilization review on the other, however, are unlikely to be solved through rules alone.

**Evaluate and monitor access to services more accurately with quality and continuity measures**
The most critical element of an improved mental health workforce policy is a rethinking of how we measure the adequacy of access to mental health services. Our current measures are imprecise, difficult to measure, and challenging to enforce. Medicare currently measures network adequacy for psychiatrists and is currently proposing the addition of other provider types. States are required to establish quantitative network adequacy standards for their Medicaid plans. They vary in what information they collect, usually basing standards on time and distance to an appointment with a provider accepting that Medicaid plan (Zhu et al., 2022; Schneider and Corcoran, 2022). There are no federal Medicaid network adequacy minimum standards. Other programs use provider to population access standards.

These standards do not currently work very well. Standards do not apply at all to fee-for-service programs which, by design, do not define networks. Measuring network adequacy in plans is complicated even in straightforward situations where there is only one appropriate type of provider to treat a condition (Hall and Ginsburg, 2017). Directory information is often out-of-date or inadequate (Busch and Kyanko, 2020). Even when a provider is correctly identified, the same provider may be included in multiple insurers' directories and have limited availability for each of them (Haeder, Weimer, and Mukamel, 2019). In addition, measures currently used generally require the collection of additional information (for example, the use of secret shoppers or analysis of provider directories). That means that they can't be used routinely to see whether access is adequate. They also are difficult to use to calibrate access across diverse groups. These challenges are amplified in the mental health context where networks may include many different types of providers offering similar services (while for physical health services only one or two types of practitioners may provide the service). Network adequacy standards must either separately define adequacy for each type of provider (limiting substitution among them) or a combined standard (which might lead plans to inappropriately substitute lower cost providers for higher cost providers). Measurement of network adequacy becomes even more challenging when we consider it within the context of parity, since that will generally require measurements across multiple types of providers, and when we consider telemedicine, which will make distance-based measures obsolete. It is not surprising that enforcement of network adequacy has been very limited.[13] Weaknesses in enforcement have led Medicare to propose changing its standards for MA plans beginning in 2024, though the basic adequacy constructs will remain the same (Fingold and Dockrey, 2022).

A policy priority should be developing measures of network adequacy that focus on the process and appropriateness of care. Rather than – or in addition to – counting how many providers are available in an area, these measures should assess whether there are enough providers to ensure that people are, in fact, getting the care they need. These measures should be constructed using utilization data, which is already used for risk adjustment purposes. Considerable work will be needed to develop measures, and they will need to be routinely updated to address changes in practice patterns and to address any gaming responses. Measures might include the rate at which members with a behavioral health diagnosis are

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[13] See Ariz. Ass'n of Providers for Pers. with Disabilities v. Arizona, 219 P.3d 216 (Ariz. Ct. App. 2009) for an example of weak enforcement of network adequacy.

referred to specialty care, the fraction of members with one visit to a specialty provider who have repeat visits over some specified period of time (note that similar measures already exist for substance use disorders), evidence of guideline-consistent medication monitoring, etc. Plans should also be required to report rates of emergency service use and inpatient hospitalization of members, separating those with and without prior consultations with behavioral health providers.

Defining network adequacy standards using utilization data based on processes and outcomes will encourage managed care plans to steer beneficiaries to the right level of care and will also incentivize them to ensure that care that people are willing to use is truly accessible. For example, plans may need to raise reimbursement rates to ensure that their members are being seen in a timely way by providers they want to use. Utilization-based measures can be collected in nearly real time. They can be separately collected for underserved populations within a plan. To go a step further, risk adjustment weights for mental health diagnoses could be adjusted based on the adequacy of care provided.

## Conclusions

Many people who need and seek mental health care, particularly those in rural areas and those who are members of underserved groups, experience real difficulty in finding practitioners to serve them. Lack of availability of qualified providers reduce our ability to address mental health problems, particularly given the troubling trends in the mental health of the population. Across all provider groups and geographies, however, it is not clear that there is an aggregate shortage of mental health practitioners. The key strategy for workforce policy in the immediate term is how to address serious problems of misallocation rather than focusing on aggregate supply.

## Figure 1. Average Time Spent with MD per Visit by Physician Type, 1993-2016
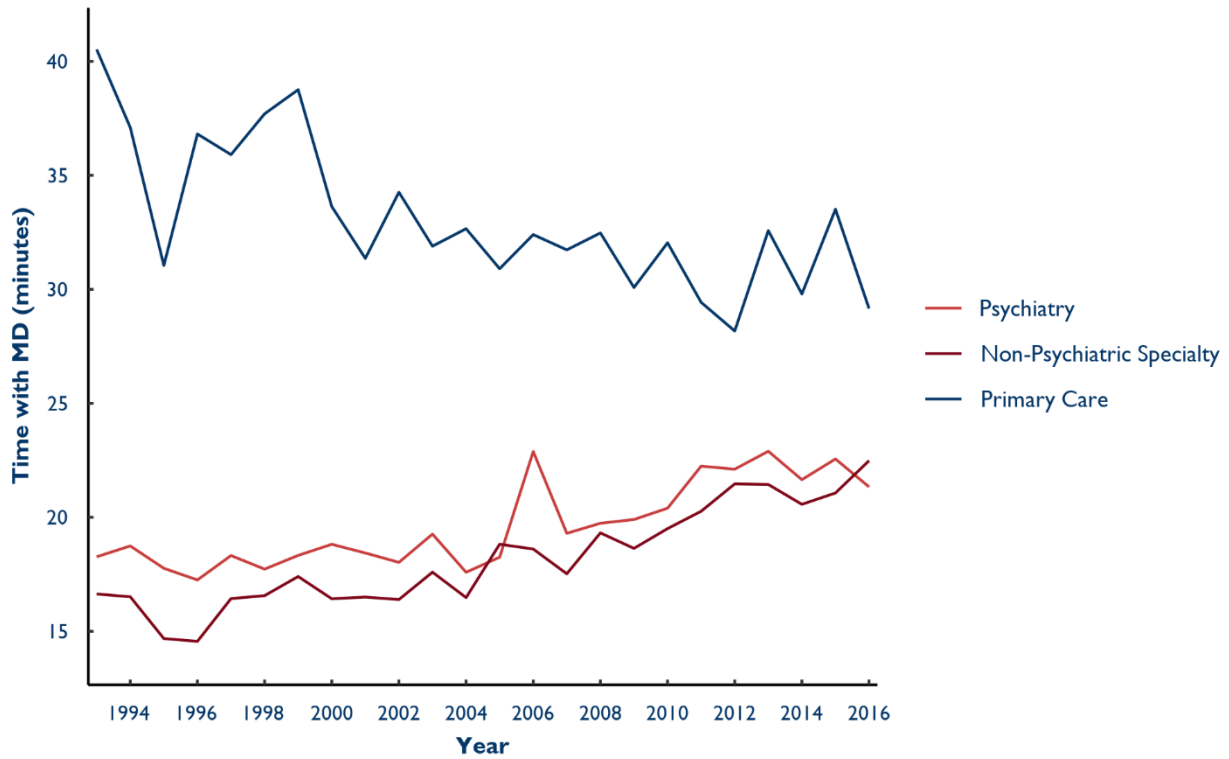


Minutes patient spent with MD as reported by physician through the National Ambulatory Medical Care Survey from 1993 to 2016.

## Figure 2. Time Spent with MD at Visits to Psychiatrist by Services Administered, 1995-2016



Time spent with MD and services administered as reported by physician through the National Ambulatory Medical Care Survey from 1995 to 2016. Psychotherapy and medication refer to either exclusively.

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**Figure 3. Percent of Physicians Accepting New Patients by Physician Type, 2005-2016**
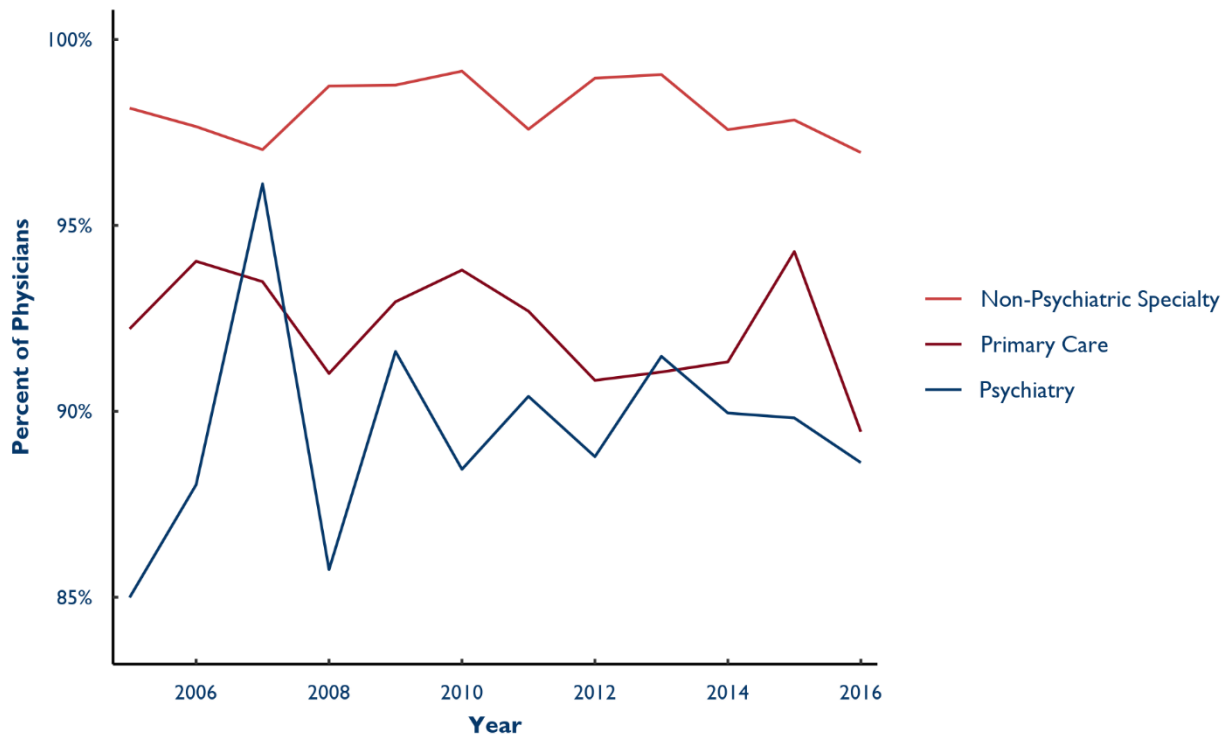


Yes or no to accepting new patients and physician specialty as reported by physician through the National Ambulatory Medical Care Survey from 2007 through 2016.

**Figure 4. Average Hours Worked per Week by Profession Type, 2005-2017**
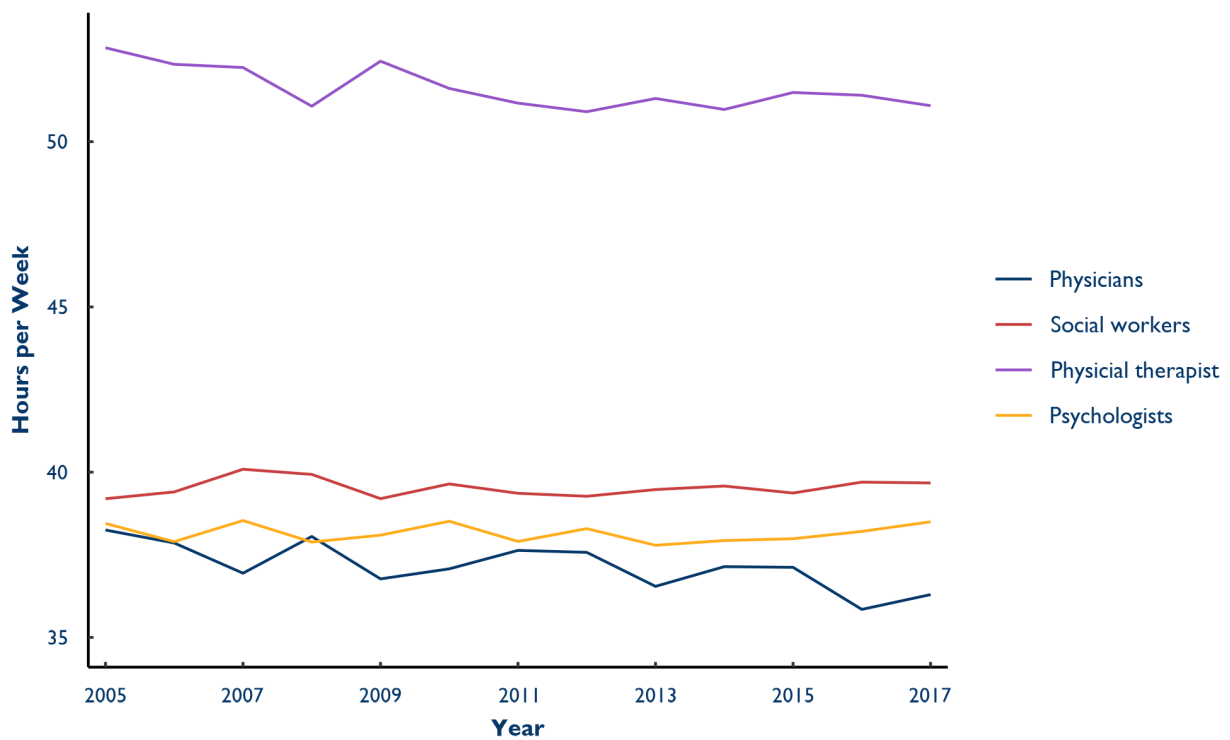


Hours worked per week on average in the last year for those who were currently employed and occupation type according to data from the American Community Survey from 2005 to 2017.

**Figure 5. Percent Working on Average 40+ Hours per Week by Profession Type, 2005-2017**
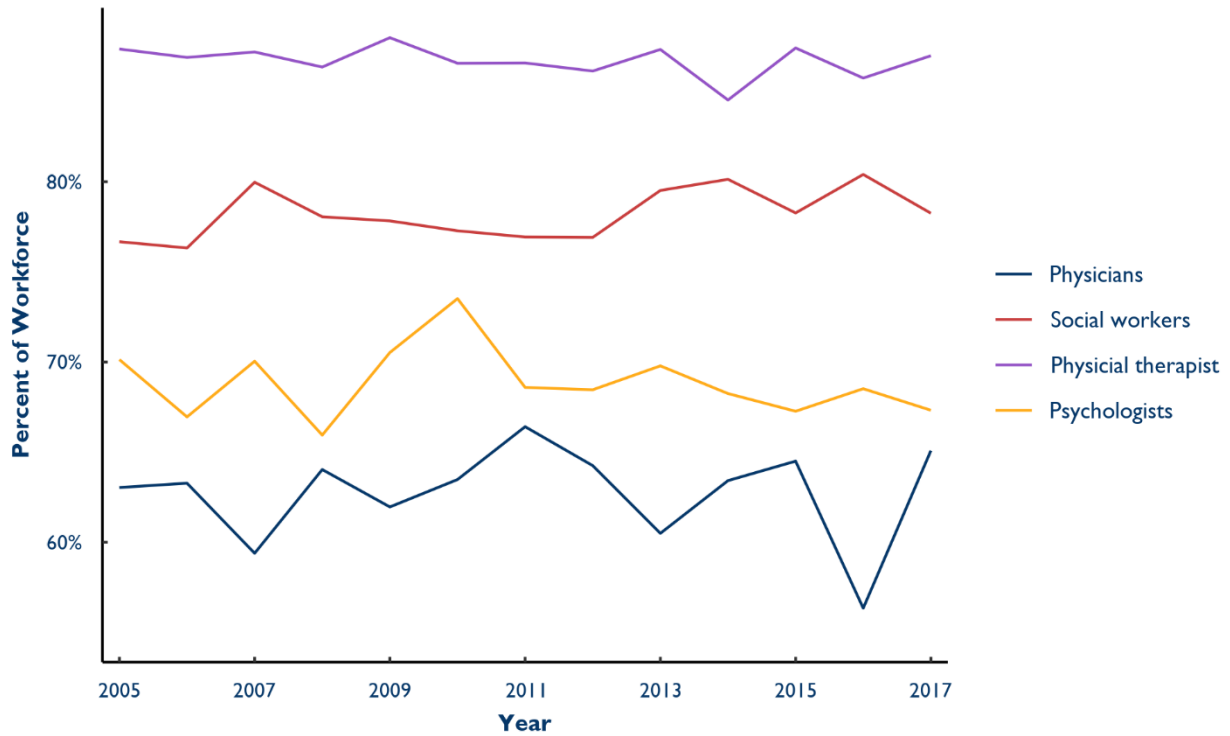


Hours worked per week on average in the last year and profession type among those who were currently employed according to data from the American Community Survey from 2005 to 2017.
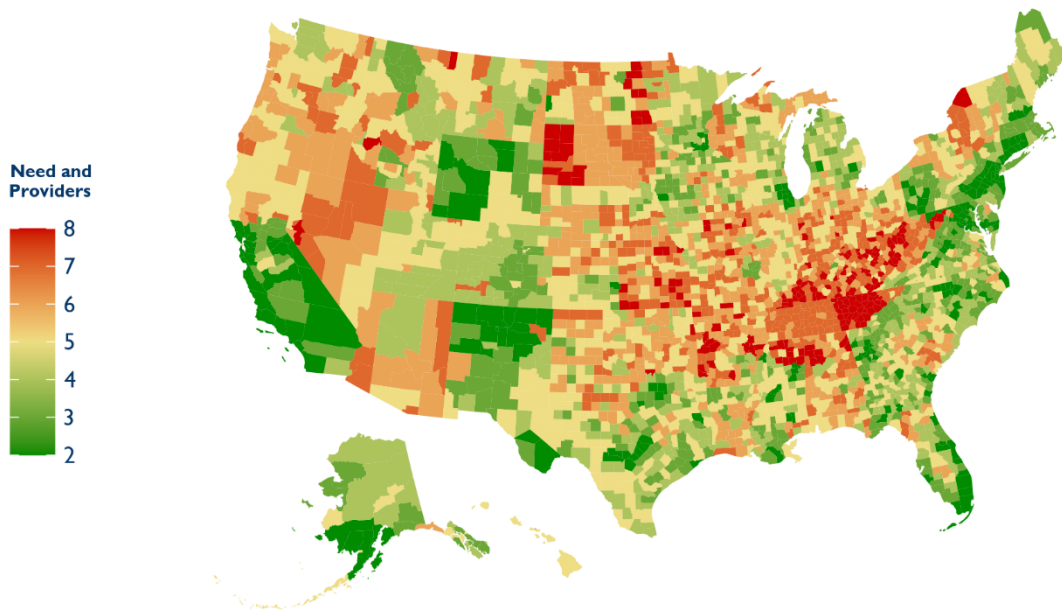
**Figure 6. County-to-Substate Match of AMI Burden and Behavioral Health Specialist Providers**
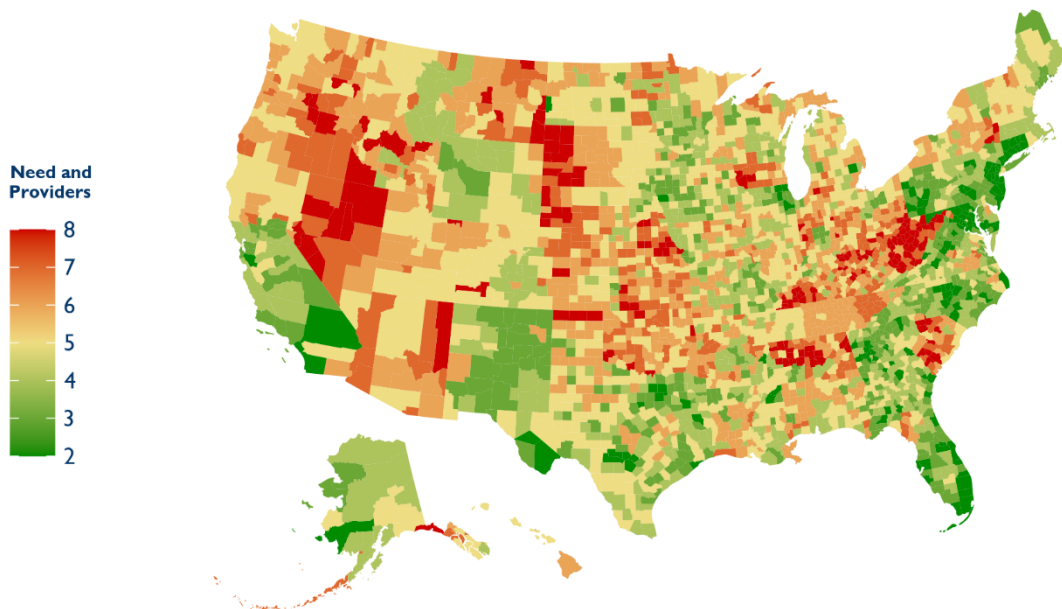


High-need/low-services counties/substates, value of 8: in the highest quartile of any mental illness (AMI) and in the lowest quartile (highest inverse quartile) of rate of behavioral health specialist providers (psychiatrists, addiction medicine physicians, psychologists, counselors, and therapists) per 100,000 people by county.
Low-need/high-services counties/substates, value of 2: in the lowest quartile of adult AMI and the highest quartile (lowest inverse quartile) of rate of behavioral health specialist providers.

## Figure 7. County-to-Substate Match of SMI Burden and Behavioral Health Specialist Providers



High-need/low-services counties/substates, value of 8: in the highest quartile of serious mental illness (SMI) and in the lowest quartile (highest inverse quartile) of rate of behavioral health specialist providers (psychiatrists, addiction medicine physicians, psychologists, counselors, and therapists) per 100,000 people by county.
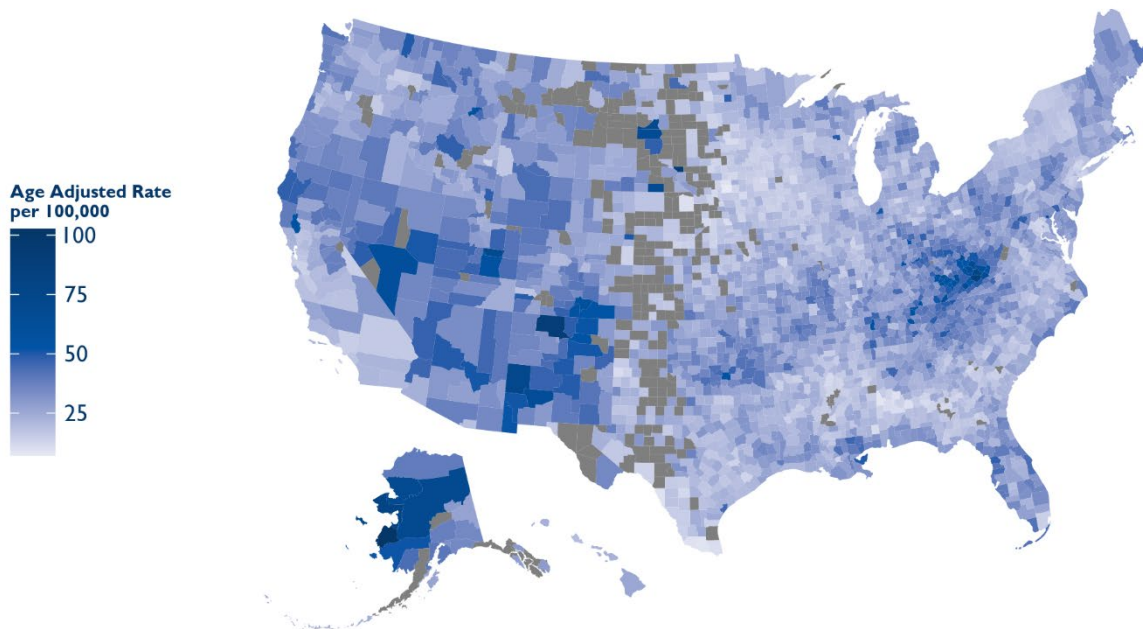Low-need/high-services counties/substates, value of 2: in the lowest quartile of adult SMI and the highest quartile (lowest inverse quartile) of rate of behavioral health specialist providers.

## Figure 8. Age Adjusted Rate of Suicide and Overdose from 1999-2020 by County



Number of suicide and overdose deaths per 100,000 people per county from 1999-2020, age adjusted.
Data are suppressed for any county with less than 20 deaths in this time period.
Data are from the Multiple Cause of Death Files, Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System, Mortality 1999-2020 via CDC WONDER Online Database.

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