CONNECTICUT
Health Strategy

Behavioral Health Insurance Coverage and Payment Parity in HUSKY, Private Insurance, and Medicare Advantage

Behavioral Health Workforce Environmental Scan

A report prepared by Acumen, LLC

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CONTENTS

Acronyms

ACA	Affordable Care Act
ACS	American Community Survey
ARP	American Rescue Plan Act of 2021
BLS	Bureau of Labor Statistics
CI	Commercial Insurance
CTS	Community Tracking Study
CPT	Current Procedural Terminology
DPH	Department of Public Health
ERISA	Employee Retirement Income Security Act of 1974
E&M	Evaluation and Management
FFS	Fee-for-service
IMS	Intercontinental Medical Statistics
IMLC	Interstate Medical Licensure Compact
MEPS	Medicare Expenditure Panel Survey
MHPA	Mental Health Parity Act of 1996
MHPAEA	Mental Health Parity and Addiction Equity Act of 2008
NBER	National Bureau of Economic Research
NEHRS	National Electronic Health Records Survey
NHIS	National Health Interview Survey
NSPL	National Suicide Prevention Lifeline
NSDUH	National Survey on Drug Use and Health
OHS	Office of Health Strategy
PPO	Preferred Provider Organization
PSYPACT	Psychology Interjurisdictional Compact
SBHC	School-based Health Center
SAMHSA	Substance Abuse and Mental Health Services Administration
VA	Veterans Affairs

Glossary

Behavioral Health Disorder: Umbrella term that captures mental health and substance use disorders.

Behavioral Health Payment Parity: Behavioral health payment parity is achieved when payment for behavioral health services is comparable to payment for other medical services.

Current Procedural Terminology (CPT®): Numerical system developed by the American Medical Association to code medical procedures and services that patients receive. *CPT Copyright 2024 American Medical Association. All rights reserved. CPT® is a registered trademark of the American Medical Association.*

Mental Health Disorder: General term for a range of conditions that impact an individual's behavior, mood, or cognition. Includes conditions such as anxiety, depression, bipolar disorder, and obsessive-compulsive disorder.

Mental Health Workforce Shortage Areas: Designation of a geographic area, population, or facility as having a shortage of mental health professionals. This is determined primarily by the number of health professionals relative to the population (30,000 to 1, or 20,000 to 1 if there is a high need for care in the area).

Narrow Provider Network: When insurance companies or managed care entities contract with a small number of providers; may result in having too few in-network providers to meet the demand for particular specialty service type.

Out-of-Pocket Costs: Share of health care services paid for by enrollees. This typically includes costs for deductibles, copayments, and coinsurance.

Reimbursement Rate: Amount paid to providers for the services and procedures they provide.

Substance Use Disorder: General term for an individual's ongoing use of alcohol or other substances, which is often out of their control, that causes significant harm and consequences to their daily life. Includes alcohol use disorder (AUD), and drug use disorders (DUD) such as opioid use disorder (OUD) and stimulant use disorder (StUD).

EXECUTIVE SUMMARY

Federal and state legislative actions to expand insurance coverage for behavioral health care have failed to achieve the goal of making behavioral health care affordable and accessible to everyone who needs it. This is due to workforce shortages, coupled with a reluctance on the part of behavioral health providers to participate in commercial insurance and Medicaid, which research suggests is partly due to low reimbursement rates and administrative challenges. This report was undertaken on behalf of Connecticut's Office of Health Strategy (OHS) to inform its efforts to increase the availability of affordable behavioral health care by investigating factors that influence behavioral health providers' willingness to participate in health insurance and Medicaid, and other potential levers to increase the supply of behavioral health providers in the state. It is part of a larger study designed to evaluate behavioral health payment parity and disparities and to examine how provider reimbursement rates impact behavioral health service use for Medicaid and commercial insurance enrollees in Connecticut and to estimate the reimbursement rates necessary to attract a behavioral health workforce sufficient to meet the service demand for individuals with all insurance types. Using the Connecticut All-Payer Claims Database, the study evaluates payment parity to ensure that Connecticut payers are compliant with the Mental Health Parity and Addiction Equity Act (MHPAEA) and Connecticut parity laws, examines disparities in provider reimbursement rates and behavioral health service use across commercial payers and Medicaid, and explores the association between provider reimbursement rates and behavioral health service use and unmet treatment demand.

The report summarizes approaches identified in the literature that have been used to expand the behavioral health workforce and incentivize providers to enroll in commercial insurance and Medicaid. The literature review is complemented by an environmental scan of the landscape of behavioral health care need and access in Connecticut and the supply of behavioral health providers in Connecticut relative to the other New England states. The sections below summarize the key findings from the review, discuss the implications of the findings, and provide recommendations for next steps.

Key Findings from the Literature Review

The literature review covered topics related to payment disparity, provider participation in public and commercial insurance, and other options for expanding the behavioral health workforce. While some of the literature reviewed included analysis of Connecticut's health insurance market, the findings from the review are not specific to Connecticut's health insurance market. As described above, as part of this project, OHS is conducting analyses to better understand these issues in Connecticut. The sections below summarize the key findings from the review organized by the main review topics.

Significant disparities persist between behavioral health provider reimbursement rates compared to other provider types and across payer types.

Research has found that, in recent years, behavioral health provider participation in insurance has declined across all insurance types and one of the most commonly discussed reasons for these declines, especially in Medicaid, has been low levels of provider reimbursement. Several studies documented disparities in reimbursement rates for behavioral health providers compared to other medical providers for the same services, and found that reimbursement rates for psychiatrists and other behavioral health providers in commercial insurance are consistently lower than Medicare rates for the same services, while rates for other provider types are higher than Medicare amounts. Medicaid rates have also been historically lower than Medicare rates across a wide range of services, including behavioral health services. More recent studies found significant disparities in reimbursement rates for in-network and out-of-network care, with commercial insurers paying less than Medicare fee-for-service (FFS) for in-network care, but paying significantly more than Medicare FFS for identical services provided out of network.

Research has also focused on the issue of narrow networks in managed care and found that narrow networks have become more common, especially in marketplace plans, and networks for behavioral health providers tend to be narrower than those for other provider types. The increased use of narrow networks by issuers coupled with disparities in reimbursement rates likely contribute to the shortage of in-network providers which results in increases in the use of out-of-network care for behavioral health services. In Connecticut, one study found that a

significantly higher proportion of behavioral health care is provided out-of-network compared to medical/surgical care provided in the same settings, with out-of-network providers providing 1.6% and 3.1% of inpatient and outpatient medical/surgical care and 27.1% and 34.4% of behavioral care in the same settings. Similar patterns were observed for behavioral health office visits compared to primary care office visits. These findings suggest that narrow provider networks and issues with network adequacy also play a part in access to affordable behavioral health care. While most states implement network adequacy standards, research suggests that low provider participation in network plans contributes to the shortage of affordable providers.

There is mixed evidence on the impact of increasing provider reimbursement rates on provider participation in insurance and access to care.

The literature on provider reimbursement rates suggests that the impact of increasing rates on participation is mixed. Several studies analyzed the impact of the temporary increase in Medicaid fees for primary care mandated by the Affordable Care Act (ACA) and found no association between increased fees and provider participation, but did find a positive association between the fee increase and appointment availability for Medicaid enrollees. However, changes in appointment availability were only observed for a sample of providers already participating in Medicaid prior to the fee increase. These studies suggest that physicians already participating in Medicaid were able to increase the number of Medicaid patients they accepted, but did not provide evidence that more providers enrolled as a result. Studies on Medicaid fee increases unrelated to the ACA temporary fee increase found that changes in fees contributed to increased healthcare utilization and improved the ability of beneficiaries to find providers accepting Medicaid.

Reducing administrative burdens related to billing and eliminating disparities in the use of prior authorization could potentially reduce barriers to insurance participation.

Research has identified administrative costs and responsibilities as additional barriers to provider participation in insurance, especially Medicaid. One study estimated that physicians lose 18% of Medicaid revenue due to issues with billing compared to 4.7% and 2.4% for Medicare and commercial insurers, respectively. Additionally, the practice of prior authorization has been cited as an administrative burden for providers and results in delays in care. Overuse of

prior authorization for behavioral health services relative to general medical services is a violation of the Mental Health Parity and Addiction Equity Act (MHPAEA); however, enforcing non-quantitative parity requirements has been very difficult. Nevertheless, state governments have acted to address issues related to prior authorization requirements, for example by removing prior authorization requirements for routine behavioral health office visits or inpatient mental health admissions following emergency room visits.

Additional approaches can be considered to expand the behavioral health workforce.

Research also identified additional approaches that states can consider to increase the overall number of and availability of providers, including using a wider range of providers to deliver behavioral health services, allowing providers to serve patients in additional settings, and attracting and reducing worker turnover. The following approaches were identified:

- **Peer Support Services** – Peer support workers are those who have successfully recovered from a mental health or substance use disorder and are certified to provide support to others experiencing similar challenges. The utilization of these workers can reduce healthcare costs through fewer hospitalizations for those with mental illness.
- **Telehealth** – Telehealth has the ability to improve access to care for patients living in underserved or rural areas and shorten wait times for appointments. Recent literature suggests that telehealth treatment outcomes for psychiatric conditions are similar to in-person treatment outcomes.
- **Inter-State Licensing** – Multi-state licensing compacts allow providers to practice in other participating states, and recent studies indicate that compact participation corresponded to a greater likelihood of a facility expanding to offer telehealth services. Increasing provider participation in these compacts could increase the supply of providers and support the expansion of telehealth services in the state.
- **School-Based Health Care** – School-based health services improve care access, prevent unnecessary emergency department visits, and reduce depressive episodes and suicide risk for adolescents. Connecticut has supported the expansion of school-based healthcare services and allows Medicaid billing for some school-based behavioral health services.

- **Crisis Care** – Crisis mental health services encompass a range of services provided to individuals experiencing psychiatric or substance abuse–related emergencies who require immediate care. These services can alleviate stress placed on emergency departments and hospitals by linking individuals with appropriate outpatient services. The American Rescue Plan (ARP) awarded grants to states for the purpose of supporting community-based mobile crisis intervention and enhanced federal Medicaid matching for qualified services.
- **Recruit and Retain Providers** – To address supply challenges, policies for attracting and retaining new workers and incentivizing providers to work in mental health shortage areas should be prioritized. Potential methods for growing the workforce include increasing psychiatry residency slots, implementing loan forgiveness and scholarship programs, providing other financial incentives for providers who practice in underserved areas or in certain settings, and establishing early outreach and mentorship programs to promote behavioral health career opportunities.

Key Findings from the Environmental Scan of the Connecticut Behavioral Health Landscape

The environmental scan examined the extent of the need for behavioral health care in Connecticut and the workforce available to meet the demand. The sections below summarize the estimated prevalence of behavioral health disorders in Connecticut and compare behavioral health provider supply and salaries in Connecticut and the other New England states.

Prevalence of Behavioral Health Disorders in Connecticut

Applying state-level prevalence estimates from the 2021 National Survey on Drug Use and Health (NSDUH), an estimated 573,000 Connecticut adults ages 18 and older were affected by mental illness and 465,000 were affected by substance use disorder. State-level prevalence rates for youth are available for major depressive disorder, but not for any mental illness. Applying the available prevalence rates to youth ages 12 to 17 indicates that 56,000 are affected by having a major depressive episode and 24,000 are affected by substance use disorder based on 2021 data. Note that these estimates do not account for co-occurring mental illness and substance

use disorder, so there is an unknown degree of overlap between mental health and substance use disorders.

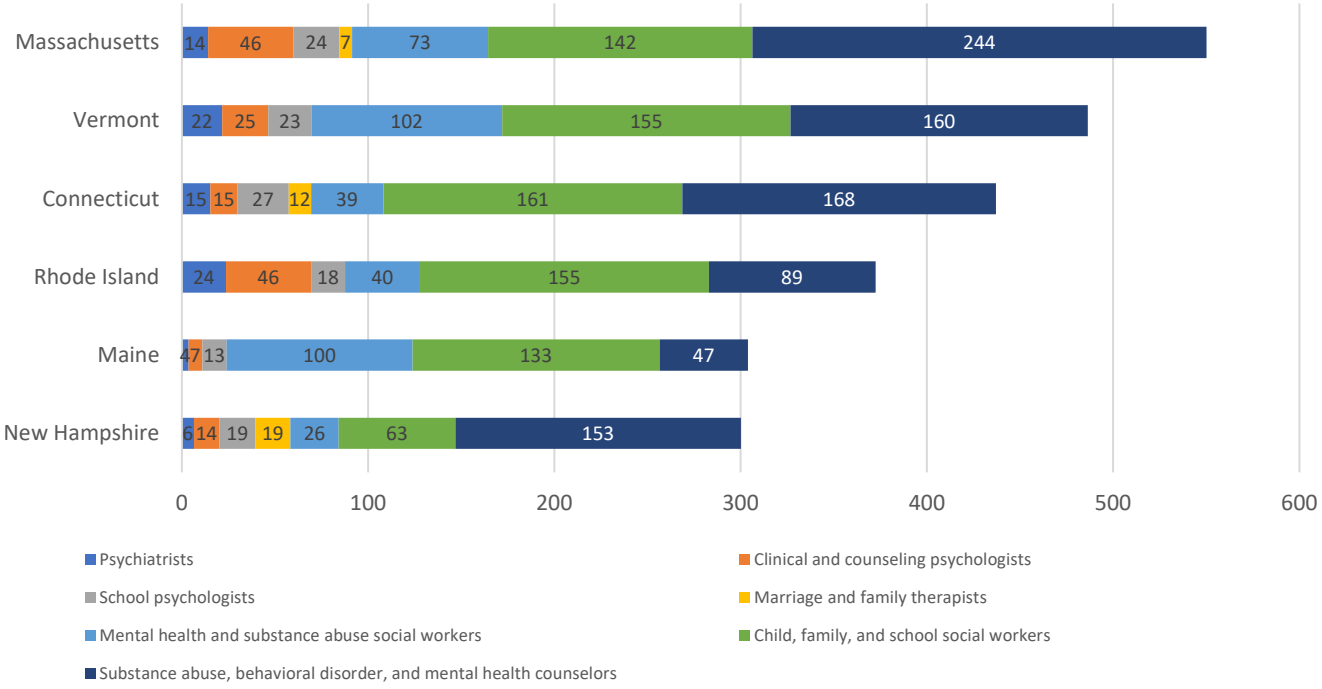
Supply of Behavioral Health Providers

We examined the number of behavioral health providers in Connecticut and other New England states using data from the Bureau of Labor Statistics (BLS) Occupational Employment and Wage Statistics database. The analysis includes a range of behavioral health professions[1] who provide direct clinical care including psychiatrists; school psychologists; clinical and counseling psychologists, mental health, substance abuse, and child/family social workers; marriage and family therapists; and mental health and substance abuse counselors. The BLS definitions of these categories are reported in Appendix A.

Connecticut is third behind Massachusetts and Vermont in the total number per capita of behavioral health providers (number of providers per 100,000 total state population). However, Connecticut has fewer providers with higher-level training than the other states. Specifically, Connecticut is fourth in the region in the per capital number of psychologists (combined school and counseling/clinical) and social workers (combined behavioral health and child/family social workers). (Figure ES.1).

[1] The BLS provider definitions describe the type of work each profession. The descriptions do not include the level of education, type of training required, or credentialing requirements for each profession. Generally, psychiatrists are physicians who specialize in psychiatry. They diagnose and treat behavioral health disorders and prescribe medications. Psychologists, including clinical and counseling psychologists and school psychologists are Ph.D. level practitioners who assess, diagnose, and treat mental and emotional disorders. They provide counseling, observation, and psychological testing. Social workers, including child and family social workers and mental health/substance use social workers, are masters-level practitioners who assess and treat individuals and/or families with behavioral health disorders or difficulties functioning. Marriage and family therapists have, at minimum, a master's degree with additional specific training and focus on treating family systems. Counselors, including substance abuse, mental health, and behavioral health counselors generally have a master's degree and training or focus in a particular area.

Figure ES.1. Number of Behavioral Health Providers per 100,000 Total Population in Connecticut and the Other New England States



Behavioral Health Salaries

Across New England states, Connecticut has the highest or second-highest average salary for selected behavioral health professions, with the exception of behavioral health counselors, which includes substance abuse, behavioral disorder, and mental health counselors.[2] While this bodes well for behavioral health professions in the state in general, behavioral health counselors represent the largest portion of the behavioral health workforce in Connecticut. Thus, while professions such as psychologists and social workers have higher average salaries, a significant portion of Connecticut's behavioral health workforce is in a lower paid profession.

Implications of the Review Findings

The findings from the review suggest several avenues for OHS to consider to increase and expand its behavioral health workforce to meet the growing demand for affordable behavioral health services. One mechanism is to ensure payment parity between behavioral

[2] U.S. Bureau of Labor Statistics, May 2022 State Occupational Employment and Wage Estimates

health and general medical services and address any discrepancies that might exist between reimbursement rates in Medicaid versus commercial payers. The current study addresses payment issues by analyzing claims data to compare reimbursement rates across behavioral health and general medical services and across payers. The results will inform OHS efforts to monitor and enforce payment parity and project the reimbursement levels needed to incentivize providers to participate in Medicaid.

Additionally, while average salaries for higher-level behavioral health professionals in Connecticut are competitive across the New England states, salaries for behavioral health counselors, who comprise the largest portion of the behavioral health workforce, may need to be higher in order to attract additional providers into this line of work. In addition to higher salaries, geographic variations in salaries should to be examined to ensure more uniform supply across regions.

In addition to addressing disparities in reimbursement rates, the state should investigate the extent to which administrative burdens affect provider participation in insurance in Connecticut and look into methods to reduce any burdens identified, particularly in Medicaid. This might require monitoring and identifying the determinants of billing disputes and denied claims as well as reviewing prior authorization requirements and review times for behavioral health services to determine if improvements could be made.

As summarized above and described in more detail in the body of this report, there are additional mechanisms OHS could consider to expand the behavioral health workforce. These include covering peer support services in Medicaid and expanding telehealth to a broader range of services, inter-state licensing, school-based care, and crisis care. Several of these mechanisms are currently in place in Connecticut. However, it was beyond the scope of this review to investigate whether they are achieving their intended goals.

For example, understanding how many providers are participating in inter-state licensing and what their experience has been, or knowing how many schools and school districts are leveraging Medicaid for school-based services, and the potential barriers for implementing school-based services, requires separate and more focused program evaluations. That said, the planned claims data analysis will shed light on some of these issues. In particular, the planned

claims analysis will look for claims for telehealth, services provided in schools, and crisis services to summarize utilization trends. However, OHS may also want to consider additional qualitative research to understand how efforts to expand access to treatment impact patient outcomes in practice.

1 INTRODUCTION

There is a growing need for affordable behavioral health care across the U.S., and states face significant challenges in meeting the demand for behavioral health treatment. Federal and state legislative actions to expand insurance coverage go a long way in addressing the financial barriers to accessing treatment. However, some behavioral health providers are reluctant to participate in commercial insurance and Medicaid. Understanding the factors that influence behavioral health providers' willingness to participate in health insurance and Medicaid is needed to inform efforts by Connecticut's Office of Health Strategy (OHS) to take meaningful action to increase the supply of behavioral health providers and expand access to behavioral health treatment.

This report reviews the literature on factors related to insurance participation as well as other more general issues related to expanding the behavioral health workforce and increasing access to behavioral health care. The report summarizes approaches that have been used to expand the behavioral health workforce and incentivize providers to enroll in commercial insurance and Medicaid. The literature review is complemented by an environmental scan designed to understand the landscape of behavioral health care need and access in Connecticut and explore issues related to the supply of behavioral health providers in Connecticut compared to the other New England states: Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont.

This introductory chapter provides an overview of the extent of the need for behavioral health services (Section 1.1) and a history of legislative action at the federal level and within Connecticut (Section 1.2).

1.1 Need for Behavioral Health Treatment

Behavioral health and substance use disorders have become more widespread in recent years, bringing more attention to the need for comprehensive and affordable behavioral health treatment. It is estimated that the number of adults with mental illness increased from 45.1 million

in 2009 to 57.8 million in 2021, according to the National Survey on Drug Use and Health.[3, 4] Rates of behavioral health conditions among children and adolescents also steadily increased and were exacerbated by the COVID-19 pandemic. In particular, the proportion of mental health–related emergency department visits for children increased since prior to the pandemic, and over a third of high school students report experiencing poor mental health.[5] These challenges are so pervasive that in 2021, the American Academy of Pediatrics, the American Academy of Child and Adolescent Psychiatry, and the Children's Hospital Association declared a national state of emergency in children's mental health.[6, 7] In Connecticut, an estimated 573,000 (~20%) individuals ages 18 or older had a mental illness in 2021 and an estimated 489,000 individuals ages 12 or older had a substance use disorder. Drug overdoses in the state also increased from 11.2 to 42.3 per 100,000 from 2011 to 2021, markedly higher than the national average of 32.4 per 100,000.[8]

The increased demand for behavioral health care far exceeds the supply of behavioral health providers, making it increasingly difficult for people to access the care they need. As of June 2023, 163 million U.S. residents resided in mental health workforce shortage areas. In Connecticut, 1.54 million people lived in mental health workforce shortage areas.[9] Low reimbursement rates and salaries for behavioral health professionals, lack of funding and investment to attract and retain workers, and high levels of administrative burden have all been cited as contributors to the shortage of workers. Shortages are further exacerbated by declines in

[3] SAMHSA. (2010). *Mental Health, United States, 2010*. https://www.samhsa.gov/data/sites/default/files/MHUS2010/MHUS2010/MHUS-2010.pdf
[4] SAMHSA. (2022). *Key Substance Use and Mental Health Indicators in the United States: Results from the 2021 National Survey on Drug Use and Health*. https://www.samhsa.gov/data/sites/default/files/reports/rpt39443/2021NSDUHFFRRev010323.pdf#page=65&zoom=100,0,602
[5] Theberath, M. et al. (2022). Effects of COVID-19 pandemic on mental health of children and adolescents: A systematic review of survey studies. In *SAGE Open Medicine*. https://doi.org/10.1177/20503121221086712
[6] Leeb, R. T. et al. (2020). Emergency Department Visits Among Children Aged <18 Years During the COVID-19 Pandemic - United States, January 1-October 17, 2020. *Morbidity and Mortality Weekly Report*, *69*(45), 1675–1680. https://doi.org/10.15585/mmwr.mm6945a3
[7] Office of Elementary and Secondary Education. (2022). *Supporting the Mental Health Needs of All Students with American Rescue Plan Funds*. https://oese.ed.gov/files/2022/04/Mental-Health-Fact-Sheet.pdf
[8] SAMHSA. (2022). *2021 National Survey on Drug Use and Health: Model-Based Estimated Totals (in Thousands) (50 States and the District of Columbia*. https://www.samhsa.gov/data/sites/default/files/reports/rpt39466/2021NSDUHsaeTotals121522/2021NSDUHsaeTotals121522.pdf
[9] Bureau of Health Workforce, Health Resources and Services Administration (HRSA), U. S. D. of H. and H. S. (2023). *Designated Health Professional Shortage Areas Statistics Third Quarter of Fiscal 2023 Designated HPSA Quarterly Summary as of June 30, 2023*.

the number of behavioral health professionals who accept insurance and the unequal distribution of providers across geographic areas.[10, 11, 12] Declines in provider participation make it more difficult for individuals to access care through their insurance, resulting in individuals seeking care from providers outside their insurance networks at much higher costs. Consequently, many individuals who are unable to afford these higher costs will choose to forgo care. In 2021, among adults ages 18 or older who reported mental illness in the past year but who did not receive care, the most common reason cited for not receiving care was lack of affordable care (42.9%). Moreover, 23.4% reported that their insurance benefits did not cover any mental health services or did not pay enough for mental health services.[13]

These gaps in the supply of behavioral health care result in increased hospitalizations and emergency department visits, which reflect the lack of accessible outpatient care and increase overall healthcare expenditures. The shortages also place additional strains on current providers, contributing to provider burnout. Further, untreated mental health conditions in children and adolescents precipitate poor school performance and higher dropout, which further compounds the social and economic burdens associated with untreated behavioral health conditions.[14, 15, 16]

1.2 Federal and State Legislative Actions to Improve Access

Achieving behavioral health payment parity, which requires health insurance companies to pay comparable rates for behavioral health and general medical services, was an important legislative goal for decades. However, it was not until 1996 that the US Congress and state

[10] Andrilla, C. H. A. et al. (2018). Geographic Variation in the Supply of Selected Behavioral Health Providers. *American Journal of Preventive Medicine*. https://doi.org/10.1016/j.amepre.2018.01.004
[11] Benson, N. M. et al. (2020). Psychiatrist participation in private health insurance markets: Paucity in the land of plenty. *Psychiatric Services*. https://doi.org/10.1176/appi.ps.202000022
[12] National Council for Mental Wellbeing. (2017). *The Psychiatric Shortage: Causes and Solutions*. https://www.thenationalcouncil.org/resources/psychiatric-shortage-causes-and-solutions/
[13] SAMHSA. (2022). *Key Substance Use and Mental Health Indicators in the United States: Results from the 2021 National Survey on Drug Use and Health*. https://www.samhsa.gov/data/sites/default/files/reports/rpt39443/2021NSDUHFFRRev010323.pdf#page=65&zoom=100,0,602
[14] Bipartisan Policy Center. (2023). *Filling the Gaps in the Behavioral Health Workforce*. https://bipartisanpolicy.org/download/?file=/wp-content/uploads/2023/01/BPC_2022_Behavioral-Health-Integration-Report_RV6Final.pdf
[15] National Council for Mental Wellbeing. (2017). *The Psychiatric Shortage: Causes and Solutions*. https://www.thenationalcouncil.org/resources/psychiatric-shortage-causes-and-solutions/
[16] The White House. (2022). *Reducing the Economic Burden of Unmet Mental Health Needs*. https://www.whitehouse.gov/cea/written-materials/2022/05/31/reducing-the-economic-burden-of-unmet-mental-health-needs/

legislatures began systematically enacting laws designed to enhance access to mental health through alterations of benefits and reimbursement levels for mental health and substance use disorder services.[17] With the passage of the Mental Health Parity Act (MHPA) of 1996, Congress required private group health plans that offered mental health benefits to apply the same annual and lifetime dollar limits as medical benefits. Despite the significance of this legislation, the MHPA (1) was limited to private, large group health plans with 50 or more employees, (2) did not apply to other mental health benefit limits, such as visit limits and higher cost sharing, and (3) did not cover substance use disorders.[18] Despite the limited scope of the MHPA, the law did serve as a catalyst for state legislatures to begin exploring strategies to implement more comprehensive mental health parity laws.

For example, in 1997, Connecticut passed its first mental health parity law (Public Act No. 97-99) requiring individual and group health insurance plans to provide coverage for biologically based mental or nervous conditions that was at least equal to coverage for medical or surgical conditions.[19] This law was expanded in 1999 (Public Act No. 99-284) to include coverage for mental and nervous conditions from the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders.[20] However, due to the Employee Retirement Income Security Act (ERISA) of 1974 that regulates employer-sponsored health plans, any firms making the decision to self-insure were exempt from any state insurance mandates. This represented a significant challenge to advancing the national mental health parity agenda until additional federal reforms were adopted.

After a 12-year impasse at the federal level since the passage of the MHPA in 1996, Congress passed the Mental Health Parity and Addiction Equity Act (MHPAEA) in 2008, which finally required most group health insurance plans (commercial and self-insured) that offer coverage for mental health conditions or substance use disorders to make these benefits no more restrictive than medical and surgical benefits. It also required reasons for denial of benefits

[17] Barry, C. L. et al. (2010). A Political History of Federal Mental Health and Addiction Insurance Parity. *The Milbank QUarterly*, *88*(3), 404–433. https://doi.org/10.1111/j.1468-0009.2010.00605.x.
[18] Barry, C. L. et al. (2010). A Political History of Federal Mental Health and Addiction Insurance Parity. *The Milbank QUarterly*, *88*(3), 404–433. https://doi.org/10.1111/j.1468-0009.2010.00605.x.
[19] An Act Concerning Managed Care, Public Act No. 97-99 (1997), https://www.cga.ct.gov/ps97/sum/sum0099.htm.
[20] An Act Concerning Managed Care Accountability, Public Act No. 99-284 (1999), https://www.cga.ct.gov/ps99/Act/pa/1999PA-00284-R00HB-07032-PA.htm.

relating to mental health or substance use disorder to be disclosed upon request. The MHPAEA was later amended by the Patient Protection and Affordable Care Act (the "Affordable Care Act" or "ACA") to also apply to individual health insurance plans. Despite its legislative significance, the MHPAEA does not apply to self-insured non-federal governmental plans or self-insured private employer plans that have 50 or fewer employees. Furthermore, research documents that since the law's passage, significant disparities persist between payments for physical and behavioral health care services.[21, 22]

To close gaps in mental health parity, in 2019 Connecticut passed "An Act Concerning Mental Health and Substance Use Disorder Benefits" (Public Act No. 19-159), a law that required all private insurance plans to follow the regulations in the 2008 federal MHPAEA.[23] It also established reporting requirements for issuers to demonstrate compliance with the federal law, with reporting starting by March 2021 and annually thereafter. The decision to collect data from insurance plans is an essential component of the state's strategy to monitor gaps in mental health parity and identify barriers created by plan designs.

In 2022, Connecticut passed "An Act Concerning Children's Mental Health" (Public Act No. 22-47), which included several provisions to promote access to mental health treatment and address shortages in the supply of mental health professionals, provided funds to support grant programs to enhance mental health care access in schools, and provided authorization to Connecticut's OHS to conduct studies of payment parity and insurance coverage.[24] Sections 57 and 58 of the law authorize the current studies of (1) how health carriers reimburse healthcare providers for physical, mental, and behavioral health benefits and (2) whether payment parity exists between behavioral and mental health services and medical and surgical services. This literature review and environmental scan were conducted to inform these studies.

[21] Goodell, S. (2015). Enforcing Mental Health Parity. *Health Affairs*. https://doi.org/10.1377/hpb20151109.624272
[22] Hockenberry, J. M. et al. (2019). Trends in Treatment and Spending for Patients Receiving Outpatient Treatment of Depression in the United States, 1998-2015. *JAMA Psychiatry*, *76*(8), 810–817. https://doi.org/10.1001/jamapsychiatry.2019.0633
[23] An Act Concerning Mental Health and Substance Use Disorder Benefits, Public Act No. 19-159 (2019), https://www.cga.ct.gov/2019/ACT/pa/pdf/2019PA-00159-R00HB-07125-PA.pdf.
[24] An Act Concerning Resources and Support Services for Persons with an Intellectual or Developmental Disability, Public Act No. 22-47 (2022), https://www.cga.ct.gov/2022/ACT/PA/PDF/2022PA-00047-R00HB-05001-PA.PDF.

2 OBJECTIVES AND APPROACH

This environmental scan was conducted to identify strategies that have been successfully used to incentivize behavioral health providers to accept insurance payment or more generally address the behavioral health workforce shortage. The environmental scan includes two components: (1) a review of the literature related to reimbursement rates for behavioral health providers and other factors that may reduce barriers to their insurance participation, and (2) research on the current landscape of behavioral health care and access in Connecticut compared to other New England states.

The literature review was conducted with the following objectives:

1. Understand the disparities that currently exist between behavioral health provider reimbursement rates compared to other provider types as well as disparities in reimbursement rates across various insurance coverage types
2. Assess evidence on the impact of increasing provider reimbursement rates on provider participation in insurance and access to care
3. Identify other potential levers to attract behavioral health providers and reduce barriers to insurance participation
4. Identify additional approaches that have been successful in alleviating the behavioral health workforce shortage and improving access to care

The literature review included searches of grey literature sources[25] and peer-reviewed publications to support these objectives. The grey literature search focused on identifying state and federal programs and policies used to address the behavioral workforce shortage. We searched state and federal resources (e.g., state Medicaid sites, other state government sites, and state legislative activities), as well as websites of foundations and non-profit organizations. Results from the grey literature review informed the initial peer-reviewed literature search. The peer-reviewed literature search involved searching a variety of databases, journals, and organization websites (e.g., *Health Affairs*, the National Library of Medicine, the *Journal of the*

[25] Grey literature is literature that is not formally published in sources such as books or journal articles and can include information from government reports, and non-governmental organizations.

American Medical Association (JAMA) and its sister *JAMA* journals, the American Psychiatric Association, and the National Bureau of Economic Research).[26]

The environmental scan reviewed and compiled data from multiple sources to summarize the prevalence of behavioral health disorders in Connecticut and the supply of behavioral health providers, provider salaries, and Medicaid reimbursement rates in Connecticut and its neighboring New England states. The intent of the scan was to better understand the demand for treatment in Connecticut, the workforce available to meet the demand, and reimbursement for behavioral health services. Table 2.1 provides an overview of the data sources used. Appendix B provides a description and reference for each data source used.

Table 2.1. Summary of Data Sources Used in the Environmental Scan

Data Source	Description
Survey data from the National Survey on Drug Use and Health (NSDUH)	Prevalence of substance use disorders and mental illnesses, as well as access to treatment were examined across various age groups to better understand the current impact of behavioral health issues.
United States Bureau of Labor Statistics' Occupational Employment and Wage Statistics and the National Council for Education Statistics	The supply of behavioral health providers was examined across the six New England states for selected professions to gain a better understanding of the existing workforce. The following professions are included: psychiatrists, child, family, and school social workers; school psychologists; mental health and substance abuse social workers; clinical and counseling psychologists; marriage and family therapists; and substance abuse, behavioral disorder, and mental health counselors. Appendix A provides definitions for these professions.
United Sates Bureau of Labor Statistics' Occupational and Wage Statistics - May 2022 State Occupational Employment and Wage Estimates	Behavioral health provider salaries were examined across the New England states to observe any potential disparities in wages between states that may impact where a provider chooses to practice. Salary information is included for the following professions: psychiatrists; clinical and counseling psychologists; school psychologists; mental health and substance abuse social workers; child, family, and school social workers; substance abuse, behavioral disorder, and mental health counselors; and psychiatric technicians.
Medicaid and Medicare fee schedules	Observed across the New England states to examine potential differences in the maximum reimbursement fees for a set of selected behavioral health procedures. The following procedures are included: family psychotherapy including patient (50 minutes); family psychotherapy (50 minutes); group psychotherapy, psychiatric diagnostic evaluation, psychotherapy (30 minutes); psychotherapy (45 minutes); and psychotherapy (60 minutes).

[26] Acumen conducted an initial search and gathered relevant literature for each of the review objectives. We reviewed abstracts of the peer-reviewed literature to identify articles relevant to the review objectives. Next, we retrieved the full-text version of each selected article and assessed whether each article provided relevant information as indicated in the abstract. If an article was determined to provide relevant information, we conducted an in-depth data abstraction of its content. We identified additional relevant literature by retrieving articles cited in the initially returned articles.

3 ADDRESSING BEHAVIORAL HEALTH WORKFORCE SHORTAGES

Researchers have devoted considerable attention to understanding the various factors that contribute to behavioral health workforce shortages. Declines in providers participating in insurance plan networks due to low provider reimbursement rates are often cited as a major contributor to these shortages, however, the literature on provider reimbursement rates suggests that the impact of increasing rates on participation is mixed. This section reviews the literature on provider reimbursement rates and their potential impact on provider participation in insurance, discusses additional barriers to provider participation in insurance, and discusses several other levers identified in the research that may be utilized to address workforce shortages and build a comprehensive behavioral health care system.

Section 3.1 discusses declines in providers participating in health plans across different health insurance coverage types. Section 3.2 reviews the literature documenting disparities in reimbursement rates for behavioral health providers and other providers as well as differences in rates across insurance markets and assesses the evidence on whether increases in reimbursement rates attract providers to participate in insurance plans. Section 3.3 identifies other barriers to provider participation. Last, Section 3.4 outlines additional approaches to addressing the behavioral health workforce shortage and improving access to care.

3.1 Provider Participation in Medicaid and Commercial Health Insurance

The MHPAEA, as amended by the Affordable Care Act, generally requires that group health plans and health insurance issuers offering group or individual health insurance coverage ensure that the financial requirements and treatment limitations on mental health or substance use disorder benefits provided to enrollees are no more restrictive than those on medical or surgical benefits. The ACA further expands parity requirements of Medicaid programs in states that elected to expand their Medicaid programs. The parity legislation is intended to increase access to behavioral health care by ensuring equal payment for behavioral health treatment. However, the parity mandates have failed to expand access to the extent advocates had hoped. As detailed below, in recent years, provider participation in insurance has actually declined across all insurance types, contributing to ongoing problems with access to care. As the share of providers who accept insurance decreases, it becomes more difficult for consumers to find in-network

providers, leading to higher utilization of out-of-network care, with higher cost sharing, or care from providers who do not accept insurance at all.

Several early studies documented lower participation in insurance for behavioral health providers compared to general medical providers. A study using nationally representative survey data from 2005 to 2010 compared the share of psychiatrists and physicians who accepted various forms of insurance. The study found that the percentage of psychiatrists who accepted non-capitated private insurance was considerably lower than acceptance rates of other physicians, and the difference grew substantially from 2005-2006 to 2009-2010, dropping from 72.3% in 2005-2006 to 55.3% in 2009-2010. In contrast, the percentage of physicians in other specialties decreased from 93.1% to 88.7% over the same time period. The percentage of psychiatrists who accepted Medicare in 2009-2010 (54.8%) was significantly lower than that for other physicians (86.1%) and had declined by 19.5% since 2005-2006. The study also found that Medicaid acceptance rates among psychiatrists were lower than other physicians in all years, but did not decrease significantly over the years. In 2009-2010, Medicaid acceptance rates were 43.1% for psychiatrists and 73% for other physicians.[27]

An analysis of psychiatrist participation in Massachusetts using 2013 Massachusetts licensing data and the All-Payer Claims Database found participation in the private insurance market to be limited. The cross-sectional analysis included group commercial, individual Marketplace, Medicare Advantage, and Medicaid managed care plans. Out of 2,348 licensed psychiatrists, 79% had at least one outpatient claim, but only 6% had claims for at least 300 unique patients (i.e., a full caseload) and the median number of claims for unique patients per year was 18. Of the psychiatrists with at least one outpatient claim, 93% participated in group commercial insurance; however, only 33% participated in Medicare Advantage, Marketplace plans, or Medicaid managed care.[28]

More recent research has focused on the issue of narrow networks—defined as fewer than 25% of providers in a given market—and the higher occurrence of narrow networks for

[27] Bishop, T. F. et al. (2014). Acceptance of insurance by psychiatrists and the implications for access to mental health care. *JAMA Psychiatry*. https://doi.org/10.1001/jamapsychiatry.2013.2862
[28] Benson, N. M. et al. (2020). Psychiatrist participation in private health insurance markets: Paucity in the land of plenty. *Psychiatric Services*. https://doi.org/10.1176/appi.ps.202000022

psychiatrists. Providers have the choice to participate in managed care plans as in-network or out-of-network providers rather accepting fee-for-service payments for care or opting out of insurance entirely. Additionally, the size of plan networks has implications for the availability of affordable care. Narrow network plans have become common, particularly in ACA Marketplace plans, with approximately half of Marketplace plans having narrow networks in 2016.[29] Provider networks for behavioral health services have also been found to be narrower than networks for other provider types and increasing shares of behavioral health services are provided out of network.[30, 31, 32] While most states implement network adequacy standards, research suggests that low provider participation in network plans contributes to the shortage of affordable providers.

Several studies have examined network sizes for several provider types across insurance markets. One study analyzed 500 ACA Marketplace networks to evaluate network size and to compare participation in networks between mental health care providers and primary care providers. The study found that 21.4% of all mental health care providers and 45.6% of primary care providers participated in at least one ACA Marketplace network, and 42.7% of psychiatrists participated in at least one network compared with 58.4% of primary care physicians.[33] A 2019 study linking several data sources to compare psychiatrist network breadth for plans across Medicare Advantage, Medicaid managed care, and ACA Marketplace plans found that 64.6% of psychiatrist networks in Medicare Advantage were narrow compared with 43.1% in Medicaid managed care and 39.5% in ACA Marketplaces.[34] A third study examined participation in Medicaid managed care plans in four states from 2015 to 2017 and found that about one-third of primary care and specialist physicians contracted with managed care plans. Care was highly

[29] Zhu, J. M. et al. (2017). Networks in ACA marketplaces are narrower for mental health care than for primary care. *Health Affairs*. https://doi.org/10.1377/hlthaff.2017.0325
[30] Melek, S. P. et al. (2017). *Addiction and mental health vs . physical health : Analyzing disparities in network use and provider reimbursement rates A quantitative approach to investigating nonquantitative treatment* (Issue December).
[31] Xu, W. Y. et al. (2019). Cost-Sharing Disparities for Out-of-Network Care for Adults with Behavioral Health Conditions. *JAMA Network Open*. https://doi.org/10.1001/jamanetworkopen.2019.14554
[32] Zhu, J. M. et al. (2023). Psychiatrist Networks In Medicare Advantage Plans Are Substantially Narrower Than In Medicaid And ACA Markets. *Health Affairs (Project Hope)*. https://doi.org/10.1377/hlthaff.2022.01547
[33] Zhu, J. M. et al. (2017). Networks in ACA marketplaces are narrower for mental health care than for primary care. *Health Affairs*. https://doi.org/10.1377/hlthaff.2017.0325
[34] Zhu, J. M. et al. (2023). Psychiatrist Networks In Medicare Advantage Plans Are Substantially Narrower Than In Medicaid And ACA Markets. *Health Affairs (Project Hope)*. https://doi.org/10.1377/hlthaff.2022.01547

concentrated; a small fraction of primary care and specialist physicians (around 25%), including psychiatrists, accounted for a large portion of care (75% to 85%).[35]

Finally, Milliman analyzed in-network and out-of-network utilization rates for medical/surgical and behavioral health services from 2013 to 2015 for patients in preferred provider organization (PPO) plans that offered both in-network and out-of-network providers. In 2015, its researchers found that out-of-network providers provided 4.0% and 5.5% of care in inpatient and outpatient settings for medical/surgical care (respectively) compared to 16.7% and 31.6% of behavioral care in the same settings (respectively). They also found that out-of-network providers provided 3.7% of primary care visits, 5.2% of specialty office visits for medical/surgical, and 18.7% of behavioral office visits. Similar patterns were found in Connecticut, with out-of-network providers providing 1.6% and 3.1% of inpatient and outpatient medical/surgical care and 27.1% and 34.4% of behavioral care in the same settings, with the share of out-of-network behavioral health care increasing from 13% in 2013. Lastly, 3.3% and 4.3% of primary and specialty office visits were out-of-network (respectively) compared to 34.2% of behavioral health office visits.[36]

3.2 Impact of Reimbursement Rates on Insurance Participation

One of the most commonly discussed reasons for declining provider participation in insurance, especially in Medicaid, has been low provider reimbursement rates for behavioral health services. The literature has documented significant disparities in rates for behavioral health providers compared to other providers for the same services as well as in rates across different insurance coverage types.[37, 38, 39, 40] A 2022 study comparing psychiatrist reimbursement rates to those of other providers for the same commonly billed services found that Medicaid rates for

[35] Ludomirsky, A. B. et al. (2022). In Medicaid Managed Care Networks, Care Is Highly Concentrated Among A Small Percentage Of Physicians. *Health Affairs (Project Hope)*. https://doi.org/10.1377/hlthaff.2021.01747
[36] Melek, S. P. et al. (2017). *Addiction and mental health vs . physical health : Analyzing disparities in network use and provider reimbursement rates A quantitative approach to investigating nonquantitative treatment* (Issue December).
[37] Mark, T. L. et al. (2020). Comparison of medicaid reimbursements for psychiatrists and primary care physicians. *Psychiatric Services*. https://doi.org/10.1176/appi.ps.202000062
[38] US Government Accountability Office. (2014). *Medicaid Payment: Comparisons of Selected Services under Fee-for-Service, Managed Care, and Private Insurance*. *July*, 32. http://www.gao.gov/assets/670/664782.pdf
[39] Zuckerman, S. et al. (2004). Changes in medicaid physician fees, 1998-2003: Implications for physician participation. *Health Affairs*. https://doi.org/10.1377/hlthaff.W4.374
[40] Zuckerman, S. et al. (2021). Medicaid physician fees remained substantially below fees paid by medicare in 2019. *Health Affairs*. https://doi.org/10.1377/hlthaff.2020.00611

psychiatrists were about 81% of the Medicare rate for the same services provided by other providers. At the state level, Connecticut's Medicaid-to-Medicare ratio was around 90%; Maine and Rhode Island had two of the three lowest ratios in the U.S., 49% and 47%, respectively.[41] The payment parity study includes an examination of reimbursement rate disparities across payers in the state.

A Milliman study of the large group employer market found that in 2015, primary and medical/surgical providers were paid on average 15.2% and 11.3% more, respectively, than Medicare amounts, while behavioral health providers were paid an average of 4.9% less than Medicare for the same services.[42] Researchers have also documented that Medicaid rates have historically been lower than Medicare rates across a wide range of services. As of 2019, Medicaid reimbursements over a set of 27 procedures including primary care, obstetric care, and other services were estimated to be equal to 72% of Medicare rates at the national level, with significant variation in state-level rates. Connecticut's Medicaid-to-Medicare ratio was estimated to be 75%.[43, 44]

Disparities in reimbursement rates for in-network and out-of-network care may also be contributing to the shortage of in-network providers. Two studies using private insurance data analyzed reimbursement rates for in- and out-of-network care. Benson and Song's analysis of outpatient claims data from 2007 to 2017 found that provider reimbursement rates for in-network adult psychotherapy were $88.56 and $114.67 for office visits and hospital outpatient department visits, respectively, while out-of-network care rates were $133.72 and $160.67 in the same settings. They also found similar differences in prices for child psychotherapy.[45] A second study using data from 2014 analyzed reimbursement rates for evaluation and management services provided to individuals with a mental health disorder as their primary diagnosis. The median

[41] Zhu, J. M. et al. (2023). Medicaid Reimbursement For Psychiatric Services: Comparisons Across States And With Medicare. *Health Affairs*, *42*(4), 556–565. https://doi.org/10.1377/hlthaff.2022.00805
[42] Melek, S. P. et al. (2017). *Addiction and mental health vs . physical health : Analyzing disparities in network use and provider reimbursement rates A quantitative approach to investigating nonquantitative treatment* (Issue December).
[43] Zuckerman, S. et al. (2004). Changes in medicaid physician fees, 1998-2003: Implications for physician participation. *Health Affairs*. https://doi.org/10.1377/hlthaff.W4.374
[44] Zuckerman, S. et al. (2021). Medicaid physician fees remained substantially below fees paid by medicare in 2019. *Health Affairs*. https://doi.org/10.1377/hlthaff.2020.00611
[45] Benson, N. M., & Song, Z. (2020). Prices and cost sharing for psychotherapy in network versus out of network in the united states. *Health Affairs*. https://doi.org/10.1377/hlthaff.2019.01468

reimbursement rate for in-network care ranged from 13% to 20% less for psychiatrists than medical doctors, depending on the severity of diagnosis. However, out-of-network care reimbursements for psychiatrist services were 28% and 6% higher for low to moderate and moderate to high severity, respectively.[46]

Pelech and Hayford (2019) compared Medicare Advantage and commercial insurance prices for mental health services and found that commercial insurers paid an average of 13% to 14% less for in-network mental health services than Medicare fee-for-service for identical services (psychotherapy and evaluation and management [E&M] services). However, commercial insurers paid 12% more for E&M services when delivered by a non-mental health physician. Furthermore, the authors found commercial insurers paid 43% and 53% more than fee-for-service (FFS) Medicare for out-of-network E&M and psychotherapy services.[47]

While the disparities in provider reimbursement rates are well documented[48, 49, 50, 51] and providers seem to consistently cite reimbursement rates as a reason for not participating in Medicaid,[52, 53, 54] there is very limited literature on whether increasing behavioral health provider rates affects provider participation. To date, studies on provider reimbursement rates have focused on increasing fees for primary care and other services and examined the impacts of changes in Medicaid fees on provider participation, access to care, and health care utilization. Increases in fees could affect patient access to care in two ways: (1) incentivizing more providers to participate in insurance, or (2) incentivizing already participating providers to accept more

[46] Mark, T. L. et al. (2018). Differential reimbursement of psychiatric services by psychiatrists and other medical providers. *Psychiatric Services*. https://doi.org/10.1176/appi.ps.201700271
[47] Pelech, D., & Hayford, T. (2019). Medicare advantage and commercial prices for mental health services. In *Health Affairs*. https://doi.org/10.1377/hlthaff.2018.05226
[48] Mark, T. L. et al. (2020). Comparison of medicaid reimbursements for psychiatrists and primary care physicians. *Psychiatric Services*. https://doi.org/10.1176/appi.ps.202000062
[49] US Government Accountability Office. (2014). *Medicaid Payment: Comparisons of Selected Services under Fee-for-Service, Managed Care, and Private Insurance*. *July*, 32. http://www.gao.gov/assets/670/664782.pdf
[50] Zuckerman, S. et al. (2004). Changes in medicaid physician fees, 1998-2003: Implications for physician participation. *Health Affairs*. https://doi.org/10.1377/hlthaff.W4.374
[51] Zuckerman, S. et al. (2021). Medicaid physician fees remained substantially below fees paid by medicare in 2019. *Health Affairs*. https://doi.org/10.1377/hlthaff.2020.00611
[52] Cunningham, P., & May, J. (2006). Medicaid patients increasingly concentrated among physicians. *Tracking Report [Electronic Resource] / Center for Studying Health System Change.*, *16*, 1–5.
[53] Holgash, K., & Heberlein, M. (2019). Physician Acceptance of New Medicaid Patients: What Matters and What Doesn't. *Health Affairs*. https://www.healthaffairs.org/content/forefront/physician-acceptance-new-medicaid-patients-matters-and-doesn-t
[54] Sommers, A. S. et al. (2011). Physician willingness and resources to serve more medicaid patients: Perspectives from primary care physicians. *Medicare and Medicaid Research Review*. https://doi.org/10.5600/mmrr.001.02.a01

patients. For instance, many providers who accept Medicaid limit the number of Medicaid patients they see, but rising fees may enable providers to increase their Medicaid service volumes.[55] The literature seems to agree that fee increases improve access to care, but results are mixed on whether increases lead to higher levels of overall provider participation.[56]

Several studies examined the impact of the Affordable Care Act's temporary primary care fee increase, which increased physician fees for certain primary care services in 2013 and 2014, and found mixed results. Decker used National Electronic Health Records Survey (NEHRS) data from 2011 to 2015 to analyze the impact the fee bump had on physician participation in Medicaid and found that although the percentage of physicians reporting accepting new Medicaid patients increased from 65% to 67%, this increase was not statistically significant. Additionally, the percentage of physicians reporting more than 1% of their patients on Medicaid increased slightly over the study period, but this increase occurred in states with the lowest fee increases and highest pre-ACA Medicaid-to-Medicare fee ratio.[57] Another study used Intercontinental Medical Statistics (IMS) Health claims data for primary care provider professional services that were eligible for the ACA's payment increase from January 2012 to December 2015 and found no association between increased fees and several measures of physician participation and Medicaid service volume.[58]

On the other hand, a 2015 study[59] found a positive association between the fee increase and appointment availability for Medicaid enrollees. As part of the study, research staff posed as Medicaid enrollees seeking to obtain appointments with primary care physicians before and after the ACA reimbursement increase across 10 states.[60] The proportion of research staff who were able to acquire appointments increased from 58.7% to 66.4% from November 2012 to July 2014.

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[55] Sommers, A. S. et al. (2011). Physician willingness and resources to serve more medicaid patients: Perspectives from primary care physicians. *Medicare and Medicaid Research Review*. https://doi.org/10.5600/mmrr.001.02.a01

[56] Saulsberry, L. et al. (2019). The Impact of Changes in Provider Fees on Provider Participation and Enrollees' Care: a Systematic Literature Review. *Journal of General Internal Medicine*, *34*(10), 2200–2209. https://doi.org/10.1007/s11606-019-05160-x

[57] Decker, S. L. (2018). No association found between the medicaid primary care fee bump and physician-reported participation in medicaid. *Health Affairs*. https://doi.org/10.1377/hlthaff.2018.0078

[58] Mulcahy, A. W. et al. (2018). Associations between the patient protection and affordable care act medicaid primary care payment increase and physician participation in medicaid. *JAMA Internal Medicine*. https://doi.org/10.1001/jamainternmed.2018.2610

[59] Polsky, D. et al. (2015). Appointment Availability after Increases in Medicaid Payments for Primary Care. *New England Journal of Medicine*. https://doi.org/10.1056/nejmsa1413299

[60] Arkansas, Georgia, Illinois, Iowa, Massachusetts, Montana, New Jersey, Oregon, Pennsylvania, and Texas.

The study also found that the largest increases in availability occurred in states with the largest increases in reimbursements. However, it is important to note that since the study only includes providers that accepted Medicaid prior to the fee increases, it does not provide any insight as to whether there was an increase in the total number of providers accepting Medicaid. The study only demonstrates that physicians already participating in Medicaid were able to increase the number of Medicaid patients they accepted.

The ACA's temporary fee increase expired at the end of 2014 and only 19 states continued the fee increases in some form.[61] As a follow-up to the 2015 analysis by Polsky, another study estimated the impact of declining fees resulting from the end of the policy on appointment availability for Medicaid enrollees. Once again, trained staff were utilized to simulate new patients seeking appointments in the same 10 states as the Polsky study. The study found that the states with the largest changes in Medicaid fees from 2014 to 2016 also experienced declines in appointment availability. Overall, they found that a $10 change in Medicaid fees was associated with a 1.7-percentage-point change in appointment availability for new Medicaid patients, and the impact did not depend on whether fees increased or decreased. That is, a $10 increase was associated with a 1.7% increase in appointment availability, and a $10 decrease was associated with a 1.7% decrease.[62]

Qualitative studies on the implementation of the ACA fee increase documented that other barriers in addition to fee disparities may have affected the success of the policy. The two most commonly reported factors were: (1) the fee increases were temporary, and (2) high levels of administrative burden were associated with the policy, including unclear program requirements and needing to reprocess claims to receive enhanced payment rates.[63, 64]

Other studies used survey data to estimate changes in access to care, provider participation, and utilization due to fee changes unrelated to the ACA temporary fee increase. Using Medical Expenditure Panel Survey (MEPS) data from 2008 to 2012, Callison and Nguyen

[61] Zuckerman, S. et al. (2017). Medicaid physician fees after the ACA primary care fee bump: 19 states continue the Affordable Care Act's temporary policy change. *Urban Institute Research Report*.
[62] Candon, M. et al. (2018). Declining medicaid fees and primary care appointment availability for new medicaid patients. In *JAMA Internal Medicine*. https://doi.org/10.1001/jamainternmed.2017.6302
[63] MACPAC. (2015). *An Update on the Medicaid Primary Care Payment Increase*. *Chapter 8*, 130–138.
[64] Timbie, J. et al. (2017). Examining the Implementation of the Medicaid Primary Care Payment Increase. In *Examining the Implementation of the Medicaid Primary Care Payment Increase*. https://doi.org/10.7249/rr1802

found that increases in the Medicaid-to-Medicare fee ratio for primary care services had little impact on access to care using self-reported measures of access to care. However, the authors did find that fee increases do affect utilization, estimating that a 10-percentage-point increase in fees leads to an 11% increase in the number of physician visits.[65] Another study using National Health Interview Survey (NHIS) data found that a $10 increase in Medicaid payments reduces reports of doctors telling adult Medicaid beneficiaries they are not accepting new patients, or their insurance, by 13% and 11%, respectively. The same change in fees was associated with a 25% decrease in parents reporting having trouble finding a doctor for their children.[66]

Additionally, Zuckerman et al. used Community Tracking Study (CTS) Physicians Survey data and changes in Medicaid primary care fees from 1998-2003 and found that large fee increases were associated with greater willingness to accept new patients. Large fee increases seemed to have the most impact in states with the lowest fee ratios in 1998 and acceptance rates did not change much in states with moderate to high fee ratios.[67]

3.3 Other Factors Affecting Insurance Participation

While low reimbursement rates are commonly cited as a barrier to provider participation, the literature suggests that they are not the only factors taken into consideration when deciding to participate in insurance, especially in Medicaid. Researchers have identified administrative costs and responsibilities as important decision-making factors. Administrative costs include the non-clinical costs of running a medical system and include billing and insurance-related expenses such as claims management and prior authorization, as well as non-billing and insurance expenses, which include general business overhead, credentialing, and customer service.[68] Studies have found that these costs account for 15% to 25% of total US healthcare expenditures, and time and

[65] Callison, K., & Nguyen, B. T. (2018). The Effect of Medicaid Physician Fee Increases on Health Care Access, Utilization, and Expenditures. *Health Services Research*. https://doi.org/10.1111/1475-6773.12698
[66] Alexander, D., & Schnell, M. (2019). The Impacts of Physician Payments on Patient Access, Use, and Health. In *Paper Knowledge . Toward a Media History of Documents*.
[67] Zuckerman, S. et al. (2004). Changes in medicaid physician fees, 1998-2003: Implications for physician participation. *Health Affairs*. https://doi.org/10.1377/hlthaff.W4.374
[68] Cutler, D. M. (2020). Reducing Administrative Costs in U.S. Health Care. *Brookings*, *March*.

resources spent on these types of tasks has increased significantly over the last decade.[69, 70, 71] Time spent on these tasks and their estimated costs vary by insurance coverage type, but physicians commonly report billing requirements, difficulties in claim processing, reimbursement delays, and paperwork to be factors determining their participation in Medicaid or limiting the number of Medicaid patients they accept.[72, 73, 74, 75] These studies included both managed care and FFS states, however, the administrative burdens may be different because Connecticut's Medicaid program only uses FFS.

A National Bureau of Economic Research (NBER) study found that providers encounter more issues with billing for Medicaid. Using remittance claims data for over 100,000 physicians, the study found that almost one-fourth of Medicaid claims had at least one line item denied upon initial submission, compared with 6.7% and 4.1% for Medicare and commercial insurers, respectively. Providers were required to resubmit denied claims sometimes several times to receive payment, resulting in time spent on administrative tasks and lost revenue.[76] These are national estimates and may not apply in Connecticut, where steps have been taken to reduce or eliminate billing problems in Medicaid.

Cunningham and O'Malley linked average reimbursement times for FFS Medicaid claims to survey data from approximately 6,000 physicians and found that slow reimbursement times were associated with lower physician participation in Medicaid, but the effect of reimbursement times depended on fee levels. For instance, reimbursement times had a smaller impact on

[69] Chernew, M., & Mintz, H. (2021). Administrative Expenses in the US Health Care System: Why so High? *JAMA*, *326*(17), 1679–1680. https://jamanetwork.com/journals/jama/fullarticle/2785479
[70] Health Affairs. (2022). *The Role of Administrative Waste in Excess US Health Spending*. https://doi.org/10.1377/hpb20220909.830296
[71] Schoenman, J. A., & Feldman, J. J. (2002). *2002 Survey of Physicians About the Medicare Program*. https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/contractor-reports/Mar03_02PhysSurvRpt2.pdf
[72] Berman, S. et al. (2002). Factors that influence the willingness of private primary care pediatricians to accept more medicaid patients. *Pediatrics*. https://doi.org/10.1542/peds.110.2.239
[73] Cunningham, P. J., & O'Malley, A. S. (2009). Do reimbursement delays discourage medicaid participation by physicians? *Health Affairs*. https://doi.org/10.1377/hlthaff.28.1.w17
[74] Long, S. K. (2013). Physicians may need more than higher reimbursements to expand medicaid participation: Findings from Washington state. *Health Affairs*. https://doi.org/10.1377/hlthaff.2012.1010
[75] Schoenman, J. A., & Feldman, J. J. (2002). *2002 Survey of Physicians About the Medicare Program*. https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/contractor-reports/Mar03_02PhysSurvRpt2.pdf
[76] Dunn, A. et al. (2021). A Denial a Day Keeps the Doctor Away. *SSRN Electronic Journal*. https://doi.org/10.2139/ssrn.3885053

participation in states with lower Medicaid fees suggesting that addressing delays in billing related to Medicaid will also be necessary to see significant changes in provider participation. In Connecticut, they found that the average reimbursement time for Medicaid was 73.6 days compared with an average reimbursement time of 36.4 days for commercial insurers.[77] Another study focused on the participation of primary care pediatricians found that Medicaid participation decreased as the proportion of Medicaid enrollees in managed care plans increased and as paperwork concerns increased. Because Connecticut does not utilize MCOs for its Medicaid program, this should not be a concern of providers in their decision to participate but paperwork concerns may still contribute to lower levels of provider participation in the state.[78]

The practice of prior authorization, which requires approval for a healthcare service or medication before care is provided, has also been cited as an administrative burden for providers and can often cause delays in care.[79, 80] Prior authorization is considered a non-quantitative treatment limit in the context of the MHPAEA. The 2020 Consolidated Appropriations Act[81] requires plans to document the use of prior authorization and submit comparative analyses to show that prior authorization and other non-quantitative treatment limits are not more restrictive than requirements for medical or surgical benefits. However, enforcing this has proven extremely difficult.[82]

In response, state governments have acted to address issues related to prior authorization requirements. Arkansas passed legislation that allows non-physician staff to review and approve prior authorizations.[83] In Massachusetts, several issuers have reached agreements with the state to change their prior authorization requirements. These changes include no longer requiring prior

[77] Cunningham, P. J., & O'Malley, A. S. (2009). Do reimbursement delays discourage medicaid participation by physicians? *Health Affairs*. https://doi.org/10.1377/hlthaff.28.1.w17
[78] Berman, S. et al. (2002). Factors that influence the willingness of private primary care pediatricians to accept more medicaid patients. *Pediatrics*. https://doi.org/10.1542/peds.110.2.239
[79] American Medical Association. (2023). *2022 AMA prior authorization (PA) physician survey*. American Medical Association. https://www.ama-assn.org/system/files/prior-authorization-survey.pdf
[80] Andrews, M. (2022, May 17). Why So Slow? Legislators Take on Insurers' Delays in Approving Prescribed Treatments. *Kaiser Family Foundation*. https://kffhealthnews.org/news/article/prior-authorization-treatment-insurers-doctors-faster/?utm_campaign=KHN%3A First Edition&utm_medium=email&_hsmi=213337234&utm_content=213337234&utm_source=hs_email
[81] Consolidated Appropriations Act, 2021, Pub. L. No. 116-260 (2020). https://www.govinfo.gov/app/details/PLAW-116publ260.
[82] (Departments of Labor, Health and Human Services, and Treasury 2022)
[83] Ivers, D. (2018). *No Arkansas Setting the Pace on Prior Authorization Transparency*. Arkansas Medical Society. https://www.arkmed.org/wp-content/uploads/2018/03/Act-815-of-2017-FINAL.pdf

authorization for routine behavioral health office visits or inpatient mental health admissions after treatment in an emergency department, and not overruling provider decisions on what constitutes appropriate care.[84] New York has also prohibited the use of prior authorization during the first 14 days of an inpatient admission for mental health treatment for children.[85] Several states and some health plan issuers have implemented "gold carding," which exempts providers from requiring prior authorization if a portion (typically 90%) of their prior authorization requests were approved in the past year. This applies to all healthcare services, not specifically to behavioral health. Reducing or eliminating administrative burdens related to prior authorization requirements may incentivize providers to opt in to insurance plans and result in fewer delays in receiving care.

3.4 Additional Levers to Address Workforce Shortages

Increasing provider participation in insurance is one avenue to addressing shortages in the behavioral health workforce and making behavioral health services more widely accessible. However, there are other potential levers states can consider to increase the overall number and availability of providers. These levers fall into two groups:

1. Extend the current workforce – Using a wider range of providers to deliver behavioral health services and allowing providers to serve patients in additional settings to improve access to care
2. Attract new workers – Increasing the overall supply of behavioral health professionals to keep up with increasing demand for services and incentivize providers to work in underserved areas

The following sections discuss several methods identified through the literature review that could be utilized to attract new workers and extend the current workforce.

3.4.1 Peer Support Services

Peer support workers are being used more frequently to provide a wide range of services to individuals with mental health and substance use disorders and to complement traditional

[84] Office of the Attorney General. (2020). *AG Healey Announces Groundbreaking Agreements that Expand Access to Behavioral Health Services for More than One Million Residents*. https://www.mass.gov/news/ag-healey-announces-groundbreaking-agreements-that-expand-access-to-behavioral-health-services-for-more-than-one-million-residents
[85] New York Office of Mental Health. (2019). *Memorandum*. https://omh.ny.gov/omhweb/bho/guidance-memo-on-14-day-no-um-for-under-18-inpatient.pdf

mental health services. The Substance Abuse and Mental Health Services Administration (SAMHSA) defines a peer worker as a person who has successfully recovered from a mental health or substance use disorder and provides support to others experiencing similar challenges. Peer support workers are certified and trained to provide a range of services including advocacy, sharing of experience, community and relationship building, mentoring, skill building, and more.[86] In 2015, SAMHSA developed core competencies for peer workers in behavioral health, and Connecticut has developed a certification process for peer workers that aligns with SAMHSA's guidelines.[87, 88]

The literature shows that peer workers can help support recovery from behavioral health conditions through improvements in social functioning, quality of life, and help with depression and feelings of isolation. These services have also been known to reach individuals who would not normally seek out mental health services, such as individuals who are homeless or those who have had negative interactions with the mental health services system, and can reduce societal stigma of persons with mental health conditions.[89] The utilization of peer support services can also reduce costs through fewer hospitalizations for those with mental illness. A 2018 study of 76 patients at a psychiatric hospital in Connecticut with a psychotic or mood disorder found that participants who received peer support as part of a peer mentor program were not readmitted to the hospital for significantly longer periods of time than those not receiving peer support.[90] A 2006 Georgia study also found that patients receiving peer support reported reductions in symptoms and increases in skills and abilities that generated an average of $5,494 per person per year in savings for the state.[91]

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[86] SAMHSA. (2015). Core Competencies for Peer Support Workers in Behavioral Health Systems. *Substance Abuse and Mental Health Services Administration*, *25*(2001), 1–7. https://www.samhsa.gov/sites/default/files/programs_campaigns/brss_tacs/core-competencies_508_12_13_18.pdf

[87] Connecticut Department of Mental Health and Addiction Services. (2022). *Peer Recovery Support Certification Frequently Asked Questions*. https://portal.ct.gov/DMHAS/Newsworthy/News-Items/Connecticut-Peer-Recovery-Support-Certification-Process

[88] SAMHSA. (2015). Core Competencies for Peer Support Workers in Behavioral Health Systems. *Substance Abuse and Mental Health Services Administration*, *25*(2001), 1–7. https://www.samhsa.gov/sites/default/files/programs_campaigns/brss_tacs/core-competencies_508_12_13_18.pdf

[89] Fortuna, K. L. et al. (2022). An Update of Peer Support/Peer Provided Services Underlying Processes, Benefits, and Critical Ingredients. *Psychiatric Quarterly*. https://doi.org/10.1007/s11126-022-09971-w

[90] O'Connell, M. J. et al. (2018). Outcomes of a peer mentor intervention for persons with recurrent psychiatric hospitalization. *Psychiatric Services*. https://doi.org/10.1176/appi.ps.201600478

[91] Mental Health America. (2019). *Evidence for Peer Support*. https://www.mhanational.org/sites/default/files/Evidence for Peer Support May 2019.pdf

Support for these services has grown and 40 states cover these services under Medicaid as of 2022.[92] While Connecticut has a certification process for peer support workers, it does not currently cover peer support services under Medicaid. Expanding Medicaid to cover these services may improve access to care and alleviate some of the burden that current providers face.

3.4.2 Telehealth

The provision of virtual or remote care, telehealth, has become more common in recent years and significantly increased during the COVID-19 pandemic. The federal government and state governments implemented temporary policy and regulation changes in response to quarantine and isolation requirements during the pandemic, including allowing reimbursement for telehealth services for Medicare and Medicaid and establishing payment parity between telehealth and in-person services to ensure that consumers did not experience disruptions in medical care. As a result, in April 2020, almost half of Medicare primary care visits were provided through telehealth compared to less than 1% prior to the pandemic.[93]

At the state level, for example, Connecticut's governor issued several telehealth-focused executive orders in spring 2020, which later led the legislature to enact a temporary law for enhanced telehealth access until March 15, 2021. The law, "An Act Concerning Telehealth" (Public Act [PA] 20-2), made several critical changes to enhance access to telehealth services, which included provisions that ranged from expanding the types of healthcare providers that could deliver telehealth services to reimbursement parity and limiting out-of-pocket costs.[94] These temporary telehealth policies were enhanced and extended to June 30, 2023 and to June 30, 2024 through the passage of PA-21 and PA 22-81, respectively.

While many of these temporary changes have expired and utilization of telehealth services has decreased since the start of the pandemic, significant utilization of telehealth is expected to continue. In a survey by the American Medical Association, 69% of medical practices said they intended to continue using telehealth in their practice and more than half of physicians reported

[92] Kaiser Family Foundation. (2022). *Medicaid Behavioral Health Services: Peer Support Services*. https://www.kff.org/other/state-indicator/medicaid-behavioral-health-services-peer-support-services/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D
[93] Harris, J. et al. (2021). *What eliminating barriers to interstate telehealth taught us during the pandemic*. *November*.
[94] Dube, N. (2023). *Recent Changes to Connecticut's Telehealth Laws*. https://www.cga.ct.gov/2023/rpt/pdf/2023-R-0173.pdf

that they would continue providing telehealth.[95] Furthermore, in Connecticut, several notable temporary telehealth policies were permanently written into law. The most notable changes included expanding Medicaid telehealth coverage and allowing qualified out-of-state mental health and behavioral health providers to practice telehealth in Connecticut.[96] The behavioral health telehealth expansion is notable because, starting July 31, 2024, PA 22-81 allows nearly all appropriately licensed behavioral health providers with liability insurance at the statutory minimum under Connecticut law to provide reimbursable mental and behavioral health services.

Although the literature on the effectiveness of telehealth services compared to in-person services is relatively new, it suggests that telehealth treatment outcomes for psychiatric conditions are similar to in-person treatment outcomes.[97] Telehealth also has the ability to improve access to care for patients living in underserved or rural areas, reduce transportation times for patients, and shorten wait times for appointments.[98, 99, 100] Implementing permanent changes to telehealth regulations will likely expand telehealth availability and improve access to behavioral health care, especially for individuals living in underserved areas.

3.4.3 Inter-State Licensing

States have the authority to license and regulate healthcare providers, and differences in licensing requirements among states make it difficult for providers to practice across state lines. However, in recent years, the use of multi-state licensing compacts, which are agreements between states to allow providers to practice in other participating states, has expanded to improve access to care and has enabled the expansion of telehealth services.[101] Several states have joined inter-state licensing compacts such as the Psychology Interjurisdictional Compact

[95] McBain, R. K. et al. (2023). Expansion of Telehealth Availability for Mental Health Care After State-Level Policy Changes From 2019 to 2022. *JAMA Network Open*, *6*(6), e2318045. https://doi.org/10.1001/jamanetworkopen.2023.18045
[96] Dube, N. (2023). *Recent Changes to Connecticut's Telehealth Laws*. https://www.cga.ct.gov/2023/rpt/pdf/2023-R-0173.pdf
[97] Shigekawa, E. et al. (2018). The current state of telehealth evidence: a rapid review. *Health Affairs*. https://doi.org/10.1377/hlthaff.2018.05132
[98] Gajarawala, S. N., & Pelkowski, J. N. (2021). Telehealth Benefits and Barriers. *Journal for Nurse Practitioners*. https://doi.org/10.1016/j.nurpra.2020.09.013
[99] Harris, J. et al. (2021). *What eliminating barriers to interstate telehealth taught us during the pandemic*. *November*.
[100] Health Resources and Services Administration. (2023). *What is telehealth?* https://telehealth.hhs.gov/patients/understanding-telehealth
[101] Health Resources and Services Administration. (2023). *What is telehealth?* https://telehealth.hhs.gov/patients/understanding-telehealth

(PSYPACT) and the Interstate Medical Licensure Compact (IMLC). PSYPACT enables psychologists to practice telepsychology in all participating states and practice temporary in-person psychology across states. As of 2022, 26 states including Connecticut had joined. As of 2023, 70 psychologists have applied to practice telepsychology and four have applied for temporary authorizations for in-person practice of psychology.[102] IMLC also allows physicians to practice in other states; 31 states, including Connecticut, are members of IMLC and additional states are in the process of passing legislation to join.

A recent study examining the impacts of various policies to improve access to telehealth, including the use of interstate licensing compacts, estimated that state participation in PSYPACT and IMLC corresponded to 21% and 40% greater likelihood of a facility expanding to offer telehealth services, respectively.[103] Additionally, during the pandemic providers were temporarily allowed to practice across state lines, which enabled providers to reach a larger pool of patients. The Johns Hopkins Health System in Baltimore, Maryland reported that about 10% of the 330,000 patients who used telehealth services during the pandemic were from out of state.[104] Promoting awareness of these licensing opportunities and increasing participation would increase the supply of providers along with supporting the expansion of telehealth services in the state.

3.4.4 School-Based Health Care

As the number of children experiencing mental health issues increases, actions need to be taken to ensure children have adequate access to behavioral health services. School-based health care enables students to have direct access to healthcare providers and can provide a wide range of services to children through various delivery methods. School-based health care can include having a nurse or counselor on site, utilizing school-linked services such as community clinics that can serve several schools, or having more comprehensive on-site care such as school-based health centers (SBHCs). The types of school-based care available to students can depend on many factors, including funding available and the needs of school districts, but the use of SBHCs has

[102] Psychology Interjurisdictional Compact Commission. (2023). *PSYPACT Commission Annual Report 2022*. https://cdn.ymaws.com/psypact.org/resource/resmgr/annual_report_/psypact_commission_annual_re.pdf
[103] McBain, R. K. et al. (2023). Expansion of Telehealth Availability for Mental Health Care After State-Level Policy Changes From 2019 to 2022. *JAMA Network Open*, *6*(6), e2318045. https://doi.org/10.1001/jamanetworkopen.2023.18045
[104] Harris, J. et al. (2021). *What eliminating barriers to interstate telehealth taught us during the pandemic*. *November*.

received significant support in recent decades.[105] Studies indicate that a significant share of children who receive behavioral health care do so in school-based settings, and school-based health services are sometimes the only care to which children have access.[106] Literature also suggests that SBHCs improve access to care, prevent unnecessary emergency department visits, and reduce depressive episodes and suicide risk for adolescents.[107]

Connecticut's school-based health center program allows the use of two types of centers: SBHCs and expanded SBHCs. SBHCs provide comprehensive on-site medical and behavioral health services, while expanded SBHCs only provide either medical or behavioral services. SBHCs are licensed by the Connecticut Department of Public Health (DPH) as outpatient clinics or hospital satellites and receive funding through a variety of sources including state and federal grants, non-profits, and insurance billing.[108] During the 2020-2021 school year the DPH funded 90 SBCHs, including 12 expanded SBHCs. During the 2021-2022 school year, these SBHCs served about 32% of the student population and had about 63,000 mental health visits.[109] One study estimated that utilization of SBHC behavioral health services in Connecticut increased by 12.3% during the pandemic.[110]

Connecticut allows SBHCs to bill Medicaid for behavioral health services, including psychological testing and psychotherapy.[111] Allowing providers to be reimbursed through Medicaid provides an additional funding stream for SBHCs that can help cover the costs of treatment for a significant portion of students. The majority of students (60%) receiving care at DPH-funded SBHCs have public insurance, 23% of students have no health insurance, and the

[105] Love, H. E. et al. (2019). Twenty years of school-based health care growth and expansion. *Health Affairs*. https://doi.org/10.1377/hlthaff.2018.05472
[106] Merikangas, K. R. et al. (2011). Service utilization for lifetime mental disorders in U.S. adolescents: Results of the national comorbidity surveyAdolescent supplement (NCS-A). *Journal of the American Academy of Child and Adolescent Psychiatry*. https://doi.org/10.1016/j.jaac.2010.10.006
[107] Arenson, M. et al. (2019). The Evidence on School-Based Health Centers: A Review. In *Global Pediatric Health*. https://doi.org/10.1177/2333794X19828745
[108] Love, H. E. et al. (2019). Twenty years of school-based health care growth and expansion. *Health Affairs*. https://doi.org/10.1377/hlthaff.2018.05472
[109] Connecticut Department of Public Health. (2023). *School Based Health Centers*.
[110] Damian, A. J., & Oo, M. (2022). Examining School Based Health Service Utilization Among Marginalized Youth in Connecticut During COVID. *Inquiry (United States)*. https://doi.org/10.1177/00469580221105998
[111] Connecticut Department of Social Services. (2022). *Medicaid School Based Child Health Program User Guide*. https://portal.ct.gov/-/media/Departments-and-Agencies/DSS/Health-and-Home-Care/Reimbursement/School-Based-Healthcare-Program/SBCH-User-Guide-updated-May-2022.pdf

remaining students have private insurance.[112] While SBHCs in Connecticut provide much-needed care to children, there are shortages in funding and centers have waitlists to see students. DPH funding for SBHCs has decreased in recent years and some clinics do not receive funding and rely on insurance reimbursements to pay for the cost of providing services.[113] Ensuring that provider reimbursements for Medicaid are adequate to cover the costs of services and funds are allocated to SBHCs will help centers continue to provide care for children throughout the state.

3.4.5 Crisis Care

Crisis mental health services encompass a range of services provided to individuals experiencing psychiatric or substance abuse–related emergencies who require immediate care. Historically, individuals experiencing serious psychiatric or substance abuse symptoms receive care in hospital emergency departments or are admitted to a hospital for treatment. In some cases, law enforcement is the first point of contact for these individuals.[114] In recent years, there has been an increase in the number of visits to emergency departments for those with behavioral health issues, especially among children.[115] Unfortunately, hospital emergency departments and law enforcement have limited capacity and may not be equipped to appropriately address the needs of individuals in these situations. Establishing a crisis care infrastructure has gained support to address the growing need for these services and to alleviate the stress placed on emergency departments and hospitals and provide appropriate behavioral health care. Studies have indicated that crisis services reduce suicide rates, divert people in crisis from hospitalization, and are better at linking individuals in crisis with appropriate outpatient services.[116] In 2020, SAMHSA released

[112] SBHC Expansion Working Group. (2022). *School-Based Health Center (SBHC) Expansion Working Group Final Report*. https://portal.ct.gov/-/media/DPH/School-Based-Health-Centers/PA-2135-SBHC-Report-Updated-32922-final.pdf

[113] Otte, E. (2022, March 31). Limited Funding as Schools Report Waitlists, Growing Demand for Mental Health Services. *CT Examiner*. https://ctexaminer.com/2022/03/31/limited-funding-as-schools-report-waitlists-growing-demand-for-mental-health-services/

[114] Abramson, A. (2021). Building mental health into emergency responses. *American Psychological Association*, *52*(5), 30. https://www.apa.org/monitor/2021/07/emergency-responses

[115] Child Health and Development Institute. (2018). *Issue Brief 65 - Mobile Crisis Services: An Effective Approach for Reducing Emergency Department Utilization*. https://www.chdi.org/index.php/publications/issue-briefs/mobile-crisis-services-effective-approach-reducing-emergency-department-utilization-among-youth-behavioral-health-conditionsLaderman, M. et al. (2018). *Tackling the Mental Health Crisis in Emergency Departments: Look Upstream for Solutions*. Health Affairs Blog. https://www.healthaffairs.org/content/forefront/tackling-mental-health-crisis-emergency-departments-look-upstream-solutions

[116] SAMHSA. (2014). *Crisis Services: Effectiveness, Cost-Effectiveness, and Funding Strategies*. https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf

national guidelines for behavioral health crisis care and identified three elements of an integrated crisis system:

1. Regional Crisis Call Center – 24/7 center that provides crisis intervention capabilities and meets National Suicide Prevention Lifeline (NSPL) standards and offers quality coordination of crisis care in real time
2. Crisis Mobile Team Response – Mobile crisis teams available to reach any person in the service area in a timely manner
3. Crisis Receiving and Stabilization Facilities – Facilities providing short-term (under 24 hours) observation and crisis stabilization services to referrals in a home-like, non-hospital environment[117]

The American Rescue Plan (ARP) awarded planning grants to states for the purpose of providing community-based mobile crisis intervention services and enhanced the federal Medicaid matching percentage to 85% for qualifying community-based mobile crisis intervention services.[118] States such as West Virginia, are taking advantage of these policies and expanding their mobile crisis services. Connecticut has made investments in its behavioral crisis care infrastructure with call centers, mobile crisis teams, urgent crisis centers for youth, and emergency rooms dedicated to those with psychiatric emergencies, and a study found that use of the mobile crisis services reduced the likelihood of emergency department utilization.[119] SAMHSA guidelines for crisis care also recommend utilizing peer support workers on crisis teams to improve the quality of care for individuals receiving crisis care and expand the number of workers available.

[117] SAMHSA. (2020). *National Guidelines for Behavioral Health Crisis Care Best Practis Toolkit*. https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf
[118] Centers for Medicare & Medicaid Services. (2021). *RE: Medicaid Guidance on the Scope and Payments for Qualifying Community-Based Mobile Crisis Intervention Services*. https://www.medicaid.gov/sites/default/files/2021-12/sho21008.pdf
[119] Child Health and Development Institute. (2018). *Issue Brief 65 - Mobile Crisis Services: An Effective Approach for Reducing Emergency Department Utilization*. https://www.chdi.org/index.php/publications/issue-briefs/mobile-crisis-services-effective-approach-reducing-emergency-department-utilization-among-youth-behavioral-health-conditionsDepartment of Mental Health and Addiction Services, D. of C. and F. (2022). *Mental Health Crisis Intervention Services/Mobile Crisis Intervention Services - Connecticut*. 211 of Connecticut. https://uwc.211ct.org/mental-health-crisis-intervention-services-connecticut/

3.4.6 Recruit and Retain Providers

Expanding the settings in which care is provided and allowing a wider range of providers to reimburse for services will not resolve the shortage alone. States also need to attract and retain new workers and incentivize providers to work in mental health shortage areas in order to keep up with the increased need for behavioral health care. Potential methods for growing the behavioral health workforce include:

1. Increasing psychiatry residency slots
2. Implementing loan forgiveness and scholarship programs
3. Providing other financial incentives for workers who practice in underserved areas or in certain settings
4. Establishing early outreach and mentorship programs to promote awareness of behavioral health career opportunities

4 NEED FOR BEHAVIORAL HEALTH SERVICES IN CONNECTICUT

As described, the need for behavioral health services is considerable. Section 4.1 quantifies the number of individuals in Connecticut who are affected by behavioral health disorders and potentially in need of treatment. Section 4.2 documents levels of insurance coverage by payer in Connecticut to inform projections of the number of providers that would be needed to adequately serve enrollees across the various payers.

4.1 Prevalence of Behavioral Health Disorders

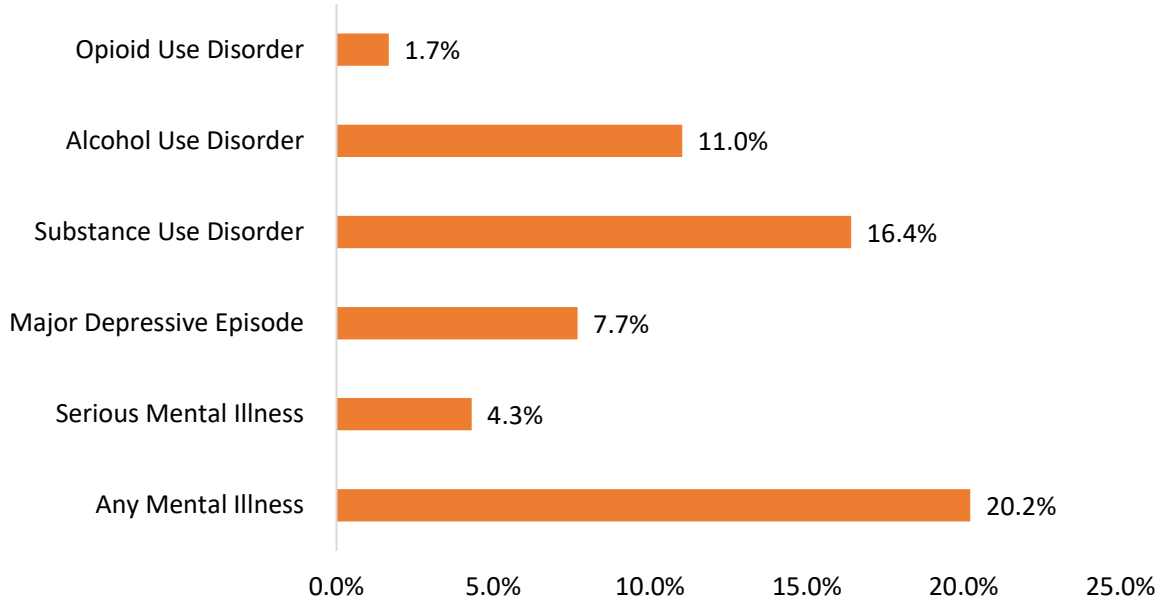
This section examines the overall need for behavioral health services among adults and youth ages 12 to 17 in Connecticut. It summarizes prevalence data for behavioral health disorders, use of mental health services, and reported unmet need for substance use services and the projected number of non-institutionalized Connecticut adults and youth who are affected by behavioral health disorders and potentially in need of behavioral health treatment.

State-level prevalence data from 2021 were available from the NSDUH for past-year opioid use disorder, alcohol use disorder, any substance use disorder, serious mental illness, major depressive episode, and any mental illness for adults ages 18 and older (Figure 4.1). Based on these data, the overall prevalence of any mental illness was 20.2% and the overall prevalence of

any substance use disorder was 16.4%. Applying these rates to the Connecticut 2021 population indicates that an estimated 573,000 Connecticut adults were affected by mental illness and approximately 465,000 by substance use disorder. Note that these estimates do not account for co-occurring mental illness and substance use disorder, so the total number of individuals affected with any behavioral health disorder is less than the total of the two combined.

According to the NSDUH, just 20.6% of Connecticut adults with mental illness received treatment in a specialty mental health setting in 2021. Moreover, 15.6% of adults who needed treatment for substance use disorder use did not receive it. As described in Section 1, the most common reason reported for not getting treatment was lack of affordable care.

Figure 4.1. Prevalence of Past Year Behavioral Health Disorders for Connecticut Adults Ages 18 and Older, 2021



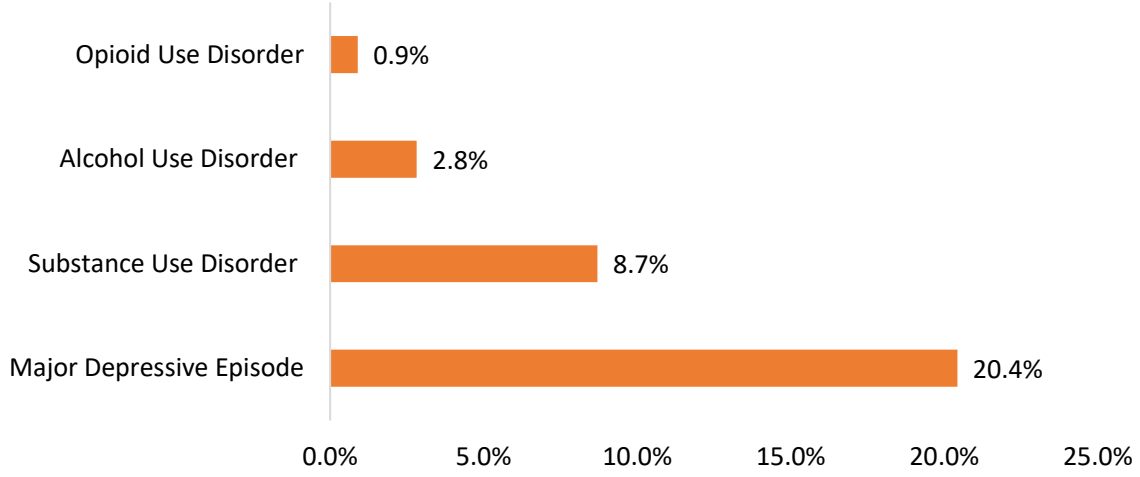
Source: 2021 National Survey on Drug Use and Health.

For youth ages 12 to 17, state-level prevalence data were available from the NSDUH for past-year opioid use disorder, alcohol use disorder, and any substance use disorder. The NSDUH does not report state-level estimates for mental illness for this age group, but does include an estimate for major depressive episode. A total of 8.7% of youth had substance use disorder; 20.4% had a major depressive episode. Applying the prevalence rates to the Connecticut youth population indicates that approximately 56,000 were affected by a major depressive episode and 24,000 affected by substance use disorder. Like the projections for the adult population, these

numbers do not account for co-occurring substance use and mental illness. Moreover, they do not reflect the total number of youths with mental health conditions, as the available estimates do not include all mental health conditions. They do, however, provide gross estimates of the number of adolescents with potential need for behavioral health treatment.

A total of 23.6% of youth with a severe major depressive episode reported receiving consistent treatment for their condition.[120] However, 6.5% needed, but did not receive, treatment for substance use disorder. This translates to approximately 18,000 youth with unmet need for substance use treatment.

Figure 4.2. Prevalence of Past Year Mental Health Disorders for Connecticut Youth Ages 12 to 17, 2021



Source: 2021 National Survey on Drug Use and Health.

4.2 Insurance Coverage in Connecticut

Connecticut has one of the lower uninsured rates in the country at 5.2% overall, and just 3.2% of Connecticut youth under the age of 19 are uninsured, according to the U.S. Census Bureau's 2022 American Community Survey (ACS) (United States Census Bureau 2022-c). As such, nearly all residents of the state with behavioral health care needs would potentially benefit from adequate coverage for behavioral health treatment. This section reports the distribution of

[120] This result was not reported in the 2021 state-level NSDUH results; it is based on 2019 NSDUH data published in a 2022 report from Mental Health America: https://www.mhanational.org/issues/2022/mental-health-america-youth-data. All other results in this section are from the 2021 NSDUH.

insurance coverage in the state from the ACS to inform estimates of how many providers might be needed to serve enrollees across the payer types. Using prevalence estimates by payer from the claims data, the number of providers the Medicaid program would need to enroll to achieve certain provider-to-enrollee ratios could be estimated. These results could also inform network adequacy standards for the minimum number of behavioral health providers health plans need to contract with.

Of the state's total population, 68.9% are covered by commercial insurance and 37.6% by public health insurance. The public health insurance group comprises the following groups: Medicare coverage alone or in combination, Medicaid/means-tested public coverage alone or in combination, and Veterans Affairs (VA) healthcare coverage alone or in combination. In total, 18.8% have Medicare coverage, 22.4% have Medicaid coverage, and 1.3% have VA health coverage. By age category, among individuals ages 19 and younger, 0.4% have Medicare coverage, 36.7% have Medicaid/means-tested public coverage, and none have VA healthcare coverage. Among the 19- to 64-year-old age group, 3.1% have Medicare coverage, 19% have Medicaid/means-tested public coverage, and 0.9% have VA healthcare coverage. Among the 65 and older age group, 93.8% have Medicare coverage, 16.3% have Medicaid/means-tested public coverage, and 4.2% have VA healthcare coverage.

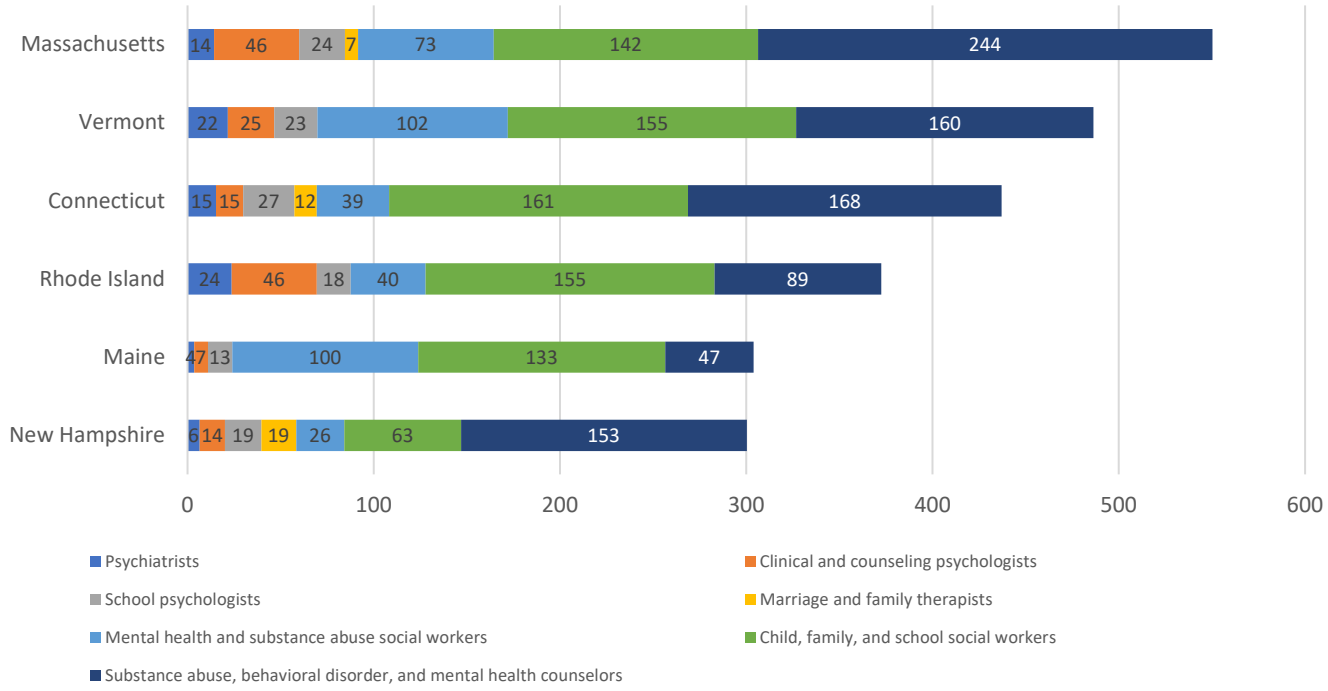
5 THE BEHAVIORAL HEALTH WORKFORCE IN CONNECTICUT AND THE OTHER NEW ENGLAND STATES

This section provides information on the behavioral health workforce in Connecticut and the other New England states. It is intended to inform our understanding of the supply of providers available to meet service demand and factors potentially impacting provider supply. It summarizes the number of behavioral health providers in each state and average salaries for different provider types.

5.1 Size of the Behavioral Health Workforce

Figure 5.1 presents the numbers of psychiatrists, psychologists, social workers, marriage and family therapists, and counselors per 100,000 state residents in Connecticut and the other New England states. For reference, the actual 2022 employment counts for Connecticut and the other New England states are included in Appendix D. Connecticut follows Massachusetts and Vermont in terms of the total number of behavioral health providers per capita across the provider types. However, it has fewer providers with higher-level training. Specifically, Connecticut has just 42 psychologists per 100,000 residents (combining clinical and counseling psychologists and school psychologists) compared to Massachusetts, Rhode Island, and Vermont which have 70, 64, and 48 psychologists per 100,000 residents, respectively. It also has fewer total social workers (200 per 100,000 residents) than Vermont, Maine, and Massachusetts (257, 233, and 215 per 100,000, respectively).

Figure 5.1. Number of Behavioral Health Providers per 100,000 Total Population in Connecticut and the Other New England States



Note: Appendix C also provides these data in a table displaying complete numbers.
Source: U.S. Bureau of Labor Statistics, May 2022 State Occupational Employment and Wage Estimates.

5.2 Behavioral Health Salaries

Table 5.1 presents average salaries for behavioral health providers in Connecticut and the other New England states. The comparison includes psychiatrists, psychologists, behavioral health social workers, counselors, and psychiatric technicians ordered from highest to lowest salary, which reflects the relative level of training for the professions. The national average salaries are also provided as an additional comparison to the New England region.

Connecticut has higher average salaries for behavioral health professions than the national average salaries (Table 5.1). Across the New England states, Connecticut has the highest or second-highest average salary for all of the selected behavioral health professions, with the exception of behavioral health counselors, which includes substance abuse, behavioral disorder, and mental health counselors. While this bodes well for Connecticut behavioral health professions in general, behavioral health counselors are often the front-line workforce treating individuals with behavioral health conditions. Moreover, they represent the largest portion of the behavioral

health workforce in Connecticut (see Figure 5.1). Thus, while a larger number of professions have higher average salaries, a significant portion of Connecticut's behavioral health workforce is in a lower paid profession.

Table 5.1. Average Salaries for Behavioral Health Professions in the Nation, Connecticut and Other New England States

Profession	National	CT	ME	MA	NH	RI	VT
Psychiatrists	$247,350	$308,690	$272,740	$196,230	$233,920	$231,000	$202,470
Clinical and Counseling Psychologists	$102,740	$112,280	$102,910	$100,510	$79,270	$117,760	$91,240
School Psychologists	$87,550	$94,050	$92,720	$95,680	$76,870	$84,210	$78,460
Mental Health and Substance Abuse Social Workers	$60,130	$79,080	$68,900	$56,860	$65,760	$61,460	$56,080
Child, Family, and School Social Workers	$56,680	$71,970	$61,760	$57,370	$56,520	$66,460	$54,820
Substance Abuse, Behavioral Disorder, and Mental Health Counselors	$56,230	$56,980	$62,910	$59,780	$50,860	n/a	$55,120
Psychiatric Technicians	$40,760	$55,040	$40,220	$44,380	$43,080	$44,770	$43,550

Note: The color coding is applied for each row in the table (i.e., for each profession) so that higher salaries are highlighted in green and lower salaries are highlighted in red. The color gradient ranges from red (lowest salary for the respective profession) to orange to yellow to green (highest salary for the respective profession).
Source: U.S. Bureau of Labor Statistics, May 2022 State Occupational Employment and Wage Estimates.

Table 5.2 presents the average salaries for Connecticut metropolitan areas to examine variation in behavioral health professional salaries within the state. The Bridgeport-Stamford-Norwalk and Hartford metropolitan areas generally had the highest average salaries. The non-metropolitan areas have some of the lowest average salaries in the state, except for child, family, and school social workers, which have the highest. However, data are not available for several non-metropolitan area categories due to too few individuals in the category.

Table 5.2. Average Salaries for Behavioral Health Professions in Connecticut by Region of the State

Profession	Bridgeport-Stamford-Norwalk	Danbury	Hartford, West Hartford, East Hartford	New Haven	Norwich-New London-Westerly, CT-RI	Waterbury	Non-metropolitan area
Psychiatrists	N/A	N/A	$272,960	$250,020	N/A	N/A	N/A
Clinical and Counseling Psychologists	$112,960	N/A	$113,620	$108,820	$108,630	N/A	N/A
School Psychologists	$105,320	$95,250	$90,470	$82,990	$93,320	$82,470	N/A
Mental Health and Substance Abuse Social Workers	$80,950	$76,800	$87,750	$65,750	$77,740	$65,890	$67,980
Child, Family, and School Social Workers	$75,540	$66,440	$71,290	$71,900	$70,650	$72,040	$77,070
Substance Abuse, Behavioral Disorder, and Mental Health Counselors	$60,460	$55,370	$56,680	$57,280	$53,660	$55,670	$52,160
Psychiatric Technicians	$55,970	N/A	$54,830	$53,320	$55,060	N/A	$49,870

Note: The color coding is applied for each row in the table (i.e., for each profession) so that higher salaries are highlighted in green and lower salaries are highlighted in red. The color gradient ranges from red (lowest salary for the respective profession) to orange to yellow to green (highest salary for the respective profession).
Source: U.S. Bureau of Labor Statistics, May 2022 State Occupational Employment and Wage Estimates.

6 REIMBURSEMENT RATES IN CONNECTICUT AND THE OTHER NEW ENGLAND STATES

As described in Section 3 of this report, low reimbursement rates are frequently cited as a reason that behavioral health and other providers do not enroll in Medicaid. This section compares Medicaid reimbursement rates for specific behavioral health services across Connecticut and the other New England states using the published fee schedules from state Medicaid websites. The section also includes a comparison of reimbursement rates from the CMS Medicare Physician Fee Schedule. The Medicare Physician Fee Schedule serves as a benchmark for how reimbursement rates would be expected to rank across the New England states, accounting for regional economic factors. Because the Medicare Physician Fee Schedule rates are adjusted for regional economic factors, it is reasonable to expect that Medicaid fees would follow a similar ranking if economic factors account for differences in Medicaid rates across the states. For example, if the Connecticut Medicare rates are the highest in the region, Connecticut Medicaid rates would also be expected to be correspondingly high.

6.1 Medicare Behavioral Health Reimbursement Rates

Table 6.1 summarizes the maximum allowed reimbursement rates from the 2022 Medicare fee schedule for selected behavioral health services identified by Current Procedure Terminology (CPT) codes. The Medicare fees are set at the state level for Connecticut, New Hampshire, Rhode Island, and Vermont. Massachusetts has separate fee schedules for the Boston metropolitan area and the rest of the state. Maine has a fee schedule for the southern counties of Cumberland and York and a separate schedule for the rest of the state. As shown in Table 6.1, Connecticut has the second highest fees after Metropolitan Boston for all of the CPT codes examined.

Table 6.1. Medicare Physician Fee-for-Service Fee Schedule Rates – New England Region

Service	State							
		Maine		Massachusetts				
	Connecticut	Southern Maine	Rest of State	Metro Boston	Rest of State	New Hampshire	Rhode Island	Vermont
Developmental and behavioral screening and testing	$136	$128	$124	$140	$133	$130	$133	$127
Developmental and behavioral screening and testing, each additional 30 minutes	$64	$60	$58	$66	$63	$61	$63	$60
Family psychotherapy including patient, 50 minutes	$106	$101	$99	$108	$104	$102	$104	$100
Family psychotherapy, 50 minutes	$103	$97	$96	$104	$101	$98	$101	$97
Group psychotherapy	$29	$27	$26	$30	$28	$28	$28	$27
Hypnotherapy	$113	$106	$103	$116	$110	$108	$110	$106
Interactive complexity	$16	$15	$15	$16	$15	$15	$15	$15
Multiple-family group psychotherapy	$38	$35	$34	$39	$37	$36	$36	$35
Psychiatric diagnostic evaluation	$188	$177	$177	$193	$184	$180	$184	$177
Psychiatric diagnostic evaluation with medical services	$211	$198	$198	$217	$206	$202	$206	$198
Psychotherapy, 30 minutes	$82	$77	$75	$84	$80	$78	$80	$77
Psychotherapy, 45 minutes	$108	$102	$99	$111	$106	$103	$105	$101
Psychotherapy, 60 minutes	$159	$149	$146	$163	$155	$152	$155	$149

Note: The color coding is applied for each row in the table (i.e., for each service) so that higher fees are highlighted in green and lower fees are highlighted in red. The color gradient ranges from red (lowest fee for the respective service) to orange to yellow to green (highest fee for the respective service).

6.2 Medicaid Behavioral Health Reimbursement Rates

Connecticut has four behavioral health fee types: Behavioral Health Clinicians, Psychologists, Psychiatric Facility, and Behavioral Health Facility. The fee for a particular CPT code can vary by the fee type. Acumen compiled the fees for all the behavioral health services (by CPT code) on the Connecticut fee schedule. We then compiled and reviewed the fee schedules from the other New England states. As expected, the fee schedules are not directly comparable across the states. However, we were able to identify a core set of CPT codes across the states and align them by fee type to correspond with the Connecticut fee schedule. Note that there may be differences in how the fee schedules are applied in each state that are not described in the public fee schedule documentation. Additionally, for facilities, the fee may not represent the full amount paid for services provided in the facility because state Medicaid agencies may make additional direct payments to facilities to cover the costs of services and these are not reflected in the fee schedules. However, without additional input from the states, we assume that the fees for Behavioral Health Clinicians and Psychologists reflect the amount that states permit individual clinicians to bill for their services in Medicaid. For these reasons, we report the fee comparison for Behavioral Health Clinicians and Psychologists, but have not included the results for the facility fee types.

The fees for Behavioral Health Clinicians in Connecticut are the lowest in the region for four out of the seven services examined, and near the bottom for the remaining three services (Table 6.2). A similar pattern is observed for Psychologists, where Connecticut has the lowest fees for four out of the seven services examined, among the three states that reported different fees for PhD-level clinicians. One exception is for the service “Family psychotherapy including patient, 50 minutes” where Connecticut has a higher rate than Rhode Island.

Generally, these results indicate that behavioral health clinicians in Medicaid in Connecticut have lower allowed reimbursement rates compared to the neighboring New England states. The Medicare results suggest that the differences are not explained by local economic factors. The low rates may contribute to a reluctance to accept Medicaid patients in Connecticut.

Table 6.2. Medicaid Fee Schedule Rates for Individual Clinicians – New England Region

Procedure/ Service	Behavioral Health Clinicians						Psychologists		
	CT	ME	MA	NH	RI	VT	CT	MA	RI
Family psychotherapy including patient, 50 minutes	$80	$71	N/A	$120	$72	$85	$97	N/A	$77
Family psychotherapy, 50 minutes	$65	$68	N/A	$120	$68	$82	$79	N/A	$81
Group psychotherapy	$25	$19	$30	N/A	$36	$23	$30	$30	$38
Psychiatric diagnostic evaluation	$107	$123	$130	$170	$132	$150	$130	$136	$155
Psychotherapy, 30 minutes	$45	$53	$52	$61	$53	$65	$54	$59	$56
Psychotherapy, 45 minutes	$66	$70	$95	$85	$72	$86	$80	$95	$77
Psychotherapy, 60 minutes	$98	$104	$126	$113	$75	$126	$120	$126	$80

Note: The color coding is applied for each row in the table (i.e., for each service) so that higher fees are highlighted in green and lower fees are highlighted in red. The color gradient ranges from red (lowest fee for the respective service) to orange to yellow to green (highest fee for the respective service).

Note: The Connecticut Department of Social Services increased reimbursement for select behavioral health services for HUSKY Health (Medicaid) members age 20 years and under pursuant to Public Act 23-204 §1 through a state plan amendment effective July 1, 2024. Affected behavioral health services, inclusive of family therapy, include behavioral health clinics, psychologists, physician office and outpatient; medical clinics, inclusive of school-based health clinics, and rehabilitation clinics. These increases represent an estimated additional aggregate expenditure of $13.8 million in state fiscal year 2025 and $15.5 million in state fiscal year 2026.

7 CONCLUSION

This environmental scan, and comparative analysis of New England states contained herein, reveals important insights into the challenges Connecticut faces with behavioral health service delivery. Comparing salaries and reimbursement fees points to larger pipeline issues and potential incentives to encourage provider participation in behavioral health services via Medicaid. Based on the analysis, identifying incentives for providers to participate in Medicaid and streamlining credentialing processes and requirements across states to encourage individuals to seek behavioral health professions in Connecticut represent strategies that are worth investigating further.

The average salaries for most behavioral health professions are competitive in the region. However, salaries for behavioral health counselors, who comprise the largest portion of the behavioral health workforce, are comparatively low in Connecticut relative to the other New England states. Connecticut should consider mechanisms to increase salaries for these workers to be competitive in the region and attract more people into this line of work. There is also considerable variation in average salaries across the state. The state may need to consider options for increasing rates to attract workers to the areas with lower salaries.

Cross-state comparisons of Medicaid reimbursement rates are complicated. However, Connecticut appears to have comparatively lower rates for behavioral health clinicians compared to the other states, while Connecticut's Medicare rates are second only to the Boston metropolitan area. Additional research may be warranted to try to obtain comparable rates across the states. However, increasing reimbursement in Medicaid seems warranted.

APPENDIX A – DESCRIPTION OF BEHAVIORAL HEALTH PROVIDERS

Profession (Occupation Code)	Description
Psychiatrists (29-1223)	Diagnose, treat, and help prevent mental disorders.
Clinical and Counseling Psychologists (19-3033)	Assess, diagnose, and treat mental and emotional disorders of individuals through observation, interview, and psychological tests. Help individuals with distress or maladjustment understand their problems through their knowledge of case history, interviews with patients, and theory. Provide individual or group counseling services to assist individuals in achieving more effective personal, social, educational, and vocational development and adjustment. May design behavior modification programs and consult with medical personnel regarding the best treatment for patients.
School Psychologists (19-3034)	Diagnose and implement individual or schoolwide interventions or strategies to address educational, behavioral, or developmental issues that adversely impact educational functioning in a school. May address student learning and behavioral problems and counsel students or families. May design and implement performance plans, and evaluate performance. May consult with other school-based personnel.
Mental Health and Substance Abuse Social Workers (21-1023)	Assess and treat individuals with mental, emotional, or substance abuse problems, including abuse of alcohol, tobacco, and/or other drugs. Activities may include individual and group therapy, crisis intervention, case management, client advocacy, prevention, and education.
Child, Family, and School Social Workers (21-1021)	Provide social services and assistance to improve the social and psychological functioning of children and their families and to maximize the family well-being and the academic functioning of children. May assist parents, arrange adoptions, and find foster homes for abandoned or abused children. In schools, they address such problems as teenage pregnancy, misbehavior, and truancy. May also advise teachers.
Marriage and Family Therapists (21-1013)	Diagnose and treat mental and emotional disorders, whether cognitive, affective, or behavioral, within the context of marriage and family systems. Apply psychotherapeutic and family systems theories and techniques in the delivery of services to individuals, couples, and families for the purpose of treating such diagnosed nervous and mental disorders.
Substance Abuse, Behavioral Disorder, and Mental Health Counselors (21-1018)	This occupation includes the 2018 Standard Occupational Classification (SOC) codes, 21-1011 (Substance Abuse and Behavioral Disorder Counselors) and 21-1014 (Mental Health Counselors). Substance Abuse and Behavioral Disorder Counselors (21-1011): counsel and advise individuals with alcohol, tobacco, drug, or other problems, such as gambling and eating disorders. May counsel individuals, families, or groups or engage in prevention programs. Mental Health Counselors (21-1014): counsel and advise individuals and groups to promote optimum mental and emotional health, with an emphasis on prevention. May help individuals deal with a broad range of mental health issues, such as those associated with addictions and substance abuse; family, parenting, and marital problems; stress management; self-esteem; or aging.
Psychiatric Technicians (29-2053)	Care for individuals with mental or emotional conditions or disabilities, following the instructions of physicians or other health practitioners. Monitor patients' physical and emotional well-being and report to medical staff. May participate in rehabilitation and treatment programs, help with personal hygiene, and administer oral or injectable medications.

Note: The behavioral health provider descriptions were taken from the U.S. Bureau of Labor Statistics' Occupational Employment and Wage Statistics database (https://www.bls.gov/oes/).

APPENDIX B – DESCRIPTION OF DATA SOURCES

Data Type	Data Description	Source
Employment Counts	U.S. Bureau of Labor Statistics, May 2022 State Occupational Employment and Wage Estimates	Bureau of Labor Statistics, U.S. Department of Labor. 2022. "Occupational Employment and Wage Statistics." https://www.bls.gov/oes/
Salary Estimates	U.S. Bureau of Labor Statistics, May 2022 State Occupational Employment and Wage Estimates – Salary Estimates	Bureau of Labor Statistics, U.S. Department of Labor. 2022. "Occupational Employment and Wage Statistics." https://www.bls.gov/oes/
Fee Schedules	Connecticut Department of Social Services – Behavioral Health Clinician Fee Schedule	Connecticut Department of Social Services. 2023. "Provider Fee Schedule – Behavioral Health Clinician." https://www.ctdssmap.com/ctportal/provider/provider-fee-schedule-download
	MaineCare Services – MaineCare Fee Schedule	MaineCare Services, Maine Department of Health and Human Services. 2023. "MaineCare Fee Schedule." https://mainecare.maine.gov/Provider%20Fee%20Schedules/MaineCare%20UCR/2-MaineCare%20UCR%20(pdf).pdf
	Mass.gov – Provider Payment Rates: Community Healthcare Providers	Mass.gov. 2023. "101 CMR 329.00: Rates for Psychological and Independent Clinical Social Work Services." https://www.mass.gov/regulations/101-CMR-32900-rates-for-psychological-and-independent-clinical-social-work-services
	New Hampshire MMIS Health Enterprise Portal – 2023 NH Fee Schedule	New Hampshire Department of Health and Human Services. 2023. "2023 NH Fee Schedule – Covered Procedures Report." https://nhmmis.nh.gov/portals/wps/wcm/connect/5c80b6fe-1a37-4d9e-b15e-30222d0c94cf/2023+Fee+Schedule+-+Covered+Procedures+Report+with+SA+Requirement+as+of+07-01-2023.pdf?MOD=AJPERES&CVID=oCYD7R8
	Executive Office of Health and Human Services – State of Rhode Island – Fee Schedules	Executive Office of Health & Human Services – State of Rhode Island. 2023. "Fee For Service Fee Schedule." https://providersearch.riproviderportal.org/ProviderSearchEOHHS/FFSFeeSchedule.aspx
	Vermont Medicaid Portal – Fee Schedule	Vermont Medicaid Portal. 2023. "Fee Schedule – CPT Codes." http://www.vtmedicaid.com/#/feeSchedule/cptCodes
	Centers for Medicare & Medicaid Services – Physician Fee Schedule	Centers for Medicare & Medicaid Services. 2023. "Physician Fee Schedule." https://www.cms.gov/medicare/physician-fee-schedule/search
Behavioral Health Disorder Prevalence	Substance Abuse and Mental Health Services Administration – 2021 NSDUH	Substance Abuse and Mental Health Services Administration. 2023. "2021 National Survey on Drug Use and Health: Model-Based Prevalence Estimates." https://www.samhsa.gov/data/sites/default/files/reports/rpt39465/2021NSDUHPercents_ExcelTabsCSVs110322/2021NSDUHsaePercentsTabs110322.pdf
	Centers for Disease Control and Prevention – Stats of the States	Centers for Disease Control and Prevention. 2023. "Suicide Mortality by State." https://www.cdc.gov/nchs/pressroom/sosmap/suicide-mortality/suicide.htm

Data Type	Data Description	Source
		Centers for Disease Control and Prevention. 2023. “Drug Overdose Mortality by State.” https://www.cdc.gov/nchs/pressroom/sosmap/drug_poisoning_mortality/drug_poisoning.htm
	Mental Health America – Youth data 2022	Mental Health America. 2022. “Youth data 2022.” https://www.mhanational.org/issues/2022/mental-health-america-youth-data

APPENDIX C – BEHAVIORAL HEALTH PROVIDER COUNTS PER 100,000

Table C1. Behavioral Health Providers per 100,000 Population

Profession	CT	ME	MA	NH	RI	VT
Psychiatrists	15	4	14	6	24	22
Total Psychologists	42	20	70	33	64	48
Clinical and Counseling Psychologists	15	7	46	14	46	25
School Psychologists	27	13	24	19	18	23
Marriage and Family Therapists	12	N/A	7	19	N/A	N/A
Total Social Workers	200	233	215	89	195	257
Mental Health and Substance Abuse Social Workers	39	100	73	26	40	102
Child, Family, and School Social Workers	161	133	142	63	155	155
Substance Abuse, Behavioral Disorder, and Mental Health Counselors	168	47	244	153	89	160

APPENDIX D – BEHAVIORAL HEALTH PROVIDER TOTAL COUNTS

Table D1. Behavioral Health Employment Counts for the New England Region

Profession	CT	ME	MA	NH	RI	VT
Psychiatrists	550	50	990	90	260	140
Clinical and Counseling Psychologists	530	100	3,200	190	500	160
School Psychologists	990	180	1710	270	200	150
Mental Health and Substance Abuse Social Workers	1,400	1,370	5,090	360	440	660
Child, Family, and School Social Workers	5,790	1,820	9,920	870	1,700	1,000
Marriage and Family Therapists	430	N/A	490	260	N/A	N/A
Substance Abuse, Behavioral Disorder, and Mental Health Counselors	6,070	650	17,030	2,130	980	1,030
Psychiatric Technicians	950	360	2,380	150	560	360

Table D2. Behavioral Health Employment Counts for the Connecticut Metropolitan Areas

Profession	Bridgeport-Stamford-Norwalk	Danbury	Hartford-West Hartford-East Hartford	New Haven	Norwich-New London-Westerly	Waterbury
Psychiatrists	160	N/A	240	80	N/A	N/A
Clinical and Counseling Psychologists	60	N/A	190	170	30	N/A
School Psychologists	310	50	330	130	60	50
Mental Health and Substance Abuse Social Workers	230	30	610	270	100	70
Child, Family, and School Social Workers	1,210	320	2,430	770	380	360
Marriage and Family Therapists	N/A	N/A	190	50	N/A	40
Substance Abuse, Behavioral Disorder, and Mental Health Counselors	1,060	220	2,470	1,100	440	320
Psychiatric Technicians	160	N/A	500	110	40	N/A