



Integrating Clinical and Mental Health: Challenges and Opportunities

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HEALTH PROJECT

Under the leadership of former Senate Majority Leaders Tom Daschle and Bill Frist, the Bipartisan Policy Center's Health Care Coverage and Payment Project develops bipartisan policy recommendations to improve health care quality, lower costs, and enhance health care coverage and delivery. The project focuses on coverage and access to care, delivery system reform and cost containment, and long-term care

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Glossary of Acronyms

ACA: Affordable Care Act

ACH: Acute Care Hospitals

CCBHC: Certified Community Behavioral Health Clinic

CFR: Code of Federal Regulations

CHIP: Children's Health Insurance Program

CMS: Centers for Medicare and Medicaid Services

DOL: Department of Labor

EBSA: Employee Benefits Security Administration

FFS: Fee-for-Service

GAO: Government Accountability Office

GME: Graduate Medical Education

HHS: Department of Health and Human Services

HIPAA: Health Insurance Portability and Accountability Act of 1996

HITECH: Health Information Technology for Economic and Clinical Health Act of 2009

HPSA: Health Care Professional Shortage Area

IMD: Institutions for Mental Diseases

IPF: Inpatient Psychiatric Facility

MHPAEA: The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008

NQTL: nonquantitative treatment limitations

SAMHSA: Substance Abuse and Mental Health Services Administration

SMHA: State Mental Health Agency

SUD: Substance Use Disorder

SUPPORT Act: Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act



Executive Summary

Nearly 45 million American adults suffered from some form of mental illness in 2016. Although there is little change in the estimates of those with mental illness over the last few years, rates of death due to drugs, alcohol, and suicide are increasing. In 2016, about 45,000 Americans age 10 and over died by suicide.¹ Twenty-five states experienced at least a 30 percent increase in suicide rates between 2014 and 2016.²

The national opioid crisis has resulted in significant attention to federal policy associated with substance use disorder (SUD). Mental illness along with SUD comprise a broad category of illness commonly referred to as “behavioral health.” In 2016, 44.7 million American adults experienced a mental illness, 20.1 million experienced a SUD, and 8.2 million experienced both—and these numbers are likely underestimated due to lack of identification and issues of stigma.³ Collectively, more than 1 million people have died from drugs, alcohol, and suicide over the past decade. If these trends continue, the death rate could grow to claim 2 million more lives by 2025.⁴

The purpose of this paper is to examine the barriers to the integration of clinical health care and mental health services, and to identify policy options for consideration in advancing integration of services. In 2018, the Bipartisan Policy Center hosted a series of public and private discussions on this topic. As part of this research, BPC consulted patient advocates; clinical and behavioral health care providers; federal, state, and county agency officials and staff; insurers; academics; and other experts. The goal was to identify barriers to integration caused by federal policy, to identify policy options to mitigate or remove those barriers, and, through policy changes, to advance evidence-based treatment for mental health in the United States.

EARLY INTERVENTION AND TARGETING OF SERVICES

A number of experts raised concerns about the need for early intervention to prevent or delay the development of more serious conditions and the need to focus on children through school-based screenings and treatment. The evidence base for early intervention has grown significantly and increased the availability of data around early intervention, which will help shift the focus of policy interventions to a broader definition of mental illness.

USE OF GRANT PROGRAMS IN TREATING MENTAL ILLNESS AND THE TRANSITION TO INTEGRATED CARE

In response to historical gaps in access to mental health services, policymakers have used grant and demonstration programs as a source for initiating and, in some cases, sustaining treatment for mental health and substance use. Reasons for this include:

- The ability to target spending through grants to address a perceived need or public crisis;
- Fragmentation in public financing for mental health and medical care;
- The perceived cost associated with expanding insurance coverage for mental health services in public and private insurance;
- The cost of increasing payments to mental health providers not covered by increased public financing;
- The ability to limit federal spending through discretionary grant programs, which are capped, compared with what policymakers see as open-ended expenditures in fee-for-service (FFS) insurance coverage; and
- The relative lack of a political challenge in creating new grant programs as opposed to trying to reform the major source of federal funding for medical education and training, or Medicare graduate medical education (GME).

Research has shown the value of integrating clinical and mental health services for improving outcomes and access to care. Leading experts conclude that the support of stand-alone mental health treatment centers undermines evidence-based integrated care models and perpetuates existing silos of care. At the same time, ongoing gaps in health insurance coverage and the shortage and often maldistribution of mental health professionals makes it difficult to promote federal policy that moves toward sustainable insurance-financed care and away from grant-financed care and siloed, stand-alone outpatient mental health services.

Advocates for a rapid transition to a fully integrated care system will understandably be frustrated by the slow pace of an integration. While the evidence has been available, change requires leadership; a commitment to addressing parity in coverage and reimbursement, delivery, and financing; a willingness to address mental health workforce shortages; and a unified vision across the myriad programs that fund treatment of mental illness.

Due to the challenge associated with reaching agreement and the need for long-term and broader dialogue, BPC chose to identify federal policy options, rather than to issue general recommendations for change. Achieving comprehensive integration of care will require stakeholders from all sides to come together and develop policies that represent the whole and not the part. No single organization or advocacy group can develop recommendations absent a more inclusive process. **With that in mind, these policy options are a starting point for discussion and are not BPC's recommendations or those of its leaders or staff.**

For this report, BPC identified three major areas for policy solutions: (1) health insurance coverage and payment barriers, (2) workforce barriers, and (3) administrative barriers that promote fragmentation. BPC has identified a preliminary list of options to address those barriers.

INSURANCE COVERAGE AND PAYMENT BARRIERS

Differences and disparities in coverage of clinical health and mental health services in public and private health insurance plans continue. Coverage of mental health as an “essential health benefit” and the expansion of mental health parity laws are no longer guaranteed under new interpretations of short-term insurance and state insurance waivers. Mental health parity does not exist in the Medicare and Medicaid programs. Coverage gaps in public and private insurance discourage the integration of services.

Private Insurance Policy Options:

1. **Conduct Random Audits for Parity Requirements.** Direct the secretary of the Department of Labor (DOL) to conduct random compliance audits to identify system-wide themes in noncompliance to help increase global compliance. This would also serve as a guide for the DOL in preparing compliance guidance for health plans and other stakeholders.
2. **Require Certification of Parity.** Require separate federal certification with parity laws as a condition of being offered in state and federal marketplaces. To avoid additional cost to the federal government, health plans could pay a fee to cover the cost of certification.
3. **Permit Individual Enforcement of Mental Health Parity.** Create a federal right of action to permit individuals to sue the secretaries of the U.S. Department of Health and Human Services (HHS) and the DOL to enforce mental health parity laws.
4. **Issue Additional Guidance for Plans.** Direct the secretaries of HHS and DOL to issue detailed guidance regarding nonquantitative treatment limitations, such as prior authorization requirements, fail-first/step therapies, written treatment plan requirements, and network design in mental health provider shortage areas.
5. **Report on the Impact of Insurance Market Regulations on Patients with Mental Illness.** Congress could instruct the director of the Office of Management and Budget and the secretaries of each agency providing services to individuals with mental health and SUD to compile the report. The report should include information from the Centers for Medicare and Medicaid Services (CMS) on the impact of access to mental health services as well as the changes to insurance market regulations. This should include the number of individuals enrolled in plans that do not meet the mental health parity law, including short-term insurance plans and plans offered through waivers granted to states under Section 1332 of the Affordable Care Act.



Medicaid Policy Options:

1. **Phase Out “Medicaid Carve-Outs.”** Require full integration of all services in Medicaid managed care contracts, prohibiting mental health carve-outs by a date certain.
2. **Repeal the Medicaid IMD Exclusion.** Repeal Medicaid’s institutions for mental diseases (IMD) exclusion for behavioral health diagnoses in facilities with more than 16 beds.
3. **Establish Mental Health Parity.** Congress could ensure mental health parity in Medicaid by expanding the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 to all Medicaid FFS and alternate payment and delivery models.
4. **Expand the Certified Community Behavioral Health Clinic Demonstration.** Congress could consider expanding the Excellence in Mental Health Act’s Certified Community Behavioral Health Clinic demonstration. This expansion should reauthorize funding for the eight pilot states based on the effectiveness of the pilots, should lengthen the demonstration period from two to four years for further study and evaluation, and should expand the demonstration to more states based on available evidence. Expansion, however, should more explicitly integrate clinical health and mental health services in the reauthorization and expansion legislation language.

Medicare Policy Options:

1. **Establish Mental Health Parity in Medicare.** Remove the 190-day lifetime limit on inpatient psychiatric facility (IPF) admissions for those having conditions best suited for the IPF setting. Non-IPF admissions are more expensive on average compared with IPF admissions, despite shorter lengths of stay. Assess overall value in longer IPF admissions versus multiple acute care stays. If outcomes are not better in acute care hospitals (ACHs), care provided in an IPF should be prioritized and the 190-day lifetime limit should be removed.
2. **Allow “Incident To” Billing Under General Supervision in Certain Instances.** “Incident to” restrictions limit access to therapy by licensed mental health workers unless the supervising provider is on-site. Allow licensed mental health workers to bill for “incident to” services when the supervising physician or non-physician provider is “accessible”—that is, change from direct supervision to general supervision. This provision would be subject to state scope-of-practice laws.
3. **Strengthen Current Primary Care Accreditation Standards to Promote Integration.** Strengthen current primary care accreditation standards (for example, for patient-centered medical homes and accountable care organizations) to help focus primary care practices on developing and implementing procedures that integrate behavioral health, enhance behavioral health referrals, and improve communication and scheduling for behavioral health services. These standards can be similar to those in place for specialty medical homes, such as cardiology and endocrinology.
4. **Extend Home Health Waivers for Behavioral Health Services.** Extend waivers for face-to-face requirements for home health services for appropriate behavioral health patients.
5. **Reimburse Behavioral Health Telehealth Services.** Expand Medicare fee schedule reimbursement for virtual services to include multiple settings for limited codes related to behavioral health.

WORKFORCE BARRIERS

A shortage of mental health professionals—stemming from inadequate training opportunities, conflicting state scope-of-practice laws, and inadequate reimbursement—affects access to mental health services, inhibiting integration of care.

Workforce Policy Options:

1. **Train Behavioral Health Providers.** Improve directed financing for allied mental health professionals and encourage pipeline programs at community colleges as well as in structured programs for layperson training.
2. **Promote Workforce Training Programs.** Direct and indirect subsidization of training programs at the federal and state level can also enhance the full spectrum of available mental health professionals.
3. **Promote Practice in High-Need Areas.** Encourage more clinicians to choose mental health specialization in their training through financial resources from states and educational institutions that help compensate for lower pay and high costs of training, especially in high-need areas (for example, low-income rural and urban areas).
4. **Improve Behavioral Health GME.** Build a more robust behavioral health GME policy and financing infrastructure in accordance with the Institute of Medicine's recommendations:
 - a. Create a GME Policy Council in the Office of the Secretary of Health and Human Services.
 - b. Establish a GME Center within CMS with the following responsibilities:
 - i. Management of operational aspects of GME Medicare funding;
 - ii. Management of the GME Transformation Fund; and
 - iii. Enhanced workforce data collection.
5. **Promote Integration in Training.** Evidence-based teaching and training in behavioral health integration needs to be standardized with support from undergraduate and graduate medical and nursing education funding directed toward such goals; the Health Resources and Services Administration and relevant federal agencies should also underscore these priorities. Accrediting bodies also need to play a role in establishing reforms that keep pace with evidence-based practices and guidelines, quality-improvement efforts, and innovative models of care.
6. **Support Development and Dissemination of Evidence-Based Telehealth.** The HHS secretary could build on current efforts—such as the Office for the Advancement of Telehealth's Telehealth Resource Center Grant Program—that support the development and dissemination of evidence-based best practices and tools to support clinicians' provision of telehealth services, including addressing changes in clinical workflow, facilitating care coordination, providing team-based care, supporting patient-centered care, and offering other opportunities.
7. **Promote Licensure Compacts.** The HHS secretary could incentivize or require states to comply with licensure compacts through guidance, encouragement to states, or the provision of technical assistance through a resource center to support implementation.
8. **Adopt Consensus Guidelines.** The HHS secretary could promote adoption of consensus guidelines for evaluating the appropriate standards of care among state medical boards. Examples of standards include establishing a clinician-patient relationship prior to treatment, documentation of evaluation and patient history, patient-informed consent, continuity of care and referral for emergency services, and meeting both state and federal privacy standards.^a

^a Policy options 6, 7, and 8 were included in BPC's *Improving Care for Patients with Serious Illness, Part 1*.



Improved integration of clinical and mental health services will require changes to address federal laws and regulations that create financial disincentives to integration. Federal policymakers must make a concerted effort to set aside jurisdictional issues to assure full integration of care. Reaching agreement will require solutions that move toward full integration over time without undermining the existing safety net of providers, including state and local governments and stand-alone mental health service agencies.

ADMINISTRATIVE BARRIERS

Multiple agencies and programs within agencies at all levels of government serve patients with mental illness. While Congress has taken action to improve coordination, experts express concern about overlapping responsibilities, duplication of services, and the absence of a strategic plan to address gaps in services.

Administrative Policy Options:

1. **Report on the Impact of Programs Serving Patients with Mental Illness.** The 21st Century Cures Act requires the assistant secretary for mental health and substance use to submit a report every two years on inter- and intra-agency coordination efforts across programs. Congress could expand the report to (a) include information required under the Government Performance and Results Modernization Act of 2010, (b) make recommendations to Congress on how best to improve program coordination and thus improve care for patients with mental illness, and (c) avoid fragmentation and duplication of services. The report should include an estimate of the number of individuals who receive treatment under grant programs and who also have insurance coverage. The report could also make recommendations to Congress on how best to transition stand-alone grantee providers to integrated provider systems.
2. **Direct Federal Funding to Stand-Alone Mental Health Facilities.** Have the HHS secretary report to Congress on the number of federally funded grantees providing treatment to patients with mental illness. Congress could consider requiring that by a date certain, all federally funded entities must have co-located primary care services. Congress could also define minimum standards for the co-location of services based on best practices in the integration of clinical and mental health services.
3. **Encourage or Require Mental Health Providers to Use Electronic Health Records.** Permit funding for the Health Information Technology for Economic and Clinical Health Act to be made available to mental health and SUD providers to encourage or require the adoption of electronic health records.
4. **Provide Health Information.** The 21st Century Cures Act directed the HHS secretary to offer guidance to providers to help them understand their responsibilities under the Health Insurance Portability and Accountability Act of 1996. Additional focus should be given to this area, as confusion continues.

Background

INTRODUCTION

Nearly 45 million American adults suffered from some form of mental illness in 2016. Although there is little change in the estimates of those with mental illness over the last few years, rates of death due to drugs, alcohol, and suicide are increasing. In 2016, about 45,000 Americans age 10 and over died by suicide.⁵ Twenty-five states experienced at least a 30 percent increase in suicide rates between 2014 and 2016.⁶

The national opioid crisis has resulted in significant attention to federal policy associated with substance use disorder (SUD). Mental illness along with SUD comprise a broad category of illness commonly referred to as “behavioral health.” In 2016, 44.7 million American adults experienced a mental illness, 20.1 million experienced a SUD, and 8.2 million experienced both—and these numbers are likely underestimated due to lack of identification and issues of stigma.⁷ Collectively, more than 1 million people have died from drugs, alcohol, and suicide over the past decade. If these trends continue, the death rate could grow to claim 2 million more lives by 2025.⁸

To the extent possible, the focus of this report will be mental illness. However, where research cited in the report does not distinguish between SUD and mental illness, the Bipartisan Policy Center uses the term used in the research literature. BPC leaders and staff recognize the relationship between the two diseases, including the millions of Americans who suffer from both.

The purpose of this paper is to examine barriers to the integration of clinical health care and mental health services, and to identify policy options for consideration in advancing integration of services. The Agency for Healthcare Research and Quality defines integrated behavioral health and primary care as health care that is the result of a group of primary care and behavioral health clinicians working together as a team, along with patients and their families, to provide patient-centered care.⁹ A considerable body of research exists on the benefits of integrating mental health and primary care. In 1996, the Institute of Medicine concluded that treating behavioral health and primary care independently leads to lower-quality care and noted that the integration of services is critical to the diagnosis and treatment of mental illness.¹⁰ Integration of primary care and behavioral health has been linked to cost savings, better treatment outcomes, and lower rates of mortality.¹¹

The 1996 Institute of Medicine report recommended eliminating financial and organizational disincentives to the integration of services and developing and evaluating integrated care models.¹² More than 20 years later, a number of care models have been accepted as successful in improving quality of care,¹³ however, less progress has been made in eliminating the organizational and financial barriers to integration of care.

BPC’s goal is to identify barriers to integration caused by federal policy, to identify policy options to mitigate or remove those barriers, and to advance mental health care in the United States.

EARLY INTERVENTION AND TARGETING OF SERVICES

A number of those interviewed raised concerns about the need for early intervention to prevent or delay the development of more serious conditions as well as the need to focus on children through school-based screenings and treatment. Policymakers focus on serious illness because they are responding to available data. The evidence base for early intervention has grown significantly, and increased availability of data around early intervention will help shift the focus of policy interventions to a broader definition of mental illness.



Use of Grant Programs in Treating Mental Illness and the Transition to Integrated Care

In response to historical gaps in access to mental health services, policymakers have used grant and demonstration programs as a source for initiating and, in some cases, sustaining treatment for mental health and SUD. Reasons for this include:

- The ability to target spending through grants to address a perceived need or public crisis;
- Fragmentation in public financing for mental health and medical care;
- The perceived cost associated with expanding insurance coverage for mental health services in public and private insurance;
- The cost of increasing payments to mental health providers not covered by increased public financing;
- The ability to limit federal spending through discretionary grant programs, which are capped, compared with what policymakers see as open-ended expenditures in fee-for-service (FFS) insurance coverage; and
- The relative lack of a political challenge in creating new grant programs as opposed to trying to reform the major source of federal funding for medical education and training, or Medicare graduate medical education (GME).

Research has shown the value of integrating clinical and mental health services for improving outcomes and access to care. Leading experts conclude that the support of stand-alone mental health treatment centers undermines evidence-based integrated care models and perpetuates existing silos of care. At the same time, ongoing gaps in health insurance coverage and the shortage and often maldistribution of mental health professionals makes it difficult to promote federal policy that moves toward sustainable insurance-financed care and away from grant-financed care and siloed, stand-alone outpatient mental health services.

Advocates for a rapid transition to a fully integrated care system will understandably be frustrated by the slow pace of integration. While the evidence has been available, change requires leadership; a commitment to addressing parity in coverage and reimbursement, delivery, and financing; a willingness to address mental health workforce shortages; and a unified vision across the myriad programs that fund treatment of mental illness.



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Due to the challenge associated with reaching agreement and the need for long-term and broader dialogue, BPC chose to identify federal policy options, rather than to issue general recommendations for change. Achieving comprehensive integration of care will require stakeholders from all sides to come together and develop policies that represent the whole and not the part. No single organization or advocacy group can develop recommendations absent a more inclusive process. **With that in mind, these policy options are a starting point for discussion and are not BPC's recommendations or those of its leaders or staff.**

For this report, BPC identified three major areas for policy solutions: (1) health insurance coverage and payment barriers, (2) workforce barriers, and (3) administrative barriers that promote fragmentation. BPC has identified a preliminary list of options to address those barriers.

1. **Insurance coverage and payment barriers.** Differences and disparities in coverage of clinical and mental health services in public and private health insurance plans continue. Coverage of mental health as an “essential health benefit” and the expansion of mental health parity laws are no longer guaranteed under new interpretations of short-term insurance and state insurance waivers. Mental health parity does not exist in either the Medicare or Medicaid program. Coverage gaps in public and private insurance discourage the integration of services. Likewise, studies have shown that reimbursement rates for mental health services across payers are lower compared with clinical health services.
2. **Workforce barriers.** A shortage of mental health professionals—stemming from inadequate training opportunities, conflicting state scope-of-practice laws, and inadequate reimbursement—affect access to mental health services, which inhibit integration of care.
3. **Administrative barriers.** Multiple agencies and programs within agencies at all levels of government serve patients with mental illness. While Congress has taken action to improve coordination, experts express concerns about overlapping responsibilities, duplication of services, and the absence of a strategic plan to address gaps in services.

Improved integration of clinical and mental health services will require changes to address federal laws and regulations that create financial disincentives to integration. Federal policymakers must make a concerted effort to set aside jurisdictional issues to assure full integration of care. Reaching agreement will require solutions that move toward full integration over time without undermining the existing safety net of providers, including state and local governments and stand-alone mental health service agencies.

HISTORY OF COVERAGE, PAYMENT, AND TREATMENT OF MENTAL ILLNESS

The United States has a history of inequity in the treatment and coverage of mental health care relative to clinical health services—a history that has contributed to a bifurcated system of care making full integration of services difficult to achieve. Federal law and policy, as well as similar state laws, have resulted in isolation and stigmatization of mental illness. Factors contributing to these state and federal policies include a lack of understanding about mental illness as a physical disease as well as a lack of understanding about how to treat mental illness.



Figure 1. Major Federal Mental Health Laws

Event	Date	Details
National Mental Health Act	1946	Authorized the U.S. surgeon general to: <ul style="list-style-type: none"> • finance training programs for mental health professionals; • finance development of community mental health services in local areas; and • conduct and support research. The National Institute of Mental Health was established in 1949 under National Mental Health Act Authority.
Mental Health Study Act	1955	Authorized the surgeon general to award grants to non-governmental organizations for partial support of a nationwide study and reevaluation of the problems of mental illness.
Temporary Mental Health Parity in Federal Employees Health Benefits Program	1961	President John F. Kennedy directed the precursor agency to the U.S. Office of Personnel Management to require the Federal Employees Health Benefits Program to cover psychiatric illnesses at a level equivalent to general medical care. This policy was reversed by subsequent administrations.
Community Mental Health Centers Act	1966	Authorized the establishment of community mental health centers.
Mental Health Parity Act	1996	Temporarily removed caps on aggregate lifetime and annual dollar limits for mental health coverage unless similar limitations were imposed on medical and surgical benefits.
Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act	2008	Parity of coverage between physical and mental health treatment must be maintained for certain types of health care plans.
Patient Protection and Affordable Care Act	2010	Requires coverage of mental health services as an “essential health benefit” in health insurance plans offered by employers and through state and federal insurance marketplaces.
The 21st Century Cures Act	2016	Required greater accountability and coordination for federal mental health programs.

The current framework for the administration and financing of behavioral health services is an outgrowth of historical payments for services at the state level, the exclusion of mental health treatment in private insurance, and two significant pieces of legislation enacted in the 1960s: the Community Mental Health Act of 1963 and the establishment of Medicaid in 1965. The Community Mental Health Act of 1963 committed the federal government to the goal of establishing community-based mental health services throughout the country, rather than in state mental hospitals. The focus on a community-based system was reinforced two years later by Medicaid rules, which prohibit covering the cost of care of mentally ill adults in inpatient psychiatric hospital settings. This created another incentive for states to transition from psychiatric hospitals to outpatient settings, with treatment costs shared by the federal government.¹⁴

One significant difference between financing for behavioral health services compared with financing for general medical services is the stark imbalance in public financing. The imbalance between public and private spending on mental health has been consistent over the last 30 years. Historic limitations in private mental health coverage and the fragmentation of the mental health system have contributed to the disparity.¹⁵



Insurance Coverage Barriers and Policy Options

Since the federal government began to reimburse health care services through Medicare and Medicaid in the late 1960s, there has been little coordination between public health programs eligible for grant funding for behavioral health services and federal and state reimbursement of these services. Over the next few decades, policymakers worked to address the unmet need for mental health services, resulting in a system of federal, state, and local grants as well as limited insurance coverage and reimbursement. When insurance coverage was available, it was largely provided by employer-sponsored health insurance and varied by state.

While many states took steps to promote equity in coverage, the laws applied only to state-regulated plans and did not address differences in coverage under federal insurance programs or large self-funded employer plans. One factor identified as a barrier to the integration of clinical and behavioral health services continues to be the inconsistency of coverage. Despite federal requirements for parity, access to mental health services continues to be a problem to varying degrees in private health insurance, Medicare, and the Medicaid program.

Mental Health “Carve-Outs”

One issue that is common to public and private health insurance is the trend from the late 1990s for employers, states, and insurers to separately contract for, or “carve out,” mental health services. This practice can involve contracting with a managed care plan that specializes in behavioral health, or contracting for physical health services, while mental health services continue to be provided on a FFS basis. Data from the late 1990s and the early 2000s indicate that these carve-outs resulted in significant savings for insurers, primarily because of reduced inpatient hospital admissions.¹⁶ At the same time, research has shown the negative effects of mental health carve-outs, including incentives for cost-shifting, concerns about diminished access to care, and difficulty in coordinating care.¹⁷ Recent studies have shown that, while the use of mental health carve-outs is declining, they continue to exist.

PRIVATE INSURANCE

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) and the Patient Protection and Affordable Care Act (ACA) of 2010 helped jump-start the movement toward integration by elevating mental health coverage in private health plans.

Before enactment of the parity law, health plans typically included coverage levels that were lower for mental health than for physical health. The parity law required the equal treatment of mental health and physical health benefits in most group health plans, including the treatment of annual visit limits, co-payments, and pre-authorizations.¹⁸ Two years later, the ACA expanded the reach of the parity law by requiring health plans in the individual and small group insurance markets to cover mental health as an essential health benefit. Improving the scope of coverage of mental health services, however, does not necessarily translate into access to care, as the law does not require parity in reimbursement for services.¹⁹ Low reimbursement rates have resulted in health plan challenges, such as providers reaching agreement on reimbursement rates, especially in areas where there are provider shortages. At the same time, health plans must meet federally mandated network adequacy requirements, which are often difficult to meet in areas with provider shortages.

Two actions taken in 2017 threaten to reverse some recent progress. Congress eliminated tax penalties for individuals who failed to obtain health insurance coverage. This effectively amounts to a repeal of the individual mandate beginning in 2019 and could lead to more people forgoing coverage altogether or buying less expensive, but less comprehensive, short-term policies.²⁰

In October 2017, President Donald Trump issued an executive order directing the secretary of the U.S. Department of Health and Human Services (HHS) to make short-term, limited-duration health plans more available.²¹ Notably, these plans, which were originally designed to fill gaps in coverage (for example, between jobs) and last only a few months have been expanded under new regulations finalized by the Trump



administration in August 2018. Under the new regulations, short-term plans are exempt from the definition of “individual coverage” under the ACA and may now be one year or longer in duration, as they are renewable up to 36 months.²² The plans are not required to cover essential health benefits, including mental health, and the shorter duration of the plans may be less effective in promoting the long-term investment needed to fully treat chronic conditions, including mental health disorders.²³

Insurance experts have raised concerns that these limited-duration plans are re-segmenting care, as those who are relatively healthy and without mental health treatment concerns (or any chronic conditions for that matter) may purchase these plans due to their less expensive cost without realizing the effects of their less comprehensive care.

Further compounding the recent changes, compliance with the parity law, in general, has not been consistent and enforcement has been spotty, partly because a patchwork of federal and state entities share authority. In 2016, the Obama administration’s Mental Health and Substance Use Disorder Parity Task Force spent seven months interviewing stakeholders, during which time health plans called for additional guidance about requirements to help them better assess their compliance with the law. They specifically asked for guidance regarding nonquantitative treatment limitations (NQTL), such as prior authorization requirements, fail-first/step therapies, and written treatment plan requirements.²⁴

Compliance and enforcement also vary from state to state. Over the last year, five states have passed legislation intended to improve compliance by requiring health plans to meet reporting requirements.²⁵ However, for those in states that have not focused on compliance for mental health parity, the onus is largely on consumers to seek enforcement. Those who purchase insurance on their own or through the ACA marketplace, and employees with fully insured health plans, must file complaints through state insurance departments if they believe their insurer is not complying with federal law.²⁶ Efforts have been made to improve state-level enforcement of mental health parity.²⁷ The majority of Americans, however, have health insurance through large employers and public programs such as Medicare and Medicaid, so the role of the federal government cannot be ignored.

The Department of Labor (DOL) enforces the provisions of the parity law for employer-sponsored group health plans that are self-insured. The DOL investigates cases as they arise and conducts investigations if violations might affect multiple individuals.²⁸ Within the DOL’s Employee Benefits Security Administration (EBSA), 400 investigators review more than 5 million health plans nationwide—or roughly one investigator for every 12,500 plans—for compliance with Title I of the Employee Retirement Income Security Act of 1974, which includes the parity law. An additional 110 benefits advisors—who act essentially as customer-service agents for parity implementation—educate consumers and provide compliance assistance with the law to participating plans so that fewer violations will result from how plans implement the law.²⁹

EBSA found 92 violations of the parity law in fiscal year 2017. Nearly half (49 percent) were violations involving NQTL—violations that included fail-first policies that were too restrictive, prior authorization requirements that either should not have been in place or were too stringent, and medical management requirements that included written treatment plans as a required coverage component despite such conditions not being required in similar physical care management.³⁰ The final rules for the parity law sought to clarify ambiguity around these offending limitations, but health plans continue to struggle with compliance.³¹ Although not as obvious as quantitative treatment limits, which are more broadly known, this is clearly an area where further plan education—both from the government and internally at plans—is needed.

Quantitative treatment limitations accounted for 28 percent of violations (higher co-payments or visit limits as compared with medical care), cumulative financial requirements/treatment limitations for 9 percent, annual and lifetime dollar limits for 9 percent, and benefit classifications for 5 percent. When EBSA finds violations, it requires the health plan to pay benefits that were improperly denied and to remove the offending barriers to mental health benefits in the plan design.³²

Private Insurance Policy Options:

1. **Conduct Random Audits for Parity Requirements.** Direct the secretary of the Department of Labor (DOL) to conduct random compliance audits to identify system-wide themes in noncompliance to help increase global compliance. This would also serve as a guide for the DOL in preparing compliance guidance for health plans and other stakeholders.
2. **Require Certification of Parity.** Require separate federal certification with parity laws as a condition of being offered in state and federal marketplaces. To avoid additional cost to the federal government, health plans could pay a fee to cover the cost of certification.
3. **Permit Individual Enforcement of Mental Health Parity.** Create a federal right of action to permit individuals to sue the secretaries of the U.S. Department of Health and Human Services (HHS) and the DOL to enforce mental health parity laws.
4. **Issue Additional Guidance for Plans.** Direct the secretaries of HHS and DOL to issue detailed guidance regarding nonquantitative treatment limitations, such as prior authorization requirements, fail-first/step therapies, written treatment plan requirements, and network design in mental health provider shortage areas.
5. **Report on the Impact of Insurance Market Regulations on Patients with Mental Illness.** Congress could instruct the director of the Office of Management and Budget and the secretaries of each agency providing services to individuals with mental health and SUD to compile the report. The report should include information from the Centers for Medicare and Medicaid Services (CMS) on the impact on access to mental health services as well as the changes to insurance market regulations. This should include the number of individuals enrolled in plans that do not meet the mental health parity law, including short-term insurance plans and plans offered through waivers granted to states under Section 1332 of the Affordable Care Act.

MEDICAID

According to the Medicaid and Children's Health Insurance Program (CHIP) Payment and Access Commission, Medicaid was the single largest payer of mental health services, accounting for 26 percent of all behavioral health spending in 2009. Nearly 9 million Medicaid enrollees under age 65 had a behavioral health condition diagnosis in 2011.³³ About 20 percent of all adults ages 18 to 64 had a mental disorder. Medicaid enrollees were more likely to have mental illness than privately insured or uninsured individuals in that age group and were more likely to have had a major depressive episode or suicidal plans in the prior year.³⁴

Mental Health "Carve-Outs"

While the majority of states provide Medicaid services through managed care, most states carve out behavioral health services from managed care contracts and risk arrangements through separate managed behavioral health organizations or under FFS.³⁵ According to a report by the Center for Health Systems Change, an increasing number of states are reversing that trend by moving services into a single plan by combining physical and behavioral health services. This integration of clinical and behavioral health help align incentives and increase accountability while providing more seamless care for beneficiaries.³⁶ As early as 2011, the CMS encouraged states to integrate physical and mental health services by offering technical guidance to states and by providing options on how to best integrate services to decrease fragmentation of care.³⁷ According to recent reports, as many as half of Medicaid managed care plans will be integrated by 2020.³⁸

Institutions for Mental Diseases Exclusion

Federal law allows states to use federal Medicaid funds for inpatient hospital and nursing facility services in institutions for mental diseases (IMDs) for individuals ages 65 and older. The law also permits the use of federal Medicaid funds for inpatient psychiatric hospital services for individuals under age 21.³⁹ An IMD is defined as a "hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services."⁴⁰ Because IMD services are not covered for those between the ages of 21 and 65, mental health



services must be provided in an outpatient setting or states must pay 100 percent of the cost of the IMD for the Medicaid-eligible individual. For those with severe mental illness who require inpatient treatment, the exclusion may limit access to medically necessary inpatient services.

In 2016, the CMS modified the IMD exclusion to permit Medicaid managed care organizations to cover acute care services (defined as fewer than 15 days per month) for non-elderly Medicaid-eligible adults. Recently enacted legislation designed to address opioid addiction, the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (the SUPPORT Act), partially repeals the IMD exclusion. The new law allows for the use of federal Medicaid funds for services for people with opioid use disorders and individuals using cocaine.^{41,42} However, it does not allow for the use of federal Medicaid funds to pay for residential treatment for Medicaid beneficiaries with other SUDs or mental illness.

States have sought to address the lack of inpatient care for non-elderly adults through waivers—with one exception, waivers have all been substance-use-related. As of June 2018, there were 12 approved and 13 pending Section 1115 waivers related to IMD payments in 24 states.⁴³ Only one state (Vermont) has waiver authority for IMD mental health services.^{b,44} Other approved states have authority that distinguishes the use of federal Medicaid funds to pay for IMD SUD services. Both Vermont and Illinois have requested expanded authority for both IMD mental health and SUD services through their 1115 SUD waivers, though the CMS approved only SUD authority, citing its policy to not allow Medicaid payments for individuals who receive only mental health treatment in IMDs.

Mental Health Parity in Medicaid

The MHPAEA requires the equal treatment of mental health and physical health benefits in Medicaid for benefits offered through managed care organizations, CHIP, and alternative benefit plans (plans that cover the Medicaid expansion population).^c It does not apply to those receiving benefits through FFS. In traditional Medicaid, behavioral health is not a specifically defined category in the benefit package, and Medicaid covers these services only when they are organized within other benefit categories, which can vary depending on the state. While the ACA required that alternative benefit plans, which are permitted as a state option, must adhere to the essential health benefits requirements, for other Medicaid eligibility groups, parity can vary significantly across states and may not include the types of services that various eligibility groups need.

Challenges in Caring for Medicare-Medicaid Beneficiaries

Experts have stressed the importance of better integrating mental health and clinical health for low-income Medicare beneficiaries with multiple chronic conditions, including a diagnosis of mental illness. For these Medicare-Medicaid beneficiaries, or “dual-eligible” individuals, the integration of care is much more difficult, since providers must coordinate clinical health, mental health, and long-term services and supports across two programs: Medicaid, which is administered by the state, and Medicare, which is administered by the federal government. Others needing attention include veterans, Native American populations, immigrants, and homeless individuals of all ages. As policymakers work to address the opioid crisis, the links between mental illness and substance abuse are highlighted, as is the interaction of both populations with the criminal-justice system. BPC also consistently heard about the need to address the social stigma associated with mental illness.

Limited Scope of Certified Community Mental Health Clinics Demonstration

The Protecting Access to Medicare Act⁴⁵ was passed by Congress in March 2014 and signed into law on April 1, 2014. Section 223 of the act requires the evaluation of a two-year demonstration program, for up to eight states, to implement certified community

^b In Vermont, IMD mental health payments must be phased out between 2021 and 2025. Another state (Maryland) indicated that the CMS denied its request for IMD mental health payment waiver authority, while approving its request for IMD SUD payment authority.

^c Coverage for Medicaid benefits is not subject to these parity standards for those beneficiaries who are not enrolled in a managed care organization and who receive non-alternative-benefit state plan benefits offered under a FFS basis.

behavioral health clinics (CCBHCs). This demonstration is intended to test whether CCBHCs are effective in delivering behavioral health services through a robust coordinated care structure and restructured payment system that promotes the delivery of high-quality services. The demonstration requires programs to be evaluated annually and requires HHS to report to Congress on the outcome of the demonstration.

The demonstration requires that programs meet one of four goals to qualify for participation in the demonstration: (1) provide the most complete scope of services to eligible individuals; (2) improve availability of, access to, and participation in services to those eligible individuals; (3) improve availability of, access to, and participation in assisted outpatient mental health treatment; or (4) demonstrate the potential to expand services without increasing net federal spending. Twenty-four states signed up for the demonstration. The eight states approved were Minnesota, Missouri, Nevada, New Jersey, New York, Oklahoma, Oregon, and Pennsylvania. The number of participating clinics varied by state, ranging from three to 15. States received an enhanced match for services.

Participating CCBHCs improve access to behavioral health services through expanding service delivery and implementing the latest evidence-based practices along the continuum of care. They are required to offer the following services:

- crisis mental health services;
- mental health screening, assessment, and diagnosis;
- patient-centered treatment planning, mental health services, and addiction services;
- screening for primary care conditions;
- case management;
- psychiatric rehabilitation;
- peer support and family support; and
- intensive, community-based mental health care for members of the armed forces and veterans.

In November 2017, The National Council for Behavioral Health released survey results from 47 of the 67 participating clinics. Results from this survey demonstrated an increase both in personnel—with more than 1,000 new staff hired—as well as the number of patients served.⁴⁶ Comments from the respondents suggest that these CCBHCs are better able to integrate their patients with the community to provide care more effectively. Demonstration funding will end in 2019 without congressional action.

Medicaid Policy Options:

1. **Phase Out “Medicaid Carve-Outs.”** Require full integration of all services in Medicaid managed care contracts, prohibiting mental health carve-outs by a date certain.
2. **Repeal the Medicaid IMD Exclusion.** Repeal Medicaid’s institutions for mental diseases (IMD) exclusion for behavioral health diagnoses in facilities with more than 16 beds.
3. **Establish Mental Health Parity.** Congress should ensure mental health parity in Medicaid by expanding the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 to all Medicaid FFS and alternate payment and delivery models.
4. **Expand the Certified Community Behavioral Health Clinic Demonstration.** Congress could consider expanding the Excellence in Mental Health Act’s Certified Community Behavioral Health Clinic demonstration. This expansion should reauthorize funding for the eight pilot states based on the effectiveness of the pilots, should lengthen the demonstration period from two to four years for further study and evaluation, and should expand the demonstration to more states based on available evidence. Expansion, however, should more explicitly integrate clinical health and mental health services in the reauthorization and expansion legislation language.



MEDICARE

The health care delivery system poses a number of barriers to high-quality integrated care. There is a shortage of inpatient units that can treat both psychiatric and substance abuse issues, as well as a lack of collaboration between hospitals, community mental health centers, and a variety of other community-based organizations. Regulatory barriers—such as same day billing, the practice of keeping patients in observation for more than 24 hours to avoid a hospital admission, and face-to-face documentation requirements in Medicare—pose challenges to successful integration. Even in highly evolved patient-centered medical homes or accountable care organizations, there are often arbitrary silos between mental health professionals and other health professionals. This creates barriers such as differing electronic records, disparate billing systems, and varied administrative support systems.

In recent years, policymakers have taken steps to modernize coverage for mental health care across medical and behavioral services. Provider-types eligible for mental health reimbursement^d have been expanded to improve access to behavioral health services. Prior to 2010, the Medicare program imposed either coverage or reimbursement limitations on both inpatient and outpatient mental health services. The Medicare Improvements for Patients and Providers Act of 2008 phased-out limits on outpatient coverage by 2014,^e but restrictions on inpatient psychiatric coverage remain.

Congress recently enacted the SUPPORT for Patients and Communities Act, which allows Medicare beneficiaries with a SUD diagnosis to receive telehealth services at home. Under the law, telehealth services for either substance abuse or mental illness may be provided; the law also directs the secretary to implement this change by July 2019. The recent signing of the SUPPORT Act, as well as other updates across the Medicare payment systems, demonstrate a willingness to consider new reimbursement strategies for mental health services by the administration.

Lifetime Limit on Inpatient Psychiatric Coverage

Medicare imposes a 190-day lifetime limit for inpatient psychiatric facility (IPF) treatment.⁴⁷ This restriction may have been made, in part, to limit federal spending for these, traditionally, state-covered services.⁴⁸ However, while the average length of admission in IPFs is longer than admissions in acute care hospitals (ACH), average cost per admission is significantly less.⁴⁹

Inpatient psychiatric care provided in the ACH setting increased more than 20 percent between 2005 and 2014.⁵⁰ This likely reflects a transition from IPFs to inpatient psychiatric units in ACHs and general community hospitals. Those Medicare beneficiaries needing care that cannot be provided in the outpatient or acute care setting likely suffer from more severe mental illness. It is these individuals, requiring intensive and extended care, who are treated in IPFs and who are at greatest risk of exceeding the 190-day cap. Once the lifetime limit has been reached, patient care is disrupted by a dictated transfer of care. This may likely be to a less optimal setting, lacking the appropriate staff for the fully integrated care coordination traditionally found in specialized facilities. Efforts to protect access have been introduced by members of both chambers, but there has been little traction for repealing the limit.

Depending on the type of facility, mental health services are covered by either the Inpatient Psychiatric Facility Prospective Payment System, which do not include those provided in the psychiatric unit of an ACH, or the inpatient prospective payment system.⁵¹ The lifetime limit exists only for IPFs and does not apply to ACHs.

The MHPAEA requires that psychiatric care must be consistent with other medical and surgical care for any plan offering mental health and SUD benefits. Although the act prohibits unequal coverage and limits cost-sharing structures between medical and mental health, the law does not apply to the Medicare program.

^d Medicare-eligible professionals for mental health services include physicians, clinical psychologists, clinical social workers, clinical nurse specialists, nurse practitioners, physician assistants, certified nurse-midwives, and independently practicing psychologists. Mental health services must be provided by participating providers, with the exception of physicians (may be reimbursed through assignment). Coverage is also dependent on state licensure laws.

^e Prior to the Medicare Improvements for Patients and Providers Act, Medicare payments to providers for outpatient mental health services were limited to 62.5 percent of covered expenses in a calendar year. The remaining percentage of outpatient charges were billed to Medicare beneficiaries in the form of a co-payment.

Prohibition on Billing Same-Day Visits

The Medicare Claims Processing Manual prohibits the payment of more than one evaluation and management visit by providers of the same specialty and practice for a single patient on a single day unless the services are unrelated.⁵² The assumption is that these visits would not be medically necessary. However, there are several legitimate reasons for multiple visits related to a single condition.

Mental illness and SUDs are often addressed with more than one type of treatment, resulting in services provided by subspecialists and sharing a diagnosis. For example, a SUD care plan may include individual and group therapy in addition to prescribed medication. A single provider might be seen for a medication follow-up visit on the same day as individual and/or group therapy. Under the current policy, the beneficiary might need to attend follow-ups at least three times per week, likely resulting in increased transportation costs and loss of employment. For those requiring multiple therapy sessions per week, Medicare would not cover the full treatment.

The 2019 Medicare physician fee schedule proposed rule, released in September 2018, included a comment solicitation on the elimination of same-day billing restrictions among providers in the same group and specialty.⁵³ The CMS received significant support for the change and will continue to consider the issue in future rulemaking.⁵⁴ Notably, comments were also requested on a proposal to discount payment for additional services provided on the same day by 50 percent. While this was not finalized, future consideration of a sizable payment reduction could subvert the intent of the same-day visit coverage.

“Incident to” Billing Restriction

Team-based care continues to be instrumental to care coordination and improved outcomes. The health system is increasingly reliant on non-physician providers, such as clinical social workers, physician assistants, and nurse practitioners, to expand access to services. Non-physician providers are limited in the services they can provide, as dictated by licensure and scope of practice. However, certain billing rules under Medicare further limit the ability of non-physician providers to augment the services of the physician.

“Incident to” billing restrictions have posed a significant hurdle to mental health treatment facilities, particularly in rural settings. For example, therapy provided by a clinical social worker is only considered “incident to” when furnished under direct supervision⁵⁵ (that is, the physician must be in the office suite). For supervising physicians covering multiple offices or buildings, this requirement is exceedingly restrictive. Ensuring supervision creates scheduling difficulties and precludes the ability to provide home services. CMS acknowledged this barrier to behavioral health integration in the 2017 Medicare physician fee schedule final rule.⁵⁶ As a result, a general supervision exception was made for psychiatric collaborative care management services within the Psychiatric Collaborative Care Model. A similar general supervision allowance for mental health providers would expand access to services and cultivate team-based care.

Medicare Policy Options:

1. **Establish Mental Health Parity in Medicare.** Remove the 190-day lifetime limit on inpatient psychiatric facility (IPF) admissions for those having conditions best suited for the IPF setting. Non-IPF admissions are more expensive on average compared with IPF admissions, despite shorter lengths of stay. Assess overall value in longer IPF admissions versus multiple acute care stays. If outcomes are not better in acute care hospitals (ACHs), care provided in an IPF should be prioritized and the 190-day lifetime limit should be removed.
2. **Allow “Incident To” Billing Under General Supervision in Certain Instances.** “Incident to” restrictions limit access to therapy by licensed mental health workers unless the supervising provider is on-site. Allow licensed mental health workers to bill for “incident to” services when the supervising physician or non-physician provider is “accessible”—that is, change from direct supervision to general supervision. This provision would be subject to state scope-of-practice laws.
3. **Strengthen Current Primary Care Accreditation Standards to Promote Integration.** Strengthen current primary care accreditation standards (for example, for patient-centered medical homes and accountable care organizations) to help focus primary care practices on developing and implementing procedures that integrate behavioral health, enhance behavioral health



referrals, and improve communication and scheduling for behavioral health services. These standards can be similar to those in place for specialty medical homes, such as cardiology and endocrinology.

4. **Extend Home Health Waivers for Behavioral Health Services.** Extend waivers for face-to-face requirements for home health services for appropriate behavioral health patients.
5. **Reimburse Behavioral Health Telehealth Services.** Expand Medicare fee schedule reimbursement for virtual services to include multiple settings for limited codes related to behavioral health.

Workforce Barriers and Policy Options

A highly skilled, collaborative workforce is essential for delivering high-quality integrated behavioral health services. As experts attempt to better meet the needs of patients and their families, the health policy community must expand its understanding of who should be included in the workforce. Simply repurposing, or imposing more responsibility on, the existing workforce will be insufficient to fully address the necessary changes for optimal care redesign. Both a growing aging population and a recognition of the need for early intervention following traumatic events are contributing to the strain on the current system. A meaningful consideration of the workforce supply or pipeline must also be taken into consideration.

Figure 2 examines the full community of mental health workers; a host of individuals are involved in the treatment of mental illness. Health care providers are licensed by the state and include a full range of professionals. Those most commonly identified are psychiatrists and psychologists; however, mental health professionals include virtually every medical professional, such as nurses, primary care physicians, licensed clinical social workers, and school guidance counselors. Licensed professionals may also be certified as having an expertise in the treatment of mental illness. Finally, a host of other professionals and laypersons—including volunteers, law-enforcement officers, criminal-justice system employees, case workers, and others—may interact with and assist those with mental illness (see Figure 2).

Figure 2. The Mental Health Workforce: An Inexhaustive List

Licensed Professionals	Certified Professionals	Other Employees and Volunteers
<ul style="list-style-type: none"> • Psychiatrists • Nurses • Psychologists • Primary Care Physicians • Advanced Practitioners • Marriage and Family Therapists • Social Workers <ul style="list-style-type: none"> • Licensed Clinical Social Workers • Licensed Independent Social Workers • Licensed Professional Counselors • Nurse Educators • School Guidance Counselors <ul style="list-style-type: none"> • Licensed Counselors • Licensed Professional Counselors • Licensed Mental Health Counselors • Licensed Clinical Alcohol and Drug Abuse Counselors 	<ul style="list-style-type: none"> • Addiction Counselors • Peer Providers and Specialists • Psychiatric Rehabilitation Specialists • Psychiatric Aides and Technicians • Case Managers • Pastoral Counselors • Academy of Certified Social Workers • Art and Music Therapists 	<ul style="list-style-type: none"> • Social-Service Program Workers <ul style="list-style-type: none"> • Adult and Child Protective Services • Alcohol and Drug Abuse Prevention • Services for Housing Assistance • Criminal-Justice: Juvenile Court Liaisons • Law-Enforcement and Probation Officers • Volunteer Mental Health Counselors (trained) • Students <ul style="list-style-type: none"> • Nursing • Medical • Public Health • Social Work • Therapy • Volunteers <ul style="list-style-type: none"> • Schools • Faith-Based Social Services • Community-Based Organizations • Peer Supports



WORKFORCE SHORTAGES

While the behavioral health workforce is one of the fastest-growing in the country, serious shortages continue to exist.⁵⁷ The Kaiser Family Foundation reports that as of December 2017, there were 5,042 mental health care professional shortage areas (HPSAs) in the United States. A HPSA designation is applied to an area with a population-to-provider ratio of at least 30,000 to one.^{58,59} States with the largest numbers of HPSAs include Texas, Arizona, California, and Michigan. According to the Association of American Medical Colleges, the United States will face a shortage of between 8,700 and 43,100 primary care physicians by 2030.⁶⁰ The National Center for Health Workforce Analysis projects significant shortages for most of the practitioner types providing the greatest volume of behavioral health services. The data in Figure 3 assumes those individuals reporting behavioral health issues in a national SAMHSA survey would seek treatment.⁶¹

Figure 3. National Supply and Demand, All Behavioral Health Practitioner Categories, 2013 and 2025

Practitioner	2013 Estimates Scenario Two			2025 Projections Scenario Two		
	Supply	Demand	Difference*	Supply	Demand	Difference*
Psychiatrist	45,580	56,980	-11,400	45,210	60,610	-15,400
Behavioral Health Nurse Practitioners	7,670	9,590	-1,920	12,960	10,160	2,800
Behavioral Health Physician Assistants	1,280	1,600	-320	1,800	1,690	110
Clinical, Counseling, and School Psychiatrist	186,710	233,390	-46,680	188,930	246,420	-57,490
Substance Abuse and Behavioral Disorder Counselors	85,120	106,380	-21,260	105,970	122,510	-16,540
Mental Health and Substance Abuse Social Workers	110,880	138,630	-27,750	109,220	157,760	-48,540
Mental Health Counselors	120,010	150,000	-29,990	145,700	172,630	-26,930
School Counselors	246,480	308,130	-61,650	243,450	321,500	-78,050
Marriage and Family Therapists	30,560	38,250	-7,690	29,780	40,250	-10,470

Notes: All numbers full time equivalent. Numbers may not sum to totals due to rounding. Scenario Two assumes that approximately 20 percent of the 2013 U.S. population needed but did not receive treatment for mental illness, substance use and/or substance dependence in 2013. This model reflects expanded insurance coverage of mental health and substance use disorder services associated with Medicaid expansion and Affordable Care Act marketplaces, as well as federal parity protections.

*Difference = (supply - demand); a negative difference reflects a shortage (i.e., supply is less than demand), while a positive difference indicates a surplus (i.e., supply is greater than demand).

Source: U.S. Department of Health and Human Services, 2016.⁶²

These workforce shortages also translate to critical gaps in caring for particular demographics; for example, by 2030, analysts predict that, if no workforce changes are made and other trends continue, there will be only one geriatric psychiatrist for every group of 6,000 older Americans with a mental illness or SUD.⁶³ Furthermore, the U.S. Bureau of Health Professions estimates that, in 2020, 12,624 child and adolescent psychiatrists will be needed, far exceeding the projected supply of 8,312.⁶⁴

Rural areas are particularly vulnerable to a decline in behavioral health providers. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), while over 20% of the US population lives in rural counties, 3 quarters of those counties do not have an advanced behavioral health provider.

A deeper look at five driving factors that have contributed to workforce barriers are described below—along with potential policy-based solutions.

Education and Training

An underlying cause of projected workforce shortages is the waning number of students specializing in or concentrating on behavioral health. A recent study conducted by the University of California, San Francisco found that by 2028 the state of California will have 41% fewer psychiatrists than required, assuming that current needs for behavioral health services remain constant (which seems unlikely given demographic trends).⁶⁵ Additionally, accredited psychology doctoral programs in the United States are experiencing a steady decrease in the number of applicants, despite an increasing number of available positions.⁶⁶ The number of available accredited doctoral positions increased to 3366 in 2018 from 2365 in 2012. However, applicants have decreased from 4067 to 3661 during that same period. Whereas all positions were filled in 2012, this mismatch of doctoral candidate supply and demand resulted in 162 unfilled positions in 2018.

Even when positions are available, or training opportunities exist, there is an inadequate emphasis on the need for care integration. For example, there are few curricula in nursing or medical schools that address behavioral health integration, and even fewer interdisciplinary training environments. There is also a lack of behavioral health training for advanced practitioners; currently, more than 50 percent of patients receive routine care from the primary care workforce, but most primary care physicians and advanced practitioners have little to no training in behavioral health. While advanced practitioners are becoming critical to the provision of primary care, scope-of-practice conflicts continue among physicians, nurses, and other behavioral health providers.

Finally, the behavioral health workforce is aging, in general, further exacerbating shortage issues. According to the California Health Care Foundation, in 2016, 45 percent of psychiatrists and 37 percent of psychologists were older than 60.⁶⁷

Workforce Financing

Training programs are largely siloed and specific to the specialty areas of interest. Fellowship, residency, and other training slots are widely regulated by several bodies and are contingent on the availability of financing from the federal government and other public payers as well as on the availability of open training program slots. The issues of workforce financing are intrinsically linked to the overall proportional spending on behavioral health. According to SAMHSA and the Centers for Disease Control and Prevention, proportional spending on behavioral health care is far below spending on other types of health expenditures; furthermore, behavioral health integration, while not as explicitly measured, is less likely to be proportionally financed. Based on data from the National Center for Health Statistics, the United States spent \$3.0 trillion on health care in 2014. Mental health and SUD comprised \$220 billion, which was only 7.5% of total spending.⁶⁸ There are other indicators of poor financing in this area, including the lack of dedicated federal financing for innovative models of behavioral health integration; in fact, many integration programs are funded in part by philanthropic efforts, leading to program cancellations when funding is completed or when a sustainable financing model is not readily available.



Recruitment and Retention

Despite the passage of the MHPAEA and the ACA, there has been only a limited increase in the delivery of behavioral health services, with resultant implications for the workforce. Geographic challenges are a leading factor. It's a poorly distributed workforce, with a high concentration of psychiatrists, psychologists, and other behavioral health professionals in affluent urban and suburban areas despite an increased need in low-income rural and urban communities. Additional factors include: challenging workloads, social stigma, and low compensation (related to aforementioned financing discussion). Clinical psychologists comprise the largest number of mental health professionals and average \$78,000 annually, even after spending between four to six years in graduate school as well as subsequent training in postdoctoral programs. This creates an incentive to practice in research-oriented universities, where clinical psychologists can earn roughly \$119,000 while also attaining a perceived higher professional status—in part, due to frequent corporate and foundation donations that fund clinical psychologists' research.⁶⁹

Burnout is another driver; across several studies, it appears that 21 to 67 percent of mental health workers may be experiencing high levels of burnout.⁷⁰ Finally, specific professions are facing an aging workforce: Although 37.6 percent of the physicians in the United States are 55 years or older, in psychiatry, nearly 55 percent are in this age range.⁷¹ This is explained in part by the fact that only 4.5 percent of recent U.S. medical school graduates apply for residency training in psychiatry due to the high demands but relatively low compensation compared with higher-paying specialties.⁷² Physicians increasingly have higher student loan debt to consider when they make choices about specialization after medical school. Psychiatry has seen high needs for decades and these financial and social factors only compound the issue. Additionally, differences in burnout between various mental health occupations yield some evidence of higher burnout among community social workers compared with nurses and psychiatrists.

Licensure

In the United States, the practice of medicine is regulated by state. Each state's medical practice act establishes rules for licensing, provision of care, discipline, prescribing, and scope of practice. Additionally, states have different guidelines and governing bodies for each of the different health care professionals. Providers may face challenges in obtaining their license to practice, including: long wait time, high costs, and disparate requirements between states. Aside from the traditional challenges of securing and updating health care provider licensure, providers face barriers to practicing in more than one state or offering care across state lines. Licensing and prescribing requirements in some states are more restrictive than in others, which often prevents certain providers from offering telehealth across state lines if they are not also licensed in that state. Obtaining a license in multiple states can be burdensome and can prevent some providers from filling workforce shortages.

Additionally, state scope-of-practice regulations vary and may limit providers from practicing at the top of their license. This is a growing challenge as demands on the current behavioral health workforce continue to grow.

Reimbursement for Behavioral Health Services

Another aspect of behavioral health financing that creates a significant barrier is the reimbursement of health services across most payment types. This is directly linked to the provider shortage in many areas around the country. More than half of all U.S. counties (all rural) have no practicing psychiatrists, psychologists, or social workers.⁷³ Even those areas that do have sufficient behavioral health professionals are deterred from accepting patients with complicated reimbursement programs, both government and private insurance, due to the low reimbursement rates and the difficult paperwork processes often involved. Only 55 percent of psychiatrists accepted private insurance compared with 89 percent of other specialists in 2010.⁷⁴ This was a 17% decline since 2005. The acceptance rate for Medicare and Medicaid in the study were just as poor or even lower. The Medicare acceptance rate for mental health services was 55 percent compared with 86 percent in other specialties, and just 43 percent accepted Medicaid compared with 73 percent in other specialties.^{75,76} In a 2017 survey of medical specialties most chosen by new providers coming out of medical school, psychiatry ranked 19th out of 23 specialties, largely due to inadequate reimbursement rates.⁷⁷

The decline in acceptance of the most common payment models is also frequently related to the stagnation of reimbursement rates over the past decade. Other specialties receive comparably higher reimbursement rates,⁷⁸ despite changes in the behavioral health field. For example, current Medicare FFS codes are inadequate for reimbursing providers using integrated behavioral health services. As FFS-based care is moved to value-based care, integration will be valued as well, and inconsistent billing practices will no longer cause such barriers to high-value care.

Similar situations occur even with reimbursement from private payers. If behavioral health professionals are not being adequately reimbursed for trying new integrated models of care, many will revert to what they are paid to do or simply refuse to accept insurance altogether in the interest of providing the best care. Forty-five percent of psychiatrists in the United States accept cash-only for payment compared with only 11 percent of other specialists.⁷⁹ As a result, many patients cannot access care through government programs nor through many private insurers. Those that can access care are often treated by professionals who are overworked, as many in-network providers frequently have waiting lists or no longer accept new patients.

Workforce Policy Options:

1. **Train Behavioral Health Providers.** Improve directed financing for allied mental health professionals and encourage pipeline programs at community colleges as well as in structured programs for layperson training.
2. **Promote Workforce Training Programs.** Direct and indirect subsidization of training programs at the federal and state level can also enhance the full spectrum of available mental health professionals.
3. **Promote Practice in High-Need Areas.** Encourage more clinicians to choose mental health specialization in their training through financial resources from states and educational institutions that help compensate for lower pay and high costs of training, especially in high-need areas (for example, low-income rural and urban areas).
4. **Improve Behavioral Health GME.** Build a more robust behavioral health GME policy and financing infrastructure in accordance with the Institute of Medicine's recommendations:
 - a. Create a GME Policy Council in the Office of the Secretary of Health and Human Services.
 - b. Establish a GME Center within CMS with the following responsibilities:
 - i. Management of operational aspects of GME Medicare funding;
 - ii. Management of the GME Transformation Fund; and
 - iii. Enhanced workforce data collection.
5. **Promote Integration in Training.** Evidence-based teaching and training in behavioral health integration needs to be standardized with support from undergraduate and graduate medical and nursing education funding directed toward such goals; the Health Resources and Services Administration and relevant federal agencies should also underscore these priorities. Accrediting bodies also need to play a role in establishing reforms that keep pace with evidence-based practices and guidelines, quality-improvement efforts, and innovative models of care.
6. **Support Development and Dissemination of Evidence-Based Telehealth.** The HHS secretary could build on current efforts—such as the Office for the Advancement of Telehealth's Telehealth Resource Center Grant Program—that support the development and dissemination of evidence-based best practices and tools to support clinicians' provision of telehealth services, including addressing changes in clinical workflow, facilitating care coordination, providing team-based care, supporting patient-centered care, and offering other opportunities.
7. **Promote Licensure Compacts.** The HHS secretary could incentivize or require states to comply with licensure compacts through guidance, encouragement to states, or the provision of technical assistance through a resource center to support implementation.



8. **Adopt Consensus Guidelines.** The HHS secretary could promote adoption of consensus guidelines for evaluating the appropriate standards of care among state medical boards. Examples of standards include establishing a clinician-patient relationship prior to treatment, documentation of evaluation and patient history, patient-informed consent, continuity of care and referral for emergency services, and meeting both state and federal privacy standards.^f

^f Policy options 6, 7, and 8 were included in BPC's *Improving Care for Patients with Serious Illness, Part 1*.

Federal Administrative Barriers and Policy Options

NATIONAL-LEVEL BEHAVIORAL HEALTH SPENDING AND FUNDING

Mental health and SUD services are financed by a mix of state and local revenues, Medicaid and CHIP, Medicare, private insurance coverage, patients' out-of-pocket expenditures, and an array of public and private programs.⁸⁰ National spending on mental health and SUD treatment services is projected to reach \$281 billion in 2020.⁸¹ Mental health spending is projected to account for 85 percent (\$238 billion) of all mental health and SUD treatment spending in 2020. Mental health and SUD treatment services represent a relatively small share of overall health spending, projected to be about 6.5 percent in 2020. The rate of growth for behavioral health spending is estimated to be about 4.6 percent per year between 2009 and 2020, compared with 5.8 percent for overall health spending.

One significant difference between financing for behavioral health services compared with financing for general medical services is the stark imbalance in public financing. In 2011, public sources financed 61 percent of behavioral health care compared with 46 percent of overall health services. State and local dollars play a larger role in behavioral health care than overall medical care, reflecting their historical role in financing these services.⁸²

Public programs pay the largest share (60 percent) of behavior health treatment costs, mostly through Medicaid, Medicare, and other state and local funding.⁸³ Public payers also continue to pay for most SUD treatment services; these include Medicaid, Medicare, other state and local funding sources, and other federal funding sources (including SAMHSA's Substance Abuse Prevention and Treatment Block Grant). In 2020, public payers are projected to spend roughly \$29.9 billion on such services, roughly 70 percent of SUD spending.⁸⁴

The availability of Medicaid to finance state-based behavioral health services creates incentives for states to shift programs financed exclusively with state dollars to services reimbursable with federally matched Medicaid dollars. In many states, Medicaid and mental health services are jointly budgeted, with states attributing their matching funds for Medicaid to the budget of state mental health agencies.⁸⁵

Government Accountability Office Report

The release of a highly critical report by the Government Accountability Office (GAO) in 2014 prompted congressional action to promote coordination of federal programs to treat serious mental illness, as part of the 21st Century Cures Act.⁸⁶

The GAO was critical of agencies' inability to identify a comprehensive list or inventory of programs for persons with serious illnesses. The GAO cited the Government Performance and Results Modernization Act of 2010, which requires the U.S. Office of Management and Budget to compile a list of all federal programs, their purposes, how they contribute to the agency's mission, and their funding information; the GAO recognized the importance of the compilation to assist Congress and the executive branch in avoiding fragmentation and duplication of services.

The GAO noted that studies have shown that meaningful results require coordinated efforts of more than one department and within and among departments. The report was especially critical of HHS for (1) failing to call meetings of the Federal Executive Steering Committee for Mental Health, which is charged with coordination across the federal government; (2) inaccurately stating that the Behavioral Health Coordinating Council (an HHS-only council) performed many of the same functions; (3) relying on program-level coordination, which they argued is important, but cannot take the place of higher-level coordination; and (4) a lack of engagement at the leadership level. Accordingly, the GAO recommended that HHS develop a process to engage in inter- and intra-agency coordination, noting that coordination at the leadership level is necessary. The GAO reported that HHS disagreed with the recommendation, noting that because Congress allocates specific programs to SAMHSA, coordination should be done at the congressional level.



Mental Health Provisions of 21st Century Cures Act

In response, Congress enacted legislation as part of the 21st Century Cures Act⁸⁷ to improve inter- and intra-agency coordination by establishing the position of assistant secretary for mental health and substance use to head SAMHSA, rather than an administrator, and directed the assistant secretary to promote the dissemination of research findings and evidence-based practices; to monitor and evaluate grants; to collaborate with other federal departments to improve care for special populations, including veterans, service members, and homeless individuals; and to improve recruitment and retention of mental health and SUD professionals. The act included a number of other requirements to improve and promote new models of care for persons with severe mental illness. The Behavioral Health Coordinating Council worked for nearly 18 months before issuing a major report to Congress with recommendations.⁸⁸

DATA-RELATED BARRIERS

A major integration barrier in a coordinated care setting is the inability to easily share patient information between providers. Providers are allowed to share information only with elaborate contractual agreements, which creates barriers for care coordination, an essential component of successful integration.

Patient Privacy

Specifically, a federal statute written in the 1970s called the Confidentiality of Alcohol and Drug Abuse Patient Records, 42 Code of Federal Regulations (CFR) 2 (known as 42 CFR Part 2) was intended to protect patient privacy by keeping SUD records separate from other medical records.⁸⁹ To be sure, disclosure of information related to the diagnosis and treatment of SUD could harm patients and cause them to avoid treatment. The disclosure of treatment records has the potential to lead to adverse outcomes such as loss of employment, loss of housing, loss of child custody, discrimination by medical professionals and insurers, arrest, prosecution, and incarceration.⁹⁰ While intended to protect individuals from these outcomes related to the stigma surrounding treatment, 42 CFR Part 2 has had the unintended consequence of limiting treatment providers from sharing information that would provide better and more integrated care for a patient who is also seeking care for other health conditions.

Today's opioid addiction crisis has highlighted the need for easier data sharing. Primary care practitioners, for example, have no way of knowing about a patient's SUD and accompanying treatment unless the patient discloses that information during a visit. By contrast, the Health Insurance Portability and Accountability Act (HIPAA) allows patient information to be shared in order to provide care coordination. HIPAA allows disclosure without the consent of the patient for purposes of payment, treatment, and health care operations.⁹¹

Electronic Health Records

One barrier to integration is the lack of information sharing, spurred by privacy concerns, which has limited the adoption of electronic health records by mental health and SUD providers. The Health Information Technology for Economic and Clinical Health Act (HITECH) of 2009, which was part of the American Recovery and Reinvestment Act of 2009, provided billions of dollars in subsidies for medical providers to purchase and maintain electronic health records, but the act did not make incentive payments available for mental health and SUD providers. While the adoption of electronic health records has increased among other health care providers and entities, adoption by mental health and SUD providers has lagged.⁹²

Administrative Policy Options:

1. **Report on the Impact of Programs Serving Patients with Mental Illness.** The 21st Century Cures Act requires the assistant secretary for mental health and substance use to submit a report every two years on inter- and intra-agency coordination efforts across programs. Congress could expand the report to (a) include information required under the Government Performance and Results Modernization Act of 2010, (b) make recommendations to Congress on how best to improve program coordination and thus improve care for patients with mental illness, and (c) avoid fragmentation and duplication of services. The report should include an estimate of the number of individuals who receive treatment under grant programs and who also have insurance coverage. The report could also make recommendations to Congress on how best to transition stand-alone grantee providers to integrated provider systems.
2. **Direct Federal Funding to Stand-Alone Mental Health Facilities.** Have the secretary report to Congress on the number of federally funded grantees providing treatment to patients with mental illness. Congress could consider requiring that by a date certain, all federally funded entities must have co-located primary care services. Congress could also define minimum standards for the co-location of services based on best practices in the integration of clinical and mental health services.
3. **Encourage or Require Mental Health Providers to Use Electronic Health Records.** Permit funding for the Health Information Technology for Economic and Clinical Health Act to be made available to mental health and SUD providers to encourage or require the adoption of electronic health records.
4. **Provide Health Information.** The 21st Century Cures Act directed the HHS secretary to offer guidance to providers to help them understand their responsibilities under the Health Insurance Portability and Accountability Act of 1996. Additional focus should be given to this area, as confusion continues.



Conclusion

The history and structure of the mental health system has resulted in payment and policy silos and a host of agencies and providers that, while committed to quality care for people with mental illness, have significant interest in changes to the status quo. Integration of services financed at the federal level will require collaboration among traditional mental health providers, public health departments, states, health plans, and federal government agencies that have not traditionally been required to work together and may not have aligned interests. Integration of mental health financing will also require agreement among committees of jurisdiction in the U.S. House of Representatives and U.S. Senate, including the House Ways and Means Committee, the House Energy and Commerce Committee, the Senate Finance Committee, and the Senate Committee on Health, Education, Labor and Pensions, as well as the House and Senate Budget and Appropriations Committees. Ultimately, consensus must be achieved among a host of stakeholders to fully integrate financing of services.

In addition to political and jurisdictional concerns associated with some of the options, many will require increased federal spending. BPC has typically sought to identify savings or additional revenues to avoid policies that add to the federal deficit. This will need to be considered as policymakers weigh options.

To be sure, policymakers worked in recent years to improve care for patients with mental illness. The MHPAEA represented a major milestone by requiring private insurers to provide the same level of benefits for treatment of mental illness as they do for physical conditions. Ultimately, the ACA included language requiring all insurers to provide coverage for mental health services. Likewise, as part of the 21st Century Cures Act, Congress enacted legislation to improve inter- and intra-agency coordination and to create more accountability in coordinating programs for patients with serious mental illness. More can be done, however to improve coordination and to avoid duplication of services, as well as to move toward integration of services as a condition of receipt of federal funding in both grant and entitlement programs. A logical next step in developing bipartisan recommendations would be to convene a task force of stakeholders representing patient advocates, health care providers, insurers, and state and federal policymakers to consider options and find consensus on recommendations.

Appendix A

Number of States Using Funding Sources to Finance Community Mental Health Services, By Type of Service, 2015 (n=46 states)

Funding Source	Inpatient Hospital Services	Residential Room and Board	Residential Support Services	Outpatient Testing and Treatment	Extensive/Intensive Outpatient	Collateral Treatment	Case Management	Crisis Services	Assertive Community Treatment	Supported Treatment	School Based Services	Wraparound Services	In Home Services	Peer/Consumer Run Services	Co-occurring MH and SUD Services
State General Fund	37	37	40	41	37	28	40	44	35	35	29	32	29	37	23
State Special Fund	7	7	8	10	7	3	5	9	6	3	4	4	5	4	4
State Medicaid Match	30	7	26	34	32	16	32	32	25	13	26	20	24	17	14
Medicaid (federal)	22	7	28	41	38	22	39	37	32	16	23	24	27	20	20
Clinic Option	5	0	2	17	13	6	5	9	5	1	4	2	2	0	7
Rehabilitation option	2	4	18	25	24	10	16	22	21	7	13	10	19	13	12
12 Targeted Case Management	0	0	1	1	2	1	21	2	3	1	0	3	3	2	0
1915(i) waiver	0	0	2	2	3	0	1	3	1	3	0	0	2	2	0
1115 waiver	9	0	4	8	9	4	7	7	5	5	1	2	3	4	0
1915(b) waiver	5	0	5	9	7	4	7	7	6	4	4	6	7	4	3
1915(c) waiver (HCB)	1	1	6	1	1	1	6	2	0	3	3	5	6	0	4
EPSDT	6	2	5	9	8	5	5	5	1	1	7	6	7	1	1
Other Medicaid	9	0	0	3	3	0	0	2	0	0	2	0	0	0	1
Medicare	23	1	2	16	9	0	0	4	3	0	0	0	1	0	4
Veterans Affairs	5	1	3	6	4	3	4	3	3	3	2	1	2	1	1
SAMHSA Mental Health Block Grant	1	6	16	27	21	10	22	19	14	14	20	20	13	30	10
Social Services Block Grant	1	4	6	5	4	4	8	5	3	4	3	4	3	2	3
Housing and Urban Development	0	9	3	1	0	1	3	1	1	1	0	2	2	1	1
Other federal	1	2	6	2	4	2	5	3	0	4	1	3	1	3	4
Local Government	12	11	13	16	13	9	14	15	13	10	9	9	10	11	8
First party	17	15	13	21	18	13	17	15	10	7	5	9	10	7	5
Third Party	23	8	9	25	20	9	12	15	11	6	6	7	9	6	10
Charity	3	3	3	5	3	2	3	2	1	2	1	2	1	2	0
Other Funds	1	0	0	1	1	1	1	1	0	2	2	1	1	1	1

Abbreviations: EPSDT, Early and Periodic Screening, Diagnostic, and Treatment; FY, fiscal year; HCBS, home- and community-based services; MH, mental health; SUD, substance use disorder; SAMHSA, Substance Abuse and Mental Health Services Administration; SMHA, state mental health agency.



Appendix B

Federal Programs in Funding and Delivering Behavioral Health Services

SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION

HHS is the lead agency for the federal government's provision of mental health services, and SAMHSA is tasked with promoting coordination of programs relating to mental illness throughout the federal government.⁹³ SAMHSA administers an array of grant programs:

- **Community Mental Health Services Block Grant (\$533 million in FY 2016).** States use these funds for a variety of programs, including employment, housing, rehabilitative, and clinical services. Mental health block grant funds are not intended to be a sole funding source and are meant to complement other sources and to leverage existing state systems.
- **Programs of Regional and National Significance.** Supports activities within three areas: mental health (\$407 million in FY 2016), substance abuse treatment, and substance abuse prevention (\$211 million in FY 2016). Funded activities may include competitive grants, contracts, and cooperative agreements, and may vary significantly.
- **Children's Mental Health Services** (\$119 million in FY 2016).
- **Projects for Assistance in Transition from Homelessness** (\$65 million in FY 2016).
- **Protection and Advocacy for Individuals with Mental Illness** (\$36 million in FY 2016).⁹⁴

HEALTH RESOURCES AND SERVICES ADMINISTRATION

The Health Resources and Services Administration finances health care for people who are geographically isolated, and/or economically or medically vulnerable, including people living with HIV/AIDS, pregnant women, mothers and their families, and those otherwise unable to access high-quality health care. The Health Resources and Services Administration oversees the Health Center Program, a national network of health clinics that provide comprehensive primary health care services, regardless of a patient's ability to pay, charging for services on a sliding scale.

Authorized under the Health Center Program Statute: Section 330 of the Public Health Service Act (42 U.S.C. §254b), community health centers serve the primary health care needs of more than 24 million patients in more than 1,300 health centers at more than 9,000 locations across the United States.⁹⁵ A 2010 survey by the National Association of Community Health Centers reported that 71 percent of health centers provide mental health services and 20 percent provide SUD treatment services.⁹⁶ These centers often serve as the primary medical home for people with severe and persistent mental illness. However, as primary care-focused health centers, community health centers function as a gateway to more intense community-based treatment.⁹⁷

CENTER FOR INTEGRATED HEALTH SOLUTIONS

The Center for Integrated Health Solutions is a collaborative program between SAMHSA and the Health Resources Services Administration, and it is charged with promoting the development of integrated primary and behavioral health services in primary care or specialty behavioral health services. The center is the first national home for information, experts, and other resources dedicated to bidirectional integration of behavioral health and primary care.⁹⁸ The program provides training and technical assistance to community behavioral health organizations, community health centers, and other primary care and behavioral health organizations.

CENTER FOR MEDICARE AND MEDICAID SERVICES

The CMS administers Medicaid, Medicare, the Children's Health Insurance Program, and insurance regulations for federally qualified health insurance policies offered through state and federal insurance marketplaces established under the ACA.

Medicare

The Medicare program is a federal insurance program that provides coverage to older Americans, individuals with end-stage renal disease, and those who are receiving Social Security disability insurance. In 2018, 59 million individuals were enrolled in Medicare, including 50.3 million elderly individuals, and 8.8 million disabled individuals.⁹⁹ The CMS has supported integrated care models in Medicare. The Collaborative Care Model, as part of the 2017 physician payment rule, supports reimbursement of a team of providers led by a primary care provider. Other team members include care managers, psychiatrists, and other mental health professionals who work develop and work together under an individual care plan, which includes evidence-based practice guidelines.

Medicaid

The Medicaid program provided health insurance coverage for 75 million individuals in 2018, more than 20 percent of Americans, and is a primary source of coverage for low-income individuals. In total, Medicaid covered 21 percent of adults with mental illness, 26 percent of adults with serious mental illness, and 17 percent of adults with SUD (2015).¹⁰⁰ As the single largest payer in the United States for behavioral health services, one in five Medicaid beneficiaries have a behavioral health diagnosis.¹⁰¹ Though there is variation in behavioral health diagnosis rates among differing eligibility groups within Medicaid, those beneficiaries with a diagnosis have higher total expenditures writ large than individuals without a behavioral health diagnosis in each eligibility group.¹⁰²

Private Health Insurance

The CMS Center for Consumer Information and Insurance Oversight is responsible for overseeing the regulation of private insurance, including essential health benefits, health plan network adequacy requirements, operation of individual and small group insurance marketplaces, and oversight of state insurance marketplaces. The center administers the health insurance premium tax credits for the purchase of qualified health insurance plans through federal and state insurance marketplaces.

AGENCY FOR HEALTHCARE RESEARCH AND QUALITY

Although not directly involved in the payment or delivery of mental health services, the Agency for Healthcare Quality and Research produces evidence to improve health care quality, safety, access, and affordability. The agency serves as a resource for organizations that seek to better integrate mental health and primary care.



Appendix C

State and Local Agency Roles in Funding and Delivering Behavioral Health Services

States and localities have a critical role in funding, organizing, and delivering behavioral health prevention services, treatment, and recovery supports. Multiple state agencies may provide mental health services—including agencies responsible for disability services, education, juvenile justice, or corrections—but the lead agency for administering services in the public mental health system is the state mental health agency (SMHA).

Every state has an SMHA that serves as the lead government agency responsible for the administration, financing, and delivery of mental health services to adults with severe mental illness and children with serious emotional disturbance within the state. The Hughes Act (Comprehensive Alcohol Abuse, and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970, P.L. 91-616) requires each state to establish a single state authority to administer federal substance abuse funds and to develop and regulate services.¹⁰³ Most states have combined the planning and delivery of mental health and SUD services into a single state government agency. The single state authority and the SMHA are further combined into a single state agency in 35 states and are within the same umbrella state department in 11 states. In four states, the single state authority and the SMHA are located in separate state departments. In three of these states, the SMHA has an interagency agreement with the single state authority.¹⁰⁴

The locations of the SMHAs within state governments varies among states but are typically located within a larger umbrella agency. The SMHAs are located within the state's Department of Human Services (21), the state's Department of Health (nine), or the state's Department of Health and Human Services (four). In 12 states, the SMHA is an independent department of mental health.¹⁰⁵

The SMHA and the state intellectual disability agency are combined into a single agency in 11 states and are within the same umbrella state department in 25 states. In 14 states, the intellectual-disability agency is located in a different state department. In 11 of these states, the SMHA has an interagency agreement with the state intellectual-disability agency. In two states (Arizona and Texas), the SMHA is within the state public health agency and is in the same umbrella state department in 19 states. In 28 states, the state public health agency and the SMHA are in separate state departments. In 11 of these states, the SMHA has an interagency agreement with the state public health agency.¹⁰⁶

Because of the large role Medicaid plays in financing behavioral health, it is important to examine the relationship between these agencies. The SMHA is housed within the state Medicaid agency in one state (Pennsylvania) and is located within the same umbrella state department in 28 additional states. In 21 states, the SMHA and state Medicaid are located in different state department. In 16 of these states, the SMHA has an interagency agreement with the state Medicaid agency.¹⁰⁷

ROLE OF STATE MENTAL HEALTH AGENCIES

The SMHAs organize, coordinate, and directly operate some mental health services and allocate funds to community providers for additional mental health services not provided directly by the SMHA. In FY 2014, the SMHA systems served more than 7.3 million individuals at a cost of \$41 billion. The services provided or supported by the SMHAs included direct psychiatric treatments and medications as well as a variety of critical supports, such as housing, employment, education, and primary care coordination to help individuals recover and be able to live in their own communities. While there is variation in how the SMHAs are structured and how they deliver services, they share common functions. Figure 4 outlines the core functions of the SMHAs.

SERVICES OFFERED AND ELIGIBILITY CRITERIA

State laws define which services are offered in individual states. The SMHAs vary from state to state in the types of mental health services, treatment settings, and specific mental illnesses that each is responsible for organizing, funding, and providing. In most states, the SMHA is responsible for organizing and funding both psychiatric hospital services and community-based services for children and adults. However, in a few states, some of these responsibilities are outside the SMHA.

There are no specific federal mandates for the services that the SMHAs must provide. In order to qualify for federal Community Mental Health Services Block Grant funds, the SMHAs are expected to offer “comprehensive community-based mental health systems” to adults and children. States have the flexibility to set eligibility criteria for SMHA-operated or SMHA-funded services based on various standards, including severity and duration of mental illness, sickness, insurance status, and income.¹⁰⁸

Figure 4. Core Functions of State Mental Health Agencies

- Educate the public about mental illness, combat discrimination and stigma surrounding mental illness, and support public health prevention activities for mental health.
- Plan the development of a comprehensive array of mental health services—including coordination with other state government agencies and local mental health and SUD agencies—and submit an annual comprehensive community mental health block grant plan to SAMHSA.
- Organize, coordinate, fund, and in some states directly operate a comprehensive system of community-based mental health services to meet the mental health treatment needs of individuals in the state.
- Monitor the outcomes of the service system by collecting data and evaluating services.
- Serve a public-safety function by providing and coordinating services to individuals with mental illnesses who are determined by courts to be dangerous to themselves or others.
- Operate and fund inpatient psychiatric beds that provide critical, intensive treatment to individuals with high levels of need or those at risk of harm to themselves or others.

Source: Substance Abuse and Mental Health Services Administration, 2015.¹⁰⁹

States have used the flexibility to establish differing eligibility criteria. In 26 states, mental health services funded through state general or special funds are available to all adults with any mental illness, and in 27 states, the mental health services funded through state general or special funds are available to all children with any mental illness. Other states limit access to care based on severity of illness. In 18 states, services funded through state general or special funds are available only to adults who meet the state’s definition of severe mental illness; in 15 states, services funded through general or special funds are available only to children who meet the state’s criteria for serious emotional disturbance. Twenty-five states have an illness-severity requirement. Illness-severity requirements vary from specified functioning levels on standardized measures to a combination of specified diagnoses along with duration of illness.¹¹⁰ Some states use an income standard to determine eligibility for care. In 13 states, individuals must have incomes below a state-specified level to qualify for SMHA services.¹¹¹

Aggregate statistics from across states underscore how community-based the delivery system for behavioral health has become. While the SMHAs support mental health services in a large number of organizations (8,500) and a wide range of settings, almost nine out of 10 providers (87 percent) are community-based (see Figure 5). Only in five states does the SMHA directly operate community mental health programs with state employees. In all other states, the provider system is based on a collaboration among state, county, city, and local authorities.



Figure 5. Number of Facilities State Mental Health Agencies Operate and Fund, FY 2015

Service Setting	SMHA Operated	SMHA Funded	Total
State Psychiatric Hospitals	159	15	174
Community Mental Health Providers	91	7,290	7,381
Private Psychiatric Hospitals	NA	69	69
General Hospitals with Separate Psychiatric Units	12	459	471
Nursing Homes and other ICF-MI and SNF Providers	20	34	54
Residential Treatment Centers	12	339	351
Total Number of Mental Health Providers	294	8,206	8,500

Abbreviations: ICF-MI, intermediate care facilities for individuals with mental illness; NA, not applicable; SMHA, state mental health agency; SNF, skilled nursing facility.

Source: Substance Abuse and Mental Health Services Administration, 2015.¹¹²

Community mental health systems provide mental health services and supports through a combination of state and local governments as well as non-profit and for-profit organizations, which vary from state to state. In about half the states, county or city authorities administer mental health services (25 of the 47 states reporting). In 16 of these states, county or city authorities administer mental health services throughout the state. In nine out of those 25 states reporting, the county or city authorities administer mental health services only in parts of the state.¹¹³

In 21 states, local governments contribute to the funding of mental health services. This contribution is required in 13 of these 21 states.¹¹⁴ Almost all the individuals served by the SMHAs receive services in community settings. In 2014, 98 percent of the 7.3 million individuals accessing services received them in community settings, such as medical provider offices. Only 6 percent of individuals received services in other psychiatric inpatient settings.¹¹⁵

ROLE OF STATE SUBSTANCE ABUSE AGENCIES

States have developed networks of primary prevention, treatment, and other providers since the 1970s, supported primarily through federal and state funding. There are 2,452 primary prevention providers funded with Substance Abuse Prevention and Treatment Block Grant funds through the State Substance Abuse Agencies. In addition, 7,802 providers of specialty SUD treatment are owned by non-profit organizations or by state or local governments and largely provide care for people who are underinsured or who have low incomes.¹¹⁶

State Substance Abuse Agencies treated 2.3 million individuals and reported that 17.5 million people received individual-based SUD prevention services in FY 2014, and population-based prevention strategies produced an estimated 484 million person-exposures.¹¹⁷

The majority of primary prevention providers are non-profit, non-governmental organizations, and a minority of prevention providers are government units, such as local health departments or school districts.¹¹⁸

ROLE OF STATE MEDICAID AGENCIES

State Medicaid agencies have an increasing role in funding, managing, and monitoring public mental health services in states, reflecting the increasing reliance on Medicaid-funded services (see funding discussion following). The shift is encouraged by the movement of services from institutional settings, in which Medicaid funding is restricted, to community settings.

Federal law requires that there be a “single state agency” that administers or supervises the administration of the state Medicaid program. The Medicaid agency may delegate responsibility of some responsibilities to other state agencies or private contractors as long as it maintains ultimate authority. Other state agencies or contractors may be given responsibility for certifying and enrolling providers, defining covered services and setting rates, administering payments to providers, collecting and reporting data, and determining the eligibility of applicants and enrolling them into the program.¹¹⁹

Each state has its own unique Medicaid system that can adopt a variety of state optional services and waivers that permit the use of managed care. In 2015, 31 SMHAs were using a combination of managed care and FFS plans to pay for mental health services, whereas 13 SMHAs relied on FFS-only approaches and four SMHAs were managed-care-only systems.¹²⁰

States may have the Medicaid agency retain full responsibility for services funded with Medicaid dollars and provided to Medicaid enrollees, or else share those responsibilities in with other state agencies. As a result of this flexibility, there is variability in the way responsibilities are divided among agencies across states. The SMHAs work with their Medicaid counterparts on the design and delivery of Medicaid services. Broadly speaking, the SMHA has more freedom than the Medicaid agency in deciding which populations to cover, what services to provide, and how services are administered.¹²¹

Medicaid state agencies are responsible for setting payment rates, but the SMHAs are often involved in the process. In 16 states, the SMHAs set the rates for mental health services that SMHA-funded programs provide, and 15 SMHAs are responsible for setting rates for mental health services that SMHA-operated programs provide. In nine states, the SMHA is responsible for setting Medicaid rates for services in various Medicaid options, and in three states, the SMHA sets rates for mental health services in non-SMHA-funded (private) programs.¹²²

Medicaid agencies define what types of providers are qualified to provide services to Medicaid beneficiaries and to enroll willing providers. States are generally required to allow any qualified provider who is willing to provide services at the reimbursement level set by the Medicaid program to enroll as a provider.¹²³ Most states require providers to have a mental health designation in order to be Medicaid providers, and 22 states delegate the enrollment of mental health providers to the mental health agency. Twenty-six states reported that at least some Medicaid mental health services or populations are covered through behavioral health organizations or administrative services organizations.¹²⁴

States also have more flexibility in choosing the SMHA organizational structure than the Medicaid structure because there is no federal “single state agency” requirement as there is in Medicaid. In order to receive federal mental health formula grants, states must establish a State Mental Health Planning Council that includes a representative of the state Medicaid agency.¹²⁵ Medicaid also establishes federal requirements for what services can be reimbursed and who is eligible to have services reimbursed. Some believe that a focus on maximizing the drawdown of federal funds has distorted state mental health policy by shifting focus away from those who don’t meet Medicaid eligibility rules, in particular the uninsured (often the highest risk) individuals and services they need.¹²⁶

States classify a wide range of services as Medicaid mental health services for state budgeting or rate-setting purposes. This includes every state that defines outpatient services provided by psychiatric or designated mental health providers as Medicaid mental health services; 45 states classify outpatient services provided at a community mental health center, or mental health services provided under the rehabilitation option, or inpatient mental health services in a psychiatric hospital as Medicaid mental health services. Forty-three states classify inpatient mental health services at a general hospital as Medicaid mental health services, and 31 states include outpatient mental health services provided by a general or family physician as Medicaid mental health services.¹²⁷



State Substance Abuse Agencies and SMHA Funding Sources

Medicaid was responsible for nearly half of SMHA revenues (49 percent), but only 16 percent of State Substance Abuse Agencies funding.^{g.128} The SAMHSA Substance Abuse Prevention and Treatment Block Grant accounted for nearly one-third of State Substance Abuse Agencies funds (32 percent), and the Mental Health Block Grant represented only 1 percent of SMHA funding.¹²⁹ Medicaid's share of SMHA revenue has increased over time, growing from 42 percent in fiscal year (FY) 2004 to 49 percent in FY 2012. The increase in Medicaid funds accounts for almost all of the growth in SMHA revenue from state FY 2004 to FY 2012. In FY 2012, 63 percent of SMHA clients were at least partially funded by Medicaid, up from 57 percent in 2007.¹³⁰ (See Appendix A for a detailed chart of how states use Medicaid funds to support behavioral health services.)

SMHA Expenditures by Type of Mental Health Program

Every SMHA funds or operates community mental health programs, and every state operates state psychiatric inpatient beds (usually provided in a facility called a state psychiatric hospital). In FY 2014, the SMHAs spent \$30.6 billion providing community-based mental health services, which represented 75 percent of total SMHA expenditures. Expenditures for state psychiatric hospital inpatient services were an additional \$9.4 billion, representing 23 percent of total SMHA expenditures. The SMHAs spent an additional \$845 million (2 percent) on administration, prevention, research, and training.¹³¹

Funding Sources for SMHA Mental Health Services

Each state uses a unique mix of state, federal, local, and other funding sources to finance mental health services. In FY 2014, the SMHAs controlled a total of \$41.2 billion in revenues for mental health, of which 60 percent (\$24.8 billion) came from state government sources. State general revenue funds of \$15.6 billion (63 percent of state funds) were the largest state government source of SMHA funds. State Medicaid match funds accounted for \$8.2 billion (33 percent), and state special revenues of \$1 billion accounted for the rest.¹³² Most often, other state and local dollars for behavioral health services are financed through state general funds, rather than through a dedicated revenue source. Using state and local revenue sources makes these services particularly sensitive to state budget conditions.¹³³ In 11 states, cities and county governments contributed their own local tax dollars to pay for SMHA mental health services, and local funds accounted for \$0.7 billion (1.6 percent of total SMHA funds).¹³⁴

State Mental Health Agency Funding Sources for Community Mental Health Services, FY 2014

Community mental health programs received 73 percent (\$29.9 billion) of total SMHA funds in FY 2014. As highlighted in Appendix A, most states depend on a variety of Medicaid options and waivers to finance community mental health services. Medicaid (state and federal shares combined) contributed 59 percent (\$17.7 billion) to all SMHA community mental health funding in FY 2014, and in 21 states Medicaid represented more than 70 percent of community funding.¹³⁵

State government sources for community mental health services came from state general funds (\$8.2 billion), the state Medicaid match (\$7.2 billion), and state special funds (\$591.5 million) for a total of \$16 billion. Nearly nine out of every 10 (89 percent) federal dollars (\$11.8 billion total) comprised the federal share of Medicaid (\$10.5 billion). The SAMHSA Mental Health Block Grant (\$390.3 million), Medicare (\$319.6 million), and other federal funds (\$401.5 million) accounted for the remaining funding available to the SMHAs.¹³⁶

The SMHAs are responsible for paying the Medicaid match for mental health services that SMHA-funded programs provide in 31 states. Local counties and cities in 13 states are responsible for paying a portion of the state Medicaid match.¹³⁷

^g Figures presented in this section reflect expenditures within the control of the SMHAs. However, many of these expenditures are outside the control of the SMHA. Studies by SAMHSA suggest that the total Medicaid expenditures for mental health may be double those controlled by the SMHAs. The National Spending Estimates identified \$39 billion in total Medicaid expenditures for mental health in FY 2009; according to the State Mental Health Profiles, in FY 2009 SMHA Medicaid revenues totaled \$17.9 billion (46 percent of Medicaid spending for mental health).

Insurance payments and co-pays make up a small share of SMHA funding. Only 1.5 percent of SMHA funds are from first-party and third-party payments (insurance payments and co-pays for services). All other sources—which include donations, funds from foundations, and other sources—totaled an additional \$1.5 billion (4 percent).¹³⁸

Another important step in incorporating primary care into mental health care is to integrate health screenings. In 40 (out of 49) states, the SMHA screens or assesses individuals for physical health issues in community mental health settings. Sixteen of these states screen or assess all individuals served in all community mental health programs that the SMHAs fund or operate. Twelve states screen or assess some individuals served in all community mental health programs that the SMHAs fund or operate.¹³⁹



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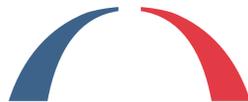
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