



Defining the Behavioral Health Workforce:

The Need for a Standardized Typology



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Background

Equitable access to high-quality behavioral health care is a significant challenge in the United States. Despite legislation aimed at increasing parity between coverage for behavioral health and medical/surgical care and improving network adequacy, millions of Americans still struggle to obtain mental health and substance use services.

In 2023, the National Committee for Quality Assurance (NCQA), with support from the Sozosei Foundation, published a [white paper](#) that synthesized the state of evidence on behavioral health network adequacy standards and metrics, and called for increased accountability for access to behavioral health care.¹ Among the key issues identified is an inconsistently defined behavioral health workforce comprised of diverse provider types with differing scopes of practice (SOPs), which has historically excluded qualified behavioral health providers from health plan networks. For example, marriage and family therapists and mental health counselors could not enroll as Medicare providers until 2024, representing the first update to Medicare's list of covered behavioral health providers in over 30 years.²

NCQA's white paper further detailed that even when behavioral health providers are eligible for network inclusion, they participate at low rates. One study of ACA Marketplace networks found only 21.4% of mental health providers participated in at least one network, compared to 58.4% of primary care physicians.³ Stakeholders cite high administrative burden and poor reimbursement rates as key barriers to network participation. In fact, a recent report found that in-network reimbursement levels for behavioral health provider office visits average 21.7% lower than for medical/surgical clinician office visits.⁴

To effectively meet the varied behavioral health care needs, consumers need access to services across the care continuum. Multidisciplinary care teams consisting of licensed and non-licensed provider types, collaborating across health care settings, have been shown to be effective in improving access to services and allowing providers to work at the top of their license.^{5,6} These teams often include provider types and services not typically covered in traditional fee-for-service payment models, however.

Addressing issues in defining the behavioral health workforce is critical to expanding provider networks and ensuring equitable access to services across the behavioral health care continuum. This issue brief provides an overview of the consequences of an inconsistently defined behavioral health workforce, and makes recommendations for future directions in improving behavioral health network adequacy.

INCONSISTENTLY DEFINED BEHAVIORAL HEALTH WORKFORCE WITH DIFFERING SCOPES OF PRACTICE

There is a significant range of behavioral health provider types and titles in the United States that vary by education, training, licensure and certification requirements (refer to [Appendix 1 of NCQA's white paper](#)); for example, there are more than 400 substance use disorder practitioner credentials across the country.⁷ Similarly, licensed professional counselors are variously referred to by ten different titles, such as "professional counselors," "clinical mental health counselors," and "licensed clinical professional counselors."⁸

Mirroring the diversity of provider types and titles, state laws and regulations surrounding SOPs lack uniformity, leading to state-to-state differences in functions behavioral health provider types may perform. Nurse practitioners require physician supervision to prescribe psychotropic medications in 23 states, despite evidence that full prescriptive authority granted to them by 27 states has improved access to care and behavioral health outcomes.^{9,10} Only 34 states expressly grant licensed professional counselors the ability to diagnose behavioral health conditions.¹¹ Master's-level clinical social workers in 3 states are similarly unable to diagnose, regardless of prior education and training.¹² Further, although there is evidence for the effectiveness of peer support services in improving a variety of outcomes, including reduced inpatient service use and better engagement in treatment, lack of standardization has led to confusion regarding their role in the care team.^{13,14}

The complexity of behavioral health provider types and titles, paired with inconsistent SOPs, have produced a mismatch between professional competencies and the services providers can deliver. This leaves many providers unable to practice at the top of their license, and individuals who need mental health and substance use care unable to access the full range of services the behavioral health workforce is trained to provide.

"There is a lack of common definitions for behavioral health care providers. There's a lot of non-psychologists and non-psychiatrists providing a lot of the mental health services that are hard to pull into these network adequacy categories, let alone then have consumers search for these kinds of providers when they try to access them[,] because there's no consistency."
— Stakeholder interviewee from [NCQA's white paper report](#)

IMPACT OF SCOPE OF PRACTICE REGULATIONS ON REIMBURSEMENT AND SERVICE DELIVERY

SOPs that fail to account for the full range of providers' competencies may restrict services a provider may offer, as well as services for which they are eligible to be reimbursed.¹⁵ And including services in a state's SOPs does not guarantee payment for those services. Reimbursement policies vary across payers, and may have specific eligibility requirements that conflict with state SOPs, such as training/certificate and supervision requirements or service settings.¹⁶ As a result, these regulations create unnecessary barriers to service delivery, undue administrative burden and financial stress for providers and their practices as they navigate complex state and health plan regulations.

For example:

- Clinical psychologists are not eligible for reimbursement for psychiatric diagnosis and evaluation without medical services in at least 10 states, even though this falls within their SOP and competencies.¹⁷
- Although insurance plans require a state license for network participation as an independent provider, 19 states do not offer state licensure for substance use counselors. Therefore, substance use counselors are eligible for reimbursement only if they provide services in an in-network facility rather than in private practice.¹⁸
- Several states do not allow licensed addiction counselors to provide counseling services to individuals for whom substance use disorder is not the primary behavioral health diagnosis, even if the individual has a co-occurring substance use disorder, and an addiction counselor may be best suited to provide care.¹⁵
- Several states limit reimbursement for peer services for individuals with only a mental health or substance use disorder diagnosis, and often only when delivered in a certain health care setting.¹⁹

This unstandardized approach limits a provider's ability to work to the full extent of their license to deliver high-quality care. It also limits provider mobility, authority to treat patients across state lines and use of telehealth modalities. Administrative burdens reduce provider willingness to participate with health plan networks, and contribute to provider burnout.¹⁶ As more than half of office-based behavioral health providers have solo practices, accepting health insurance significantly impacts administrative costs. For solo practices, the revenue from participating in insurance networks does not adequately cover the time devoted to administrative tasks, especially when requirements and reimbursement eligibility differ across health plans.²⁰

Variation in provider types and SOPs, and eligibility for reimbursement, impact not only how providers can practice or inclusion in plan networks, but also the availability of accessible services. These discrepancies make it difficult to compare access to care, network adequacy, coverage and quality of care across payers and states.²¹



IMPROVED DATA INFRASTRUCTURE NEEDED TO MONITOR ACCESS

Provider directories—health plan-maintained lists of in-network providers—are a data source for health plans and regulators to evaluate network adequacy and help consumers connect with potential providers. However, directories frequently lack essential details such as provider specializations, advanced trainings or certifications, populations served, treatment services offered, provider characteristics, cultural competency and appointment availability.²² These missing data elements not only impede consumers' ability to choose a provider suited to their behavioral health needs, but also limit assessment of the network's capacity to deliver services across the care continuum.²³ Additional data on provider specializations and qualifications would allow plans to better identify gaps in services across the care continuum and evaluate access to needed services within their network. This information would also help consumers identify appropriate providers to meet their needs, and produce better health outcomes. Stakeholders have also supported tracking and measuring behavioral health services. This may prove to be a preferred method for monitoring behavioral health network adequacy; however, additional research is needed to determine its effectiveness.

There is a lack of suitable data to accurately evaluate how well networks are performing to meet consumers' behavioral health needs. It is well established that provider directories are inaccurate and outdated, which has resulted in an overestimation of network performance.²² These provider directory inaccuracies impede consumer access to care and interfere with regulators' monitoring and compliance efforts.²³ Additional investment in data infrastructure, to adapt existing technology platforms that foster data accuracy and interoperability, is an essential step in improving access to and regulation of behavioral health services. Over 20 states, and several proposed federal legislations, have been initiated to improve data accuracy in an effort to increase access to behavioral health services.²⁴

FUTURE DIRECTIONS

Given the range of behavioral health professional types, titles, levels of certification and licensure, credentialing requirements and standards in current use by states, policymakers and health plans need a standardized typology to better measure, monitor and apply best practices for deploying the existing behavioral health workforce.²⁵ A standardized typology will facilitate research on the quality of services delivered and the utilization of varying behavioral health provider types, and in the future, may contribute to the development of improved quality metrics for behavioral health outcomes. This typology would also allow meaningful comparison of network adequacy across states and plans—aiding both consumers and regulators.

Professional health care organizations and stakeholder groups recommend developing a standardized typology, stating that increased standardization of provider types and SOPs will foster team-based care; improve access to care and care quality; and reduce the administrative burden and system complexities that hamper access to high-quality care.^{9,26,27} While additional research is needed on the impact that standardizing SOPs would have on access to care, evidence demonstrates that when a variety of health care professionals (e.g., NPs, nurses, pharmacists, psychologists, social workers, counselors, peer specialists) work at the top of their license, health care capacity and utilization of behavioral health services improve, especially for underserved populations.^{5,10,28,29}

It is well supported that no single solution can ensure equitable access to behavioral health services across the care continuum, yet an improved understanding of the breadth and capabilities of the existing workforce will be essential as the country continues to work to meet the growing demand for behavioral health services amid long-standing workforce shortages. Developing a standardized typology of providers and the set of services they can offer is an important incremental step toward transforming behavioral health service delivery, and effectively measuring and managing the behavioral health workforce.



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