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Filling the Gaps in the Behavioral Health Workforce

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HEALTH PROGRAM

Under the leadership of former Senate Majority Leaders Tom Daschle and Bill Frist, M.D., BPC's Health Program develops bipartisan policy recommendations that will improve health care quality, lower costs, and enhance coverage and delivery. The program focuses on coverage and access to care, delivery system reform, cost containment, chronic and long-term care, and rural and behavioral health.

ACKNOWLEDGMENTS

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Summary and Overview

The United States faces a growing shortage of licensed behavioral health care specialists—psychiatrists, psychologists, and clinical social workers—and that shortage comes at a time when rates of mental illness and substance use disorder (SUD) are high and rising. The shortage has severely limited access to treatment, particularly among underserved communities.[1, 2] To help address the access gap, federal policymakers should take steps to foster a behavioral health workforce that extends beyond licensed professionals.

Through regulation and legislation, policymakers and lawmakers should build on previous modest steps in two areas. First, they should nurture a greater role for behavioral health support specialists (BHSSs)—peer specialists, community health workers, and paraprofessionals—in delivering critical nonclinical behavioral health services and freeing up the licensed behavioral health workforce for more important tasks. Many states, communities, and insurers have begun to recognize the vital role of BHSSs in delivering such services and to rely on them more fully as part of teams that administer comprehensive care.

Second, policymakers and lawmakers should augment the behavioral health care that patients receive by leveraging support networks that exist within communities but that often go unused for this purpose. In particular, they should encourage greater use of community-initiated care (CIC), which empowers community members to assume some behavioral health responsibilities when appropriate and trains those in other fields (e.g., educators, faith-based leaders) to respond to individuals' mental health needs.

Behavioral health services in the U.S. are in alarmingly short supply, due in large part to a shortage of providers and the decision by many providers not to participate in insurance networks.[3] As of March 2021, approximately 37% of Americans (122 million people) lived in what the Health Resources and Services Administration (HRSA) calls "mental health shortage areas[a]."[4,5] In fact, the U.S. has noticeably fewer behavioral health providers than Canada, Switzerland, and Norway.[6]

HRSA projected that for certain specialties the shortage could reach as many as 35,000 full-time employees by 2030, with most states facing shortages within their borders.[7] The dearth of trained workers is so severe and so strained by the growing demand for services that the deficit cannot be adequately addressed through a redistribution of resources.[8]

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a   The HRSA tracks health professional shortage areas (HPSA), which are geographic areas, population groups, or health care facilities designated as having a shortage. "Shortage" is defined as a ratio of at least 3,500 patients per health care provider across primary care, dental care, and mental health care.

Even before COVID-19, the need for a strong behavioral health workforce was great. In 2019, just more than 1 in 5 adults in the U.S. (51.5 million) had a mental health condition.[9, 10] That year, 19.3 million adults experienced a SUD, and 9.5 million faced both SUD and mental health conditions.[11]

By 2019, workforce shortages were a persistent challenge for a myriad of health care professions, especially in rural and underserved communities. For behavioral health in particular, fewer than half of adults with mental health conditions (nearly 26 million) received services in 2019, and the percentage was lower in Black and Latino communities.[12] More than 85% of people with a SUD did not receive treatment that year.[13, 14] The scale of unmet behavioral health needs will likely have profound implications on other areas of society, including work productivity of those individuals who did not receive the services they needed.[15]

The shortage of behavioral health care workers has caused other problems as well. Mental health disorders are a leading cause of hospitalization: From 2017 to 2019, the percentage of emergency department (ED) visits that led to hospital admissions was 52% higher for adults with mental health disorders than for those without them.[16] Mental health-related ED visits strain hospital schedules as well: On average, these visits take roughly 42% longer than nonpsychiatric visits.[17]

In addition, behavioral and physical health conditions are commonly diagnosed in a patient at the same time, putting still greater strain on behavioral health care providers.[18, 19] To be sure, the integration of behavioral and primary health care has emerged as a cost-effective way to improve the quality of care for individuals with such comorbidities. However, without a robust health care workforce that can address a wide range of behavioral and physical issues, the ability to integrate care is limited.[20]

The pandemic only worsened the rising rates of behavioral health problems and the workforce shortage. For starters, the number of individuals with mental health issues rose. A May 2020 survey found that mental health conditions tripled during the peak of stay-at-home orders in April 2020, compared with two years earlier.[21] That percentage spiked to more than 41% in 2021.[22,23,24]

Meanwhile, after decades of rising overdose deaths from prescription opioids, heroin, and synthetic opioids, overdose deaths reached a record. In 2021, according to the Centers for Disease Control and Prevention (CDC), 107,622 died of overdoses—a 15% increase over the 93,145 in 2020—and there are still over 102,000 deaths in the 12-month period ending in June 2022.[25] COVID-19 also exacerbated the opioid crisis, with overdose deaths rising 30% from 2019 to 2020.[26]

At the same time, COVID-19 intensified the health care worker shortage, with staff burnout accelerating the already high rates of worker attrition.[27] The pandemic put unprecedented stress on health care professionals (nurses,

doctors, physician assistants, nursing home workers, and other support staff), including those who work in behavioral health. The effects were particularly traumatic for frontline staff, who faced co-worker deaths, isolation from their families, and an overwhelming loss of patient life. Because strict hospital protocols kept families away from patients, nurses were often the last people to comfort the dying.[28] These restrictions likely had profound implications for families and individuals' mental health.

To help address the growing shortage of licensed behavioral health care specialists during this critical time, BPC researched BHSSs and CIC and interviewed experts and stakeholders. Building on our previous work, BPC undertook this project to develop policy recommendations for the executive branch and Congress that would strengthen the role of the nonclinical workforce in support of licensed behavioral health professionals. If implemented, our recommendations would quickly improve access to behavioral health care.

Methodology

For this report, BPC:

- **Reviewed literature—**examined peer-reviewed articles, reports, issue briefs, and other gray literature to identify current best practices, processes, and priorities.

- **Engaged state and federal experts and stakeholders—**hosted virtual stakeholder roundtables during which experts provided input on effective best practices for addressing community behavioral health and discussed policy barriers and how to overcome them. BPC also engaged state, federal, and local stakeholders with experience and expertise in the roles of BHSSs and community-based care.

- **Identified federal discretionary programs with areas of overlap—** reviewed the descriptions for each discretionary funding stream across agencies and determined the programs with areas of overlap. BPC then categorized programs based on their relevance to BHSSs and the CIC model.

Recommendations

Our recommendations include:

1. **The federal government should build a set of core competencies for behavioral health support specialists that would serve as a resource to states as they create their own core competencies.**

   - Substance Abuse and Mental Health Services Administration (SAMHSA) and HRSA should:

     i. Create a model set of BHSS core competencies and get input and buy-in from states.

ii. Develop a performance assessment approach for states to determine whether individuals meet core competencies.

iii. Develop and establish federal data infrastructure to standardize and optimize state-level reporting and assess areas of need.

- Centers for Medicare & Medicaid Services (CMS) should work with the SAMHSA and HRSA to designate core competencies and categories of providers that should be eligible for expanded coverage and reimbursement.

- Congress should establish a minimum federal exemption to becoming BHSSs for those convicted of nonviolent crimes.

2. **The federal government should create pathways for coverage of BHSSs within Medicare and Medicaid.**

- The Department of Labor should create a Bureau of Labor Statistics (BLS) Standard Occupational Classification (SOC) category specifically for peer specialists (PSs).

- CMS should clarify that BHSSs can be considered "auxiliary personnel" as noted within the Medicare Physician Fee Schedule.

- CMS should provide technical assistance to help states take full advantage of existing federal Medicaid matching support of BHSSs.

3. **Congress should create a pipeline program to help interested BHSSs become licensed behavioral health professionals.**

- Congress should create a pipeline program at HRSA leveraging existing funding to help interested BHSSs become licensed.

4. **The federal government should establish a CIC-specific demonstration grant.**

- Congress and HHS should identify an existing federal demonstration program and broaden its scope to allow funding to be used for CIC programs.

- CMS should expand an existing CMMI model to allow funding to be used for CIC programs.

- Congress should design a new demonstration grant devoted to CIC.

5. **Congress should encourage the adoption of CIC by integrating existing federal funding streams that support CIC-related programs, as well as those that support the work of BHSSs.**

- Congress should integrate existing federal funding streams through House and Senate Appropriations Committee report language.

Behavioral Health Support Specialists

For the purposes of this report, BHSSs are defined as nonclinical behavioral health workers who contribute to teams that administer comprehensive patient care and who play important roles in delivering behavioral health services that support licensed professionals.

Peer Specialists (PSs)

PSs—also known as peer support workers, peer recovery coaches, and peer recovery support specialists—are individuals who have recovered from a mental health issue or SUD or, in certain cases, have served as caregivers (e.g., parents of children with behavioral health issues).

PSs provide ways to reach hard-to-engage populations. Research shows they can increase participation in treatment and community engagement.[29] As providers with lived experience, they are trusted by those with behavioral health conditions and can effectively address those conditions as well as SUD recovery.[30, 31] PSs are certified and trained to provide a wide range of services (e.g., mentoring and advocating for individuals in recovery, sharing resources with others with lived experience).[32,33] They link people to care, administer recovery programs, and build communities of support.

PSs are an asset for integrated care teams because they can help those with behavioral health conditions navigate care systems and sustain their recovery. According to a 2020 Government Accountability Office (GAO) report, some private insurers, as well as Medicaid programs in 36 states and the District of Columbia, cover peer support services.[34, 35, 36] Medicare, however, does not pay for peer supports.[37]

Even with growing recognition of, and support for, these professionals, the federal government provides only limited backing for them.[38] Nevertheless, PSs participate in successful evidence-based practices known as Assertive Community Treatment (ACT), which brings an interdisciplinary team-based approach to treating serious mental illness. In ACT, PSs administer therapeutic interventions to rehabilitate individuals' functional, adaptation, socialization, relational, and coping skills.[39] They also help individuals self-manage their symptoms and enhance their daily and community living skills, as well as their behavior and anger management skills.

In addition, the Centers for Medicare and Medicaid Services (CMS) recently provided guidance recommending that mobile crisis teams include PSs.[40] CMS

suggested that a trained PS take the lead role on client engagement and also possibly assist with continuity of care by providing support beyond the immediate crisis. Similarly, SAMHSA has developed draft core competencies for PSs with input from experts.[41] With decades of research on PSs and the growing recognition of them within the federal government, PSs could help address the behavioral health provider shortage.

Community Health Workers (CHWs)

Similarly, CHWs—also known as community health advisers, outreach workers, and patient navigators—play a critical role in behavioral health services. According to the National Association of Community Health Workers, CHWs include community health representatives, promoters (promotores in Spanish-speaking communities), and other frontline public health professionals who share life experience, trust, compassion, and cultural and value alignment with the communities where they live and serve.[42] Along with health promotion activities (e.g., providing culturally appropriate health education), the National Institutes of Health (NIH) indicates CHWs "offer interpretation and translation services[,] ... help people get the care they need, and provide some direct services such as first aid and blood pressure screening."[43]

Community organizations and social support agencies have traditionally used CHWs, and health insurers and clinics are increasingly using them as well.[44] Studies show that CHW programs reduce inequities and increase health care service utilization.[45] These workers help ensure that underserved communities have access to primary care, and they help individuals manage comorbid chronic health conditions (e.g., diabetes and hypertension).[46,47,48] Traditionally, CHWs have played a large role in primary care and chronic disease care, but other studies note that they can also help address mental health disparities.[49]

Paraprofessionals

Finally, paraprofessionals—which, for this report, are behavioral health technicians,[b] unlicensed (non-LCSW) substance use counselors/counselor assistants,[c] or qualified behavioral health specialists (not to be confused with BHSSs)[d]—also deliver behavioral health services.[50,51,52] Paraprofessionals can provide a range of services that include mental health rehabilitative services, such as skill building, employment supports, and counseling, to help individuals manage their mental health symptoms. The educational

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b   Behavioral health technicians, also known as mental health or psychiatric technicians or aides, help doctors, nurses, and other mental health professionals with the treatment of patients who have various behavioral problems, developmental disorders, or mental illness.

c   Substance abuse, behavioral disorder, and mental health counselors advise people on a range of issues, including those relating to alcoholism, addictions, or depression.

d   Qualified behavioral health specialist (QBHS) means an individual who has received training for or education in either mental health or substance use disorder competencies; and who has demonstrated, prior to or within 90 days of hire, the minimum competencies in basic mental health or substance use disorder and recovery skills listed in this rule.

qualifications for paraprofessionals vary by state, but many hold high school diplomas or their equivalent or bachelor's degree and have years of experience in providing behavioral health services and supports that do not necessarily require a licensed professional to provide.[53]

Various state behavioral health provider manuals and other guidance define roles for paraprofessionals. Georgia's manual, for instance, requires Intensive Family Intervention (IFI) teams to include two to three full-time-equivalent paraprofessionals (working under the supervision of a team leader). IFI paraprofessionals guide behavior management skills; manage interactions with individuals, their caregivers, and family members; and work with other providers.[54] Ohio allows paraprofessionals to deliver home-based treatment and other behavioral health services. These paraprofessionals are not licensed, but they have received training and demonstrate competencies in either mental health conditions or SUD.[55] In Washington state, mental health professionals (e.g., individuals with a bachelor's degree or at least five years of experience) can make clinical decisions about using manual restraint, seclusion, or other restrictive behavior management techniques for youths participating in residential programs.[56]

Although researchers have not conducted large-scale studies on paraprofessionals' effectiveness, these workers play a key role in behavioral health care. Smaller studies indicate paraprofessional case managers have effectively managed a substantial number of problems after a patient is discharged from a hospital with little to no assistance from their licensed counterparts.[57] Other studies show that paraprofessionals can effectively deliver therapies, such as cognitive behavioral therapy, to treat anxiety and depressive symptoms.[58]

Benefits of BHSSs

With demand for services rising and workforce shortages among licensed practitioners worsening, BHSSs are becoming more important in behavioral health care. Their services are not only beneficial to patients but are also cost-effective: One study estimated that for every dollar invested in CHW interventions, Medicaid enjoys an average return of $2.47 in cost savings within a fiscal year.[59] Monthly Medicaid expenditures for a peer respite program averaged $2,138 less per patient, according to a study of Medicaid claims and enrollment data in New York City.[60,61]

State Medicaid programs could better meet federal access standards if they had more workers, because that would help them deliver timelier services for routine, urgent, and emergent services.[62] Medicaid agencies could increase their efficiency by using more BHSSs, especially since these workers generally cost less than licensed professionals. Medicare is moving toward covering providers

such as marriage and family therapists (MFTs), so state Medicaid programs that do not cover certain BHSSs would be well-advised to follow Medicare's lead and do so.

Payers, health care systems, and policymakers have been skeptical about the role that BHSSs can play in providing patient care. In interviews, experts and stakeholders noted that payers have been reluctant to pay for peers who offer critical mental health services. National managed care organizations, however, are beginning to recognize the importance of PSs and permit reimbursements for certain services that they provide.

The savings that PSs generate largely outweigh the costs of peer support services.[63] A [2006 study](#) in Georgia found that patients for whom PSs provided care reported fewer behavioral health symptoms, helping to generate an average savings of $5,494 per patient for the state.[64] Similarly, a county in Washington state reduced involuntary hospitalizations among those experiencing behavioral health crises by 32%, saving it nearly $2 million a year.[65] Savings even accrued in outpatient settings: a Federally Qualified Health Center (FQHC) in Denver that used peer support secured a [return of $2.28 for every dollar](#) it spent.[66]

These specialists are effective because of their personal connection to people who have refused treatment or received treatment only in emergencies.[67] Recruiting PSs, CHWs, and paraprofessionals from target communities would likely further improve the engagement and retention of individuals seeking services (e.g., increasing screenings, promoting treatment adherence).[68,69]

Nevertheless, BHSSs might not be accepted by their non-BHSS colleagues and might even by stigmatized by them.[70] Public and private institutions such as SAMHSA, the Department of Veterans Affairs (VA), state departments of health, academic institutions, and others have undertaken efforts to address negative attitudes toward BHSSs.[71] Such efforts have included tailored information and toolkits about the roles, educational and certification processes, and seasoned supervisors of BHSSs.

For many entities administering behavioral health care, licensed staffers are a valuable and shrinking commodity. Behavioral health practices are competing with online mental health sites that give clinicians the flexibility to work when and where they want. In addition, some categories of licensed behavioral health practitioners will be in increasingly short demand; for example, more than 60% of practicing psychiatrists are nearing retirement.[72] Historically, payers have required clinical entities to use licensed clinicians to perform crucial functions. These functions include supervising, consulting, and developing and submitting necessary documentation (e.g., requests for prior authorization).

The BHSS workforce can help address shortages and enable licensed clinicians to focus on their most challenging patients.

Federal Response

The Affordable Care Act (ACA) of 2010 formally recognized the role of CHWs and paved the way for them to participate more fully in providing patient services.[73] First, the ACA authorized the CDC to award grants to organizations that use CHWs to improve health education in underserved areas. Second, the ACA clarified that states can designate nonlicensed providers, such as CHWs, to provide preventive services. Third, the ACA permitted Medicaid programs to create "Health Homes" for beneficiaries living with chronic illnesses and include CHWs as providers. Finally, the ACA provided funding for State Innovation Models to help states improve health outcomes and the quality of care to slow health care costs.

The Obama administration enacted the Behavioral Health Workforce Education and Training (BHWET) program to increase the behavioral health workforce that serves children, students, and young adults. Open to prospective behavioral health professionals and paraprofessionals, the BHWET program supports initiatives to enhance the quality of education and clinical training in behavioral health. The program focuses on training licensed behavioral health professionals, although paraprofessionals and CHWs are also eligible for the training. From 2014 to 2020, the program supported the clinical training of 22,591 professionals, including 7,714 paraprofessionals and CHWs.[74,75] In its first five years, it reduced the national behavioral health workforce shortage by 21%, and that figure is projected to rise to more than 40% by 2025.[76,77]

Since early 2021, President Biden and Congress have focused more seriously on the potential of BHSS and health care workforce recruitment (as opposed to retention) programs.[78] As part of his unity agenda, the president articulated the importance of PSs and CHWs specifically.[79] Moreover, the administration's [2022 National Drug Control Strategy](#) noted that PSs are an important mechanism for building trust and reducing stigma among those with SUD. On Capitol Hill, lawmakers have proposed legislation—such as the Promoting Effective and Empowering Recovery Services in Medicare Act (PEERS) Act and the Pursuing Equity in Mental Health Act—to strengthen the roles of BHSSs.

Federal funding has followed President Biden and Congress' focus on BHSSs and health care workforce recruitment programs. Through the American Rescue Plan Act, HRSA launched a Community Health Worker Training Program (CHWTP) with $226.5 million devoted to combating vaccine misinformation and investing in education and on-the-job training to build a pipeline of public health workers. As of September 2022, the CHWTP's 83 grantees are supporting training and apprenticeships for an estimated 13,000 CHWs over three years, who could potentially assist up to 780,000 Americans.[80,81] Policymakers also have boosted funding in recent years for programs like the Substance Abuse Prevention and Treatment Block Grant (SABG) at SAMHSA, which allows funding for PSs and reflects a greater emphasis in Washington in providing more behavioral health

supports. Despite these funding increases, the SABG does not require grantees to include BHSSs in their programming.

Policymakers also continue to recognize, and respond to, COVID-19's impact on the health care workforce. The American Rescue Plan provided $103 million for programs that promote provider wellness, reduce burnout, and boost health care worker retention. In February 2022, Congress passed, and the president signed, the Dr. Lorna Breen Health Care Provider Protection Act. Under the act, the Department of Health and Human Services (HHS) can distribute up to $135 million in grants over three years to health care entities to promote mental health and resiliency among health care providers. With so much attention on provider well-being, the need is even greater for a behavioral health workforce that includes BHSSs.

Recommendations for Building Workforce Capacity by Increasing Behavioral Health Support Specialists

1. THE FEDERAL GOVERNMENT SHOULD BUILD A SET OF CORE COMPETENCIES FOR BEHAVIORAL HEALTH SUPPORT SPECIALISTS THAT WOULD SERVE AS A RESOURCE TO STATES AS THEY CREATE THEIR OWN CORE COMPETENCIES.

Currently, no national standardized set of certification conditions exists, and state requirements vary significantly. The variety creates challenges for transient workers and makes federal assessment difficult. The decentralized approach allows states to remain nimble, and states will ultimately set their own requirements, but federal recommendations would serve as a vetted guide for states to consider.

To support states to train, assess the performance of, and track BHSSs:

- **SAMHSA and HRSA should:**

  - **Create a model set of BHSS core competencies and get input and buy-in from states.**

  - **Develop a performance assessment approach for states to determine whether individuals meet core competencies.**

  - **Develop and establish federal data infrastructure to standardize and optimize state-level reporting and assess areas of need.**

- **CMS should work with SAMHSA and HRSA to designate core competencies and categories of providers that should be eligible for expanded coverage and reimbursement.**

- **Congress should establish a minimum federal exemption to becoming BHSSs for those convicted of nonviolent crimes.**

NATIONAL CORE COMPETENCIES

Problem

A jumbled patchwork of state and federal regulations controls credentialing and certification across the health care workforce, including for behavioral health licensed practitioners and BHSSs. States establish certification requirements for their BHSS workforce, resulting in high variability.[82, 83, 84, 85] Although nationwide training and educational requirements exist for providers such as physicians, BHSSs lack the same consistency. There are national pathways into medical training and testing via medical schools and other avenues, but states maintain the authority to license and regulate physicians and other health care professionals.[86,87]

BHSSs have no such corresponding educational and training requirements, making it difficult for state and federal entities to assess effectiveness and to align and compare their skill sets. Physicians and other health care professionals adhere to an established set of training and educational requirements, as illustrated through uniform processes such as medical school and residency training. State licensing boards for health care professionals ensure those practicing within their purview meet a minimum set of professional qualifications and maintain ethical standards of care. Nevertheless, critics have questioned whether the boards remain necessary. As early as 1993, the HHS Office of the Inspector General (OIG) noted challenges with state medical boards' performance, and made recommendations to support improvements (e.g., encouraging state licensing boards to use third-party advisers to assist with improving quality of care).[88] Moreover, in 2022, the VA OIG found widespread noncompliance with state licensing boards and the National Practitioner Data Bank reporting processes.[89]

The long-standing function of state licensing boards is to protect patients from unqualified or unprofessional behavior.[90] Despite challenges, states still impose their own requirements for health care professionals to acquire and maintain licenses (e.g., additional testing, specific coursework).[91,92] BHSS certification can apply a comparable structure to promote a shared skill set while upholding state certification entities' ability to set their own requirements.

The flexibilities afforded under the COVID-19 public health emergency (PHE) have provided a window into near-total policy alignment between all states and the federal government. Policymakers suspended complicated regulations to allow health care providers to seamlessly practice across state lines.[93,94,95] Preliminary results exploring the effects of these flexibilities on behavioral health care are promising.[96,97,98,99] State practice acts and licensing boards have

been reluctant to change licensing requirements, citing concerns about the quality of care.[100] Nevertheless, state officials can apply relevant lessons learned from the PHE to BHSS certification to appropriately meet the growing need for services amid the staffing shortage.

Unlike physicians, the training requirements for BHSSs vary widely, complicating the pandemic-era policy alignment between states and the federal government.[101,102] For example, the requirements for PSs range from no certification training (e.g., Alaska) to a two-week-long training course (e.g., Georgia). Some states (e.g., Vermont) don't require a certification exam, while other states (e.g., Illinois) have lengthy exams consisting of 100 questions.[103,104]

Similarly, the educational requirements for paraprofessionals' certifications can vary widely, ranging from no minimum degree requirement to a master's degree. For unlicensed SUD counselors, the number of required practice hours needed to obtain the highest level of initial certification differ, ranging from 1,000 hours (equivalent to half of one year) to 12,000 hours (the equivalent of six years).[105]

Although BHSSs have the potential to reduce the behavioral health workforce shortage, the strength of the evidence supporting each type of BHSS varies. This variability is, in part, due to the lack of consistent training requirements across the country. Comparable baseline requirements would lay the groundwork for large-scale studies that assess the effects of each type. For the types of BHSSs with weaker evidence, such as paraprofessionals, having a set of shared requirements would help determine the extent to which they each address behavioral health needs.

While it is up to each state to decide whether to adopt a shared set of core competencies for each type of BHSS, the federal government should lead a process—with significant state input and partnership—that would build a model core set. State implementation of this model would ensure a baseline set of skills.

As part of the process, those creating the core set could use or adapt existing sets of competencies. As mentioned previously, SAMHSA has published several sets of core competencies for PSs, including the most recent ones in 2018.[106,107] Similarly, the C3 Project, which aims to expand the role of community health workers, developed a set of core competencies for CHWs in partnership with 15 national public health organizations and 20 state policy initiatives.[108,109]

Although these two sets of core competencies are publicly available for use, they are not federally mandated. National scans that review information about certification (e.g., number of hours, sign-up links) illustrate that states do not consistently align their BHSS training requirements with these existing competencies.[110,111,112] These scans do not examine BHSSs' acquired skills. The available sets of competencies focus on PSs and CHWs, but no such efforts focus on competencies for behavioral health paraprofessionals.

The CDC in 2014 created another resource that could be helpful in developing a model set of core competencies. The agency recommended several policy initiatives to support and advance the CHW workforce specifically, including a recommendation to formalize a state-level definition for CHWs. A formal definition could provide a basis for creating standards for BHSSs and lay the foundation for ensuring that BHSSs all gain a consistent, shared set of skills.[113,114,115] Other agencies have not released official guidance for states regarding baseline practice qualifications apart from a CMS guidance issued in 2007.[116,117,118,119] CDC's recommendation to establish a state-level definition could provide a basis for creating standards, and establishing core competencies through a partnership between federal and state entities would ensure that BHSSs gain a consistent, shared set of skills.

Recommendation: SAMHSA and HRSA should create a model set of BHSS core competencies with input and buy-in from states.

SAMHSA and HRSA via the Center for Integrated Health Solutions should convene states and support them in developing or revising a set of core competencies for BHSSs. Because states are responsible for implementing BHSS certification requirements, the center should lead federal agencies in coordinating a state-driven process to produce a set of competencies and lend implementation support as appropriate. States are currently not implementing BHSS certification requirements consistently.[120] To work toward a baseline set of skills nationally, states with guidance from the center could incorporate the competencies into new or existing BHSS certification requirements.

Despite the recent federal actions, no definitive federal agency is responsible for BHSS-related policies and programs. CMS guidance and discretionary grants have helped expand the BHSS workforce, but states are ultimately responsible for certifying and managing information about them. With promising research but few large-scale studies, the federal government has a limited ability to influence and mandate states' BHSS requirements. Nevertheless, the federal government can help lay the groundwork for more decisive BHSS-related policies by guiding states to develop and adopt a shared set of competencies. If aligned, policymakers would have more consistent information about BHSSs' effects on behavioral health care, the services they administer (which can inform cost estimates and quality of care), and the resources needed to train and retain these workers.

The center's involvement could bolster SAMHSA and HRSA's abilities to prepare states to incorporate these competencies into their BHSS certification processes. The center's goal is to assist providers in integrating primary and behavioral health services through interagency collaboration.[121,122] Furthermore, these two agencies are well positioned to coordinate this process, as SAMHSA manages key programs for PSs and paraprofessionals, and HRSA manages key programs for CHWs. As noted previously, SAMHSA has developed draft core competencies for PSs with input from experts.[123] The agency's experience

developing core competencies with members of the research community could inform similar efforts with the states.

The center would take the following four steps to develop or refine these competencies:

- **Conduct a preliminary scan of state-level requirements, performance assessment approaches, and reporting requirements for BHSSs by soliciting a request for information (RFI) from interested states.** An RFI could inform early discussions regarding the development of core competencies. Groups like the Association of State and Territorial Health Officials (ASTHO) have conducted state-level scans of CHW and PS requirements, and SAMHSA recently consolidated information about certification (e.g., number of hours, sign-up links).[124,125] However, these scans do not examine BHSSs' acquired skills.

- **Solicit input from a workgroup composed of state-level officials and community representatives.** Bringing these stakeholders together would help get buy-in for implementing these competencies. The workgroup would represent Medicaid programs, Medicaid managed care organizations (which cover approximately 70% of Medicaid beneficiaries), and state departments of health.[126] State departments of insurance can perform a similar effort for commercial payers. The center could also include community representatives such as types of BHSSs (e.g., adult and youth PSs) and members of specific populations (e.g., individuals who have experienced homelessness) to ensure that the result is culturally inclusive and linguistically diverse.

- **Develop a strategy for certifying BHSSs.** A framework for certifying BHSSs would aim to allow interested states to adopt the core competencies, including any infrastructure needed to certify BHSSs (e.g., administration of training courses). The center could provide technical assistance during this stage as appropriate so that relevant state-level departments could identify opportunities for consolidating, revising, and possibly eliminating existing requirements.

- **Enlist support from exemplar states.** As is typical of state-led efforts, BHSS programs have not been implemented consistently.[127] The center would designate states with advanced BHSS certification processes, such as Georgia and Rhode Island (see Figure 1), to support other states' implementation of core competencies as appropriate. Exemplar states could share implementation considerations (e.g., establishing and nurturing partnerships between the Medicaid agencies and mental health authorities) and challenges (e.g., budget allocation). Many states that already have requirements might only need to tweak their current set of guidelines, so the opportunity to collaborate would allow them to work out any kinks. However, for other states, collaboration with the exemplar states would better enable them to overcome challenges.

Figure 1: Examples of Successful State Models for Certifying BHSSs

Georgia's PSs program[128]	In July 1999, Georgia was "the first state to request and receive Medicaid reimbursement for Peer Support as a statewide mental health Rehabilitation Option service."[129] Georgia was the product of a partnership between Georgia Medicaid and Mental Health authorities, and the state has sustained the service for more than 20 years. This success has allowed space for a flourishing recovery movement within the state, with approximately 3,000 PSs trained and certified; resulted in more than $20 million in Peer Support services provided annually; and produced specialty certifications for SUD, youth, parent, whole health, and forensic lived experience.
Rhode Island's CHW program[130]	Established in 2009 by the state, the Community Health Worker Association of Rhode Island (CHWARI) was the product of a grassroots movement seeking to strengthen the role of CHWs, expand workforce skill sets through advanced training, connect CHWs to career and leadership opportunities, and conduct advocacy. CHWARI is located within the Institute for Education in Healthcare at Rhode Island College. Rhode Island's CHW program is financially supported through Rhode Island College, the state Department of Health, and the state Department of Labor and Training.
Ohio's Child and Adolescent Behavioral Health Center of Excellence[131]	In March 2021, the Ohio Department of Mental Health and Addiction Services announced that it would open the new statewide Child and Adolescent Behavioral Health Center of Excellence at Case Western Reserve University's Center for Innovation Practices. The Center of Excellence is responsible for building and sustaining standardized assessment processes; evaluating the effectiveness of services; expanding service and care coordination capacity for children with complex needs (and their families); providing training to support Ohio's statewide child care provider network; working with state partner agencies; supporting Ohio's home- and community-based services; and bolstering Ohio's continuum of care.
Louisiana's Center for Evidence to Practice (E2P)[132]	The Center for Evidence to Practice (E2P) program is an online learning platform designed to share courses and content teaching evidence-based practices with Louisiana's Medicaid behavioral health community. This platform has recently expanded to offer training for the mental health crisis response workforce, with actionable training modules, courses and webinars, and videos.

The process would yield a framework consisting of a uniform set of core competencies that states can use to meet BHSS certification requirements. While the competencies should be feasible, useful, and culturally competent, the federal government would encourage—but not mandate—their use.

Even with national core competencies, BHSSs might have limited opportunities to advance in their respective fields.[133] States could use the core competencies to construct a career ladder for select BHSS types when appropriate. Offering opportunities for growth could help recruit and retain workers in these fields.[134,135,136] For example, states could agree to adopt a set of core competencies (e.g., SAMHSA's Core Competencies [Appendix 1] for PSs), but use years of on-the-job experience to differentiate between entry-level and experienced BHSSs with more leadership responsibilities. Texas offers such growth opportunities in its PS training program, using certified PSs to train new PSs. An evaluation found that using certified PSs in Texas's PS training program both provided growth opportunities for certified PSs and enhanced the training experience for trainees.[137]

A framework with multiple levels (Appendix 2a) might serve as a model for a CHW career ladder rather than basing advancement on years of experience. For illustrative purposes (see Figure 2), a career ladder might include:

Figure 2: Sample Professional Development Ladder for CHWs

Category 1	Demonstrates proficiency in health outreach, advocacy knowledge, and skills within the "community health practice" competency (see Appendix 2b).
Category 2	Focuses on specific health conditions (e.g., chronic conditions) in addition to core competency training rather than general health issues.
Category 3	Performs functions similar to those of health care professionals.
Category 4	Performs performance planning and supervision for CHWs, and focuses on the development of a performance management system to successfully supervise CHWs.

Adapted from H. Covert, H., M. Sherman, et al. (2019). "Core Competencies and a Workforce Framework for Community Health Workers: A Model for Advancing the Profession," American Journal of Public Health, 109(2): 320–27. Available at https://doi.org/10.2105/AJPH.2018.304737.

PERFORMANCE ASSESSMENT APPROACH FOR BHSSS

Problem

As noted previously, the gap in federal guidance or requirements results in significant variability in states' certification processes for BHSSs.[138] Thus, both state and federal entities face challenges in consistently assessing whether BHSSs are trained well. As with core competencies, states might expend significant resources to develop benchmarks determining whether individuals

meet BHSS certification requirements. To assess performance, states can glean insights into the scale and scope of current BHSS workforce capacity by drawing on unified processes from the federal government.

Recommendation: SAMHSA and HRSA should develop a performance assessment approach for states evaluating BHSSs' core competencies.

To assess the degree to which trained individuals meet BHSS core competencies, SAMHSA and HRSA should partner with states to develop a uniform performance assessment. From this approach, federal agencies and policymakers could gather insights into the capabilities of the newly trained BHSS workforce. A national performance assessment could help trainees develop a consistent set of skills and give states a way to track and compare proficiency. A national performance assessment could also assist payers and health care facilities by encouraging them to establish consistent staffing requirements for quality and reimbursement.

For the agencies, one potential approach would be to define proficiency to assess the extent to which trainees meet criteria within the set of core competencies. For example, if states agreed to adopt a set of competencies that include a set of actions (such as SAMHSA's Core Competencies [see Appendix 1]), proficiency might mean trainees had achieved more than 50% of the actions.

As health care delivery continues to evolve, so must the measure of proficiency to meet patients' needs. Because BHSSs include various types of workers, each measure can demonstrate proficiency differently. For instance, states might require recertification or specialization (e.g., mental health and SUD for the former; focuses on special populations such as formerly incarcerated individuals for the latter) for different types of BHSSs. In Georgia, PSs must complete a minimum of 12 continuing education hours to maintain active certification, which renews aspects of training and fosters connections. Furthermore, different types of BHSSs can advance to more senior levels or positions based on years of experience. If core competencies include career ladders, individual BHSSs can advance if they have met requirements (similar to benchmarks for a promotion during a performance review).

DATA REPORTING AND MANAGEMENT INFRASTRUCTURE

Problem

To fully understand the BHSS workforce's scale and effects, it is necessary to establish a consistent data and reporting infrastructure at the state and federal levels. To date, no standardized collection and analysis exist regarding the effectiveness of the BHSS workforce. Federal agencies do not formally collect information on BHSSs except through grant reporting systems.[139] The only

exceptions are HRSA data collected on SUD counselors, and Bureau of Labor Statistics (BLS) data collected on CHWs. Even those only track limited information: The HRSA data only include information about demographics and training history, and the BLS data do not specify which CHWs focus on behavioral health.[140]

In addition, no federal agencies are officially responsible for managing information regarding the availability of various types of BHSSs. As indicated earlier, HRSA tracks licensed professionals, and SAMHSA tracks organizations and programs that administer behavioral health services.[141,142] The absence of consistent reporting creates significant variability in states' efforts to collect, maintain, and report data on BHSSs' footprints.

Recommendation: SAMHSA and HRSA should develop and establish federal data infrastructure to standardize and optimize state-level reporting, and assess areas of need.

To establish a process for consistently reporting BHSS certifications nationwide, SAMHSA and HRSA via the center should create a federal data infrastructure. This would allow both the federal government and states to assess the need for additional BHSS workers on key quality indicators. Importantly, it would allow the federal government to establish a clearer link between the BHSS workforce and the services they deliver, and would promote health equity (e.g., providers from, and services provided to and by, marginalized populations).

Because states are responsible for implementing reporting processes, SAMHSA and HRSA would aim to align current reporting requirements. With well-aligned requirements, states and federal agencies would be able to track workforce shortages while building a data repository that can help assess BHSS's effects on behavioral health outcomes. Through this data infrastructure, the federal government would be able to inform states about the number of BHSSs. States can currently gauge the numbers of health care professionals using unique National Provider Identifiers. However, because it is optional and thus variable to assign provider identifiers to BHSSs, it is difficult to gauge the number of these providers through federal datasets such as CMS's Transformed Medicaid Statistical Information System.[143]

The agencies would develop key metrics such as training, retention, and job performance for states to report. Listed in Figure 3 are potential reporting requirements and metrics.

Figure 3: Potential Metrics for Reporting BHSS Workforce Capacity

Training	• Number of new BHSSs (PSs, CHWs, and paraprofessionals) who have satisfied training requirements each year • Retention of BHSSs in the workforce for two years after completing training requirements
Impact	• Number of individuals receiving peer support/recovery services, community health services, and other relevant behavioral health services • Number of peer support/recovery services, community health services, and other relevant behavioral health services administered

Establishing and developing the infrastructure to support collecting, managing, and reporting of these federal data would require start-up funding. For example, House of Representatives' fiscal year 2023 appropriations bill devotes more than $1.3 billion to SAMHSA's Community Mental Health Block Grant. States receive funding awards to "support mental illness prevention, treatment, and rehabilitation services."[144] If the funding were to be used for start-up costs, SAMHSA could direct states to use a portion of the award to begin collecting relevant metrics on BHSSs. SAMHSA would report those data to the center.

JOINT GUIDANCE TO STATES ON BEHAVIORAL HEALTH SUPPORT SPECIALISTS

Problem

Although SAMHSA, HRSA, and CMS have been involved in funding programs for various types of BHSSs, they have not formally collaborated to strengthen the role of the BHSS workforce. In addition, no current agency guidance advises states on training and coverage for BHSSs. SAMHSA issued a report for PSs in 2022 with its most recent set of competencies, and HRSA has a fact sheet in 2021 illustrating the importance of CHWs and recent investments.[145,146] HRSA might publish a guide to billing pathways for PSs soon, although not for training or coverage. However, neither SAMHSA nor HRSA has issued formal guidance on BHSSs.

As noted previously, the most recent guidance from CMS was on PSs in 2007 (later clarified in 2013).[147,148] There is no specific guidance regarding the use of paraprofessionals rendering behavioral health services. Together, these three agencies would be able to provide guidance to states in two areas: adopting a set of core competencies and expanding coverage for BHSSs.

Recommendation: CMS should work with SAMHSA and HRSA to designate core competencies and categories of providers that should be eligible for expanded coverage and reimbursement.

To implement a set of core competencies, CMS should collaborate with SAMHSA and HRSA to issue joint guidance to relevant state-level stakeholders. As noted earlier, federal agencies would lead a process of developing core competencies in partnership with states. This joint guidance should focus on implementing core competencies that would promote a unified, coordinated message from all three agencies. In turn, this would help states develop or strengthen strategies to increase access to quality behavioral health services.

Guidance on implementing core competencies should note the baseline core requirements (certification and competencies) that states could integrate into their BHSS programs. The guidance would also include processes for individuals to gain and maintain these competencies (e.g., through formal training and/or some on-the-job experience), as well as processes for recertification requirements if applicable and for reporting requirements.

The proposed joint guidance would match the core competencies with states' needs for implementation support. Furthermore, the guidance would include formal processes for ensuring equity. In particular, the guidance would give states the flexibility to use the baseline competencies and tailor them to their requirements to support underserved communities, such as rural and frontier populations, children and youth, and communities of color.

In addition to providing help on implementing core competencies, SAMHSA, HRSA, and CMS would use this guidance to enhance coverage and reimbursement strategies for recruiting and retaining BHSS staff.[149] As noted previously, CMS released guidance on PSs in 2007, so the joint guidance would provide updates and include other types of BHSSs. Although CMS's previous guidance encouraged states to cover PSs under Medicaid, only 36 states and the District of Columbia have adopted this.[150] States can also offer peer support service coverage under Medicaid via Section 1905(a)(13) and 1915(b) and (c) waiver authorities. As such, SAMHSA, HRSA, and CMS should issue updated guidance on the coverage of all BHSSs and consider changes in the BHSS fields, as well as coverage options for states based on their available resources.

Because the updated guidance would reflect other types of BHSSs, SAMHSA, HRSA, and CMS should include sections devoted to CHWs and behavioral health paraprofessionals. Following CMS's 2007 guidance on peer support specialist services, this guidance would note parameters for minimum requirements for supervision, care coordination, and training and credentialing.[151]

CERTIFICATION FOR PROSPECTIVE BEHAVIORAL HEALTH SUPPORT SPECIALISTS WITH CRIMINAL RECORDS

Problem

People in the criminal justice system remain among the most vulnerable because of unmet behavioral health needs.[152] Globally, approximately 30% of males and 51% of females in the criminal justice system suffer from a SUD.[153] Similarly, about 1 in 7 people involved in the criminal justice system suffers from mental health issues, especially serious mental illnesses, such as psychosis and major depression.[154] The estimated rates of individuals involved in the criminal justice system with comorbid SUD and mental illness can range 30%.[155] Individuals involved in the criminal justice system who are experiencing a substance use disorder, a mental illness, or both have an elevated risk for a myriad of poor health and social outcomes, infectious diseases, hospitalizations, unstable housing, and reimprisonment.[156, 157, 158]

The relationship between behavioral health conditions and involvement in the criminal justice system is complicated by upstream factors, such as trauma, exposure to violence, and stigma. These factors are further obfuscated by barriers associated with reentering the community (e.g., securing housing, finding employment, reconnecting with family members, avoiding reincarceration), intensifying mistrust toward the numerous institutions involved in people's daily lives.[159] Individuals returning home from incarceration thus benefit from a community-based, tailored approach to meeting their health care and behavioral health care needs.[160, 161]

Some congressional efforts strive to address this need. For example, a 2018 law—the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act—required the HHS secretary to issue a letter to state Medicaid directors within one year of enactment. The letter would aim to improve care transitions for individuals reentering the community by allowing states to use Section 1115 waivers for systems that support assistance, health care services, and education about Medicaid enrollment. To date, HHS has not released this letter, but a handful of states have used Section 1115 waivers to fund reentry strategies that help individuals before and after incarceration.[162]

Congress has demonstrated bipartisan support to assist individuals with criminal histories obtain and retain employment. Indeed, the Second Chance Act of 2007 provides grant funding for reentry services such as SUD treatment and career training for offenders and their families.[163] At the time of its passing, the bill noted that 60% of former inmates remain jobless a year after their

release because of their criminal records.[164] In response, Section 212 of the Second Chance Act allows grants from the Department of Justice (DOJ) to provide mentoring, job training, placement services, and other services. The attorney general possesses the authority to expand opportunities for formerly incarcerated individuals to become BHSSs under the Second Chance Act if Congress appropriates funds. HHS could encourage states to set criteria and adopt Second Chance rules for BHSSs through Medicaid.

More recently, in 2021, a bipartisan group of lawmakers introduced the Medicaid Reentry Act to improve care transitions. Under the Reentry Act, Medicaid would be able to pay for jail- and prison-based health care services for up to 30 days before an individual's release, and to assess the quality and conditions of current services.

In recent years, there has been bipartisan support for grants to fund community-based reentry services. Congress is moving to authorize another grant program focused on community-based reentry services. In May 2021, the House Judiciary Committee introduced the One Stop Shop Community Reentry Program Act which would provide funding for community-based reentry centers and service assistance hotlines for formerly incarcerated individuals and their families.[165] This legislation would allow funding to be used for programs that serve the formerly incarcerated, including behavioral health care services and job training services that would encourage grantees to offer BHSS services and train new behavioral health support specialists.

In December 2020, Congress passed the Crisis Stabilization and Community Reentry Act.[166] This bill authorized grants enabling law enforcement to partner with behavioral health care providers, and to promote community-based care for incarcerated individuals upon their reentry. Section 3051 notes that grants can be used for services and supports, and it specifically mentions peer support services.

Involving BHSSs because of their relevant lived experience can be an effective engagement tool.[167,168] One such program already using this approach is a California-based model called the Transitions Clinic Network (TCN), which integrates formerly incarcerated CHWs into primary care teams.[169] Including the CHWs both builds awareness of the criminal legal system and bridges knowledge gaps in health care among both care teams and patients. This reduces mistrust in the medical system and facilitates patient-provider communication.

A study on TCN noted that formerly incarcerated patients receiving primary care were highly engaged in their care, including chronic disease treatment plans and nonmedical services such as housing.[170] Other studies examining the roles of PSs found that drawing on past experiences strengthens feelings of hope, connectedness, identity, meaningfulness, and empowerment among patients.[171, 172, 173] These promising results should inform approaches to

behavioral health patient care, particularly for enhancing patient engagement.

Despite the benefits of involving formerly incarcerated individuals in the care of others with similar experiences, BHSSs with histories of incarceration have historically had difficulties becoming certified. As noted, including BHSSs with a lived experience of incarceration is an important way to connect with patients in a way that fosters trust in patients and understanding among providers. Importantly, people who have committed nonviolent federal crimes (e.g., fraud, bribery, embezzlement, and drug distribution) might recognize their mistakes and express interest in becoming a support specialist, either as part of recovery or rehabilitation or because they see this experience as valuable to others.[174]

Some states have already begun allowing BHSSs with histories of incarceration in certain instances.[175] A comparative analysis showed that some states note clear parameters for when and in which circumstances BHSSs would qualify for certification. For example, four states use case-by-case determinations to certify their BHSSs, allowing for both guardrails against and occasions for certification. Meanwhile, nine states have permanent automatic disqualifications (e.g., capital offenses, assault and abuse offenses, kidnapping and trafficking offenses, and others) that impose limits on the types of convictions allowed.

Texas is one state that allows for BHSS certification under certain circumstances. The state requires that peer certification entities investigate select disqualifying offenses over specific time intervals. These include capital offenses over one's lifetime, and other offenses such as kidnapping within 15 years preceding the date of application.[176] A report focused on Texas's PS program found improvements across various social indicators (e.g., employment) and criminal behavior.[177] With clear parameters, federal and state entities can control prospective BHSSs' entry into their fields while benefitting patients.

While differences in state regulations and public perceptions complicate efforts to allow individuals with criminal histories to become BHSSs, leveraging these workers could enhance patient engagement in behavioral health care. The rise in behavioral health issues nationwide and the link between behavioral health issues and criminal legal consistency involvement means policymakers should consider the limited inclusion of BHSSs with criminal histories in federal policy.[178]

Recommendation: Congress should establish a minimum federal exemption for those convicted of nonviolent crimes to become BHSSs.

To allow BHSSs to become certified and administer behavioral health services in certain instances, Congress should establish a federal exemption for individuals with criminal histories of nonviolent crimes. In this complex issue, the exemption must balance the desire to protect and assist underserved patients with the benefits of maximizing inclusion. Thus, with states assuming

the certification responsibilities, the federal government can craft the exemption to establish a minimum requirement, and states can allow for a wider exemption when appropriate.

- **Prospective BHSSs with criminal histories can qualify for the federal exemption only if convicted of a nonviolent offense.** To be eligible for the federal exemption, convictions must also be federal; state-level convictions would be automatically disqualified. According to 18 U.S.C. § 16, a "crime of violence" is defined as either an offense whereby an individual uses, attempts to use, or threatens to use physical force, or involves another felony offense that involves substantial risk of physical force against a person or property.[179,180] Examples of nonviolent crimes include property crimes (e.g., burglary and theft), white-collar crimes (e.g., fraud, tax-related crimes), prostitution, gambling and racketeering crimes, bribery, and certain drug and alcohol-related crimes. As many prospective BHSSs might have SUD and/or drug and alcohol-related offenses, the federal exemption would apply only to relevant federal offenses unless states elect to allow additional exemptions for state-level drug and alcohol offenses.[181]

- **Prospective BHSSs with criminal histories must reflect patient populations' lived experiences.** Often, similar backgrounds help support specialists serve as real-life role models for formerly incarcerated patients with behavioral health issues, and they aid in fostering connections. However, to be eligible for the federal exemption, the BHSS must have a criminal history that aligns with patients' experiences. To ensure this, employers should submit documentation of these similarities to the DOJ. The department, in turn, would approve the employers' documentation of the following: demographics and experiences across patient populations; organizational guidelines about federal hiring legislation; recruitment and onboarding processes; and a hiring justification for the prospective BHSSs.

- **BHSSs with criminal histories must administer care only in select instances.** The federal exemption for BHSSs with criminal histories would apply only in instances when both patients and potential staff have a history of incarceration. As an individual's adherence to treatment can vary, so should support specialists' involvement; BHSSs should accompany providers in an initial intake visit, and continue with follow-up care when an individual is not engaged sufficiently in behavioral health treatment. In follow-up care, BHSSs would require additional layers of supervision, and work in designated sites to ensure patient safety.

New federal policies regarding criminal history reporting could include an appeal process. This would give BHSS applicants the opportunity to advocate for themselves. The prospective support specialists could include efforts they have made, such as recovery leadership, educational or vocational accomplishments, and employment achievements in their appeals processes. If any new evidence surfaces indicating BHSSs have violated the federal exemption, the state can revoke their certifications.

2. THE FEDERAL GOVERNMENT SHOULD CREATE PATHWAYS FOR COVERAGE OF BHSSs WITHIN MEDICARE AND MEDICAID.

BHSSs play a vital role in supporting the clinically licensed behavioral health care workforce and meeting the needs of patients requiring behavioral health care services. However, Medicare and Medicaid coverage of services provided by BHSSs remains inconsistent. Where coverage of BHSSs does exist, the scope of practice and qualifications for meeting training requirements can vary tremendously.

Although expanding coverage of BHSSs could be costly[e]—BPC estimates $163 million in Medicaid spending (state and federal)[f] and $89 million in Medicare spending[g]—it could ultimately result in cost savings. [182,183,184,185]

As such, and to support a more consistent expansion of coverage of behavioral health services provided by PSs, CHWs, and paraprofessionals for Medicare and Medicaid beneficiaries:

- **The Department of Labor should create a Bureau of Labor Statistics Standard Occupational Classification (SOC) category specifically for PSs.**

- **CMS should clarify that BHSSs can be considered "auxiliary personnel" as noted within the Medicare Physician Fee Schedule.**

- **CMS should provide technical assistance to help states take full advantage of existing federal Medicaid matching support of BHSSs.**

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e   BPC used estimated total additional costs using per capita behavioral health treatment costs (calculated using the average treatment costs for people with behavioral health conditions), and additional insured individuals (calculated using 2017 NSDUH data).

f   BPC estimated federal Medicaid costs using total additional costs (above), the percentage of Americans insured through Medicaid, and 55% for the Medicaid FMAP. BPC estimated state Medicaid costs using per capita behavioral health treatment costs (above), the percentage of Americans insured through Medicaid, and 45% for state and local match.

g   BPC estimated Medicare costs using total additional costs (above) and the percentage of Americans insured through Medicare.

Problem

Currently, federal occupational data for behavioral health care providers include psychologists, licensed mental health counselors, therapists, clinical social workers, and CHWs. The Labor Department has no category within its Standard Occupational Classification (SOC) system that represents PSs; it instead considers them as part of the CHW classification.[186]

While both are types of BHSSs, CHWs and PSs represent distinct professions, and combining them results in an imperfect fit. According to 2021 BLS data, the mean hourly wage for a CHW is $22.97. Few data are available on PSs, and the best available data are based on the College for Behavioral Health Leadership's 2016 report (*National Survey of Compensation Among Peer Support Specialists*). This report found the average reported hourly wage for PSs to be $15.42.[187] It is unclear whether PSs salary information is included in the BLS's mean hourly wage for CHWs, and whether the average hourly wage for PSs currently remains the same.

Furthermore, classifying CHWs and PSs together also makes it difficult to identify precisely how many of each are employed across the U.S. The BLS estimated that just over 61,000 CHWs were employed in 2021.[188] Mental Health America estimates that half of these (approximately 30,000 workers) are actually PSs.[189]

Recommendation: The Labor Department should create a BLS SOC category specifically for PSs.

The SOC is a standard classification system that federal agencies utilize to collect, review, and share data. SOC data are designed to be utilized for broad, comparable analyses of trends in employment levels, demographics, and other characteristics.[190] The BLS's Occupational Employment and Wage Statistics program, which generates employment and wage estimate resources, publishes these data, making them available for researchers, policymakers, payers, actuaries, and the general public to utilize. The data provide comprehensive information on average hourly and annual wages, including across various industries and geographies.[191]

Creating a SOC category for PS would allow researchers and policymakers to better understand the role and prevalence of PS across the nation. It would also inform both advocates and the public about the importance of the PS workforce.

As noted previously, states have developed extensive preemployment or on-the-job training requirements for PSs' certification distinct from CHWs. These training requirements affect the amount of time staff are available to deliver services, and they also do not account for rate-setting assumptions. It is

necessary to create a SOC category for PS's that can determine adequate costs of delivering relevant services. This will improve payers and actuaries' ability to attract and retain quality candidates for key behavioral health positions.

Finally, a 2018 GAO report found that Medicaid represents the largest share of funding for PS programs.[192] As such, creating a SOC category for peer specialists would also help to marry the data available from BLS and CMS and provide standardized salary information that payers and actuaries could use to determine reasonable compensation rates and develop reimbursement strategies.

COVERAGE OF BEHAVIORAL HEALTH SUPPORT SPECIALISTS UNDER MEDICARE

Problem

Medicare does not reimburse BHSSs directly, nor does it have the "authority to create a statutory benefit category for practitioner types."[193] However, in early 2022, CMS, as part of its Behavioral Health Strategy, released objectives to enhance access to behavioral health services and strengthen the behavioral health model within Medicare. This included an objective to expand access to PSs and CHWs.[194]

CMS's Calendar Year 2022 Physician Fee Schedule (PFS) allowed certain practitioners—marriage and family therapists (MFTs) and licensed professional counselors (LPCs), specifically—to be paid indirectly when they provide services as auxiliary personnel "incident to" and under the direct supervision of the billing physician. CMS permitted these indirect payments and limited their scopes, considering the increased demand for behavioral health services as a result of the COVID-19 pandemic.

CMS's Calendar Year 2023 PFS amended this to allow services to be furnished by MFTs and LPCs, as auxiliary personnel, under general supervision (as opposed to direct supervision). Operationally, this means that Medicare can cover services provided by MFTs and LPCs under the direction and control of a physician; the billing physician does not have to be physically present at the time of service.

Like CMS, Congress is moving to allow MFTs to furnish behavioral health services. In September 2022, both the Senate Committee on Finance and the House Ways and Means Committee introduced legislation expanding Medicare coverage of MFTs for behavioral health services. This legislation would allow for more expansive coverage of services furnished by marriage and family

therapists, which might pave the way for BHSS coverage.

Recommendation: CMS should clarify that BHSSs can be considered "auxiliary personnel" within the Medicare Physician Fee Schedule.

Auxiliary personnel, although not neatly defined, must still meet all state-level licensing requirements. As such, CMS should consider—either via agency guidance or the next iteration of the Physician Fee Schedule—further clarifying or providing examples of auxiliary behavioral health services that other providers can furnish alongside MFTs and LPCs. More specifically, CMS should name PSs and CHWs as allowable auxiliary personnel, which would be consistent with their actions toward boosting the roles of PSs and CHWs.

Furthermore, CMS's updated regulations will likely allow for a better, broader understanding of the role that BHSSs play in improving behavioral health needs in the short and long term. Congress should consider ways to study related outcome data to better understand BHSSs' impacts, perhaps to expand BHSS reimbursement.

TECHNICAL ASSISTANCE FOR MEDICAID COVERAGE OF BEHAVIORAL HEALTH SUPPORT SPECIALISTS

Problem

Medicaid coverage of PSs, CHWs, and paraprofessionals varies widely at the state level. This variation allows states flexibility in how they offer services vis-à-vis Medicaid population needs. At the same time, having several avenues for authorization of service can create confusion for states and might even result in uncertainty for both providers and patients.

States can offer peer support service coverage, for example, under Medicaid via Section 1905(a)(13); state plan rehabilitative services; 1915(i) and 2703 state plan services; or 1915(b) and (c) and 1115 waiver authorities. States that have the waiver can get federal matching funds to finance service coverage. However, federal statutes do not define such services and what they entail. As noted previously, states are responsible for defining their own PS training and certification processes and programs. Thus, considerable variation exists across states. The GAO, in a 2020 study, found that 36 states and the District of Columbia have Medicaid waivers to cover services offered by PSs to adults for SUD.[195]

As with peer services, Medicaid state plans and health home programs can authorize coverage of community health workers in interdisciplinary teams or through 1115 waivers or managed care arrangements. In fact, in 2021, MACPAC

found that at least 21 states had authorized Medicaid to pay for certain CHW services under one or more of these arrangements.[196] All Medicaid managed care organizations can choose to reimburse for CHWs as an administrative cost.

Finally, Section 1905(a), 1915(b) and (c) waiver authorities authorize Medicaid payment for services rendered by paraprofessionals. They can also cover services delivered by paraprofessionals as part of their Section 2703 health home programs (as part of interdisciplinary teams) and 1115 waivers. Generally, paraprofessionals offer services through various Medicaid state plan services, including rehabilitative services, targeted case management, and 1915(i) Home and Community-based Services state plans.

Recommendation: CMS should provide technical assistance to states to help them take full advantage of federal Medicaid matching support for coverage of BHSSs.

CMS's 2007 [guidance](#) to states on Medicaid coverage of peer support services was a major first step in messaging the importance and coverage of PS services, but the adoption has been slow. Furthermore, no formal messaging has focused on CHWs or paraprofessionals. Therefore, in addition to the joint guidance developed by the three federal agencies (see above recommendation on joint guidance), CMS should provide technical assistance to states on the expansion of Medicaid payment for PSs, CHWs, and paraprofessionals.

Once released, CMS should lead an overview of the guidance, providing clarity to state Medicaid agencies regarding the coverage opportunities for these staff and potential services and supports that these staff could deliver. In addition, CMS should provide examples of reimbursement for these services, both as a direct payment and administrative matching opportunities. Finally, CMS should ensure that staff working with states can directly review and approve coverage, and that they have the necessary information to help states implement the guidance. This includes the regional and central office staff who make formal decisions regarding coverage.

3. CONGRESS SHOULD CREATE A PIPELINE PROGRAM TO HELP INTERESTED BEHAVIORAL HEALTH SUPPORT SPECIALISTS BECOME LICENSED BEHAVIORAL HEALTH PROFESSIONALS.

While increasing the availability of BHSSs is important, a historical shortage of licensed behavioral health providers remains. Therefore, increasing the pool of licensed behavioral health individuals is important to offer services and to supervise BHSSs.

ACCELERATED EDUCATION

Problem

With demand for behavioral health services increasing, the dwindling licensed workforce presents a crisis for accessing services. As noted previously, burnout and attrition are prevalent across the health care workforce, including among licensed behavioral health workers.[197] Still, few federal programs focus on retaining these providers and addressing burnout and attrition directly.[198] Filling the pipeline for licensed professionals takes time. Education and training for certain types of providers (e.g., psychiatrists), meanwhile, can be cost-prohibitive, making the pathways to licensure out of reach for many.[199]

Many existing pipeline programs tend to target high school and college students rather than those who wish to undergo a career change.[200,201] Some of these programs show promise in increasing diversity across the health care workforce. One study found that diversity-oriented educational programs appeared to narrow that gap for underrepresented Black, Hispanic, and Native American populations among graduates across 10 health care professions.[202]

Pipeline programs are especially critical in underresourced communities. One such program is the Workforce Readiness Institute at Dartmouth Health.[203] Located in a rural community, this program offers apprenticeship and professional training programs at no cost to trainees for any of the following professions: nursing assistants, medical assistants, ophthalmic assistants, pharmacy technicians, and surgical technologists. The program combines on-the-job training with for-credit classes at a local college. Trainees often begin full-time employment at Dartmouth Health upon successful completion.

To address the workforce shortage, programs must emphasize maintaining the current behavioral health workforce and building shorter-term solutions for

enlarging and diversifying the workforce with BHSSs. [204] Two relatively new and critical sources of HRSA funding reflect these priorities. First, the Substance Use Disorder Treatment and Recovery Loan Repayment Program (STAR LRP), to which Congress appropriated $28 million in FY2022, gives individual behavioral health providers up to $250,000 to repay school loans in exchange for working full-time for six years at an approved facility.[205] Second, the Community Health Worker Training Program (CHWTP) supports institutions (e.g., "health professions schools," academic health centers, state/local governments, and nonprofits) to train CHWs.[206,207] These programs are promising first steps toward bolstering BHSSs with a wider range of experience.

Allowing BHSSs a pathway into the licensed workforce would offer professional development opportunities for those who choose to pursue them, while establishing a sustainable way to replenish the bench of licensed practitioners.

Recommendation: Congress should create a pipeline program at HRSA leveraging existing funding to help interested BHSSs become licensed.

To expand the licensed behavioral health workforce, Congress should direct HRSA to leverage existing funds to establish a pipeline program for interested BHSSs to become licensed behavioral health professionals. The goal is to offer an accelerated educational curriculum that will allow working BHSSs to satisfy the necessary prerequisites, including fulfilling the supervision requirements, for earning their licenses. The baseline curriculum would be nationally uniform, but states should consider their own additional state-level educational requirements. The HRSA-funded pipeline program would not include supervision; that would be the next step for trainees in their career development and identical to that of individuals who have entered via a more conventional pathway (e.g., higher education).

Funding for the new pipeline program would come from the STAR LRP and the CHWTP. The program would allow grantees to use funding from the CHWTP to develop and update an accelerated curriculum every five years and to subsidize relevant operating costs. Meanwhile, the pipeline would allow some funding from the STAR LRP, which would otherwise be used for loan repayment, to go toward trainees' tuition. Using the LRP funds during their education would further reduce financial barriers to entry; tuition payments require trainees to assume individual costs, and loan repayments might not take effect for years. Furthermore, loan repayments are often intended to incentivize other objectives, such as easing geographic dispersion. This pipeline program would incentivize participants to remain in their current roles while obtaining additional skills and eventually receiving a license. In subsequent years, HHS could reassess appropriate funding levels for the pipeline program based on participation and overall costs.

To uniformly prepare BHSSs to become licensed workers, the pipeline program would offer the same training and eligibility for all types of BHSSs, regardless

of how experienced and advanced participants are. Eligible funding recipients would be the entities that employ BHSSs. These entities might include health care systems, social assistance groups, residential care facilities, and others that employ BHSSs. Program grantees would allow employed BHSSs to enter a cohort. However, only those support specialists who are certified (or have undergone a similar process) within their state and are engaged in behavioral health work could enroll. Prospective grantees would specify an accredited teaching partner (e.g., local community colleges; state schools, including satellite campuses; virtual academic partners) in their applications from which trainees would receive credits.

The awards would fund an accelerated 32-week learning curriculum, that would be the same across all grantees and individual trainees. HRSA would enlist federal contractor support to develop the curriculum and update it every five years to align it with evolving population needs. The program would include bachelor's-level prerequisites and behavioral health subjects, including clinical assessments; treatment plans; person-centeredness; defining and understanding "medical necessity"; evidence-based practices on mental health and addiction; and service delivery. Modules devoted to behavioral health would encompass both mental health and SUDs, clarifying any differences and nuances to ensure that trainees have the knowledge to address either one.

By the end of the training, individuals would be eligible to begin fulfilling their state supervision requirements as mandated by state licensing boards.[208] As noted earlier, state licensures for licensed health care professionals vary by state, while educational requirements often do not.[209] Because the HRSA-funded program would provide BHSSs with the same educational requirements, trainees would be able to pursue licensure in any state they choose.

In both the education and supervision portions, licensed behavioral health professionals would supervise the experienced BHSSs, ensuring that overall training would be high quality. The licensed behavioral health professionals would receive continuing education units for teaching. Experienced, certified BHSSs would assist the trainers and take on more leadership roles, serving functions similar to a teacher's assistant. These experienced BHSSs would also support trainees during supervision (even though it is not part of the HRSA funding), providing management and leadership to best serve patients and promote organizational cohesion.

Community-initiated Care Model

Expanding Access through Community-initiated Care (CIC)

Expanding access to behavioral health resources requires a broader approach than just relying more on BHSSs. Individuals in the community can often recognize people with behavioral health issues and direct them to available services, and community-based resources can support nonmedical aspects of behavioral health care. As such, another approach to address the rising need for behavioral health services and the shortage of licensed behavioral health workers is to leverage support networks within communities that are otherwise overlooked.

With that in mind, BPC researched a novel model known as Community-initiated Care.[210] Federal policymakers have never used this model to address behavioral health but, by deploying it, they can support policies that enhance the roles of multidisciplinary stakeholders.

The CIC model stresses the importance of existing relationships, social norms, and multidisciplinary wraparound services through an approach called task sharing. Task sharing establishes pathways for informal behavioral health in two ways: by empowering members of the community to assume some of these responsibilities when appropriate, and by training multidisciplinary stakeholders (e.g., educators, faith-based leaders) to respond to the behavioral health needs of community members. These task-sharing processes would not replace the roles of providers within the health care system but, instead, augment them with broader community involvement.

Several programs, some of which are based outside the U.S., currently use the CIC model, while others expand upon the model. One such program is StrongMinds, which uses a train-the-trainer model to teach local women to become lay mental health counselors in Uganda and Zambia.[211,212] The trainees facilitate informal support groups for female community members suffering from depression. Through this process, StrongMinds has reached more than 160,000 individuals with depression, and 80% of participants reported that their symptoms had lessened after six months. The model uses a culturally relevant practice called "collective healing" in which people develop and use skills to enable healing in their communities, families, and themselves. Using collective healing as opposed to one-on-one sessions enhances the model's

success. Moreover, the train-the-trainer model allows others to recruit and teach program graduates to ensure an ongoing pipeline of lay workers.[213]

One U.S.-based project that leverages the CIC model is Atlanta's Confess Project, which provides community-based mental health care to men and boys of color in barbershops.[214,215,216] Barbers and hairstylists might already provide emotional support to their clients. For example, an adult Black man with depression since childhood may or may not be in treatment. Although depression can be debilitating, this man might still visit the barbershop regularly. Barbers might notice the man's depression based on the way he's sitting or talking, especially if his words mimic those of others they know with a similar condition. The barber, in turn, might relay to the man that others who the barber knows have struggled with depression, both normalizing the illness and fostering a dialogue about helpful resources.

Under the CIC framework, barbers in the Confess Project could further assume the role of an informal support system in lieu of formal health care providers. To date, the Confess Project has trained more than 600 barbers and hairstylists in 35 cities in 14 states, making it a valuable behavioral health touchpoint outside of the health care system. Addressing the root causes of behavioral health issues among people of color, such as experiencing racial discrimination, has the potential to normalize behavioral health issues and reduce the stigma around them, according to a thematic analysis that used qualitative data from trained barbers.[217]

CIC broadens opportunities for care and formally recognizes caregivers who already support the emotional needs in communities. The CIC framework reduces health care costs, improves access to care, and offers care regardless of a formal diagnosis. Although CIC-like programs can be found in the U.S., scaling this model would be necessary to meet community demand.

Using this model in a variety of settings would provide several potential benefits. It could serve communities with little access to clinical resources or with high rates of stigma related to mental illness and SUD. The model would empower individuals to become active partners in the health care system and lead to interventions that span a number of needs, including prevention, early intervention, and continuing care.

Recommendations for Community-initiated Care

4. THE FEDERAL GOVERNMENT SHOULD ESTABLISH A CIC-SPECIFIC DEMONSTRATION GRANT.

Although community-based behavioral health care programs are eligible for various types of grants (e.g., philanthropic, academic), CIC programs are not explicitly federally funded. Identifying demonstration grants to fund CIC programs would allow lawmakers to establish opportunities for scaling this framework and to assess its utility in addressing behavioral health needs.

To encourage the adoption and success of CIC programs:

- **Congress and HHS should identify an existing federal demonstration program and broaden its scope to allow funding to be used for CIC programs.**
- **CMS should expand an existing CMMI model to allow funding to be used for CIC programs.**
- **Congress should design a new demonstration grant devoted to CIC.**

Problem

Because the CIC model, born out of a partnership between Harvard Medical School and the Well Being Trust in 2021, is new, no sources of federal funding are devoted to programs that incorporate it.[218] As noted previously, the CIC model is based on "task sharing," which empowers the public and multidisciplinary stakeholders to prevent or intervene in behavioral health issues. Engaging individuals who may or may not have an in-depth understanding of behavioral health conditions normalizes the experiences and empowers people with behavioral health issues' support networks to refer them to appropriate resources. Ultimately, the CIC model allows a basic level of behavioral health education to permeate social norms, which has the potential to reduce stigma.

Although the public is the target group under the CIC model, the federal policy avenue must require a focus on both the disciplines and services provided. Multidisciplinary stakeholders in organizations such as schools, affordable

housing groups, food banks, and faith-based communities—which each could coordinate with a separate federal agency—are all potential CIC implementers.

For example, the New York City-based group Fountain House uses a delivery structure known as the ClubHouse model—a form of psychosocial rehabilitation administered through members, as opposed to a formal health care delivery structure—to address both the mental health and social needs of its members. Fountain House provides access to clinical support, housing, employment, and education opportunities, as well as to PSs who assist with care management. The program has lowered Medicaid costs by 21% for participating individuals, provided housing within one year for 99% of members who had been experiencing homelessness, and produced a less than 5% recidivism among members with a history of incarceration.[219]

Fountain House attributes its effectiveness to both the multidisciplinary services and member-led facets. For its multidisciplinary services, Fountain House receives Medicaid and other government funding for aspects of the program such as housing, according to its 2021 financials.[220] The member-led services, on the other hand, do not fit within an existing funding schema. Because this aspect of the program is so fundamental, Fountain House still offers the member-led approach; scaling a ClubHouse model, however, requires some categorization, and promotes a top-down rather than a grassroots approach.

Although programs drawing on the CIC model have shown promise, no formal federal program explores the benefits of CIC in behavioral health care, especially for community-driven programs. Other federal community-based behavioral health programs tend to emphasize service delivery. For groups such as Fountain House to qualify for funding, they must demonstrate that they administer community behavioral health services, and that those services can yield noteworthy outcomes.

The federal government must rely on a demonstration program to operationalize the CIC model and determine its effectiveness in advancing behavioral health care. Demonstration programs across the range of multidisciplinary services (e.g., for safety net programs) foster programs that deliver community-based services. Given the newness of this model, a demonstration program must also include a formal evaluation. Data evaluating any demonstration program described below would help federal entities determine whether CIC models are worth scaling. An evaluation would assess the demonstration program's effects on behavioral health outcomes and costs.

EXPAND THE SCOPE OF EXISTING DEMONSTRATION GRANTS

Recommendation: Congress and executive branch departments should identify an existing demonstration program and award grants to relevant CIC programs.

The multidisciplinary nature of the CIC model creates additional options for Congress to apply federal funding for behavioral health. Thus, Congress should specify which existing demonstration projects can award grants for relevant CIC programs. Every year, appropriations legislation lists various demonstration projects that Congress intends to allow for short-term, low-cost pilot projects with potential longer-term solutions. There are numerous examples of demonstration projects funded through SAMHSA grants, as authorized by the SUPPORT Act, and other agencies fund demonstration projects that aim to explore best practices.[221] These demonstration grants provide platforms and opportunities to test models such as CIC that could fill longer-term gaps in services. Executive branch departments, such as HHS, would then be able to harness funding from existing demonstration programs to award grants for relevant CIC programs.

In addition to the evidence-to-practice benefits, widening the net of potential demonstration grants would provide more opportunities to either offer services that address behavioral health needs or the social determinants of health essential to the CIC model; or direct funding toward community behavioral health efforts. For illustrative purposes, Congress could use any one of the following demonstration grants to fund CIC-related activities (see Figure 4):

Figure 4: Demonstration Grant Options for CIC Funding

Funding Stream	Description	Funding[222,223]
SAMHSA's Community Violence Pilot	"To establish a pilot program to provide and expand mental health services for families affected by community violence."	$50,000 provided for SAMHSA's Children's Mental Health Services program
ACF Domestic Violence Hotline Pilot	"Within the recommendation [to provide funding for the Domestic Violence Hotline], the Committee includes $1,000,000 for a pilot project to explore best practices, interventions, and prevention methods … to reduce incidents of domestic violence."	$1,000,000
HUD-SAMHSA Supportive Housing for People with Mental Illness Pilot	"To pilot [an initiative to implement … essential behavioral health wraparound services and treatment], the Committee provides up to $5,000,000 for public housing agencies to partner with SAMHSA grantees under the projects for assistance in transition from homelessness (PATH) program."	$5,000,000
HUD Continuum of Care (CoC) – Comprehensive approaches to youth experiencing homelessness	"To [provide safe, inclusive, and culturally appropriate services for at-risk youth], the recommendation provides $107,000,000 for projects dedicated to providing services to youth experiencing homelessness, including not less than $25,000,000 for youth homelessness system improvement grants and up to $10,000,000 for technical assistance to help every CoC better serve youth at risk of or experiencing homelessness."	$107,000,000

While the SAMHSA and ACF demonstrations noted above focus on a community-based approach to addressing violence, they can each apply a CIC approach. The SAMHSA demonstration recognizes the need for mental health services for families affected by community violence; such a stance is an indication that a cultural shift around awareness of mental health concerns is valuable. The ACF demonstration does not explicitly mention addressing mental health, but focuses on prevention and response services, for which a CIC approach would be well suited.

On the other hand, the HUD demonstrations focus on wraparound services, geared toward bolstering programs that serve the homeless and housing-insecure communities. Regardless of the demonstration program, any of the options listed in Figure 4 should include a formal evaluation of costs and behavioral health outcomes. Using these and potentially other demonstration grants to fund CIC programs would offer policymakers a chance to assess whether the demonstration should be included in federal policies and programs without appropriating new funding. If successful, Congress could appropriate additional funding to expand and scale the CIC program.

EXPAND THE SCOPE OF EXISTING CMMI MODELS

Recommendation: CMS should identify an existing Center for Medicare and Medicaid Innovation (CMMI) model and allow funding to be used for CIC programs.

CMS could expand the scope of an existing CMMI payment model to fund CIC-related programs, and evaluate their impact on behavioral health outcomes and costs. CMMI models chart a path for the next 10 years of value-based care to improve patient-centered care within health systems. Many of these models deliver services geared toward a specific health issue (e.g., Oncology Care Model), and aim to identify new ways to incentivize providers to tailor their care around patient outcomes. Nevertheless, several models—including the Accountable Care Organization Realizing Equity, Access, and Community Health (ACO REACH) Model and its predecessor the Accountable Health Communities Model—align their payment structure to target health equity directly.

he ACO REACH Model, launched on January 1, 2023, aims to promote health equity, support provider-led organizations, and boost transparency. It gives ACOs the option between two risk-sharing structures: 50% risk-sharing with the Primary Care Capitation payment (a risk-adjusted monthly payment for primary care services), or 100% risk-sharing with either the Primary Care Capitation payment or Total Care Capitation payment (a risk-adjusted monthly payment for all covered services).[224]

Because the sites were selected before this report was published, CMMI could incorporate CIC into its plan to "advance health equity and bring the benefits of accountable care to underserved communities." This mission would include the ACOs' attempts to involve and train members of the community and incorporate wraparound services into patient care. The primary outcome of CIC

activities would be to understand how accountable care organizations can promote multidisciplinary services that would target behavioral health needs and community-based behavioral health care. If this model is both cost-effective and improves patient outcomes, CMMI can explore expanding and scaling it.

Similarly, CMMI could consider renewing funding for the Accountable Health Communities Model, which received five years of funding starting in 2017 and is currently inactive. This payment model promoted clinical-community collaboration by screening for unmet social needs, encouraging navigation services, and fostering alignment between clinical and community services.[225] The model funded community hubs in two tracks (Assistance and Alignment), and these organizations were paid when they utilized an Accountable Health Communities Health-Released Social Needs Screening Tool.[226] After the model's five-year life span, more is known about the effective screening, referral, community service navigation, and clinical community collaboration. Renewed funding for this model could incorporate tenants of CIC and build upon the lessons learned.[227]

In particular, the hubs in the Assistance track received reimbursement for screening beneficiaries and connecting them to community services, while the Alignment track reimbursed providers for screening. This track also made a continuous effort to align community resources with screening results.[228] The Accountable Health Communities Model is a great example of a model that incorporated many facets of CIC. If restarted, the model could include subgroups focused on behavioral health, and it could incorporate a train-the-trainer screening element into both the Assistance and Alignment tracks. CMMI could expand and scale the renewed version of this model if the CIC components successfully lower costs and improve behavioral health outcomes.

NEW DEMONSTRATION GRANTS FOR CIC

Recommendation: Congress should design a new demonstration grant devoted to CIC.

As an alternative to expanding existing demonstration grant programs through discretionary and Medicaid funding, Congress could create a new demonstration program devoted solely to CIC, and evaluate it to determine its effects on behavioral health outcomes and costs. The program would operationalize the CIC model using the following features and enable the federal government to explore its utility:

- behavioral health topics that benefit from CIC programs;

- goals of task sharing;

- tasks to be shared;

- anchor roles.

The CIC model can tackle three key behavioral health topics: the delivery of nonclinical psychosocial interventions, public health and integrative approaches to mental health, and youth mental health (see Figure 5 below). One of the best practices in the "delivery of non-clinical psychosocial interventions" category examines the role of trained community members to help combat maternal depression in Pakistan.[229] Similarly, one of the best practices in the "youth mental health" category is intergenerational connections between young and elderly Indigenous individuals to combat suicide risk in Canada.[230] These promising practices highlight the need for similar U.S.-based programs, with data that can evaluate CIC in a U.S. context.

Both examples tap into a community's capabilities to meet behavioral health needs. Programs in the "public health and integrative approaches to mental health" category tend to focus both on community-based behavioral health care and multidisciplinary wraparound services, such as housing, education, and employment. Programs like Fountain House and the Confess Project discussed earlier in this report incorporate aspects of community-based screening, and then help patients find appropriate resources.[231,232]

Figure 5: Behavioral Health Topics that Could Use CIC

Category Behavioral Health Topics	Description
Delivery of nonclinical psychosocial interventions	The CIC programs in this category would train workers to deliver nonclinical versions of interventions, such as cognitive behavioral therapy (CBT) or Interpersonal Therapy (IPT), to others.[233,234,235,236] Importantly, these would incorporate tenants of psychosocial therapies but not supplant them.
Public health and integrative approaches to mental health	The CIC programs would leverage a public health approach to mental health rather than treat and support mental illness in a clinical setting. These programs would aim to implement effective wraparound services (e.g., housing, employment, education) to support mental health care.[237,238]
Youth mental health	The CIC programs in this category are primarily school-based mental health interventions.[239,240,241]

After identifying the behavioral health topic, a demonstration would need to set the goals for task sharing. Ultimately, there are three potential goals:

- **Common psychological interventions** to share tasks with community members, community-based organizations, and other health extenders. This supports tasks such as screening and shared decision-making (see Figure 6) that have medical and clinical roots even if shared and performed outside of the clinical setting.

- **Connecting and following,** which shares stakeholder engagement; relationship maintenance tasks; screening tasks; and tasks related to identifying points of contact for education, navigation, and coordination. This supports tasks such as referral and patient navigation that require a baseline level of understanding of community resources.

- **Supervision, quality, and aims-setting,** which shares supervision and coaching tasks as appropriate, quality-related tasks, and performance-related tasks. This supports tasks such as patient navigation and shared decision-making that, while often directing individuals toward the right resources and empowering them to have control of their care, can include elements of training others to facilitate these tasks.

In addition to the behavioral health topics and goals, the CIC demonstration must specify at least one task that requires sharing. Task sharing redistributes nonclinical responsibilities across members of a community, thus using available human resources more efficiently for holistic patient care. The demonstration, as a result, must specify which activities—screening, referral, patient navigation, and shared decision-making—require task sharing.[242,243] Figure 6 represents the options for tasks being shared in a CIC program:

Figure 6: CIC Tasks Being Shared

CIC Tasks Being Shared	Description
Screening	The CIC programs in this category employ a wider range of settings, including mobile, door-to-door, school-based, and other nonfacility-based screening, to diagnose health issues earlier. This would offer greater access to care for those the health care system typically misses.[244,245]
Referral	This category of CIC programs helps manage patients' health needs using resources both within and beyond those available in clinical settings.[246, 247, 248]
Patient navigation	This category leverages patient navigators—who guide patients through the health care system—to help individuals overcome barriers that prevent them from getting the care they need.[249,250,251]
Shared decision-making	This category leverages shared decision-making—a process by which clinicians and patients work together to make decisions about clinical tests, treatments, and care plans—to engage individuals and empower them to balance risks and expected outcomes with their preferences and values.[252,253,254,255] Although shared decision-making often occurs within the clinical setting, members of a community can use this task to empower one another.

Finally, a demonstration project would require grantees to identify and select anchors—organizations or individuals facilitating task sharing—who serve as a liaison between participating entities within a CIC program. Anchor roles would support task sharing and would change depending on the demonstration's overall goal. Moreover, these anchors would be accountable for managing the grant funding and operations for the demonstration project.

Anchor roles could include training anchors, coalition anchors, and quality/learning anchors. Training anchors would establish the training capacity for skill packages and functions based on local needs. Moreover, to demonstrate whether training aims are being met, training anchors would have to assess trainees and trainers using pre-post assessment. Coalition anchors would establish a network of community partners and coalitions. These anchors could also establish clinical provider partners; although they are not necessary for all CIC programs, these anchors would provide the necessary support infrastructure for supervision and coaching roles. Finally, quality/learning anchors would establish a network of trusted intermediaries (e.g., quality improvement firms, local health departments, universities, health systems, and community-based organizations) that can align aims, coordinate work, and use

data. Such intermediaries would encourage strategic planning and consistency in CIC approaches.

Ultimately, any CIC demonstration must be a grassroots effort and bidirectional, driven both by community members and relevant institutions. Community groups and nonprofit grant recipients must, in their grant applications, demonstrate that they have sufficient community-level engagement (e.g., establishing a board that is made up of at least 51% members of the local community). Community members would select and practice each of the four core aspects of CIC programs with community needs at the forefront.

Congress would instruct the agency or agencies administering the CIC program(s) to formally evaluate its effects along each of these four components. An evaluation would assess whether the program appropriately addressed the behavioral health topic (see Figure 5). It could use outcome measures to evaluate whether the CIC intervention adhered to the topic with fidelity according to program recipients (e.g., patients). The evaluation could use measures of short-term outcomes to understand whether participants (e.g., trainees, program operators) achieved the relevant goals of task sharing. To explore the extent to which participants practiced the tasks themselves (see Figure 6), the evaluation could measure the processes used. Finally, an evaluation would tally the number of each type of anchor and assess their program activities using process measures. Additionally, the CIC program evaluation would assess overall recipient outcomes, rather than just each part in isolation, to understand the entire program's impact. If the demonstration is deemed a success, Congress can allocate additional funding.

5. CONGRESS SHOULD ENCOURAGE THE ADOPTION OF CIC BY INTEGRATING EXISTING FEDERAL FUNDING STREAMS THAT SUPPORT CIC-RELATED PROGRAMS, AS WELL AS THOSE THAT SUPPORT THE WORK OF BHSSs.

Across federal agencies, programs currently exist that support the research and delivery of behavioral health care services. This includes the delivery of services by programs with similarities to the CIC model, as well as those that fund BHSSs. Formally enhancing collaboration across these agencies could be accomplished at the direction of Congress, thereby reducing duplication and enhancing the existing federal funding spent on behavioral health.

To maximize existing federal resources for the support of CIC-related programs and the work of BHSSs:

- **Congress should integrate existing federal funding streams through House and Senate Appropriations Committee report language.**

FUNDING INTEGRATION

Problem

Each fiscal year, Congress appropriates several billion dollars to address the behavioral health needs of Americans, including behavioral health research and care delivery. For SAMHSA alone, this amounted to more than $9 billion in discretionary funding for FY2022, as well as an additional $3 billion from the American Rescue Plan Act. This funding is bolstered by mandatory dollars spent for the provision of behavioral health services via Medicare and Medicaid.

Although much of the relevant discretionary funding falls under the jurisdiction of HHS—and, more specifically, SAMHSA programs—some of it is appropriated to other departments, such as the U.S. Department of Agriculture and the Department of Veterans Affairs. Although the programs within these agencies and departments might seem disparate, they are ultimately designed to meet the diverse health-related needs of different populations.

Recommendation: Congress should integrate existing federal funding streams with House and Senate Appropriations Committee report language.

To formally allow and encourage programs across federal agencies with comparable objectives to work together to maximize their resources, Congress should integrate, or "braid," existing federal funding streams by including language in the House and Senate Appropriations Committee reports. This would have the benefit of fostering the maximization of resources at no additional cost. BPC recommends the inclusion of language in report text for programs across agencies that aim to support the behavioral health needs of Americans through CIC- and BHSS-related programs.

BPC identified and reviewed relevant discretionary FY2023 funding streams approved by the House Appropriations Committee to use for CIC-related programs and programs supporting BHSSs. In addition to ensuring that various funding streams across HHS agencies collaborate, funding streams that fall outside of HHS could also coordinate with one another. This could include funding streams from programs that are within other departments' jurisdictions. Urging a collaborate to diverse set of stakeholders to collaborate with HHS on programs of shared interest and behavioral health objectives might also allow for the greater dissemination of best practices and increase consistency in goals across the federal government.

Figures 7a and 7b, below, illustrate a nonexhaustive list of programs with areas of overlap. These programs could coordinate to maximize existing monetary resources. Braiding could be accomplished by adding House and Senate Appropriations Committee report language that directs these agency programs to formally collaborate and to reduce duplication; the report language also would allow agencies to further utilize their respective areas of expertise. It is important to note that in some cases, the usage of Medicaid dollars might amplify this funding.

Figure 7a: CIC-related Programs Integration

Agency	Program	Funding
SAMHSA	National Child Traumatic Stress Initiative	$150,000,000
NIFA	Rural Health and Safety Education Programs	$5,000,000
VHA	Public-Private Partnerships[h]	$5,000,000
TOTAL	—	$160,000,000

Figure 7b: BHSS-related Programs Integration

Agency	Program	Funding
HRSA	Behavioral Health Integration Into Community-based Settings[i]	$10,000,000
HRSA	Peer Support Specialists in the Opioid Use Disorder Workforce[j]	$14,000,000
HRSA	Community Health Worker Training Program	$226,500,000
SAMHSA	State Opioid Response Grants	$1,775,000,000
SAMHSA	Peer Support Technical Assistance Center[k]	$2,000,000
VHA	Suicide prevention outreach	$498,098,000
VHA	Opioid prevention and treatment	$662,805,000
VHA	Substance Use Disorder programs	$183,287,000
TOTAL	—	$3,145,190,000

h House Appropriations Committee FY2023 Filed Report – 117-391: "The Committee recommends that the Department continue to seek out public-private partnerships, in particular with research universities, teaching hospitals, and other partners, to expand upon its existing efforts related to suicide prevention, post-traumatic stress disorder (PTDS), traumatic brain injury (TBI), and substance use disorders."

i House Appropriations Committee FY2023 Filed Report – 117-403: "To provide grants to community-based organizations and local health departments to integrate navigators and community health workers trained in Mental Health First Aid or similar trainings into non-traditional community settings."

j House Appropriations Committee FY2023 Filed Report – 117-403: "To fund training, internships, and national certification for mental health and SUD peer support specialists to create an advanced peer workforce prepared to work in clinical settings."

k House Appropriations Committee FY2023 Filed Report – 117-403: "To provide technical assistance to recovery community organizations and peer support networks."

Conclusion

The recommendations in this report can help reimagine the behavioral health workforce by generating a more comprehensive and diverse group beyond the licensed workforce.

Behavioral health support specialists—peer specialists, community health workers, and paraprofessionals—represent critical liaisons between the health care system and patients. Creating channels to enhance behavioral health support specialists' roles through consistent competencies and expanded coverage establishes a necessary foundation for understanding their true effects on behavioral health care. Behavioral health support specialists can serve valuable roles in patient care while building the necessary bench of licensed workers after the challenges of the COVID-19 pandemic. Individuals and services outside the health care sector can combat long-standing stigmas in behavioral health care through community-initiated care, normalizing such issues as mental illnesses and substance use disorders. They also can target health equity and address root causes of disparities.

With the right training, coordination, and financial support, these workers can and should work alongside the licensed behavioral health workforce to effectively address Americans' behavioral health needs.

Appendix 1:
SAMHSA Core Competencies for Peer Specialists[256]

Engages peers in collaborative and caring relationships	• Initiates contact with peers • Listens to peers with careful attention to the content and emotion being communicated • Reaches out to engage peers across the whole continuum of the recovery process • Demonstrates genuine acceptance and respect • Demonstrates understanding of peers' experiences and feelings
Provides support	• Validates peers' experiences and feelings • Encourages the exploration and pursuit of community roles • Conveys hope to peers about their own recovery • Celebrates peers' efforts and accomplishments • Provides concrete assistance to help peers accomplish tasks and goals
Shares lived experiences of recovery	• Relates their own recovery stories and, with permission, the recovery stories of others to inspire hope • Discusses ongoing personal efforts to enhance health, wellness, and recovery • Recognizes when to share experiences and when to listen • Describes personal recovery practices and helps peers discover recovery practices that work for them
Personalizes peer support	• Understands his/her own personal values and culture and how these might contribute to biases, judgments, and beliefs • Appreciates and respects the cultural and spiritual beliefs and practices of peers and their families • Recognizes and responds to the complexities and uniqueness of each peer's process of recovery • Tailors services and support to meet the preferences and unique needs of peers and their families
Supports recovery planning	• Assists and supports peers to set goals and to dream of future possibilities • Proposes strategies to help a peer accomplish tasks or goals • Supports peers to use decision-making strategies when choosing services and supports • Helps peers to function as a member of their treatment/recovery support team • Researches and identifies credible information and options from various resources

Links to resources, services, and supports	• Develops and maintains up-to-date information about community resources and services • Assists peers to investigate, select, and use needed and desired resources and services • Helps peers to find and use health services and supports • Accompanies peers to community activities and appointments when requested • Participates in community activities with peers when requested
Provides information about skills related to health, wellness, and recovery	• Educates peers about health, wellness, recovery, and recovery supports • Participates with peers in discovery or co-learning to enhance recovery experiences • Coaches peers about how to access treatment and services and navigate systems of care • Trains peers to develop the desired skills and strategies • Educates family members and other supportive individuals about recovery and recovery supports • Uses approaches that match the preferences and needs of peers
Helps peers to manage crises	• Recognizes signs of distress and threats to safety among peers and in their environments • Provides reassurance to peers in distress • Strives to create safe spaces when meeting with peers • Takes action to address distress or a crisis by using knowledge of local resources, treatment, services, and support preferences of peers • Assists peers in developing advance directives and other crisis prevention tools
Values communication	• Uses respectful, person-centered, recovery-oriented language in written and verbal interactions with peers, family members, community members, and others • Uses active listening skills • Clarifies their understanding of information when in doubt of the meaning • Conveys their point of view when working with colleagues • Documents information as required by program policies and procedures • Follows laws and rules concerning confidentiality and respects others' rights to privacy
Supports collaboration and teamwork	• Works together with other colleagues to enhance the provision of services and supports • Assertively engages providers from mental health services, addiction services, and physical medicine to meet the needs of peers • Coordinates efforts with health care providers to enhance the health and wellness of peers • Coordinates efforts with peers' family members and other natural supports • Partners with community members and organizations to strengthen opportunities for peers • Strives to resolve conflicts in relationships with peers and others in their support network

Promotes leadership and advocacy	• Uses knowledge of relevant rights and laws (ADA, HIPAA, Olmstead, etc.) to ensure that peer's rights are respected • Advocates for the needs and desires of peers in treatment team meetings, community services, living situations, and with family • Uses knowledge of legal resources and advocacy organizations to build an advocacy plan • Participates in efforts to eliminate prejudice and discrimination against people who have behavioral health conditions and their families • Educates colleagues about the process of recovery and the use of recovery support services • Actively participates in efforts to improve the organization • Maintains a positive reputation in peer/professional communities
Promotes growth and development	• Recognizes the limits of their knowledge and seeks assistance from others when needed • Uses supervision (mentoring, reflection) effectively by monitoring self and relationships, preparing for meetings and engaging in problem-solving strategies with the supervisor (mentor, peer) • Reflects and examines own personal motivations, judgments, and feelings that may be activated by the peer work, recognizing signs of distress, and knowing when to seek support • Seeks opportunities to increase knowledge and skills of peer support

Appendix 2a:
Covert Framework for Community Health Workers[257]

	Category 1 CHW	Category 2 CHW	Category 3 CHW
Training	Core competency training, augmented by health outreach and advocacy training	Core competency training, augmented by training in chronic conditions	Core competency training, augmented by disease-specific training (e.g., asthma, cancer, diabetes)
Work Setting	Community-based organizations	Community health clinics, health-focused community-based organizations	Ambulatory care settings, community health clinics
Scope of Practice	Provide health information, conduct outreach, and promote awareness	Facilitate access to primary care services, implement community health activities, engage community partners	Coordinate care, facilitate access to care, provide disease- and treatment-specific information

Increasing Specialization →

Appendix 2b:
Core Competencies for Community Health Workers from Covert Framework

Assessment	• Identify available sources of health data • Demonstrate program effectiveness with data • Prepare reports by using electronic medical records and unified data • Integrate findings of data assessment into clinic operations
Community health practice	• Identify stakeholders to support community outreach • Engage community partners around programs and activities • Organize client education opportunities • Arrange community health events • Facilitate clients' access to health services • Advocate for clients' needs
Communication	• Communicate with linguistic and cultural proficiency (e.g., in writing, orally, and visually) • Distribute health information to the community and clients • Disseminate information about health programs and policies
Diversity and Inclusion	• Describe diversity as it applies to communities (e.g., race, gender, religious beliefs, national origin, ethnicity, age, disability, political beliefs, sexual orientation, gender identity, gender expression, family status, socioeconomic level) • Identify health disparities within communities • Function without judgment, bias, or stereotype
Professional Practice	• Adapt to multiple responsibilities • Recognize the role of CHWs and other members of a health care team • Apply continuing education to work responsibilities • Incorporate ethical standards of practice into all interactions with individuals, organizations, and communities • Operate programs within a budget
Disease Prevention and Management	• Identify factors that influence access to disease prevention and management services • Share information about disease prevention and management • Facilitate referrals to disease prevention and management services • Support continuous availability of health services to clients • Explain prevention and management actions for disease conditions prevalent in the community • Explain health care payment mechanisms and procedures (e.g., Medicaid, Medicare, private insurance)

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