

The Workforce Crisis

The United States' behavioral healthcare system is facing a workforce crisis. As of March 2022, 144 million Americans lived in mental health Health Professional Shortage Areas, a designation used by the Health Resources and Services Administration to indicate areas where the demand for behavioral health services outstrips the supply. These shortages are particularly acute in rural areas, where many counties lack any behavioral health care providers, and among racially and linguistically diverse providers.

These existing workforce challenges were exacerbated by the COVID-19 pandemic, which led to both an increase in the need for mental health services and a decrease in staff. Across the healthcare industry, as many as one in five workers have left their job since the start of the COVID-19 pandemic, citing the trauma of the pandemic, higher pay in other fields, and inadequate safety protocols. This trend also hit behavioral healthcare: in a survey of provider organizations, 68% reported experiencing workforce shortages due to the pandemic, and 97% reported difficulty recruiting employees.

Workforce challenges can lead to real access issues, including growing wait lists and providers who are forced to close their doors. Addressing this crisis will require a comprehensive approach focused on increasing the supply on behavioral health professionals, ensuring that the geographic distribution of providers meets local needs, and retaining providers.

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Medicaid's Role

State Medicaid directors have identified workforce challenges as one of the biggest – if not the biggest – challenges facing their behavioral healthcare systems. Although these issues span the continuum of care, states have identified acute shortages among specific provider types (including psychiatrists, social workers, and psychiatric nurse practitioners), multilingual providers, and Black and Latino/a providers. These shortages are exacerbated by the number of behavioral healthcare providers who do not accept Medicaid patients.

Currently, Medicaid has relatively limited policy levers to improve the behavioral health workforce, with many federal funds for healthcare workforce development channeled through the Health Resources and Services Administration. Some states, such as Massachusetts, leveraged Medicaid Delivery System Reform Incentive Payment (DSRIP) funds to launch behavioral health workforce development initiatives. In 2020, however, CMS announced that they would no longer approve new DSRIP programs or renew existing DSRIP programs.

Opportunities for Federal Action

- **Allow states to generate federal match on workforce training programs**, including programs focused on developing career paths for peers and community health workers. This would give states the financial resources they need to create strong pipelines to careers in behavioral health.
- **Support behavioral health integration efforts.** Initiatives to integrate behavioral healthcare into primary care, school-based services, and other settings – along with efforts to train primary care and school-based providers on the basics of mental health care – can help maximize the existing workforce. Congress should also allow Medicaid reimbursement for electronic consultations with behavioral health specialists to support integration.
- **Support providers in participating in Medicaid and CHIP.** Many behavioral health providers do not accept Medicaid or even private insurance. Congress should take steps – including supporting states choosing to provide sustainable rate increases, providing financial resources to support the uptake of Electronic Health Records and other health IT among behavioral health providers, and launching technical assistance on the Medicaid enrollment and reimbursement process – to increase provider participation in Medicaid.
- **Expand scholarship, grant, and loan forgiveness programs** and create incentives for practicing in rural or underserved communities. Scholarship and loan forgiveness programs should explicitly aim to increase the number of multilingual and culturally competent providers.
- **Diversify the types of providers in the behavioral health workforce** by providing financial resources for the use of peer support professionals, community health workers, and health navigators. These direct support professionals can fill existing gaps in care and create a more stable and resilient workforce. Congress should also consider building pathways – including scholarships and grants – for peer support professionals, community health workers, and health navigators to become licensed providers.
- **Expand access to telehealth services.** Telehealth can help connect people living in rural areas to providers and address language access and cultural competency issues. Federal support for telehealth – including funds for providers to obtain telehealth systems and efforts to increase broadband access across communities – may help mitigate the impacts of workforce shortages.

Supporting State Innovation

Many states have already launched efforts to build up their behavioral health workforces. Arizona launched a training academy for peer support professionals, along with a peer-to-peer support resource for physicians. Massachusetts has implemented a variety of behavioral workforce training programs, including a recruitment fund aimed at increasing the number of psychiatrists and nurse practitioners with prescribing privileges at community mental health centers. As of 2018, 37 state Medicaid programs covered some type of peer support services for substance use.

You can read more about state actions to support the behavioral health workforce in [NAMD's Medicaid Forward: Behavioral Health report](#).