PayerTrends
Insights For Behavioral Health

2026 PayerTrends Behavioral Health Guidebook

Volume One: Key Trends In Behavioral Health Treatment Demand, Cost & Delivery

Trends Shaping Behavioral Health Cost, Capacity, & Performance

PayerTrends is made available free of charge by Otsuka America Pharmaceutical, Inc. as a unique contribution to set higher standards for behavioral health policy and practice driven by the health plan perspective.

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About This Guidebook

This guidebook examines the evolving behavioral health landscape and the factors shaping access, cost, and system performance across Medicaid, Medicare, and commercial populations. It analyzes trends in prevalence, workforce capacity, reimbursement models, and care delivery, with a focus on their impact on total cost of care and quality outcomes.

The goal of this guidebook is to provide a practical, data-driven perspective on how behavioral health is influencing total cost of care, quality performance, and long-term health system sustainability. As behavioral health conditions become more prevalent and increasingly associated with complex medical needs, health plans and providers are rethinking traditional models of care delivery, reimbursement, and performance management.

Strategic Planning & Decision Support

Supports executive decision-making on behavioral health strategy, including implications for benefit design, care management, and performance accountability in a high-cost, high-demand environment.

System-Level Trends Shaping Behavioral Health

Behavioral health system performance is being shaped by rising prevalence, cost concentration among high-acuity populations, workforce shortages, and the expansion of managed care and value-based reimbursement models. These dynamics are increasing the focus on integration, access, and measurable outcomes.

Data-Driven Market Intelligence

The analysis draws on data from federal agencies, national research organizations, and industry sources to provide a structured view of market trends and their implications for payers and providers.

Preparing For Future Demand

As demand continues to grow, organizations that strengthen integration, expand access, and align financial incentives with outcomes will be better positioned to manage total cost of care and long-term system performance.

Table Of Contents

Key Trends In Behavioral Health Treatment Demand, Cost & Delivery

Table of Contents continued on next page.

Table Of Contents (Continued)

Key Trends In Behavioral Health Treatment Demand, Cost & Delivery

Executive Summary

The behavioral health market is undergoing a structural shift, driven by rising prevalence across youth, working-age adults, and older populations, along with persistent workforce constraints. Increasing cost concentration among high-acuity cohorts is reshaping how payers, providers, and policymakers approach system design.

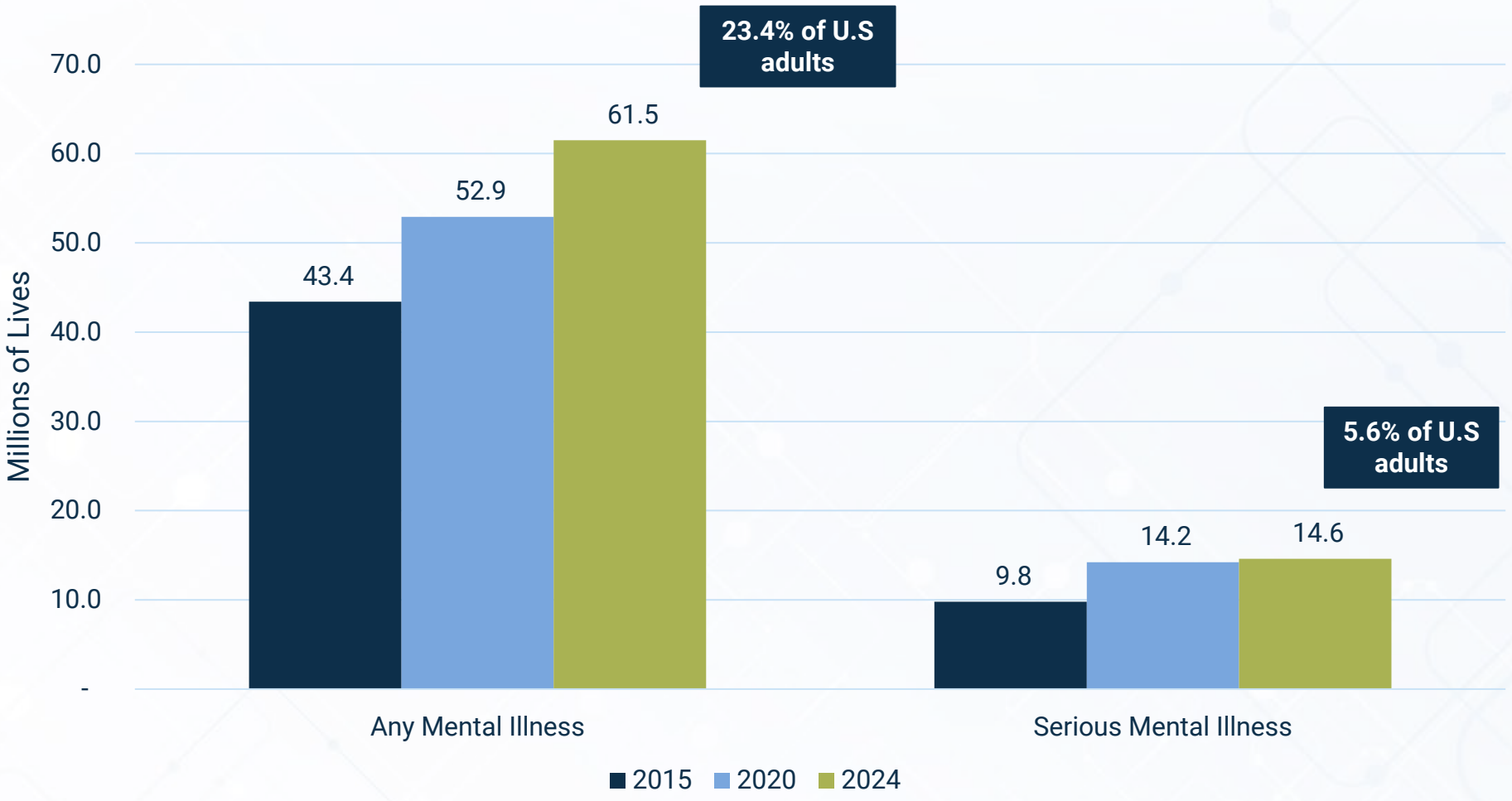
Across payer types, cost concentration is increasingly driven by members with complex medical and behavioral health needs. Individuals with serious mental illness and substance use disorders experience higher utilization, lower medication adherence, and disproportionate spending.

System performance remains uneven, with variation in follow-up care, care coordination, crisis response capacity, and adoption of value-based reimbursement models. Policy initiatives, including CCBHCs and integrated care models, are advancing standardization, but implementation maturity varies across regions.

These dynamics are compounded by persistent workforce shortages, particularly in rural and Medicaid-dominant markets. In response, payers and providers are adopting technology-enabled models, including telebehavioral health, measurement-based care, AI-assisted documentation, digital therapeutics, and remote monitoring.

1. The Changing Prevalence Of Behavioral Health Conditions & The Demand For Services

1.a. Prevalence Of Mental Health Conditions[1-3]



Approximately one in five U.S. adults experience a mental health condition each year, with an estimated 5.6% living with serious mental illness (SMI).

While the SMI population represents a smaller share of total cases, it is associated with higher clinical complexity, increased mortality risk, and greater health care utilization.

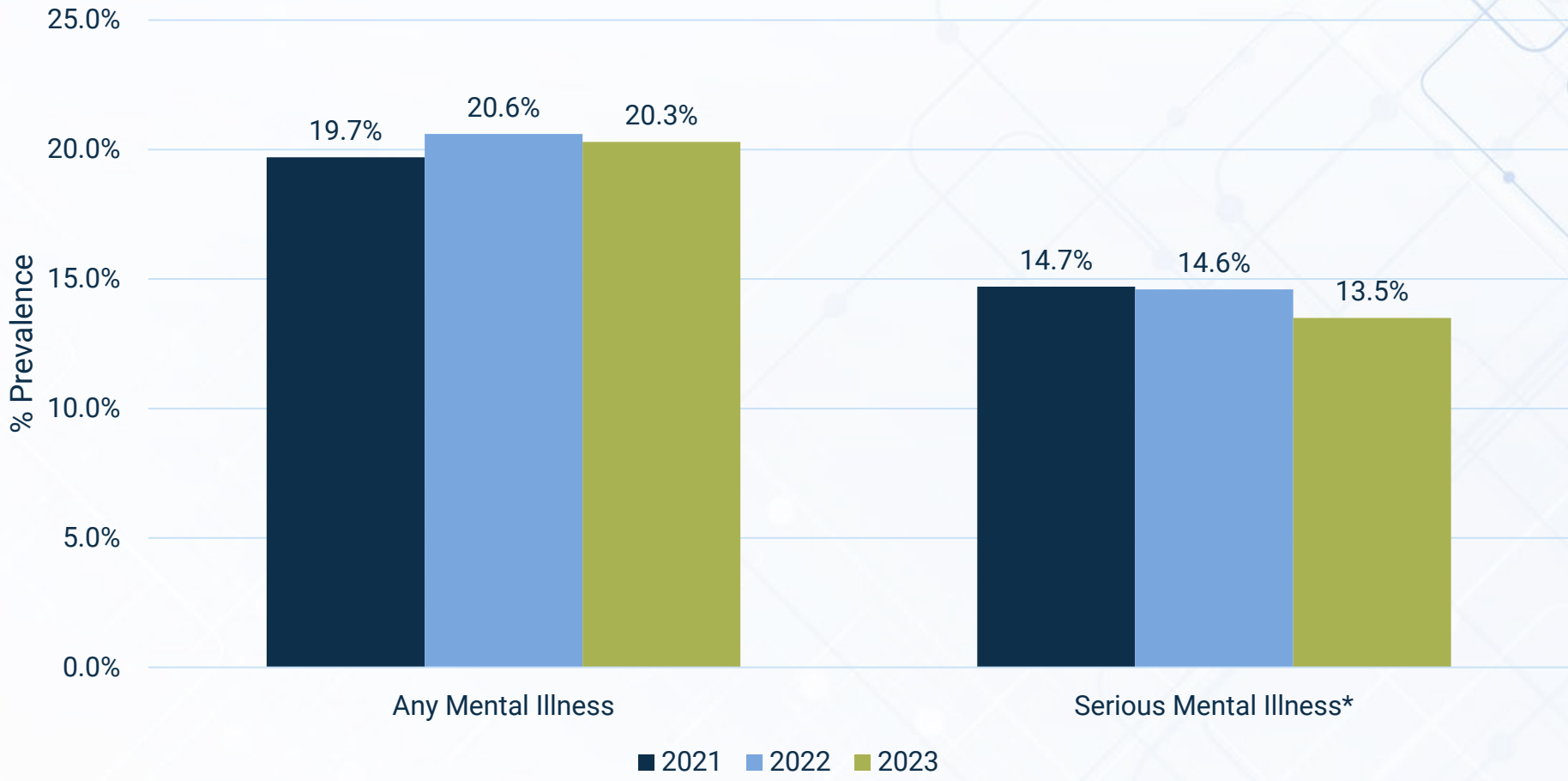
These patterns drive disproportionate cost and care management challenges, particularly within Medicaid and other public insurance programs.

1.b. Prevalence Of Mental Health Conditions In Youth[4-9]

Approximately one in five youth ages 12 to 17 experience a mental disorder each year.

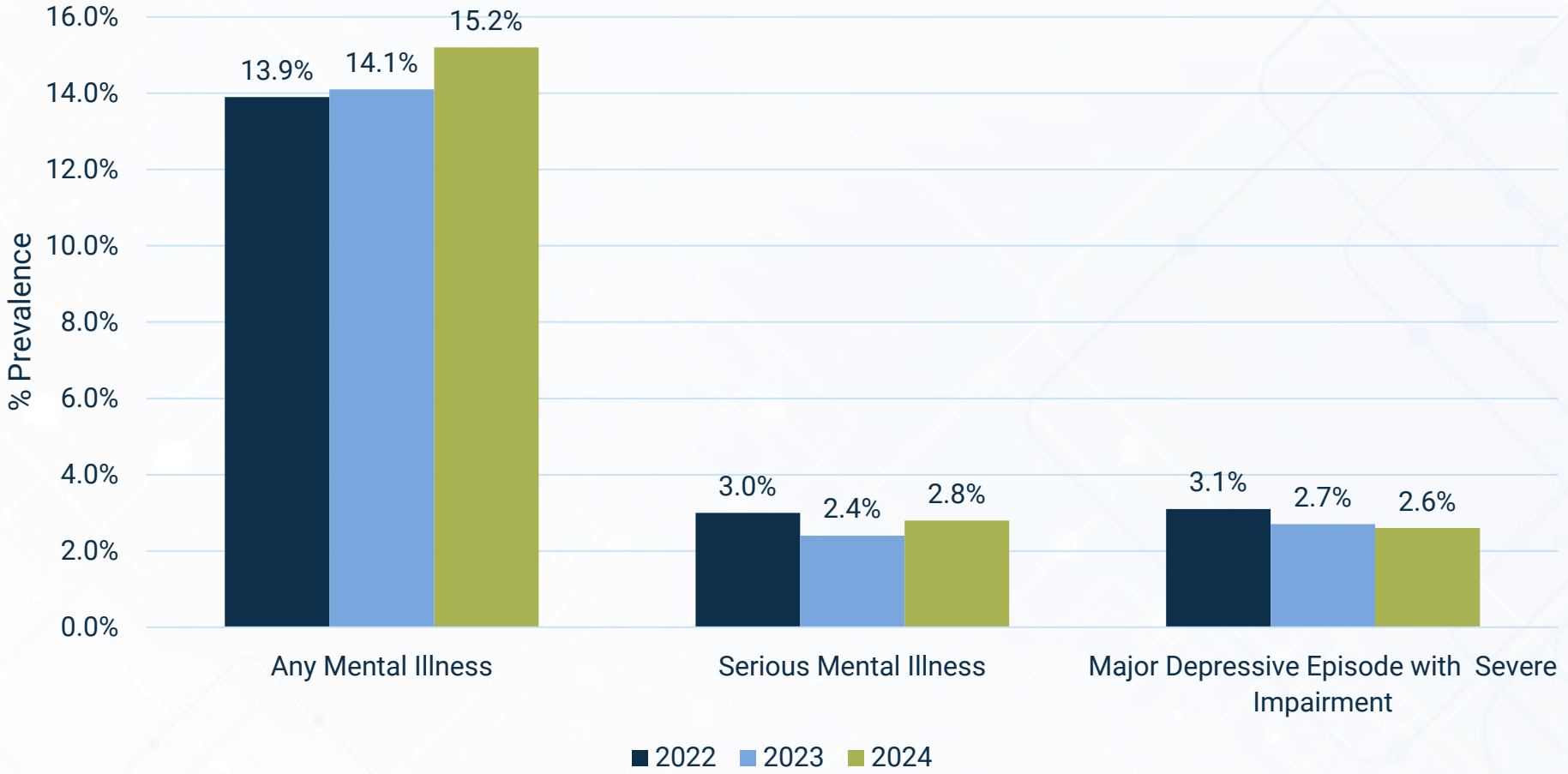
The most common conditions include anxiety disorders (approximately 11%), behavioral disorders including ADHD (approximately 8–11%), and depression (approximately 4%).

Indicators of youth distress are high, with 42% of high school students reporting persistent feelings of sadness or hopelessness in 2021.



*Major Depressive Episode with severe impairment

1.c. Prevalence Of Mental Health Conditions In The 50+ Population[3,6,7,10,11]



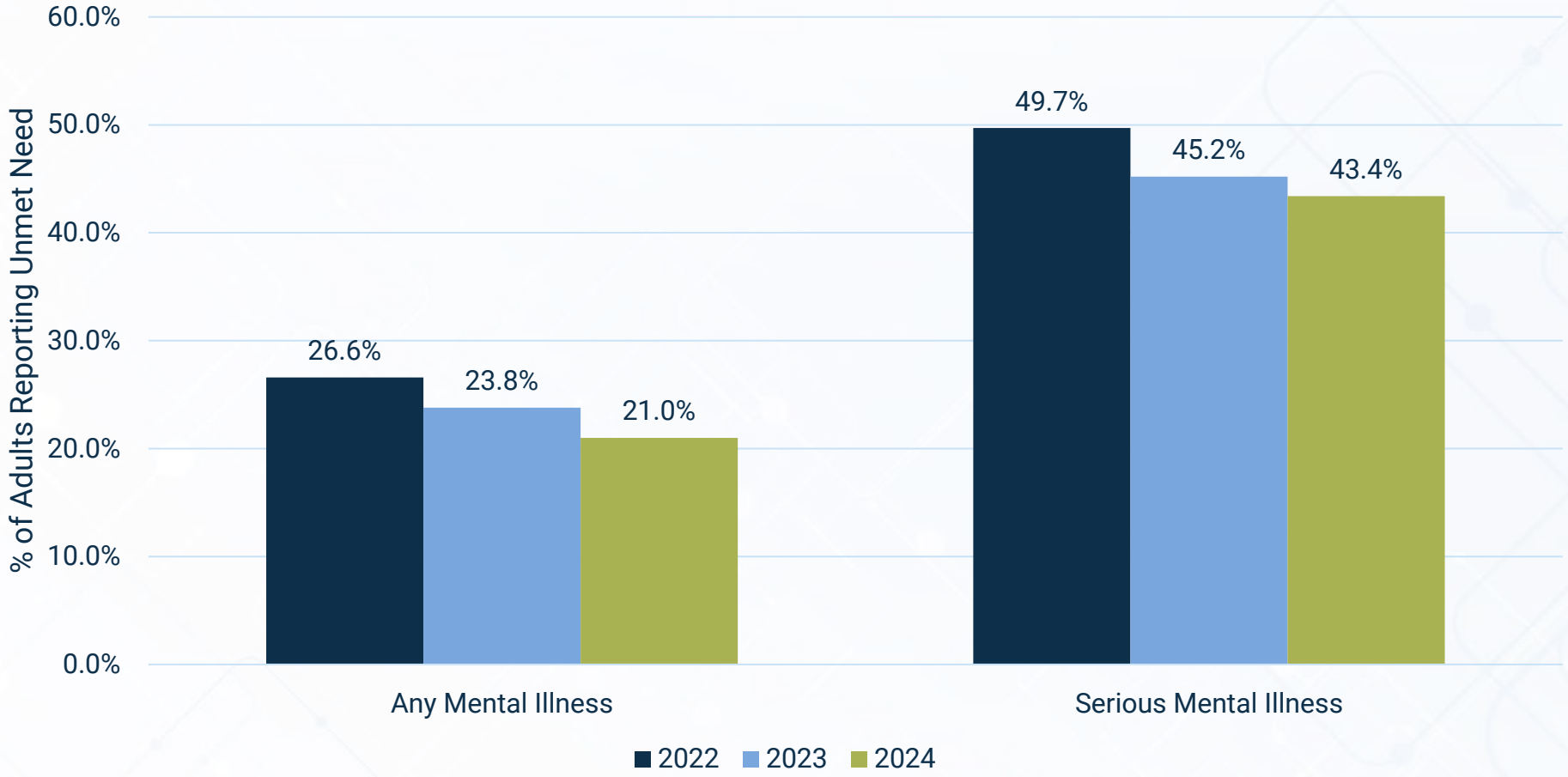
Approximately one in seven adults age 50 and older experience a mental health condition often alongside chronic medical illness.

The most prevalent conditions include depression and anxiety disorders, followed by cognitive disorders such as Alzheimer's disease and related dementias.

Substance use disorders, particularly alcohol use, are also increasing among older adults and contributing to growing clinical complexity.

1.d. Unmet Treatment Needs For Mental Illness[3,6,7]

Measured As U.S. Adults Who Reported Seeking Or Thinking They Needed Treatment But Not Receiving It



Unmet need refers to individuals with a mental health condition who do not receive treatment, often due to barriers such as cost, provider shortages, coverage limitations, or geographic access challenges.

The population has declined, over 20% of adults with a mental health condition, more than 15 million individuals, still do not receive treatment, reflecting persistent access gaps.

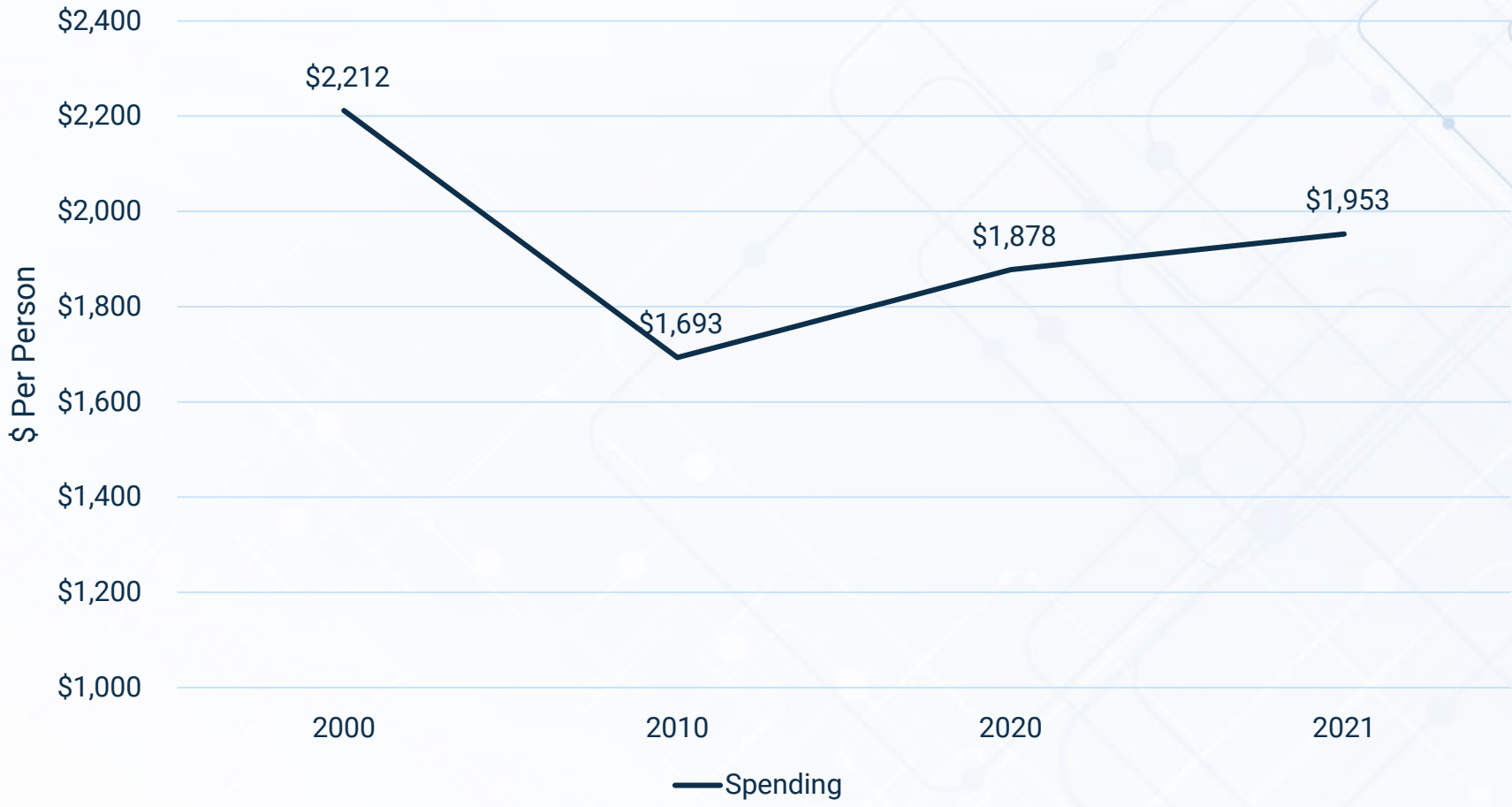
2. The Cost Of Care & The Impact Of Behavioral Health Conditions On Total Cost Of Care

2.a. U.S. Spending On Mental Health & Addiction Treatment, From 2000 To 2021 ($ Per Person Annually, Inflation Adjusted)[12-19]

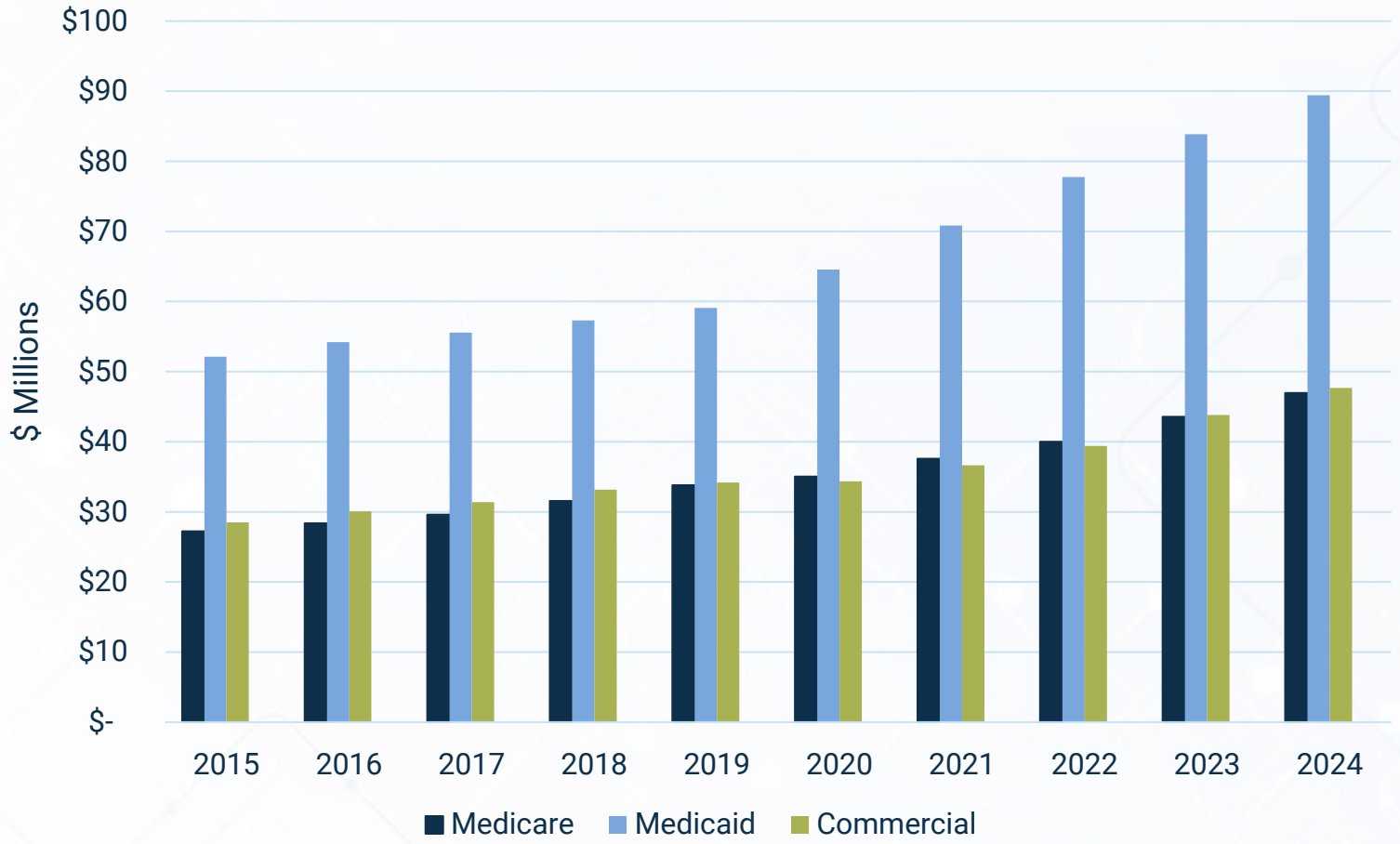
Spending on mental health and substance use disorder treatment decreased per person (inflation adjusted) until the passing of the Affordable Care Act in 2008. Since then it has increased steadily over time, reflecting rising demand and expanded coverage.

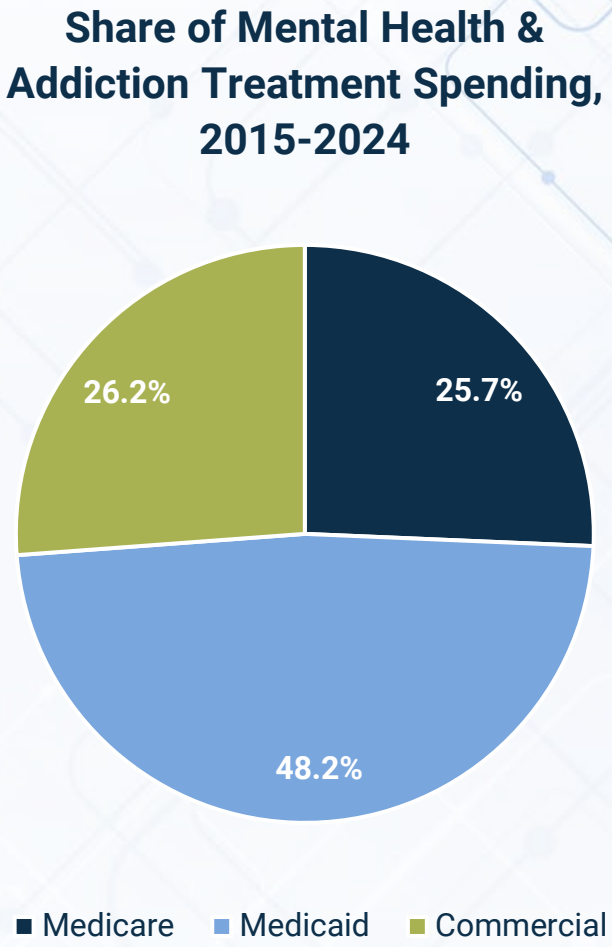
However, behavioral health services account for approximately 5-6% of total health care spending.

The financial impact of behavioral health extends beyond specialty services and is reflected in total cost of care, reinforcing the need for integrated management strategies across medical and behavioral health.

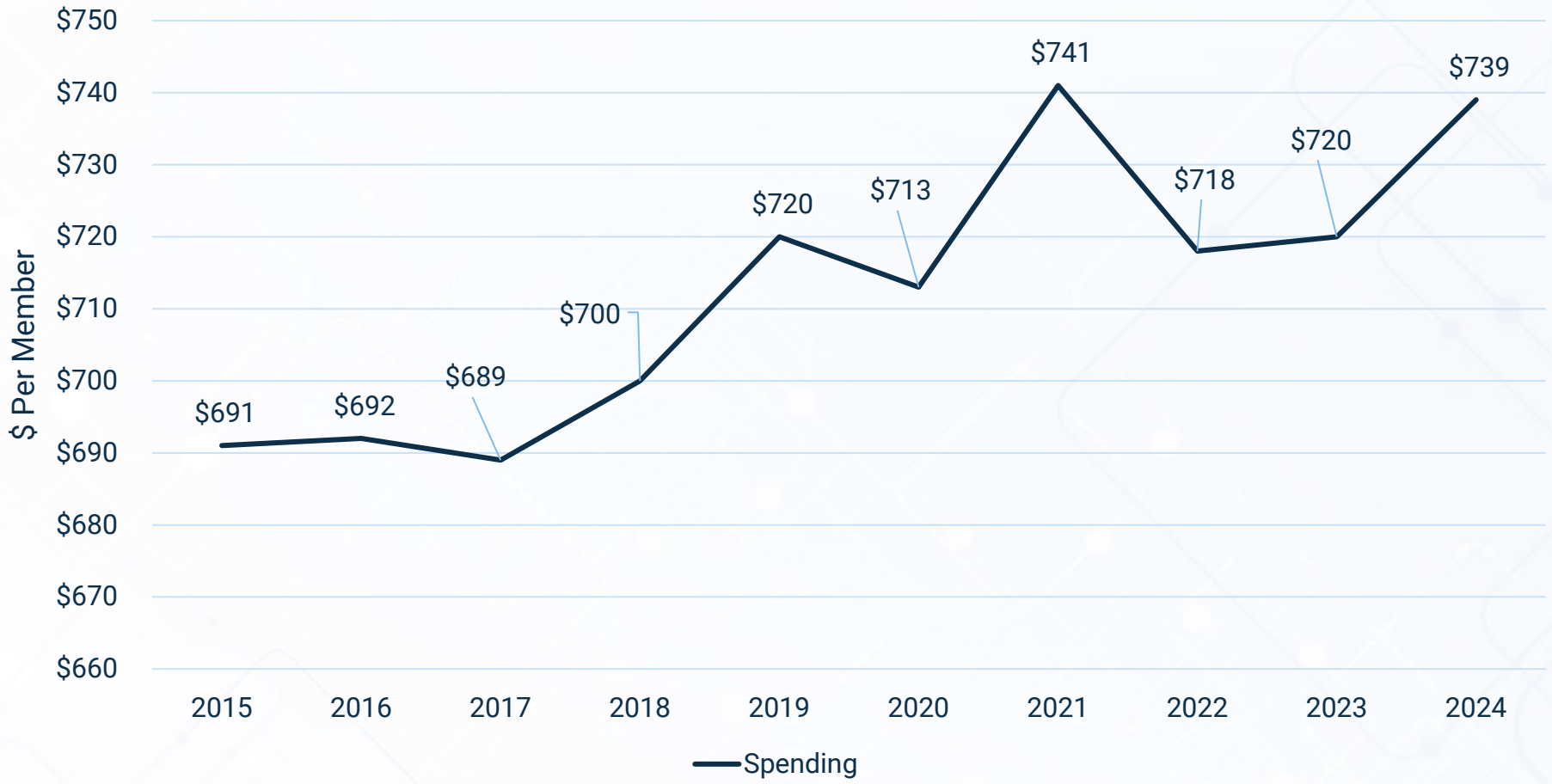


2.b. U.S. Spending On Mental Health & Addiction Treatment, From 2015 To 2024 By Payer[13-19]





2.c. Estimated Medicare Spending On Mental Health & Addiction Treatment, From 2015 To 2024 ($ Per Member Annually, Inflation Adjusted)[13-17]

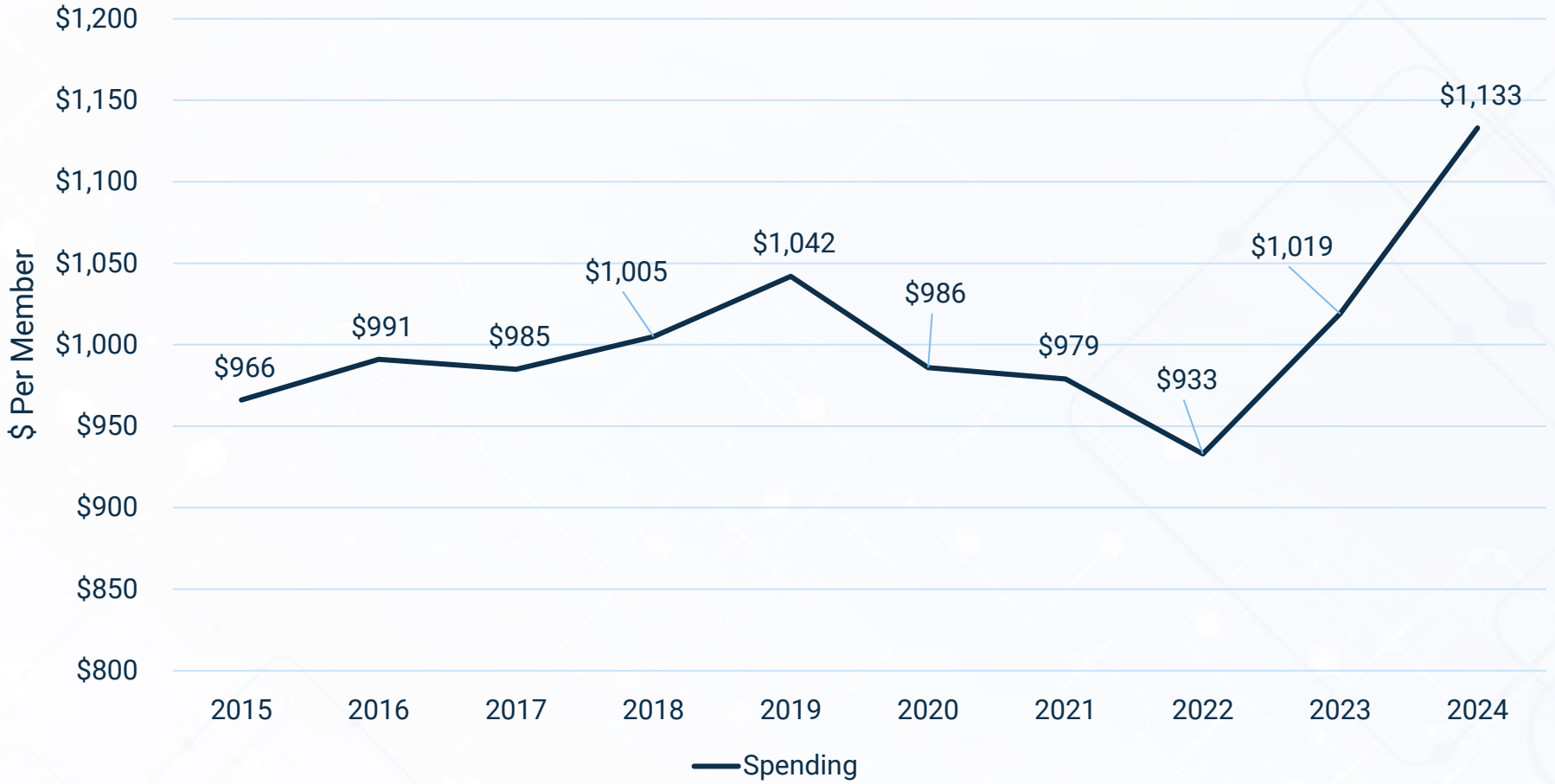


Medicare behavioral health spending reflects sustained growth in utilization as coverage expands across an aging population with increasing clinical complexity.

With Medicare enrollment exceeding 65 million beneficiaries, behavioral health represents a growing component of total cost of care.

For health plans, this increases exposure to utilization-driven cost growth and reinforces the need to manage outcomes, reduce avoidable acute care use, and improve performance in value-based arrangements.

2.d. Estimated Medicaid Spending On Mental Health & Addiction Treatment, From 2015 To 2024 ($ Per Member Annually, Inflation Adjusted)[13-16,18]

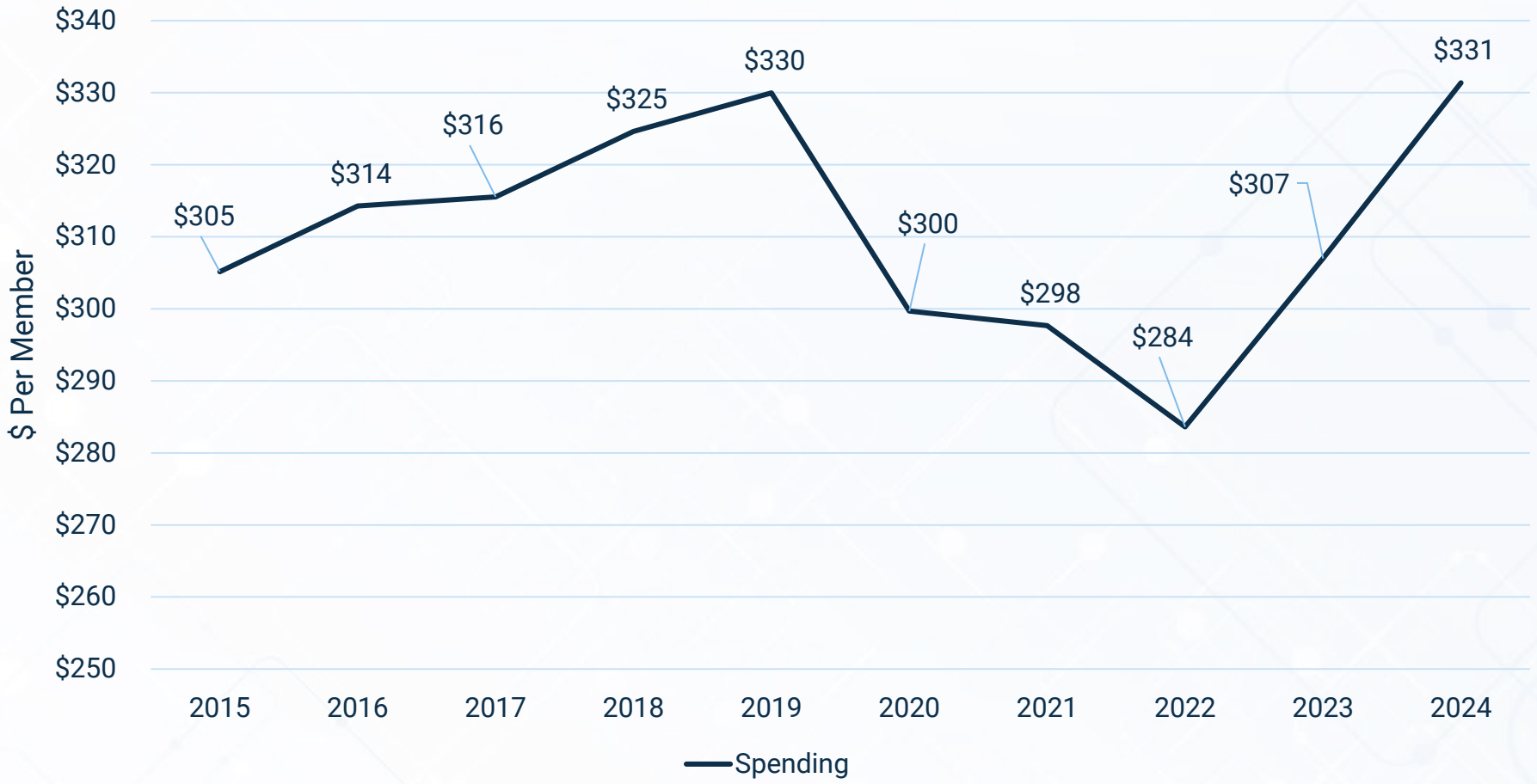


Medicaid behavioral health spending is shaped by the concentration of high-need populations, including individuals with serious mental illness and substance use disorders, whose care requires higher service intensity and coordination.

Variability in enrollment mix and utilization drives fluctuations in per-member spending.

For health plans, this underscores the need for targeted care management, integrated service delivery, and strategies that address both clinical complexity and social drivers of health to manage total cost of care.

2.e. Estimated Commercial Spending On Mental Health & Addiction Treatment, From 2015 To 2024 ($ Per Member Annually, Inflation Adjusted)[13-16,19]

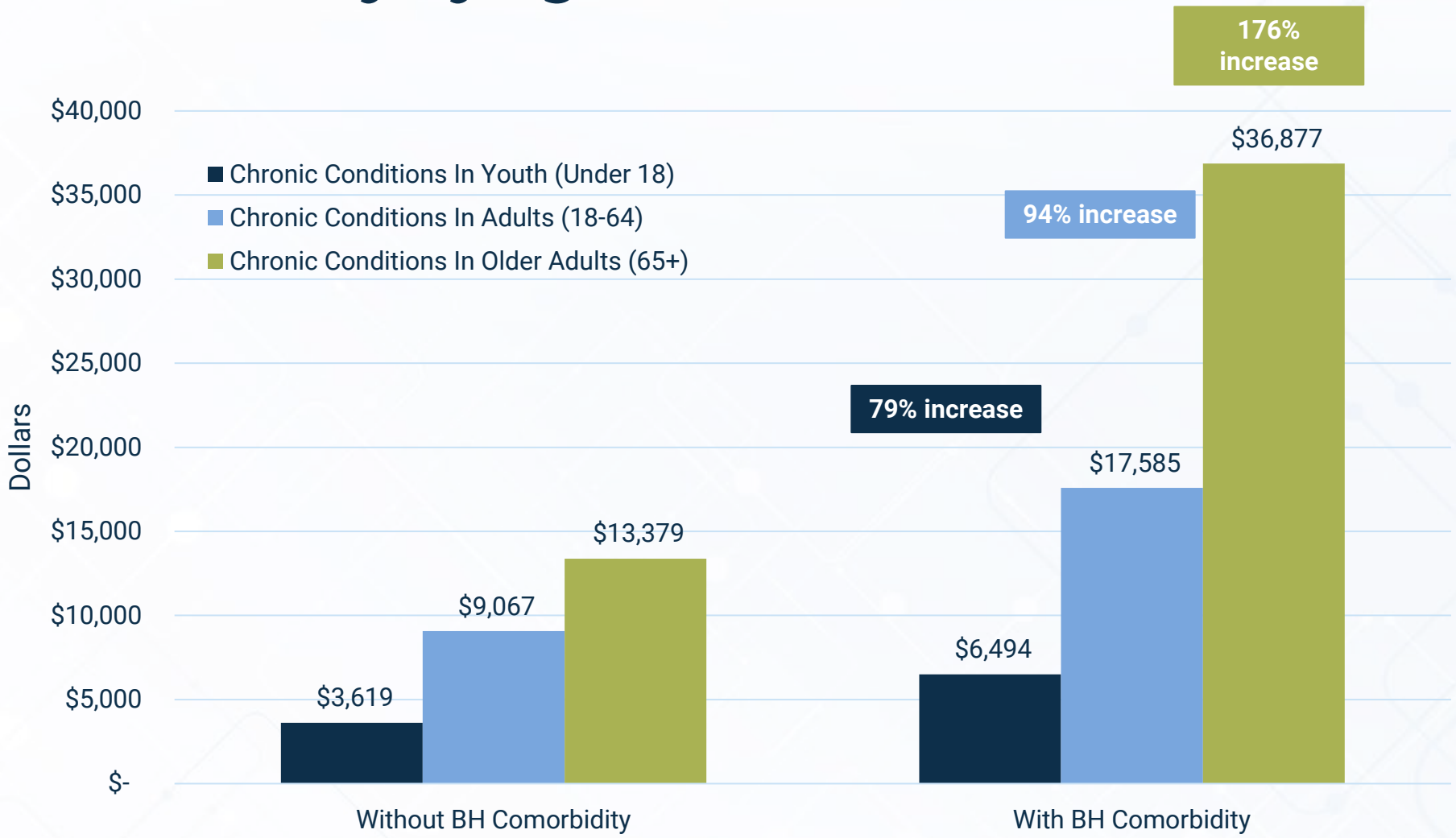


Commercial behavioral health spending is driven by benefit design, network structure, and cost-sharing strategies within employer-sponsored coverage.

With employer-sponsored insurance covering nearly half of the U.S. population, these levers play a central role in shaping access and utilization.

For health plans, benefit design and network strategy are critical tools for managing utilization patterns, improving access, and controlling total cost of care.

2.f. Annual Total Cost Of Care With Behavioral Health Comorbidity By Age[18,20-22]

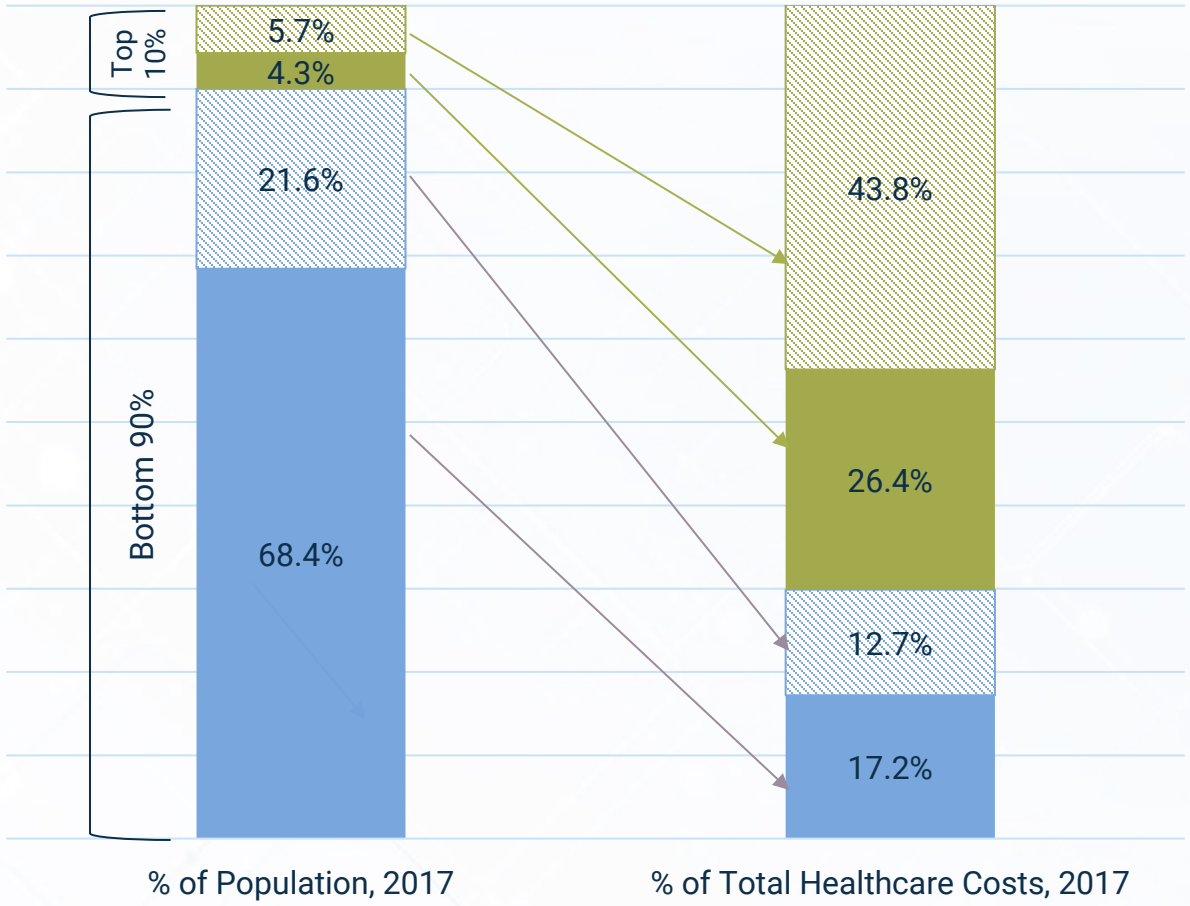


Among Medicare beneficiaries, the presence of a mental health diagnosis is associated with approximately 40–50% higher total annual healthcare spending.

Costs increase further as behavioral health conditions interact with chronic diseases such as cardiovascular disease, diabetes, and cognitive impairment.

These patterns illustrate the need for coordinated, multidisciplinary care models and strong care management infrastructure, as health plans increasingly target these high-cost population through intensive intervention and risk-based contracting strategies.

2.g. Behavioral Health Impact On High-Cost & Non-High-Cost Groups For Health Plans[23]



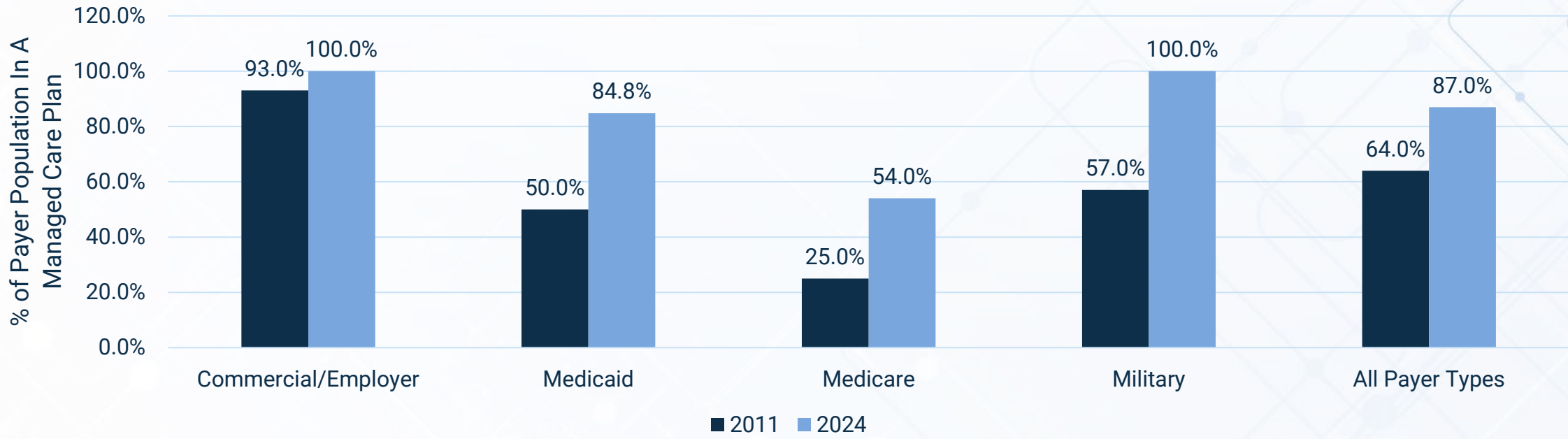
A small subset of members with behavioral health conditions account for a disproportionate share of total health care spending.

Just 5.7% of members—those in the high-cost group with a behavioral health diagnosis—account for 43.8% of total costs.

This concentration of cost among high-acuity individuals with co-occurring behavioral and medical conditions is a key driver of total cost of care, requiring targeted care management strategies, integrated care models, and advanced risk stratification.

3. U.S. Behavioral Health Service System Design & Performance

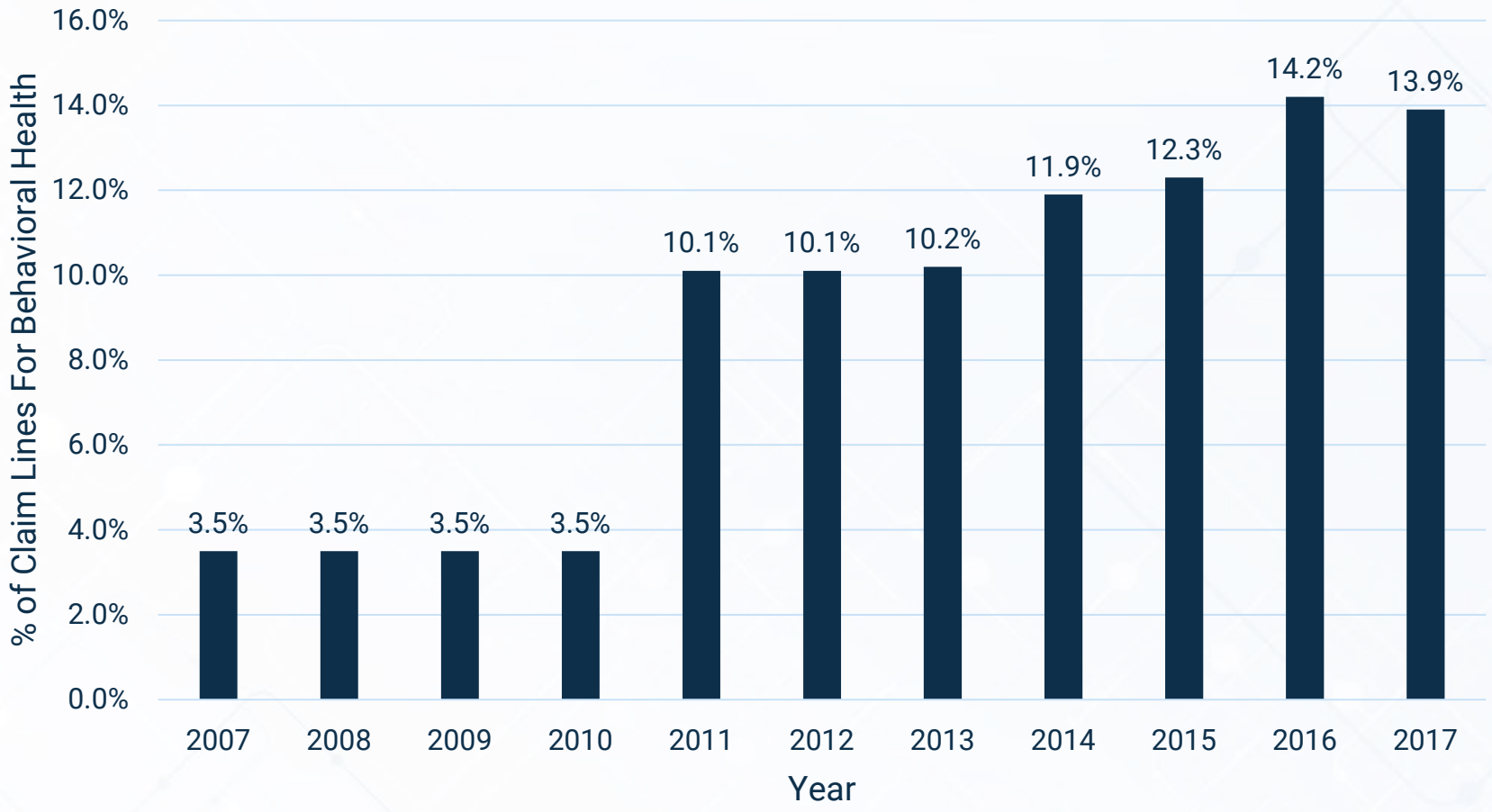
3.a. Insured Population In Managed Care Plans, Percent, By Payer Type[24-28]



Approximately 85% of Medicaid beneficiaries are enrolled in managed care arrangements nationally, including the majority of individuals with SMI. This shift represents a structural transition from fee-for-service financing to risk-based accountability.

As managed care penetration increases, payers assume responsibility for total cost of care, quality outcomes, and network adequacy for high-acuity populations. In this environment, provider organizations must demonstrate measurable outcomes and performance, as contracting increasingly favors those with capabilities to manage complex populations and succeed in value-based arrangements.

3.b. Mental Health Parity Act: Impact On Behavioral Health Services Claims From 2007 To 2017[29]



Parity legislation expanded access to behavioral health services by requiring greater alignment between behavioral and medical coverage.

Utilization increased substantially following implementation, with behavioral health claim lines rising more than 300% from 2007 to 2017, reflecting both improved access and previously unmet need.

This shift increases accountability for access, network adequacy, and benefit design, while driving higher utilization that must be managed through care coordination, quality oversight, and cost management strategies.

3.c. NCQA Requirements For Behavioral Health[30-31]

Requirements		
Initiation and Engagement of Substance Use Disorder Treatment (IET)	Follow-Up After Emergency Department Visit for Mental Illness (FUM)	Follow-Up Care for Children Prescribed ADHD Medication (ADD-E)
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)	Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)	Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-E)
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)	Follow-Up After Hospitalization for Mental Illness (FUH)	Postpartum Depression Screening and Follow-up (PDS-E)
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)	Pharmacotherapy for Opioid Use Disorder (POD)	Prenatal Depression Screening and Follow-up (PND-E)
Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)	Deprescribing of Benzodiazepines in Older Adults (DBO)	Tobacco Use Screening and Cessation Intervention (TSC-E)
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	Use of Opioids at High Dosage (HDO)	Unhealthy Alcohol Use Screening and Follow-Up (ASF-E)
Diagnosed Mental Health Disorders (DMH)	Use of Opioids from Multiple Providers (UOP)	Utilization of PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults (DMS-E)
Diagnosed Substance Use Disorders (DSU)	Depression Remission or Response for Adolescents and Adults (DRR-E)	
Follow-Up After Emergency Department Visit for Substance Use (FUA)	Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)	

National Committee for Quality Assurance (NCQA) accreditation and rating frameworks incorporate Healthcare Effectiveness Data and Information Set (HEDIS®) measures into overall health plan evaluation, spanning multiple behavioral health conditions, care settings, and populations.

From 2023 to 2024, behavioral health ratings slightly increased with 5 out of the 1,019 rated plans achieving the highest rating. (Three commercial plans and two Medicare).

The volume and scope of these measures create significant operational and performance demands, requiring coordinated investment in data infrastructure, care management, provider engagement, and quality improvement initiatives to achieve and maintain high performance.

3.d. HEDIS Behavioral Health Electronic Reporting Requirements[32]

Measures that use HEDIS ECDS Reporting Method	2022	2023	2024	2025	2026
Depression Remission or Response for Adolescents and Adults		X	X	X	X
Depression Screening and Follow-Up for Adolescents and Adults		X	X	X	X
Follow-up Care for Children Prescribed ADHD Medication		X	X	X	X
Metabolic Monitoring For Children and Adolescents on Antipsychotics		X	X	X	X
Postpartum Depression Screening and Follow-Up	X	X	X	X	X
Prenatal Depression Screening and Follow-Up	X	X	X	X	X
Unhealthy Alcohol Use Screening and Follow-Up		X	X	X	X
Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults		X	X	X	X

The HEDIS Electronic Clinical Data Systems (ECDS) Reporting Method is a newer way for health plans to report on quality measures that uses a broader range of data sources over the more cumbersome claim-based reporting of the past. As more behavioral health measures are moved to this kind of reporting, the hope is that quality can be measured more quickly and reliably so strategy can be adjusted almost real-time.

3.e. CMS Regulatory Requirements For Behavioral Health[33]

Federal oversight of behavioral health access and infrastructure has intensified in recent years.

CMS policies establish expectations related to appointment wait time standards, network adequacy transparency, and digital prior authorization processes.

Health plans and provider networks must strengthen operational and data infrastructure to meet evolving compliance requirements.

Requirements That Influence Quality Performance
Behavioral Health Integration within primary care settings supported through reimbursement policies and collaborative care models
Telebehavioral Health Coverage and reimbursement policies expanding access to remote psychiatric and counseling services
Federal support for crisis response systems and community-based behavioral health infrastructure
Alignment of behavioral health services with value-based purchasing and quality performance programs
Expectations for coordination between behavioral health and physical health providers for high-need populations
Standardized reporting of behavioral health quality and utilization measures across CMS programs
Network adequacy and access standards for behavioral health providers within Medicare and Medicaid programs
Data integration and electronic reporting requirements supporting quality measurement and care coordination

3.f. Medicare Behavioral Health Coverage: Covered Benefits[34]

Benefit Area	What Is Covered	Key Implications For Access & Payment
Outpatient & Integration Services	Psychotherapy, screening, substance use treatment, partial hospitalization, and Behavioral Health Integration (BHI) services, including Collaborative Care Model (CoCM)	CMS reimbursement for BHI and CoCM services supports integration into primary care, with payment tied to care management activities and documentation requirements.
Inpatient Services	Psychiatric hospitalization, including room, nursing, medications, and hospital-based treatment services	Coverage supports treatment of acute behavioral health needs within Medicare.
Prescription Drug Coverage (Part D)	Coverage for antidepressants, antipsychotics, anticonvulsants, and medications for opioid use disorder, with limited formulary exclusions	Medicare Part D plans are required to cover these medication classes, influencing access to pharmacologic treatment.
Cost-Sharing & Medicare Advantage Variation	Cost-sharing varies across Medicare Advantage plans and traditional Medicare, including copays and coinsurance.	Variation in cost-sharing and plan design affects access to behavioral health services and utilization across Medicare populations.

Medicare covers a range of behavioral health services, including outpatient psychotherapy, inpatient psychiatric care, and behavioral health integration services. Behavioral Health Integration (BHI) codes support collaborative care models within primary care settings. Variations in cost-sharing and provider participation across Medicare Advantage plans continue to influence access and utilization. To fully leverage these benefits, providers must align care delivery models with documentation, billing, and integration capabilities to support participation in these services.

3.g. State Medicaid Plans With Value-Based Purchasing Mandates That Include Behavioral Health[35]

States vary in how they implement value-based purchasing (VBP) requirements within Medicaid managed care.

Explicit mandates require managed care organizations to implement value-based payment arrangements or meet defined performance thresholds.

Included mandates incorporate value-based reimbursement expectations within contracts or guidance, while **partial mandates** apply requirements to specific populations, service lines, or pilot programs rather than statewide implementation.

	Number	States
Explicit Mandate	8	Arizona, California, Colorado, Massachusetts, North Carolina, New York, Oregon, Tennessee
Included Mandate	7	Maryland, Michigan, Minnesota, Pennsylvania, Rhode Island, Vermont, Washington
Partial Mandate	6	Florida, Georgia, Illinois, New Jersey, Ohio, Texas
No Mandate	29	Alaska, Alabama, Arkansas, Connecticut, Delaware, Hawaii, Idaho, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Mississippi, Missouri, Montana, North Dakota, Nebraska, New Hampshire, New Mexico, Nevada, Oklahoma, South Carolina, South Dakota, Utah, Virginia, Wisconsin, West Virginia, Wyoming

3.h. State Medicaid Plans With Value-Based Purchasing Mandates That Include Behavioral Health – Included & Partial Behavioral Health Mandates[35]

State	VBP Requirement	Behavioral Health Inclusion
Florida	Partial	Managed care incentives + BH integration pilots
Georgia	Partial	APM requirements in MCO contracts (growing BH inclusion)
Illinois	Partial	BH transformation + VBP pilots
Maryland	Total Cost of Care / AHEAD model	Includes population health + BH integration
Michigan	Specialty PIHP system + VBP pilots	BH orgs moving toward risk-based payment
Minnesota	Integrated Health Partnerships (IHPs)	Includes BH in shared savings
New Jersey	Partial	VBP roadmap with BH integration focus
Ohio	Partial	BH redesign + VBP expansion
Pennsylvania	Behavioral HealthChoices + VBP pilots	Increasing BH VBP contracting
Rhode Island	Affordability standards + APM targets	Includes BH investment + integration
Texas	Partial	DSRIP transition - directed payments with BH elements
Vermont	All-Payer ACO model	Includes BH via global budgets
Washington	Fully integrated managed care	BH included in capitation + crisis system focus

3.i. State Medicaid Plans With Value-Based Purchasing Mandates That Include Behavioral Health – Explicit Behavioral Health Mandates[35]

States are increasingly incorporating value-based purchasing (VBP) requirements into Medicaid managed care contracts.

However, the inclusion of behavioral health in alternative payment models remains uneven across states.

In markets with established integration infrastructure and data capacity, value-based approaches are more likely to drive measurable improvements in outcomes and cost management.

State	VBP Requirement	Behavioral Health Inclusion
Arizona	RBHA system (capitated regional plans)	Behavioral health fully integrated + risk-based
California	CalAIM + Enhanced Care Management	Strong VBP push + BH integration
Colorado	Accountable Care Collaborative (ACC) Phase III	BH integrated into regional accountability
Massachusetts	ACO + primary care sub-capitation	Explicit BH integration + MBHO alignment
New York	≥80–90% of MCO payments in VBP	Includes BH, SUD, and integrated bundles
North Carolina	Tailored Plans + PHPs	Mandated BH + physical health integration
Oregon	CCO global budgets	BH fully carved into capitation
Tennessee	Episodes of care + shared savings	Includes BH episodes + integration

3.j. Status Of Certified Community Behavioral Health Clinics By State[36]

As of 2026, more than 500 Certified Community Behavioral Health Clinics (CCBHCs) are operating across the country, delivering a defined set of behavioral health services, including 24/7 crisis care and care coordination.

CCBHCs are supported by prospective payment models that provide more predictable funding and enable expansion of outpatient and crisis stabilization services. Early results from participating states show increased access to care and expanded crisis response capacity.

The continued expansion of CCBHCs is reshaping outpatient behavioral health delivery, increasing expectations for access and service scope, and creating new competitive and operational pressures for provider organizations.

Planning Stage	Number	States
Implemented – Grants Only	21	Alabama, Illinois, Indiana, Iowa, Kansas, Kentucky, Maine, Michigan, Minnesota, Missouri, Nevada, New Hampshire, New Jersey, New Mexico, New York, Oklahoma, Oregon, Pennsylvania, Rhode Island, Texas, Vermont
Implemented - Independent	8	Florida, Georgia, Idaho, Mississippi, Nebraska, North Dakota, Washington, West Virginia
Implemented – Medicaid	19	Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Hawaii, Louisiana, Maryland, Massachusetts, Montana, North Carolina, Ohio, Tennessee, Utah, Virginia, Wisconsin, Wyoming
No CCBHCs	2	South Dakota, South Carolina

3.k. Medicaid Reimbursement For Peer Support Services Across States[37]

All 40 states in this analysis reimburse Medicaid for mental health peer support services.

However, differences in credentialing, supervision, and payment structures affect implementation, scalability, and consistency.

As workforce shortages persist, peer support is increasingly used to extend care for serious mental illness and substance use disorders, expanding access while raising considerations around quality oversight and integration into care teams.

State	Copayment?	Limits On Services?
Alabama	Yes - not specified	No
Alaska	No	100-hour limit for any combination of individual services; 180-hour limit for group services
Arizona	Not reported	No
California	No	No
Colorado	No	No
District of Columbia	No	Yes - not specified
Florida	No	Limit of 1 unit per day for 365/366 days per state fiscal year
Hawaii	No	No
Idaho	No	No
Indiana	No	Not reported
Iowa	No	No
Kansas	No	No
Kentucky	No	Not reported
Louisiana	No	Not reported
Maryland	No	Yes - not specified
Massachusetts	No	No
Michigan	No	No

3.l. State Medicaid Plans Requiring Peer Service Reimbursement (Continued)[37]

State	Copayment?	Limits On Services?
Mississippi	No	For community mental health centers only, limit of 6 per day; 15 minutes unit; 200 per state fiscal year
Missouri	No	No
Montana	No	Yes - not specified
Nebraska	No	No
Nevada	No	Prior authorization is required; limits vary by level of care
New Jersey	No	No
New Mexico	No	No
New York	No	No
North Carolina	No	Limit of 24 unmanaged visits once per episode of care per state fiscal year; prior authorization is required for up to 270 units of service per 90 days - additional units may be authorized if clinically appropriate
North Dakota	No	Only covered for individuals eligible for 1915(i)
Ohio	No	Covered for individuals enrolled in 1915(i) Specialized Recovery Services Program, and for Substance Use Disorder
Oklahoma	$3	No
Oregon	No	Limit of 96 units, with a 15 minute unit max
Pennsylvania	$.65 per unit of service	No
Rhode Island	No	No
South Carolina	No	Limit of 16 15-minute units per day; only provided by SC Department of Mental Health and Department of Alcohol and Other Drug Abuse Services
Tennessee	No	No
Texas	No	Limit of 104 units in a rolling 6 month period; the limit may be exceeded with documentation of medical necessity for the additional services
Virginia	No	Registration is required
Washington	No	No
West Virginia	No	Based on medical necessity
Wisconsin	No	Limited to programs that include peer supports in the State Plan (psychosocial rehab, residential SUD treatment, SUD health home)
Wyoming	No	No

4. Workforce Challenges: Closing The Behavioral Health Capacity Gap

4.a. Number Of Psychiatrists & Mental Health Specialist Prescribers, Total & Per 100,000 Population, 2026[15,38]

Occupation	Number of Providers	Number of Providers Per 100,000
Psychiatric Nurse Practitioners	25,520	7.5
Child & Adolescent Psychiatry	10,920	3.2
Psychiatric Physician Assistants	3,830	1.1

The behavioral health prescriber workforce remains limited relative to population need, with particularly low supply in specialized areas such as child and adolescent psychiatry. While psychiatric nurse practitioners represent the largest share of prescribers, overall capacity remains constrained across disciplines.

This imbalance contributes to access challenges, extended wait times, and uneven geographic distribution, reinforcing the need for multidisciplinary care models, expanded scope of practice, and strategies that optimize the effective use of available prescriber capacity.

4.b. Number Of Behavioral Health Therapists, Total & Per 100,000 Population, 2026[15,38]

Occupation	Number of Providers	Number of Providers Per 100,000
School Counselors	139,080	40.9
Mental Health Counselors	135,960	40.0
Child, Family, and School Social Workers	132,060	38.8
Psychologists	115,580	34.0
Mental Health and Substance Abuse Social Workers	77,060	22.7
Healthcare Social Workers	74,710	22.0
Addiction Counselors (MA)	58,340	17.2
Marriage & Family Therapists	52,000	15.3

Workforce projections indicate a widening structural gap between behavioral health provider capacity, as workforce growth continues to lag rising need and service utilization.

This constraint limits access across outpatient, crisis, and specialty care settings particularly in Medicaid and rural markets, and creates operational and financial exposure for health plans, including network adequacy risk, increased emergency utilization, and higher total cost of care.

4.c. Practices & Technologies As Workforce Extenders

Persistent workforce shortages have shifted behavioral health strategy from workforce expansion to productivity enhancement, as demand continues to outpace provider supply. Technology is now a structural component of access strategy rather than a temporary solution.

Technology-enabled workforce extension operates through both expanding access and increasing clinician productivity. Increasingly, these tools are tied to measurable clinical outcomes, quality performance, and value-based reimbursement, making their impact central to health plan performance and cost management. These initiatives include:

Peer Support: Extends workforce capacity by leveraging lived experience to improve engagement, retention, and care coordination for high-need populations.

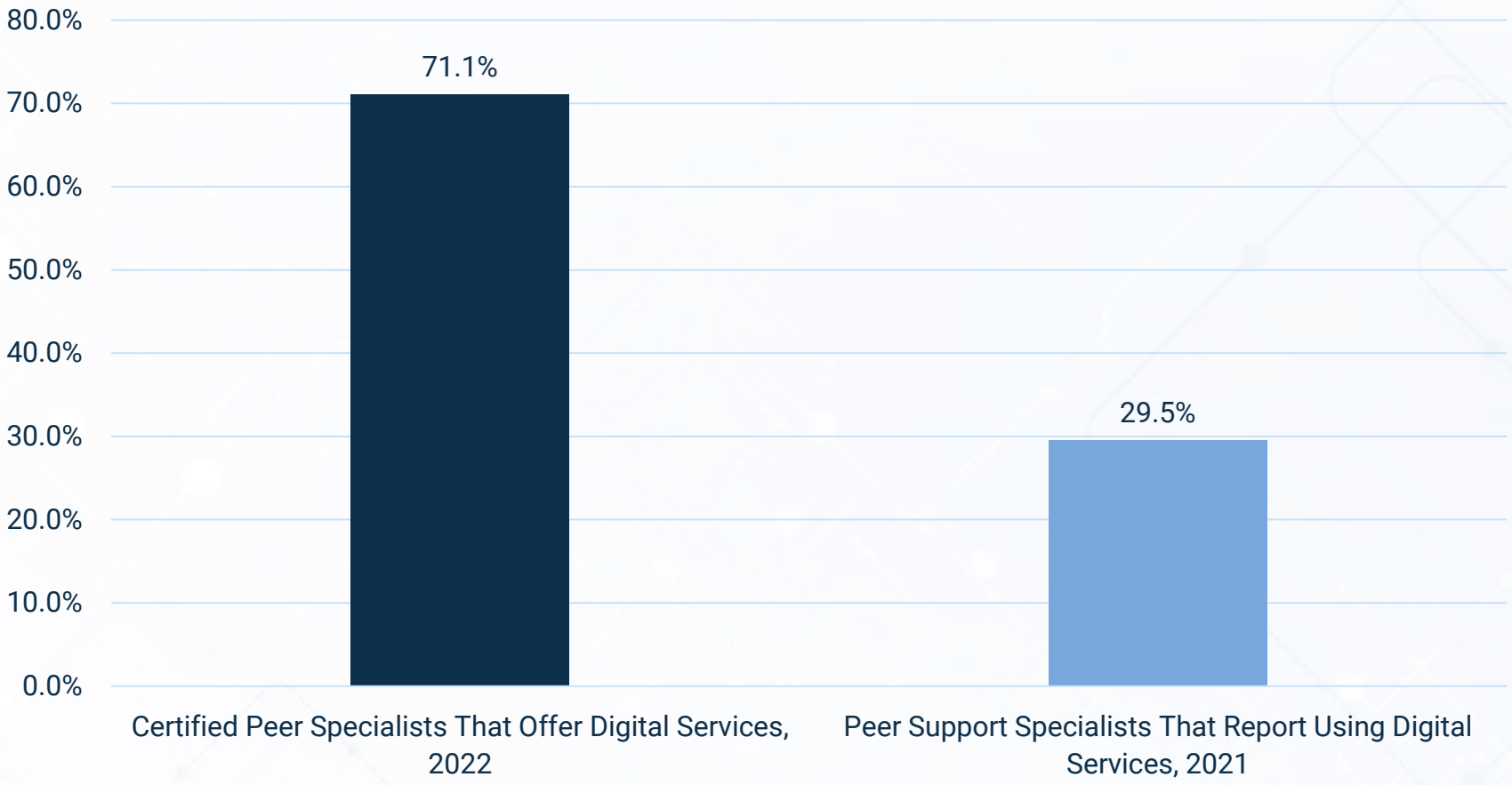
Telebehavioral Health: Expands access by increasing geographic reach and reducing barriers to care while maintaining comparable clinical outcomes.

AI-Enabled Documentation Support: Improves clinician productivity by reducing administrative burden and enhancing documentation accuracy for quality reporting and risk adjustment.

Remote Monitoring: Enables earlier intervention through ongoing symptom tracking, supporting proactive management of behavioral health conditions.

Digital Therapeutics: Delivers evidence-based interventions that augment clinical care and improve outcomes, particularly for substance use and lower-acuity population

4.d. Peer Support[39,40]

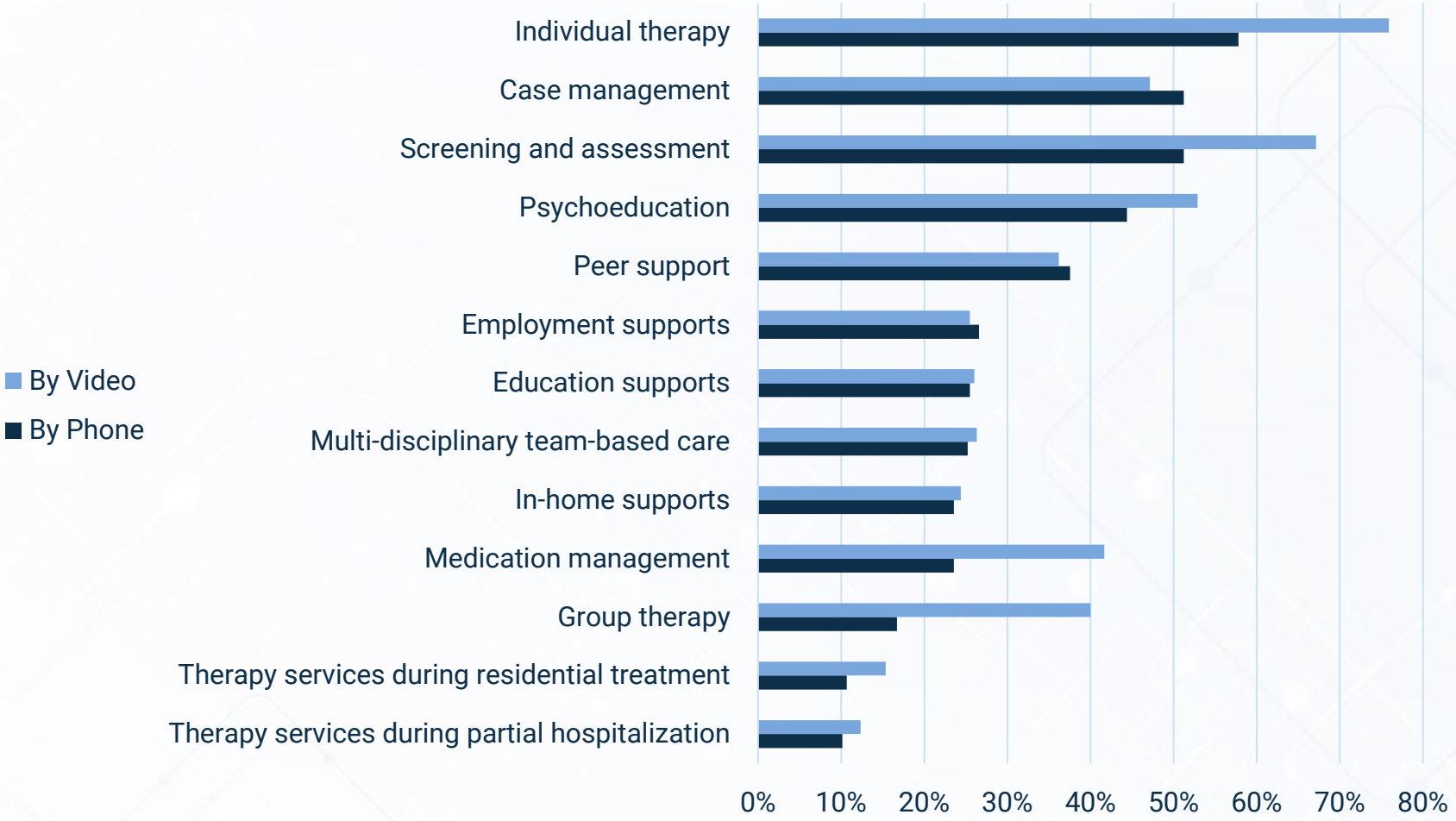


Peer support services are widely reimbursed across Medicaid and represent a key workforce strategy for individuals with serious mental illness and substance use disorders.

Adoption of digital tools among peer specialists is increasing, expanding their ability to support care delivery across settings.

By improving engagement, retention, and patient experience, peer services extend workforce capacity and support access expansion, though variation in credentialing, supervision, and reimbursement continues to affect scalability across markets.

4.e. Telehealth Availability By Type Of Service, 2024[41,42]

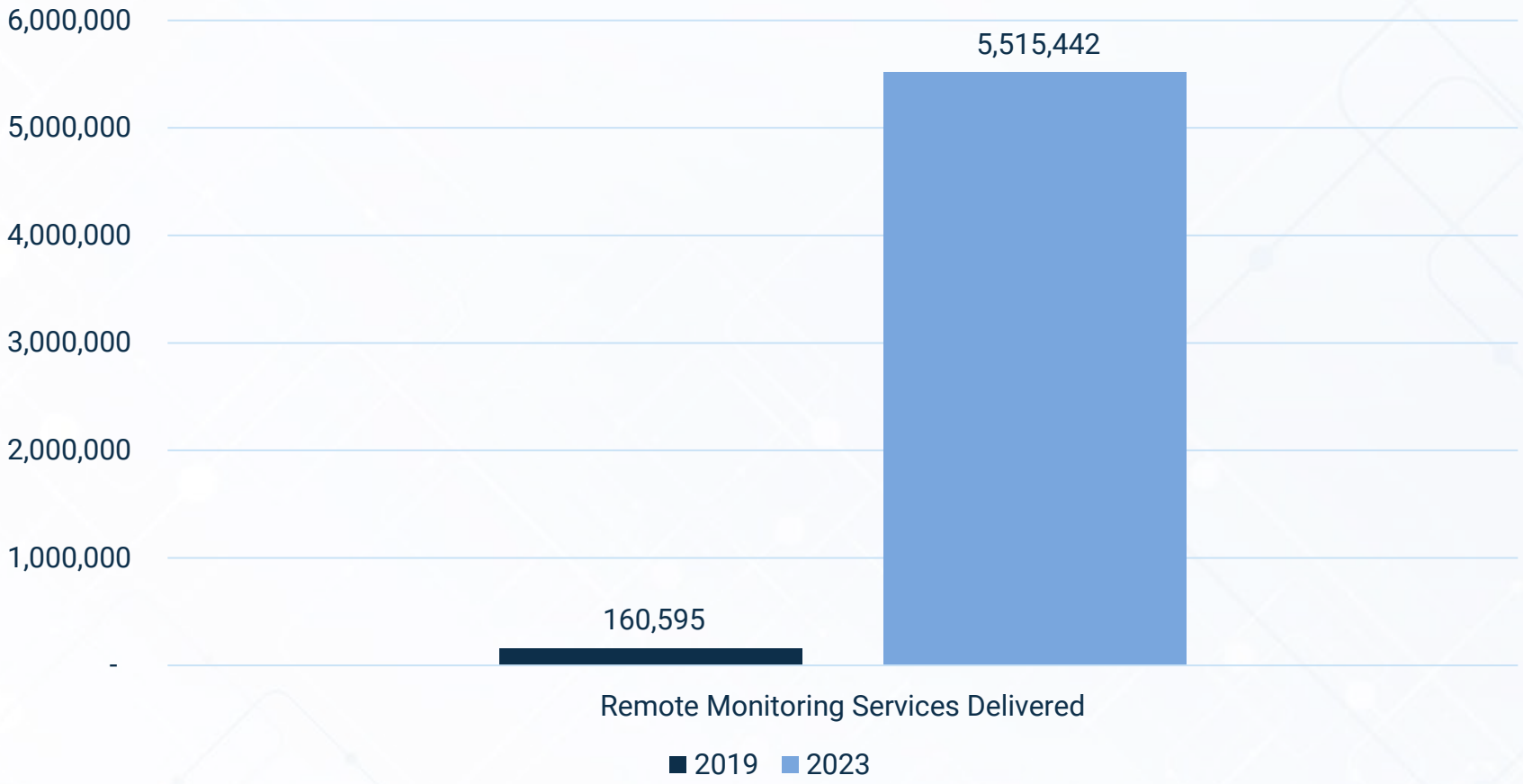


Telebehavioral health has expanded access to care by reducing geographic and logistical barriers, with behavioral health consistently representing one of the highest-utilizing telehealth service lines. Adoption varies by service type, with greater use in outpatient care settings.

In 2024, Telehealth accounted for 44% of behavioral health visits among the Medicare population.

Evidence shows telebehavioral health is associated with improved access and visit adherence, supporting its continued role in care delivery.

4.f. Remote Monitoring[43]

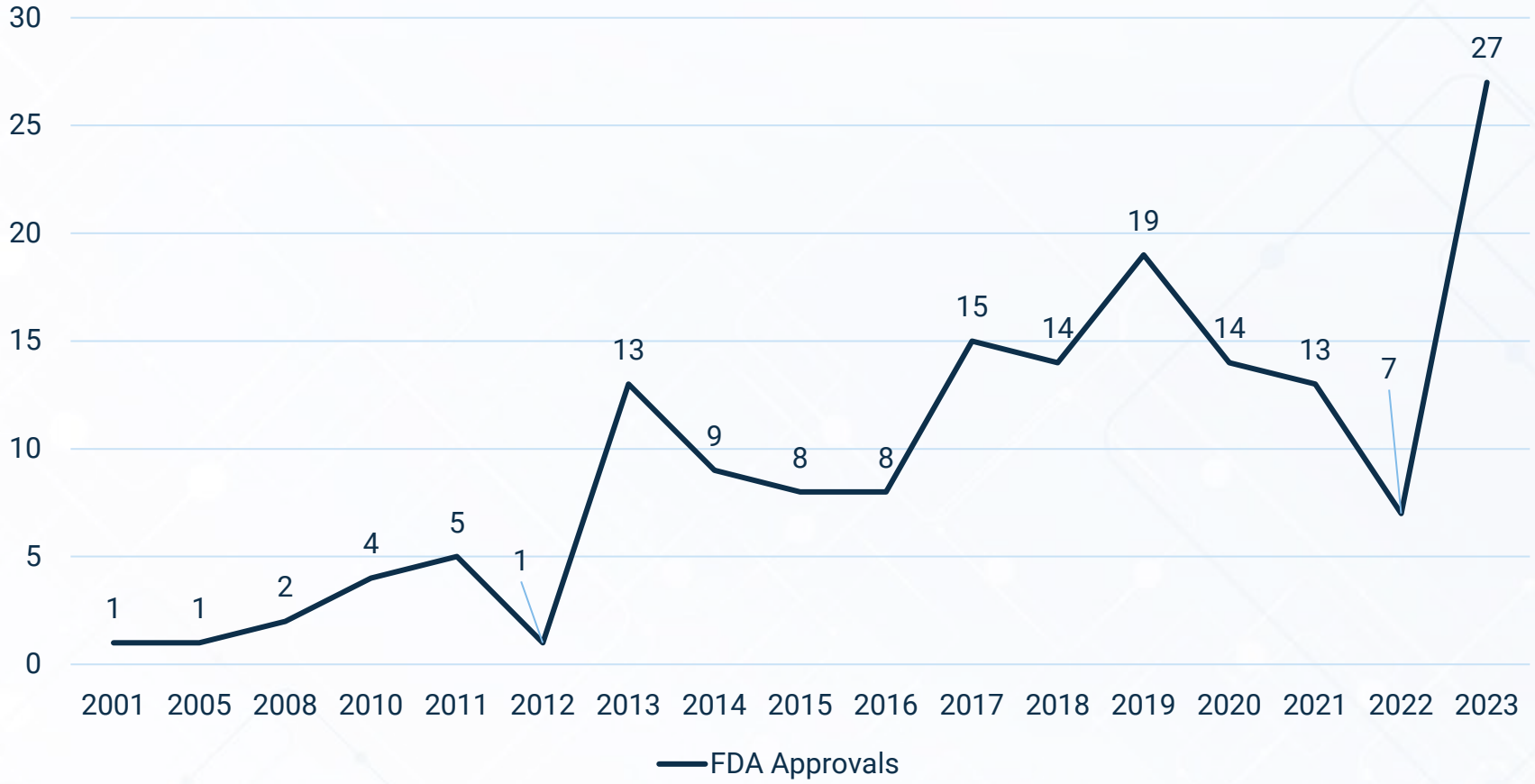


Use of remote monitoring services has increased substantially in recent years, reflecting growing adoption of technology-enabled approaches to behavioral health care delivery.

Remote monitoring supports continuous tracking of patient status between visits, improving engagement and enabling earlier identification of changes in condition, with evidence linking these tools to improved adherence and patient experience.

This approach extends care beyond traditional visit-based models and supports more proactive, continuous management of behavioral health conditions.

4.g. Digital Therapeutics[44,45]

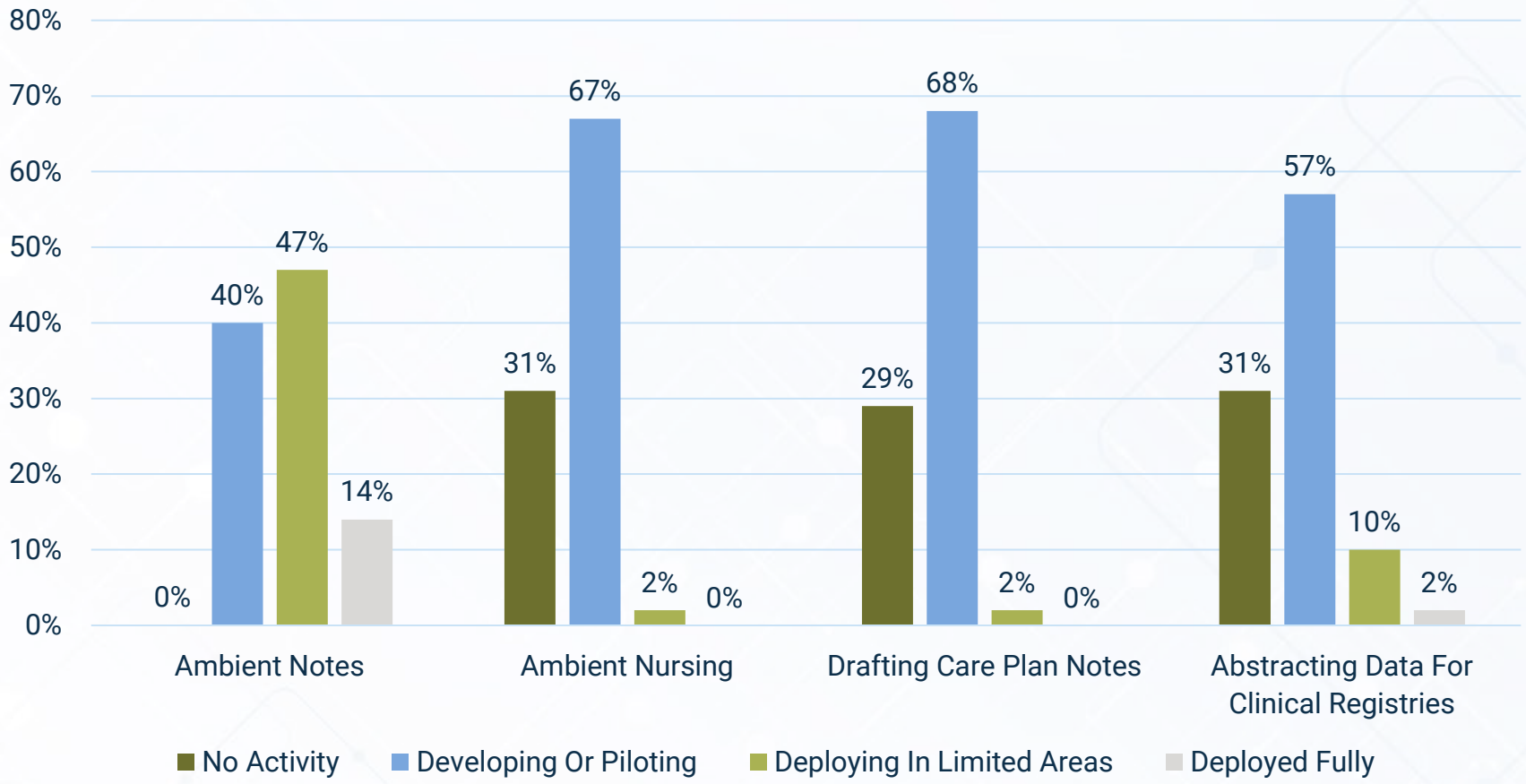


Digital therapeutics represent a rapidly expanding segment of behavioral health care, with the market projected to grow to more than $70 billion by 2034, reflecting increasing adoption of software-based, evidence-based interventions.

These solutions deliver structured therapeutic interventions outside of traditional clinical settings, supporting treatment, symptom management, and ongoing patient engagement.

As adoption increases, digital therapeutics are becoming an important component of care delivery models, extending access and complementing clinician-led services.

4.h. AI-Enabled Documentation Support, 2025[46,47]



AI-enabled documentation tools are being rapidly adopted across health systems, with all surveyed organizations reporting implementation activity in ambient note generation and more than half indicating a high degree of success in use.

These tools automate documentation workflows and reduce administrative burden, with a study showing clinicians can reduce burnout by 13.1% through use of ambient AI technologies.

By improving efficiency and reducing time spent on documentation, AI-enabled solutions increase available clinical capacity and enable greater focus on direct patient care.

*Numbers may not add to 100% due to rounding.

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