Network Adequacy
A Survey of Rhode Island’s Behavioral Health Provider Network

Mental Health Association of Rhode Island
MENTAL HEALTH PARITY INITIATIVE
A PROJECT OF THE MENTAL HEALTH ASSOCIATION OF RI
The **Rhode Island Parity Initiative** is a public awareness and education effort to help empower people to understand and assert their right to health insurance coverage for mental health and substance use disorder treatment and services. The initiative is a project of the Mental Health Association of Rhode Island.

The **Mental Health Association of Rhode Island (MHARI)** operates with the mission of promoting and nourishing mental health through advocacy, education, and policy development. Its guiding values are compassion and altruism, collaboration and cooperation, equality and justice, and innovation. MHARI is an affiliate of Mental Health America.

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I. Introduction

The United States is battling a mental health crisis. The prevalence of mental illness, including substance use disorders is greater in the U.S. than it is among other high-income nations and mental health-related outcomes compare unfavorably as well. The United States has had the highest suicide rate among high-income countries for each of the past 11 years, and the rate is only increasing. This trend is driven by a system with limited capacity to respond to crises, in addition to social and cultural issues that contribute to the reluctance of many Americans to seek assistance. Compounding the fact that nearly one in six American adults cannot afford professional care when in emotional distress, the United States mental health workforce is sorely lacking in numbers, particularly when it comes to psychologists and psychiatrists. The Kaiser Family Foundation reports that only about 25% of mental health provider needs are met. This nationwide shortage manifests in prolonged wait times or lengthy travel to receive treatment. The inability of the United States to consistently and seamlessly integrate mental health care into primary care has culminated in consequences that too often fall to patients — particularly those in vulnerable communities.

Aside from the gap between mental health care supply and demand, American adults must navigate barriers to care ranging from pervasive cultural stigmatization of mental health struggles, to insufficient or opaque insurance coverage, to a workforce whose experience and training do not align with the demographic, cultural or linguistic needs of particular communities. In Rhode Island, for example, there exists a tremendous dearth of childhood and adolescent care. According to the Rhode Island Kids Count Factbook, 36% of children aged three to 17 who needed behavioral health counseling were unable to obtain care, with wait times for youth psychiatric inpatient admission more than doubling between 2018 and 2019. Numerous surveys have demonstrated that the principal factors limiting the number of Americans who successfully seek and access behavioral health care are practical ones: high costs and lackluster insurance coverage. The Cohen Veterans Network, a not-for-profit philanthropic organization, reported in a 2018 survey that 42% of respondents cited poor insurance coverage as the reason they did not seek care and 25% went as far as to say that seeking mental health treatment would preclude them from affording everyday necessities. Of those who sought treatment, 64% expressed a belief that the government could be doing more to provide equitable access to mental health care services. Rhode Island is certainly no exception to this troubling nationwide trend; SAMHSA has reported that only 47.5% of adults with a mental illness in Rhode Island receive any treatment, a disappointing statistic that no doubt informs the state’s ranking of 36 out of 50 states by Mental Health America.
America for providing access to mental health services.\(^1\)\(^2\)

The National Council on Behavioral Health (NCBH) (now called National Council on Mental Wellbeing) has also identified social and cultural issues as primary contributors to the reluctance of Americans to seek assistance. Chief among these is a concern over judgment, as nearly one-third of Americans have reported an unwillingness to contact a mental health provider for fear that someone they know would judge them. Men and women of color are not only less likely to engage with mental health services but also experience less favorable outcomes\(^3\), a long-documented but under-acknowledged inequity that begs the question of what can be done to remedy this disparity. Numerous clinical studies have submitted that, across medical subfields including behavioral health, an increase in workforce diversity would contribute to more culturally competent care.\(^4\) Diversity is certainly an area in which the mental health workforce nationwide stands to improve: over 84% of health service psychologists were white in 2018, compared to only 14% racial/ethnic minorities.\(^5\) This enormous gap is consistent with the language barriers faced by many seeking treatment — a troubling predicament in behavioral health especially, as an interpreter is an imperfect solution due to the nuanced and interpersonal nature of the discipline. MHARI has already conducted extensive focus group-based research to underscore the vital importance of racial, ethnic, and lingual diversity in the mental health care system.\(^6\)

These multifaceted barriers to care and their complex intersection with workplace diversity and cultural competency provide the impetus for the survey detailed in this report. Through systematic outreach to thousands of licensed behavioral health care providers in Rhode Island, we solicited detailed and specific input in an effort to discern where the state stands in regard to many of the metrics mentioned above. This report is intended to inform the general public and policymakers alike, but we hope that our findings and recommendations may provide a robust and actionable basis for substantive change to the mental health care system in Rhode Island.

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II. Methodology

Sample Characteristics
The survey was crafted to be administered to behavioral health providers licensed to provide services in the state of Rhode Island. The Rhode Island Department of Health (RIDOH) is responsible for the licensing of all medical professionals. Each licensee type has a discrete application requiring varying credentials and information; full applications for over 70 licensee types can be found at www.health.ri.gov/licenses.

Active licensee lists were drawn from publicly available records on the RIDOH website.¹ According to the website, the licensee repository is updated weekly and includes the following information:²

- Name (last, first, middle, or facility name)
- Owner/Manager Name
- Identification Number
- Profession
- Specific Type
- Status
- Specialty (where applicable)
- Issuance Date
- Expiration Date
- Business Address (City, State, ZIP)
- Email
- Business Phone
- Fax Numbers

The following license categories were included in the survey cohort:

- Psychologist
- Clinical Social Worker
- Mental Health Counselor
- Allopathic Physicians (MD)
- Osteopathic Physician (DO)
- Applied Behavior Analyst
- Advanced Practice Registered Nurse (APRN)
- Marriage and Family Therapist

In total, our master list at the initiation of the survey consisted of 5,503 providers. We received 749 responses (13.6% of all behavioral health professionals licensed to provide services in Rhode Island).

² Note that for many entries, one or more of these fields were left blank. See Limitations section for further discussion.
Survey Content
For the full survey, please see Appendix A.

The survey consisted of 18 questions and was broadly intended to yield a sense of the demographic characteristics of Rhode Island’s behavioral health provider pool, the accessibility of (and barriers to) behavioral health care in Rhode Island, and participation in insurance networks among the provider pool. After providing basic demographic information and professional background, respondents were asked whether they provided outpatient services. Depending on this answer, respondents were directed to questions either about the accessibility of their services (if they answered “Yes” to providing outpatient services) or acceptance of insurance coverage (if they answered “No”). The survey’s final question provided an open-ended opportunity for respondents to share specific barriers to the provision of behavioral health services that they have observed or experienced.

Survey Distribution

In June 2020, an invitation to participate in the survey was sent to all licensed behavioral health providers whose email addresses were included in RIDOH’s licensee directory. This invitation included an overview of the survey’s purpose and content as well as an access link. The same message was additionally circulated by various community partners and state agencies, including the Rhode Island Medical Society, the Rhode Island Psychological Association, the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH), the Rhode Island chapter of the National Association of Social Workers, and the Psychiatric Association. Furthermore, targeted outreach was directed toward the directors of behavioral health provider agencies and healthcare networks who aided in distributing the survey to licensed behavioral health employees. This included agencies such as CODAC Behavioral Healthcare, the Rhode Island Veterans Administration, Care New England, Butler Hospital, and Kent Hospital, among others.

A team of five student interns telephoned licensed providers who did not receive the email invitation, informing them of the survey and inviting them to participate. Providers who did not answer were left a voicemail whenever possible. The survey remained open until October 2020.

In order to identify that all respondents were licensed behavioral healthcare providers in Rhode Island, initial responses were not anonymous. However, participants were informed that any personally identifying information would be removed from their response once it had been confirmed against the RIDOH licensee directory. No incentives, financial or otherwise, were offered for participation.
Part 1: Provider Characteristics

Providers of behavioral healthcare vary in specialty, educational background, licensure, care setting, and other professional attributes. Because the services provided and populations served vary depending upon these attributes, we began by assessing the survey’s respondent pool from a descriptive standpoint. The most common provider type among survey respondents was clinical social worker (25.4%), followed by mental health counselor (19.5%) and psychologist (13.2%) (Fig. 1.1). Responses were obtained from all 16 provider types listed on the survey form, as well as from 16 other individuals who chose “Other.” The least common provider types were substance use peer support counselor (0.1%) and school psychologist (0.4%). The majority (76.8%) of respondents were classified as “Non-Medical Providers,” meaning that they practiced in a setting outside of a hospital (Fig. 1.2).

(i) Respondents were asked, “What is your field of practice?” and were provided with the options listed.

(ii) 749 out of 749 survey participants (100%) provided a response to this question.

(i) We categorize as “Medical Providers” those who practice in a hospital-based setting, whereas “Non-Medical Providers” practice outside of a hospital-based setting. For a full list of the fields of practice placed under each categorization, see Appendix B.

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Within these broader classifications, survey respondents practiced across a wide range of care settings. When asked to identify all of the settings in which they practiced, nearly 47% of respondents chose “Private Individual Practice,” with the second- and third-most popular answers being “Private Group Practice” (14.8%) and “Community Mental Health Center” (13.9%), respectively (Fig. 1.3). The options chosen least frequently were “Integrated Primary Care Practice” (3.9%) and “Partial Hospitalization Program” (2.9%). Answers provided for “Other” included correctional facilities, home-based services, and free clinics. Survey respondents provided services in an average of 1.2 different care settings.

Most respondents to the survey (85.4%) offered outpatient services in one form or another (Fig. 1.4). According to the 2019 National Mental Health Services Survey (NMHSS) conducted by the Substance Abuse and Mental Health Services Administration (SAMHSA), 63.5% of healthcare facilities in Rhode Island offered behavioral health treatment in an outpatient service setting. In contrast, 34.9% of facilities offered 24-hour residential care and 12.7% offered inpatient care. While helpful for general context, this does not necessarily indicate that outpatient care providers comprise a disproportionate percentage of our survey sample — SAMHSA’s metric reflects the availability of services across facilities (i.e., whether or not the service is offered) and makes no mention of provider distribution among the aforementioned care settings.


(i) Respondents were asked, “In what setting do you practice? Check all that apply.”
(ii) 749 out of 749 survey participants (100%) provided a response to this question.
The decision to seek behavioral health treatment is an inherently vulnerable and courageous one, as it often requires the recounting of personal circumstances to providers who begin as complete strangers. It has been documented that patients are more likely to report positive experiences in care settings when they share the race, ethnicity, or gender of their provider.\textsuperscript{1} The evidence supports the assertion, therefore, that interacting with an individual who has a similar cultural background may make the care-seeking process less daunting by providing a baseline sense of familiarity and empathy. Furthermore, proficiency in the languages spoken by a provider’s client base is fundamentally important to the provision of culturally competent care.\textsuperscript{2}

Survey respondents were asked to identify their racial/ethnic identities by selecting from the following options: White, Black/African American, American Indian or Alaska Native, Asian\textsuperscript{3}, Latinx, “I choose not to answer,” or Other. The most common answer was White, representing 86.2\% of responses to this question. The second- and third-most common answers were Latinx (5\%) and Black (1.9\%) (Fig. 1.5). It should be noted that approximately 4\% of survey respondents chose against answering this question, and that there were no statistically significant differences in race/ethnicity between medical and non-medical providers. Helpful context for these numbers in relation to the degree to which the provider pool represents the clients it serves is offered by data tabulated in SAMHSA’s Uniform Reporting System (URS).\textsuperscript{4} These annual statistics, provided to SAMHSA by the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH), capture client demographic information including gender, race/ethnicity, and age. Of the nearly 32,000 clients served by the State Mental Health Agency (SMHA) in 2020, 68.1\% were White, 11.9\% were Black, and 3.5\% were multiracial (Fig. 1.6). Importantly, race/ethnicity information was unavailable for 14.5\% of clients.


\textsuperscript{3} Includes all individuals who identify with one or more nationalities or ethnic groups originating in the Far East, Southeast Asia, or the Indian subcontinent.

It is unclear whether our survey sample is demographically representative of Rhode Island’s entire behavioral health provider pool. However, there is an evident gap between the proportion of people of color in our respondent group and the proportion within the Rhode Island SMHA client population. The importance of racial, ethnic, and cultural representation in behavioral healthcare has long been emphasized, and the Rhode Island Parity Initiative (RIParity) highlighted it as an area of focus in its 2019 and 2020 reports entitled Mental Health Parity: Experiences of Patients and Professionals.


Language proficiency provided another intriguing metric for the evaluation of cultural competency in the provision of behavioral health care. Respondents were able to select as many languages as they speak in their professional capacity. Nearly 99% of respondents selected English, 8% selected Spanish, and 2% selected Portuguese (Fig. 1.7). Notably, only 1.1% of respondents reported fluency in American Sign Language (ASL). According to the 2020 SAMHSA URS Report for Rhode Island, nearly a quarter of clients served by the SMHA reported Hispanic or Latino ethnicity.\(^1\) However, there is reason to believe that the results of this survey question are not reflective of a broader deficiency in the State’s behavioral healthcare system. Per the 2019 NMHSS, 66.7% of facilities in Rhode Island offered services in languages other than English, 44.4% offered services in sign language specifically.\(^2\) Spanish was the most common non-English language in which services were provided (41.3% of facilities).

While this demonstrates room for improvement, Rhode Island’s performance in these metrics is similar to that of the region and nation as a whole. According to the 2019 NMHSS report, 47% of facilities in the Northeast offered services in sign language (compared to 44.4% in Rhode Island), although this figure lags far behind other parts of the country: 62% in the South, 61% in the Midwest, and 55% in the West (Fig. 1.8). Among all facilities nationwide, 73% provided services in languages other than English (compared to 66.7% in Rhode Island) and 34% provided services in Spanish (compared to 41.3% in Rhode Island).

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Cumulatively, if we endeavor to make behavioral health services accessible to individuals of all races, ethnicities, and disability statuses, continuous efforts must be made to recruit and train providers from a broad range of backgrounds.
Part 2: Insurance and Service Availability

It has been extensively reported that Americans struggle far more to gain access to mental health treatment than primary care. A 2017 survey conducted by the National Alliance on Mental Illness (NAMI) found that 45% of respondents cited “Not accepting new patients” as a major barrier to securing a regular therapist and 22% cited “No return call or email.” The same survey listed the rate of difficulty in finding a mental health provider as 34%, compared to 9% in finding a primary care provider.

When asked whether they or their practice were accepting new patients, 77.4% of respondents answered “Yes” and 22.6% answered “No” (Fig. 2.1). Notably, nearly 21% of survey participants neglected to answer this question. When given the option to specify a reason for not accepting new patients, the most common answer by far was a full caseload, sometimes with a lengthy waiting list as well (Fig. 2.2). Because the survey was taken in the early days of the COVID-19 pandemic, the difficulties of adjusting to remote work also accounted for many “No” responses.

(i) Respondents were asked, “Are you (your practice) currently accepting new patients?” and could answer “Yes” or “No.”

(ii) 592 out of 749 survey participants (79.0%) provided a response to this question.

(i) If respondents responded “No” to the question described in Fig. 2.1, they were asked to “specify why not.”

(ii) 100% of survey participants who responded “No” to the question described in 2.1 provided a response to this question.

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A 2018 study published by the National Council for Behavioral Health (NCBH) estimated that 38% of American adults have had to wait longer than one week for mental health services, while 81% of respondents to their survey agreed that no patient should have to wait longer than seven days for care. The United States performs poorly when it comes to wait times for mental health services, a shortcoming that is particularly detrimental when individuals are in need of time-sensitive, crisis-level care.

81.1% of survey respondents provided the most common wait time for their patients between a referral and a first appointment. Among those who answered this question, the most common wait time was 2-7 days (47.5% of respondents) followed by 8-14 days (28.1%) (Fig. 2.3). The majority (64.6%) of respondents reported wait times of less than two weeks, and only about 6% reported wait times exceeding three weeks. Approximately 7% of respondents answered “Other” to this question, and reasons for doing so most commonly included the following:

- Wait times vary by acuity of condition
- Provider practices in an emergency department setting
- Wait times commonly exceed 30 days (the longest time provided as an answer choice on the survey)

Our survey additionally sought to discern the manner in which providers responding to the survey most commonly engaged in patient contact, regardless of their field of practice. Providers were asked to estimate the number of patients per week with whom they interacted through each of five primary means (Fig. 2.4). 84.1% of respondents to this question reported seeing patients in an in-person, outpatient care setting, compared with 65.2% who reported interacting with patients over the phone, through video chat, or

(i) Respondents were asked, “How long is the typical wait for you to see a new patient between referral and first visit?” and were provided with the options listed.

(ii) 608 out of 749 survey participants (81.2%) provided a response to this question.
through email consults. Notably, this latter number leapt to 84.2% during the COVID-19 pandemic. Patient interactions via phone, video chat, or email was the only category for which we divided responses into pre- and mid-pandemic categories; the rest are strictly pre-pandemic estimates.

Among respondents who employed each means of seeing patients, we sought to determine the relative frequency with which each method was used (Fig. 2.5). For example, prior to the pandemic, the 84.1% of respondents who saw patients in-person in an outpatient setting saw an average of 16.74 patients per week this way, while the 40.6% of respondents who saw patients in a hospital or nursing home setting saw an average of 1.86 patients per week this way. As expected, patient volume accounted for by telephone, video chat, and email interactions skyrocketed during the pandemic. Prior to the onset of COVID-19, the 65.2% of respondents who saw patients through telephone/video chat saw an average of 5.04 patients per week this way. During the pandemic, the 84.2% of respondents who saw patients through telephone/video chat saw an average of 18.47 patients per week this way. This represents a near-quadrupling relative to pre-pandemic levels, and even exceeds the average weekly patient volume accounted for by in-person outpatient interactions prior to the pandemic.

(i) Respondents were asked, “In a typical week, how many patients do you see in the following primary way...” and were provided with the options listed. They could enter any numerical value for each field. Percentages sum to greater than 100% because most respondents selected multiple methods of seeing patients.

(ii) 527 out of 749 survey participants (70.6%) provided a response to this question.
A frequently encountered barrier to accessing behavioral health care in the United States is the prevalence of narrow provider networks resulting in prohibitively expensive costs due to a lack of insurance coverage. A 2016 analysis of 531 provider networks in the Affordable Care Act (ACA) Marketplaces found that only 42.7% of psychiatrists and 19.3% of non-physician mental health providers were participating in any network. Moreover, a 2019 report released by Milliman found that in Rhode Island, rates of out-of-network utilization for inpatient behavioral health care are 5.3 times higher than those for inpatient medical care. For outpatient care, out-of-network utilization rates are 3.28 times higher for behavioral health care.

Earlier studies sounded similar alarms, citing low rates of insurance acceptance among psychiatrists compared to other specialties as a major hurdle to timely referrals. Among responding providers who do accept insurance, the three most widely accepted plans are Commercial Blue Cross Blue Shield of Rhode Island plans (85.5% of respondents who accept insurance), Commercial United Healthcare plans (81.1%), and Commercial Neighborhood Healthcare Rhode Island plans (68.1%) (Fig. 2.7). The three least widely accepted plans were Medicaid fee-for-service (17.2%), TRICARE (28.3%), and Medicaid Managed Care - Tufts (28.3%).

4 Cunningham, P.J. (2009). Beyond Parity: Primary Care Physicians’ Perspectives On Access To Mental Health Care. Health Affairs. 28(1). https://doi.org/10.1377/hlthaff.28.1.w490
participating with insurers other than those listed as options, these most commonly included Cigna and Aetna.

(i) Respondents were asked, “Do you (your practice) accept insurance coverage?” and could answer “Yes” or “No.”

(ii) 697 out of 749 survey participants (93.1%) provided a response to this question.

(ii) Full names of insurance plans abbreviated in this figure are included below. Plans included on axis labels but not listed below were not abbreviated.

**Plan**
- BCBSRI = Commercial Blue Cross Blue Shield Rhode Island plans
- UHC = Commercial United Healthcare plans
- NHPRI = Commercial Neighborhood Health Plan of Rhode Island plans
- Tufts = Commercial Tufts Healthcare plans
- Medicaid UHC = Medicaid Managed Care: United Healthcare
- Medicaid NHP = Medicaid Managed Care: Neighborhood Health Plan of Rhode Island
- Medicaid Tufts = Medicaid Managed Care: Tufts Healthcare
- Medicaid FFS = Medicaid Fee-for-Service

(ii) 586 out of the 601 survey participants (97.5%) who responded “Yes” to accepting insurance provided a response to this question.
Those who reported not accepting insurance were asked to rank contributing factors; 81.3% of them provided responses. Factors offered as options by the survey included “Administrative Overhead,” “Reimbursement Rates,” “Credentialing Requirements,” “Utilization Review Requirements,” and “Other Reason.” The factor most frequently ranked in the top two was “Administrative Overhead” (ranked 1 or 2 in 61% of question responses, average rank of 2.49), followed by “Reimbursement Rates” (ranked 1 or 2 in 44.2% of question responses, average rank of 2.71) (Fig. 2.8). Utilization review requirements (ranked 1 or 2 in only 22.1% of question responses, average rank of 3.44) played the smallest role in providers not accepting insurance.

For those who accept insurance, prior authorizations have come to represent a burdensome and time-consuming facet of being a healthcare provider. The American Medical Association reported that 22% of physicians in a 2017 survey reported that they or their staff spent upwards of 20 hours per week completing authorization requests.1 Indeed, the insurance authorization process has also been shown — using data drawn from hospitals in Rhode Island — to present a delay in the provision of urgent, inpatient care.2 Strikingly, over 19% of respondents to our survey — nearly one in five — reported spending between 4 and 8 hours per day handling insurance authorizations. Across all respondents, the average time spent was 1.93 hours per day (7.65 hours per work week) handling insurance authorizations (Fig. 2.9).

Apart from the detrimental effects of onerous administrative tasks on provider quality of life3, they detract from time that could be spent on patient interaction — time that, studies have shown4, is crucial to the cultivation of meaningful relationships and effective treatment plans. The metrics included in this section paint a picture of a behavioral healthcare system rife with logistical shortfalls which impede a patient’s ability to access timely care, a provider’s ability to dispense it, or both. The insights gleaned and experiences highlighted by this survey call attention to the need for open dialogue between policymakers, providers, and patient advocates.

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(i) If respondents reported not accepting insurance coverage, they were asked, “Why not? (Rank responses from most important to least important factor).”

(ii) “Average Rank” refers to the average position occupied by a given factor in respondents’ rankings of contributors to not accepting insurance. For example, if the average rank of “Factor X” is 2.0, that means that respondents, on average, reported that Factor X was the second-most important in their choice not to accept insurance.

(iii) “Percent of Responses Ranked 1 or 2” refers to the percentage of responses in which a given factor was listed as the largest or second-largest contributing factor to not accepting insurance.

(iv) 79 out of the 96 survey participants (82.3%) who responded “No” to accepting insurance provided a response to this question.

Respondents were asked, “How much time do you (or your staff) typically spend per day handling insurance authorizations?”

588 out of 749 survey participants (78.5%) provided a response to this question.
Part 3: Access Barriers to Care

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) was passed in an effort to prevent health insurers from imposing disproportionately restrictive limitations on behavioral health benefits relative to those on traditional medical benefits.¹ Despite the promise of this legislation, inadequate access to mental health and substance use disorder (MH/SUD) treatment remains one of the most formidable obstacles to treatment for many Americans. Mental Health America (MHA) issues an annual report assessing the relative accessibility of behavioral health care in each state, and recent indicators have been mixed for Rhode Island. Although overall access to care in the state ranks in the top 10 nationwide, over 49% of Rhode Island adults with any mental illness (AMI) did not receive treatment in the past year and 25.71% of adults with a cognitive disability in Rhode Island could not see a doctor due to cost.²

When asked whether they had needed to stop seeing a patient in the past due to an insurance-related issue, not only did the majority of respondents to our survey answer in the affirmative, but many cited multiple insurance-related obstacles. The most frequently selected (40% of respondents) was patient loss of insurance coverage (Fig. 3.1), often resulting from switching to a plan with different benefits. Additional reasons for needing to stop seeing a patient included insurance claim denials (10.6% of respondents) and situations in which the provider no longer accepts a patient’s insurance (8.8%). A minority (39.3%) of all respondents reported never needing to stop seeing a patient due to insurance-related issues, and approximately 2.4% of respondents reported occupations to which the question did not apply (e.g., working for a program funded by a state agency or at an academic institution with students).

(i) Respondents were asked, “Have you (your practice) had to stop seeing a patient due to an insurance related issue? If yes then, why (select all that apply).” Options were as follows: “No,” “Yes — insurance denial of patient claim,” “Yes — patient loss of insurance coverage,” “Yes — provider no longer accepts insurance coverage,” and “Other.”

(ii) Note that values may not sum to 100% because some respondents selected multiple reasons.

(iii) 661 out of 749 survey participants (88.3%) provided a response to this question.

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When given the opportunity to elaborate on their response to this question with an “Other” response, several themes emerged in their descriptions. Notably, of the 100+ respondents who chose to provide an additional, unstructured response, nearly 25% mentioned financial barriers faced by patients in contending with changing plans or high deductibles. Others voiced frustration with unnecessarily complex insurance bureaucracy. Furthermore, while Medicare covers outpatient mental health services provided by psychiatrists, psychologists, clinical social workers, and pediatric nurses, the program does not reimburse licensed professional counselors (LPCs); respondents also cited this fact frequently.

Respondents were then asked to estimate how many patients in the 12 months preceding the COVID-19 pandemic they needed to stop seeing due to insurance issues. The average value provided was 3.86 patients, with the median being 3 patients and answers ranging from 0 to 40 (Fig. 3.2). Given that all plans except for Medicare, Medicaid fee-for-service, and exempted private plans must adhere to federal parity law, it is notable that care is interrupted by insurance issues so regularly.

![Table: In the past 12 months, how many patients have you had to stop seeing due to insurance reasons?](image)

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<table>
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<tbody>
<tr>
<td><strong>Mean</strong></td>
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<tr>
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<td><strong>Minimum</strong></td>
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<td>40</td>
</tr>
<tr>
<td><strong>Std. Deviation</strong></td>
<td>4.92</td>
</tr>
</tbody>
</table>

(i) Respondents were asked, “In the 12 months prior to the COVID-19 crisis (March 15, 2020), how many patients would you estimate you have had to stop seeing due to an insurance related issue?” and could enter any numerical value. Non-numerical responses were excluded, and if a respondent gave a range, the middle value of that range was counted for purposes of computing averages.

(ii) 382 out of 749 survey participants (51.0%) provided a response to this question.

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The final question on the survey was open and unstructured, inviting respondents to recount barriers that they have observed limiting patient access to behavioral healthcare. Nearly 600 responses were individually read and categorized, with prominent themes taking shape almost immediately. The trials of financial accessibility and insurance obstacles were the most frequently cited, with 37.7% of responses mentioning lack of insurance/loss of insurance/poor coverage and 33.0% mentioning the high costs of deductibles and copays (Fig. 3.3). Other, more practical logistics came up often as well — 26.5% of responses identified transportation/mobility as a barrier to accessing care, 9.5% mentioned childcare/work/scheduling difficulties, 6.5% mentioned technology issues, 3.5% mentioned language barriers, and 0.8% identified housing insecurity. References to a pervasive provider shortage (20.1% of respondents) and all-too-common encounters with stigmatization of behavioral health care (13.9%) also made up a large proportion of responses.

These responses, particularly those which invoke transportation and provider availability difficulties, align with recent data regarding statewide trends in these areas. For example, Fig. 3.4A, Fig. 3.4B, and Fig. 3.4C were featured in the 2019 National Mental Health Services Survey (NMHSS) report and depicts the geographic distribution of treatment facilities which offer MH/SUD services in Rhode Island, Connecticut, and Massachusetts, respectively. The maldistribution of such facilities evident in Rhode Island is more dramatic than in any neighboring state; for example, Washington County (population 126,000) contains only one of the 63 mental health treatment facilities profiled in the 2019 NMHSS. This is a factor that likely influences the accessibility of services, particularly for those in need of specialized care or those who have familial obligations.

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1 It is unclear whether these technology issues become more pronounced during the pandemic or prior to it, as the question did not specify a timeframe.
Figure 3.4: Geographic Distribution of Treatment Centers Offering MH/SUD Services in Rhode Island, Connecticut, and Massachusetts

(i) Figure from 2019 Rhode Island N-MHSS State Profile.
(ii) Land area of states is not depicted proportionally at this scale.
(iii) A: Rhode Island, B: Connecticut, C: Massachusetts
VI. Conclusions and Recommendations

The hundreds of responses solicited from Rhode Island behavioral health providers yielded an enlightening snapshot of the practical demands of the profession, as well as the common obstacles presented by pervasive shortcomings within the behavioral healthcare system. Based on a synthesis of information gathered, the Rhode Island Parity Initiative proposed the following policy changes geared toward improving access and quality of care for all Rhode Islanders.

**Diversity in the Provider Pool**

While our sample size is not large enough to reflect the entirety of the behavioral healthcare workforce in Rhode Island, its racial and ethnic breakdown reflects a discouraging trend across the profession: the provider pool is not culturally reflective of the population it is serving. Within our survey sample specifically, White individuals were overrepresented in the provider pool relative to their proportion of the SMHA patient population, whereas Black individuals were underrepresented (Fig. 1.5, 1.6). Similarly, while 98.9% of providers spoke English, only 8% spoke Spanish and no other language saw more than 2% of providers report fluency (Fig. 1.7).

In considering ways to ameliorate these disparities, it will be crucial to emphasize professional outreach to BIPOC communities in a push to diversify the provider pool. Such programs would not be without precedent; they have been widely discussed and implemented in clinical fields. Moreover, multilingual training should be prioritized in the education of those studying to work in care settings, including American Sign Language. This systemic change to early career training will be necessary to confront and overcome the current dearth of bilingual mental health counselors. More specifically, we recommend:

- Strengthening standards for the cultural competence of licensed behavioral health providers and clearly articulating them in agreements between funding agencies and providers.
- Investing in an expanded network of multilingual/multicultural behavioral health providers throughout Rhode Island, including the following recommendations to recruit and retain a more ethnically and racially diverse enrollment pool in academic and training programs:
  - Reduce reliance on standardized testing, including the ACT, SAT, and GRE. Mounting evidence demonstrates that family income and parent education

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have inordinate influence upon standardized test performance, a fact that serves to both highlight and exacerbate existing inequalities along racial lines. Rhode Island College (RIC) and MHARI are leading the way in this regard by advocating for the creation of an alternative to the Association of Social Work Boards (ASWB) licensing exam.

- Establish or expand services intended to support and retain minority students, such as programs providing information about application processes and/or financial resources.
- Expand practicum experiences for students interested in working with diverse populations by broadening the network of community organizations and local agencies with which colleges and universities collaborate.
- Diversify faculty in behavioral health academic programs. For example, this may include establishing specific recruitment strategies and changes to tenure policies intended to identify and address systemic racism and bias in current practices.
- Uniformly collect patient/consumer demographic data through insurance forms and community health centers.

- Investing in the growth of multilingual/multicultural assistance programs, which link the state’s service providers with Health Equity Zones and the schools, places of worship, and community-based organizations that have direct contact with populations most marginalized in the current system.
- Investing in an expanded network of multilingual community health workers, interpreters, and peer support specialists, and adapting certification training to build a deeper understanding of behavioral healthcare among these workers.
- Quantifying our progress in achieving diversity, equity, and inclusion in the workforce by collecting the demographic information of providers through licensing applications and renewals.

**Insurance and Service Availability**

Respondents to our survey most frequently cited full panels as a reason for not accepting new patients. This is an outcome that aligns with reports of longstanding shortages in the behavioral healthcare provider workforce: the needs of patients are going unmet, and primary care physicians routinely encounter difficulty in coordinating referrals. This is not the fault of the overworked provider, but rather signifies a need to raise reimbursement.

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2. The ACT. (2020). U.S. High School Graduating Class Trends. [https://www.act.org/content/emmaterial/alltoclasses/grad-class-database.html](https://www.act.org/content/emmaterial/alltoclasses/grad-class-database.html)
4. Mental Health Care Professional Shortage Areas (HPSAs). (September 30, 2020). Kaiser Family Foundation. [https://www.kff.org/other/state-indicator/mental-health-care-health-professional-shortage-areas-hpsas/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D](https://www.kff.org/other/state-indicator/mental-health-care-health-professional-shortage-areas-hpsas/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D)
5. Cunningham P. J. (2009). Beyond parity: primary care physicians’ perspectives on access to mental health care. Health affairs (Project Hope), 28(3), w490-w501. [https://doi.org/10.1377/hlthaff.28.3.w490](https://doi.org/10.1377/hlthaff.28.3.w490)
rates for behavioral health care and strictly enforce parity so that being a provider is a more attractive career financially. A failure to do so would exacerbate the already worsening problem of burnout due to large panel size\textsuperscript{1}, and the prospect of a workforce contraction is simply untenable.

Patients also all too often find access to care hindered by narrow provider networks. Respondents to our survey cited administrative overhead and poor reimbursement rates as the two largest reasons for not accepting insurance. Although health care utilization in the United States is roughly on par with that of other high-income countries, we spend twice as much per capita on health care compared with these nations.\textsuperscript{2} Billing and insurance-related (BIR) administrative complexity is not only a bottleneck in the care-seeking process, but it costs the United States nearly half a trillion dollars per year.\textsuperscript{3} Even for survey respondents who accept insurance, processing claims consumes a great deal of time (Fig. 2.9a, Fig. 2.9b) and could be better spent with clients. Thus, system-wide reform to the state’s insurance infrastructure would benefit the provider, the patient, and the state alike. Furthermore, our survey responses underscore the multidimensional means by which increased reimbursement rates and a strict commitment to parity would pay dividends for the quintessential care-seeker: not only would it cultivate an expanded provider pool, but also lower insurance-related barriers to care. Specifically, we recommend:

- Increasing reimbursement rates through both Medicaid and commercial insurers to guarantee that:
  - Reimbursement rates are sufficient for the coverage of needed services
  - Reimbursement rates are sufficient to incentivize the introduction of needed services that currently are not broadly available in Rhode Island.
  - Reimbursement to providers and consumers is executed in a timely fashion.
- Simplifying and standardizing patient/provider authorization, claims, and appeals processes and improving the transparency of plan benefits and restrictions.
- Standardizing treatment protocols, levels of treatment, and coverage limits for each mental illness, including substance use disorders, across insurers and plans. These standards must be based on evidence and should be informed by criteria determined by a group of mental health experts. No more than one-third of these mental health experts should be employed by, or contracted with, public or private insurers.
- More frequent review by the Office of the Health Insurance Commissioner (OHIC) of online provider directories to ensure current and accurate information, and

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development of an improved mechanism for consumers to report out-of-date information to the OHIC.

- Reforming Medicare to include coverage of licensed professional counselors.

Phone and video calls provided a much-needed alternative to in-person visits during the COVID-19 pandemic (Fig. 2.4, Fig. 2.5). Even during non-pandemic times, however, transportation represents a substantial barrier to care (Fig. 3.3) which can be circumvented with the aid of telehealth services. During Spring 2021, the Rhode Island General Assembly passed legislation mandating coverage for “telemedicine for medically necessary and clinically appropriate telemedicine services.”\(^1\) Such legislation expands parity to include remote appointments and enables providers to improve the accessibility of care for patients who do not own a car or live near public transportation. With this context, we specifically recommend the following:

- Quality implementation of the newly passed updates to the Telemedicine Coverage Act (Senate Bill S0004 Substitute B/ House Bill 6032 Substitute A). This includes ensuring that both patients and providers are aware of the bill’s provisions, as well as their implications for their personal treatment or practice, respectively.
- Devoting resources to the expansion of internet and broadband access in low-income communities. This “digital divide” has only become more stark over recent years\(^2\), and impedes access to telehealth services.

**Barriers to Care**

The observations provided by respondents pertaining to patient barriers to care were extremely enlightening. Over 60% of respondents reporting having had to stop seeing a patient due to insurance-related issues (Fig. 3.1), not even taking into account other obstacles such as transportation, stigma, and language barriers. The responses to our survey, in aggregate, indicate strongly that issues of insurance coverage and service costs are the two primary drivers of patient inability to access care. It is noteworthy that, in the experience of the providers who participated in our survey, the majority of access barriers were borne of systemic facets of the healthcare delivery process (limited insurance coverage, soaring expenses, etc.) and not decisions made by the patients themselves. This speaks to the urgency of reform as it pertains to behavioral healthcare services; individuals experiencing mental illness are taking the brave and laudable step of seeking care, and it is incumbent upon policymakers to ensure that such action is rewarded with seamless access to treatment.

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Final Thoughts
The insights of providers gathered through our survey highlight the extraordinary importance of a robust commitment to mental health parity. Narrow provider networks, insufficient coverage, and suffocating costs are preventing struggling individuals from getting the care they need and placing a cumbersome burden upon an overtaxed workforce. We hope that the information presented in this report serves as a springboard for continued advocacy pertaining to this crucial issue. With concerted prioritization and consistent funding commensurate with the importance of mental health parity, substantial and lasting change can be made.
VII. Limitations

Availability of Contact Information

Despite containing thousands of names, many other fields in the Rhode Island Department of Health (RIDOH) licensee list were blank, incomplete, or outdated. These omissions delayed efforts to conduct the survey by making it necessary to manually seek contact information from alternate online sources. Examples of frequently encountered obstacles are included below:

1. **Email Addresses**: Many email fields were left blank, and those that were filled often contained general addresses for an organization or business as opposed to a specific provider (e.g. “info@ABC.org” instead of “John_Smith@ABC.org”).

2. **Phone Numbers**: Much like email addresses, phone numbers were often only provided to the front desk or appointment-scheduling line of a business or practice, not to a specific provider. In other instances, the phone numbers were outdated, and calling them resulted in an automated message informing us that the number was no longer in service.

3. **Street Addresses**: Addresses were rarely provided beyond one line (the organization or business name) and were frequently listed as “Unknown.” In the absence of email addresses or direct phone numbers, this made contacting providers extremely difficult.

Timing of Survey

The survey was conducted during summer 2020, a period of time during which many offices were closed entirely due to the pandemic. Not only did this mean that providers were not physically present at work, but hours were often abridged and answering machines may have been less regularly monitored.

Difficulty of Reaching Providers at Larger Hospitals/Facilities

In the course of attempting to reach providers at larger hospitals such as Rhode Island Hospital or Providence VA Medical Center, there were many encounters with lengthy, inefficient, or unsuccessful automated systems of answering systems. This made it exceedingly time-consuming and challenging to reach providers directly at large hospitals.
APPENDIX A: Full Survey Text

Question 1: First Name
Short response text

Question 2: Last Name
Short response text

Question 3: How do you identify your race / ethnicity? (*The following questions pertaining to racial demographics and spoken languages allow us to assess the diversity of the provider pool and how well it reflects the diversity of our state.)

Checkbox Options (Multiple Selections Permitted):
- A. White
- B. Black or African American
- C. American Indian or Alaska Native
- D. Asian (includes all individuals who identify with one or more nationalities or ethnic groups originating in the Far East, Southeast Asia, or the Indian subcontinent)
- E. Latinx
- F. I choose not to answer
- G. Other (please specify)

Question 4: Which languages do you speak in your professional capacity? Check all that apply.

Checkbox Options (Multiple Selections Permitted):
- A. English
- B. Spanish or Spanish Creole
- C. French, French Patois, or French Creole
- D. Portuguese or Portuguese Creole
- E. Asian and Pacific Island Languages
- F. African Languages
- G. Arabic
- H. Sign Language
- I. I choose not to answer.
- J. Other (please specify)
Question 5: What is your field of practice?
Checkbox Options (Multiple Selections Permitted):
A. Psychiatrist
B. Neuro-psychiatrist
C. Psychologist
D. Clinical Social Worker
E. Counseling
F. School Psychologist
G. Neuropsychologist
H. Behavioral Health Nurse Practitioner
I. Behavioral Health Physician Assistant
J. Substance Use and Behavioral Disorder Counselor
K. Mental Health and Substance Use Social Worker
L. Mental Health Counselor
M. School Counselor
N. Marriage and Family Therapist
O. Substance Use Disorder Peer Support Counselor
P. Other (please specify)

Question 6: In what setting do you practice? (Check all that apply)
Checkbox Options (Multiple Selections Permitted):
A. Private individual practice
B. Private group practice
C. Community mental health center (CMHC)
D. Integrated primary care practice
E. School, college, or university student direct service
F. Hospital outpatient
G. Hospital inpatient
H. Partial hospitalization program
I. Other (please specify)

Question 7: Do you work with or supervise practitioners in any of the following fields?
Checkbox Options (Multiple Selections Permitted):
A. Behavioral Health Community Health Worker(s)
B. Behavioral Health Language Interpreter(s)
C. Peer Support Counselor(s)
D. None of the above
E. Other (please specify)
Question 8: Do you provide outpatient services?
Multiple Choice (One Selection Permitted):
   A. Yes
   B. No

Question 9: Are you (your practice) currently accepting new patients?
Multiple Choice (One Selection Permitted):
   A. Yes
   B. No (please specify why not)

Question 10: How long is the typical wait for you to see a new patient between referral and first visit?
Multiple Choice (One Selection Permitted):
   A. 1 day
   B. 2-7 days
   C. 8-14 days
   D. 15-21 days
   E. 22-30 days
   F. Other (please specify)

Question 11: In a typical week, how many patients do you see in the following primary way:
Checkbox Options (Multiple Selections Permitted):
   A. In-person outpatient are at office/clinic
   B. Telephone or email consults (pre-COVID)
   C. Telephone or email consults (post-COVID)
   D. Hospital inpatient or nursing home visits
   E. Home visits
   F. Other (please specify)

Question 12: Do you (your practice) accept insurance coverage?
Multiple Choice (One Selection Permitted):
   A. Yes
   B. No

Question 13: How much time do you (or your staff) typically spend per day handling insurance authorizations?
Short response text, in units of hours
Question 14: Are you a participating provider with any of these insurers? Check all that apply.

Checkbox Options (Multiple Selections Permitted):
- A. Commercial Blue Cross Blue Shield RI (BCBSRI) Plan(s)
- B. Commercial United Healthcare Plan(s)
- C. Commercial Tufts Healthcare Plan(s)
- D. Commercial Neighborhood Health Plans RI (NHPRI) Plan(s)
- E. Veterans / Military coverage (TRICARE)
- F. Medicaid managed care, Neighborhood Health Plan
- G. Medicaid managed care, UnitedHealth
- H. Medicaid managed care, Tufts
- I. Medicaid fee-for-service
- J. Medicare
- K. Other (please specify)

Question 15: Why not? (Rank responses from most important to least important factor)

Options to rank, 1-5
- A. Administrative overhead
- B. Reimbursement rates
- C. Credentialing requirements
- D. Utilization review requirements
- E. Other reason

Question 16: Have you (your practice) had to stop seeing a patient due to an insurance related issue? If yes then, why (select all that apply)

Checkbox Options (Multiple Selections Permitted):
- A. No
- B. Yes — insurance denial of patient claim
- C. Yes — patient loss of insurance coverage
- D. Yes — provider no longer accepts patient coverage
- E. Other (please specify)

Question 17: In the 12 months prior to the COVID-19 crisis (March 15, 2020), how many patients would you estimate you have had to stop seeing due to an insurance related issue?

Short response text, in units of patients

Question 18: What barriers, if any, do you experience that limit patient access to behavioral healthcare? (please describe)

Open response text
APPENDIX B: Fields of Practice by Category

Medical Providers (n=174)

<table>
<thead>
<tr>
<th>Field of Practice</th>
<th>Number of Respondents</th>
<th>Percentage of Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatrist/Neuropsychiatrist</td>
<td>42</td>
<td>5.6%</td>
</tr>
<tr>
<td>Psychologist/Neuropsychologist</td>
<td>99</td>
<td>13.2%</td>
</tr>
<tr>
<td>Behavioral Health Nurse Practitioner</td>
<td>33</td>
<td>4.4%</td>
</tr>
<tr>
<td><strong>TOTAL Medical Providers</strong></td>
<td><strong>174</strong></td>
<td><strong>23.2%</strong></td>
</tr>
</tbody>
</table>

Non-Medical Providers (n=175)

<table>
<thead>
<tr>
<th>Field of Practice</th>
<th>Number of Respondents</th>
<th>Percentage of Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Social Worker</td>
<td>190</td>
<td>25.4%</td>
</tr>
<tr>
<td>Counseling</td>
<td>27</td>
<td>3.6%</td>
</tr>
<tr>
<td>School Psychologist</td>
<td>3</td>
<td>0.4%</td>
</tr>
<tr>
<td>Substance Use Behavioral Disorder Counselor</td>
<td>30</td>
<td>4.0%</td>
</tr>
<tr>
<td>Mental Health &amp; Substance Use Social Worker</td>
<td>56</td>
<td>7.5%</td>
</tr>
<tr>
<td>Mental Health Counselor</td>
<td>146</td>
<td>19.5%</td>
</tr>
<tr>
<td>School Counselor</td>
<td>9</td>
<td>1.2%</td>
</tr>
<tr>
<td>Marriage &amp; Family Therapist</td>
<td>23</td>
<td>3.1%</td>
</tr>
<tr>
<td>Substance Use Peer Support Counselor</td>
<td>1</td>
<td>0.1%</td>
</tr>
<tr>
<td>Clinical Social Worker/Psychologist</td>
<td>48</td>
<td>6.4%</td>
</tr>
<tr>
<td>School Counselor/School Social Worker</td>
<td>11</td>
<td>1.5%</td>
</tr>
<tr>
<td>Social Worker/Substance Abuse</td>
<td>12</td>
<td>1.6%</td>
</tr>
<tr>
<td>Clinical Social Worker/Substance Use Behavioral Disorder Counselor</td>
<td>3</td>
<td>0.4%</td>
</tr>
<tr>
<td>Other</td>
<td>16</td>
<td>2.1%</td>
</tr>
<tr>
<td><strong>TOTAL Non-Medical Providers</strong></td>
<td><strong>575</strong></td>
<td><strong>76.85%</strong></td>
</tr>
</tbody>
</table>
Network Adequacy
A Survey of Rhode Island’s
Behavioral Health Provider Network