MILLIMAN REPORT

Access across America

State-by-state insights into the accessibility of care for mental health and substance use disorders

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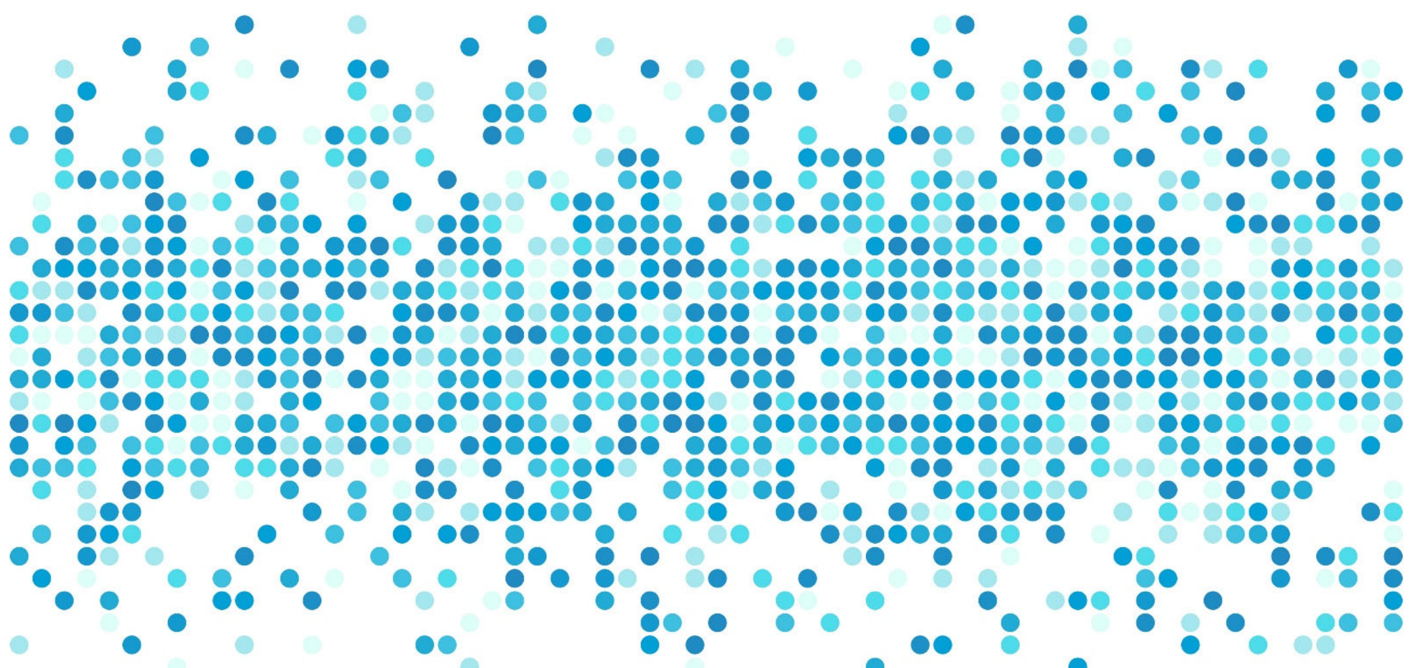

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Executive summary

Behavioral health conditions, such as mental health and substance use disorders, affect millions of Americans and contribute to significant morbidity, mortality, and economic burden.[1] However, access to behavioral healthcare across the United States is not uniform, and many individuals face challenges in obtaining timely, appropriate, and affordable services and treatment. Understanding the current state of behavioral healthcare access across the United States is crucial for developing and implementing effective policies and interventions to improve the quality and outcomes of behavioral healthcare for all.

Milliman was commissioned by Inseparable, Inc. to produce a report on measures related to access to behavioral healthcare services across the United States. Access to care is a broad concept that can mean many different things to different people. In the most general sense, access to care may refer to the ability of individuals to obtain care when needed or desired—whether or not they actually do so. Access in the abstract is challenging to measure directly, though there are many factors related to access worth consideration for which data are available.

Some have framed access as deriving from the interplay of healthcare needs, supply, and demand.[2] For the purposes of this paper, we provide statistics related to 1) the prevalence of behavioral health conditions (indicators of needs), 2) usage of behavioral health services (indicators of the portion of demand that is actually met), and 3) the availability and affordability of behavioral health providers (indicators of supply). We provide these metrics separately by state and by healthcare coverage type where sufficiently detailed data are available. This information is derived from a combination of publicly available survey data and public health surveillance tools as well as proprietary and licensed claims datasets. While these metrics may not give a full picture of access to care, our intent is to provide a broad look at some of the factors that contribute, as well as how individuals are currently using available behavioral healthcare resources.

Key findings are described below, and further details are described throughout this report. We have also provided a glossary with definitions of key terms, as well as appendices with summaries of all metrics by state for ease of reference.

KEY FINDINGS

1. By many measures, access to behavioral healthcare services is highly variable across the United States, and even among healthcare coverage types within each state. As a result, the accessibility of care can vary widely for individuals living in different areas of the country, that have different healthcare coverage types, that have different needs, or that have different levels of personal resources.

Measures of the prevalence of behavioral health conditions

2. Over 24% of individuals across three major healthcare coverage types (commercial, Medicare Fee-for-Service [FFS], and Medicaid) had diagnoses for at least one behavioral health condition in 2021. The prevalence of diagnosed behavioral health conditions was highest in Rhode Island (32%) and lowest in Texas (15%).

Measures of behavioral health treatment patterns

3. Only 33% of individuals diagnosed with a behavioral health condition received treatment from a behavioral health specialist within the year in 2021. Those with Medicaid coverage had the highest rates of behavioral health specialist care (44%) and those with Medicare FFS coverage had the lowest (15.7%). While some individuals receive appropriate treatment through primary care or other types of providers, this high percentage of individuals diagnosed with behavioral health conditions not receiving treatment from a behavioral health specialist indicates a significant gap in care.

4. Across the studied healthcare coverage types, approximately 8% of emergency department (ED) visits nationwide included a principal diagnosis of a behavioral health condition in 2021. Medicaid had the highest rate of ED visits with a behavioral health diagnosis (12.9%) compared with Medicare FFS (7.3%) and commercial (6.9%). ED visits are often used as a measure of behavioral healthcare access and quality and can indicate under-managed care.

5. Among those receiving outpatient behavioral health therapy, the average number of therapy visits was 10.8 per year in 2021. Variation between healthcare coverage types was less pronounced for this measure than for many others included in this report.

Measures of the availability and affordability of behavioral health providers

6. Mental health provider shortages are present in every state. In 2023, over half (52.7%) of the U.S. population lives in counties that are entirely designated as Mental Health Professional Shortage Areas (HPSA) and only 27.7% of the psychiatrists needed to remove these shortages are available across the United States. Psychiatrist need is not fully met in any of the 50 states.
7. While supply is not the only factor that influences the use of behavioral healthcare services, those living in areas of low behavioral health provider supply use much less behavioral healthcare services than those living in areas with the highest supply. For example, Florida has one of the lowest behavioral health provider supply ratios. Individuals with behavioral health conditions living in Florida only received 22.7% of the number of therapy visits that they would have received if they had received care at the same rates as those living in areas with the highest provider supply in 2021.
8. Nationally, psychiatrists are less likely to accept healthcare coverage of all types compared to other specialties, further limiting access to the small number of providers available for those unable to pay out of pocket.
9. The average self-pay cost for someone without insurance coverage for a 60-minute psychotherapy visit was $174 per visit in 2021. This cost represents a different level of barrier for different households depending on their income levels.
10. Among commercial health insurance plans that cover out-of-network services, 16.4% of costs for behavioral health services were for care provided out-of-network in 2021.

CONCLUSIONS

The research highlights the differences that exist in the prevalence of behavioral health conditions, the use of treatment, and the availability and affordability of behavioral health providers across the United States. While access is a complex topic and involves additional considerations beyond those included in this report, many metrics for which data are available point to aspects of access that could potentially be improved. The findings underscore the urgent need for strategies to increase the availability and affordability of behavioral health services, particularly in states with high prevalence rates and low provider availability.

The findings also highlight the financial barriers to accessing behavioral health services, particularly for individuals without healthcare coverage. Strategies to increase healthcare coverage and reduce out-of-pocket costs could help to improve access to behavioral health services.

It is critical to consider location and population factors when interpreting state-based results and considering implications for state or federal policy, insurance policies, practice guidelines, or other types of interventions. Results from this study can help shed light on specific areas of strengths or challenges across states.

Introduction

As the prevalence of behavioral health conditions (mental health and substance use disorders) in the United States has increased in recent decades, access to behavioral health services has been a critical challenge. Between 2001 and 2021, suicide death rates increased by 32% (14.1 deaths per 100,000 population in 2021 vs. 10.7 in 2001) and drug overdose death rates have increased by 376% (32.4 deaths per 100,000 in 2021 vs. 6.8 in 2001).[3,4] According to the National Institute for Mental Health, less than half (47.2%) of the approximately 57.8 million American adults living with any mental illness received any mental health services in 2021.[5] About half of Americans live in designated Mental Health Care Health Professional Shortage Areas (HPSA) and over 8,300 additional providers would be needed to remove these HPSA designations.[6]

According to an October 2022 survey conducted by CNN and the Kaiser Family Foundation, a significant majority of the American public (9 of 10 adults) believe there is a mental health crisis in the United States. Availability of mental healthcare providers, especially those who take insurance and who are culturally representative of the populations that they treat, were highlighted as contributors to the concerns around behavioral healthcare.[7] While the COVID-19 pandemic magnified these issues, access challenges for behavioral healthcare in the United States are not new.[8] In 1999, the Surgeon General published a report on mental health that highlighted the prevalence of mental health disorders, the impact on society, and the importance of improving access to mental health services.[9]

Although geographic variation in the cost and utilization of healthcare services in general is well described in the literature, less has been written about geographic variation in behavioral healthcare services specifically.[10,11,12,13] Of studies that have been published, many are limited to a single market or national survey data, and they often focus on single measures in isolation, such as provider supply or emergency department utilization.[14,15,16,17,18] In this report, we have assembled a range of measures related to behavioral healthcare access for all 50 states and (when available) Washington, D.C., including details (where applicable) by healthcare coverage type. The aim of this study is to illustrate the variation in behavioral health access measures across states. Understanding variations in these measures is crucial for informed policy decisions, targeted interventions, and ultimately, for enhancing the accessibility and effectiveness of behavioral healthcare across the nation.

It's important to acknowledge that access is a broad, complex concept, involving many factors that may or may not be readily measurable. In a general sense, access may be viewed as the ability of individuals to use behavioral healthcare services when they need or want to. Factors such as the supply of behavioral health clinicians, reimbursement structures, provider networks, socioeconomic conditions, cultural attitudes, individual and provider preferences, insurance, and benefit administration policies, as well as local-, state-, and federal-level policies can influence the extent to which individuals are able to or choose to use behavioral health services.

Some have described access as deriving from the interplay between needs, demand, and supply of healthcare services.[19] For this study we relied on a combination of publicly available health-related data sources and large commercial, Medicare, and Medicaid claims databases to quantify access to behavioral healthcare across states and markets using three categories of measures aligning with this framework:

A. Measures of the prevalence of behavioral health conditions (as indicators of needs).

B. Measures of behavioral health treatment patterns (as indicators of the portion of demand that is met).

C. Measures of the availability and affordability of behavioral health providers (as indicators of supply).

The body of this report describes national results and the range of variation across states. Additional details, including state-by-state and regional summaries across all studied metrics, are available in the appendices. When comparing results across states in the context of relative performance and potential to achieve solutions through policy changes, rulemaking, or other interventions, the reader should be mindful of any important differences in population demographics, population density, income distribution, rural/urban split, existing policies or programs, and other factors that influence the demand for and access to behavioral healthcare services.

Note that the measures included throughout this study reflect those for which appropriate data were available. Many factors influence the demand for behavioral health services and the ability of individuals to access services when

needed, and not all factors could be included in this analysis. Some additional factors that we were not able to directly measure but that should also be considered include (for example):

- Accuracy of provider directories used by consumers or providers to find providers.
- Ease of identifying and scheduling available providers, including wait times for an appointment.
- Ease of physical access to available providers, considering available modes of transportation and time or distance of travel.
- Availability of childcare and/or leave from employment to accommodate appointment times.
- The cultural competence or language concordance of available providers.
- Availability of providers adequately trained to address the unique needs of specific populations, such as trauma-informed care, gender identity and sexual orientation-related challenges, racism or discrimination related to minoritized status, etc.
- Personal preferences, social stigmas, cultural attitudes, or other factors related to perceptions and attitudes towards behavioral health conditions, providers, or services.

Care should be taken when interpreting the results in this report. We have provided each of the measures to enhance understanding around factors that influence access to care and how these factors vary across geographic regions. Populations that have access to care through commercial insurance coverage, Medicare, and Medicaid have differing demographics and characteristics and the results for these coverage types should be considered with those differences in mind.

Key data sources used for this study include publicly available data sources such as the Behavioral Risk Factor Surveillance System (BRFSS), National Center for Health Statistics (NCHS) – Mortality Files, U.S. Census Bureau, and others. We also leveraged a number of administrative healthcare claims datasets, including Milliman's proprietary Consolidated Health Cost Guidelines Sources Database for those covered by commercial insurance or Medicare Advantage, the CMS Transformed Medicaid Statistical Information System (T-MSIS) for those covered by Medicaid or the Children's Health Insurance Program (CHIP), and the CMS Medicare 100% Research Identifiable Files (RIF) for those covered by Medicare. Collectively, we included the healthcare claims experience of nearly 125 million individuals across these datasets. All data sources are further described in the Methodology section of this report.

Detailed findings

A. MEASURES OF THE PREVALENCE OF BEHAVIORAL HEALTH CONDITIONS

Access to behavioral health services is, in part, a function of the underlying need for behavioral health services. To contextualize the need for mental health and substance use disorder (SUD) services in each state, we first provide a range of statistics related to the prevalence of behavioral health conditions by state. There may be many ways to conceptualize or measure the prevalence of behavioral health conditions, but for the purposes of this report we have focused on the following measures:

- Diagnosed prevalence of any behavioral health condition, and of suicidal ideation or intentional harm, as identifiable in administrative healthcare claims data.
- Self-reported measures of mental health:
  - Percent of adults that experience frequent mental distress, as well as average number of poor mental health days per month, as self-reported in survey data.
  - Suicide and drug overdose death rates, as reported in national vital statistics.

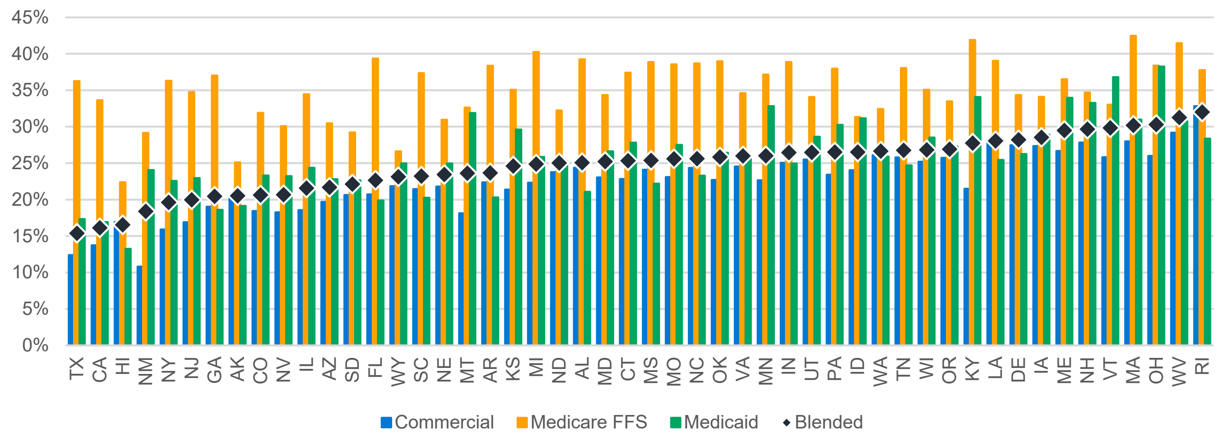
We selected these measures to reflect how behavioral health conditions manifest in healthcare settings (based on diagnoses present in claims data, how individuals subjectively rate their own mental health (as self-reported in survey data)), and the most adverse outcomes of behavioral health conditions (mortality).

Diagnosed prevalence of behavioral health conditions

Across three major healthcare coverage types in the United States combined (commercial, Medicare FFS, and Medicaid), we found that over 24% of individuals had diagnoses for at least one behavioral health condition in 2021 (see the Methodology section for specific identification criteria used). These include diagnoses by any medical provider, including behavioral health specialists, primary care providers, and others. Over 9% of individuals had diagnoses for multiple behavioral health conditions. Among all states, prevalence of diagnosed behavioral health conditions among those with healthcare coverage was highest in Rhode Island, where nearly a third of the population (32%) was diagnosed with a behavioral health condition, and lowest in Texas, at 15%. Note that because these measures are based on diagnoses present in claims data, only those with healthcare coverage are included. Prevalence rates may differ among those without healthcare coverage.

Figure 1 illustrates the prevalence of individuals diagnosed with at least one behavioral health condition by state and market. We have sorted the chart based on the blended prevalence rate across the included healthcare coverage types for each state.

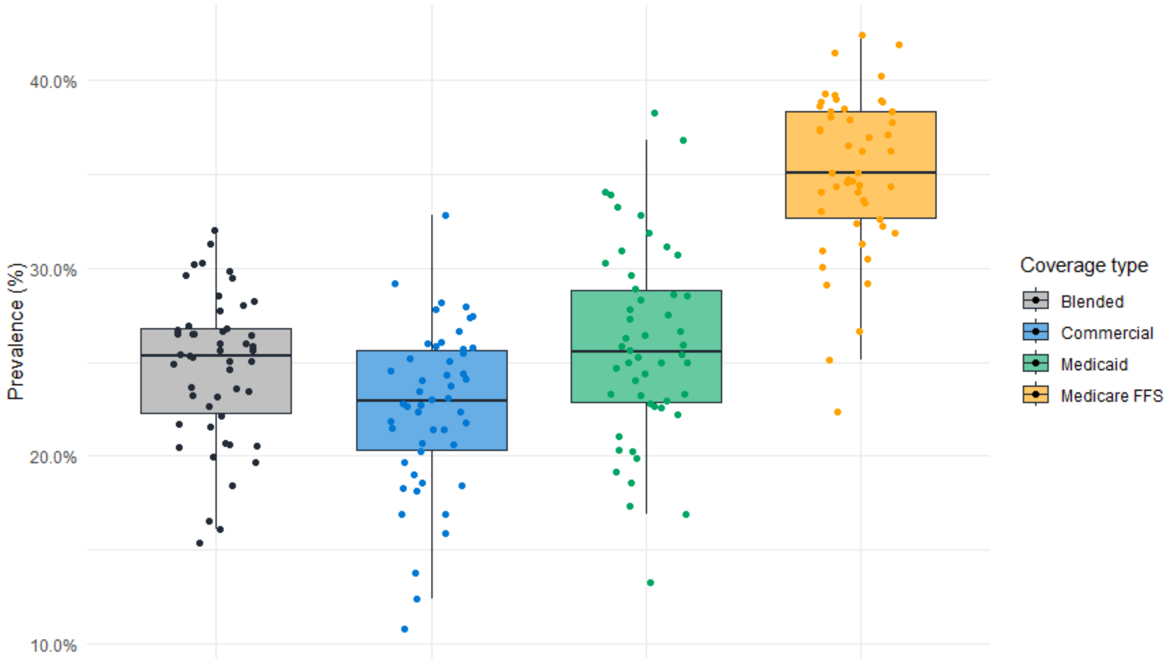
FIGURE 1 – PREVALENCE OF DIAGNOSES FOR ANY BEHAVIORAL HEALTH CONDITION BY STATE AND HEALTHCARE COVERAGE TYPE, 2021



As illustrated by both Figures 1 and 2, Medicare FFS beneficiaries on average had much higher prevalence rates than individuals with commercial or Medicaid healthcare coverage. In general, behavioral health conditions are less common for those with commercial insurance coverage than for those with Medicaid or Medicare FFS coverage.

The box and whisker plot in Figure 2 provides a visual representation of the variation between states in the prevalence of any behavioral health condition by healthcare coverage type. The height of the box represents the 25th and 75th percentiles, the horizontal line through the box represents the median prevalence rate, the vertical line represents 1.5 times the interquartile range (75th percentile minus the 25th percentile) and is used to identify outliers, which include any dots that fall outside the span of the vertical line. Each state is represented by a dot scattered around the plot. Appendix A provides further detail for each individual state.

FIGURE 2 – VARIATION BETWEEN STATES IN THE PREVALENCE OF ANY BEHAVIORAL HEALTH CONDITION, BY HEALTHCARE COVERAGE TYPE, 2021



Diagnosed prevalence of suicidal ideation and intentional self-harm

Across three major healthcare coverage types in the United States combined (commercial, Medicare FFS, and Medicaid), we found that 0.3% of individuals had a diagnosis for at least one form of suicidal ideation or intentional self-harm in 2021 (see the Methodology section for specific identification criteria used). Among all states, the prevalence of diagnosed suicidal ideation or intentional self-harm was highest in Ohio, where 0.4% had diagnoses related to suicidal ideation or intentional self-harm, and lowest in Hawaii, at 0.04%.

Figure 3 illustrates the prevalence of individuals with diagnoses for suicidal ideation or intentional self-harm by state and healthcare coverage type. Like Figure 1, the chart is sorted based on the blended prevalence rate across the included healthcare coverage types for each state. As before, we could not report Medicare Advantage rates at the state level within this figure, but instead report results by Census division in Appendix B.

FIGURE 3 – PREVALENCE OF DIAGNOSES FOR SUICIDAL IDEATION AND INTENTIONAL SELF-HARM BY STATE AND HEALTHCARE COVERAGE TYPE, 2021

1.0%
0.9%
0.8%
0.7%
0.6%
0.5%
0.4%
0.3%
0.2%
0.1%
0.0%

HI NM VT MS SD GA DE TX AR WY NY ND ME CA SC AL RI NJ CO NE OR FL AZ MD NC ID KS OK KY TN NH NV WV CT MT WA IL VA IN AK MI LA IA WI PA UT MA MN MO OH

Commercial Medicare FFS Medicaid Blended

Self-reported measures of mental health

While prevalence measures derived from healthcare claims data reflect diagnoses that were observed and recorded in healthcare settings, these measures do not necessarily reflect mental health symptoms that do not meet clinical diagnostic criteria, or that were not presented to providers. To provide a sense of how individuals subjectively describe their own mental health, we have included two self-reported metrics from the Behavioral Risk Factor Surveillance System (BRFSS, as summarized by County Health Rankings), including the percentage of adults with frequent mental distress (at least 14 days per month) and the average number of poor mental health days in the past month.[20]

About 14% of adults in the United States reported having frequent mental distress. South Dakota had the lowest percentage of adults experiencing frequent mental distress at 9.7%, and Arkansas had the highest at 18.7%. Furthermore, Americans reported an average of 4.4 days of poor mental health in the past month. Louisiana had the highest number of poor mental health days in the past month (5.7), and Illinois had the fewest (3.2).

Figures 4 and 5 provide a visual representation of variation in the rates of frequent mental distress and poor mental health days across the United States

FIGURE 4 – PERCENT OF ADULTS WITH FREQUENT MENTAL DISTRESS BY STATE, BRFSS 2020

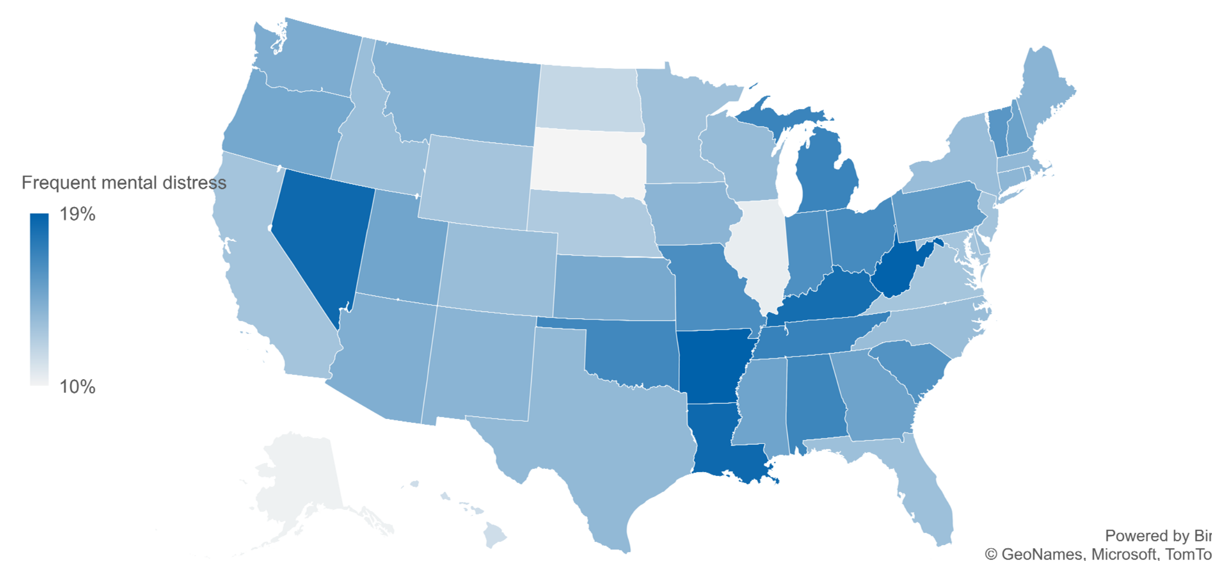
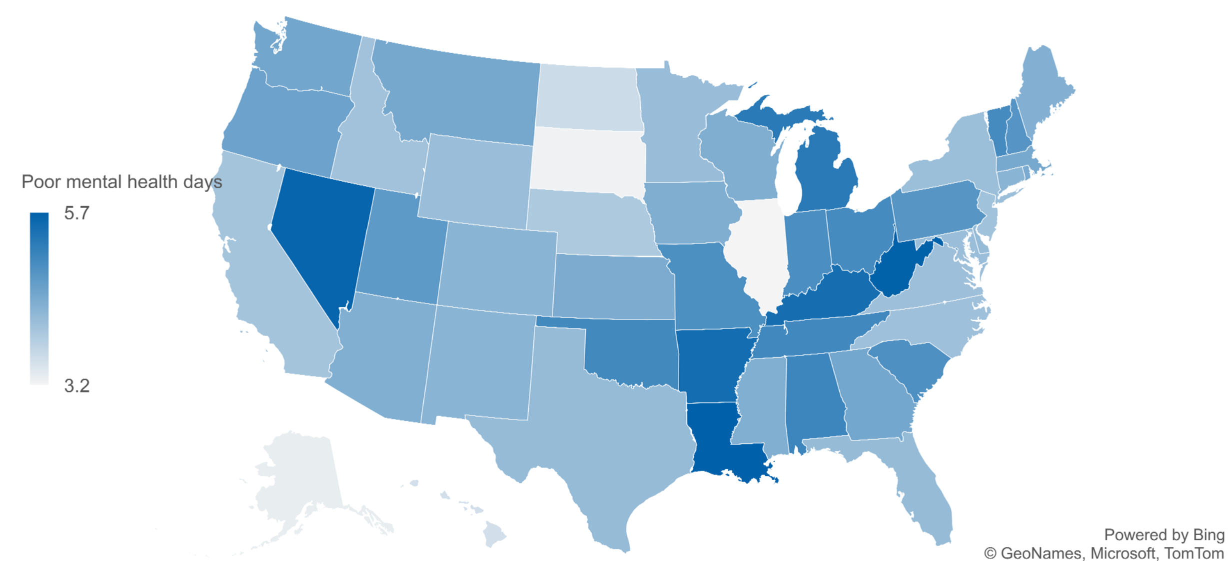


FIGURE 5 – AVERAGE NUMBER OF POOR MENTAL HEALTH DAYS IN THE PAST MONTH BY STATE, BRFSS 2020



Suicide and drug overdose death rates

The complete impact of unmet behavioral health needs is difficult to measure. However, rates of the most adverse outcomes, such as suicide and drug overdose deaths, may provide some perspective. According to the National Center for Health Statistics – Mortality Files (NCHS, as compiled by County Health Rankings), the national average suicide death rate was 13.8 per 100,000 from 2016-2020, and the national average drug overdose death rate was 23.3 per 100,000 from 2018-2020. These rates vary widely between states, ranging from 6.2 to 27.4 suicide deaths per 100,000 for Washington D.C. and Wyoming, respectively, and from 8.5 to 56.8 drug overdose deaths per 100,000 for South Dakota and West Virginia, respectively. Figures 6 and 7 provide a visual representation of variation across the nation for each metric.

FIGURE 6 – SUICIDE DEATH RATES PER 100,000 POPULATION BY STATE, NCHS 2016-2020

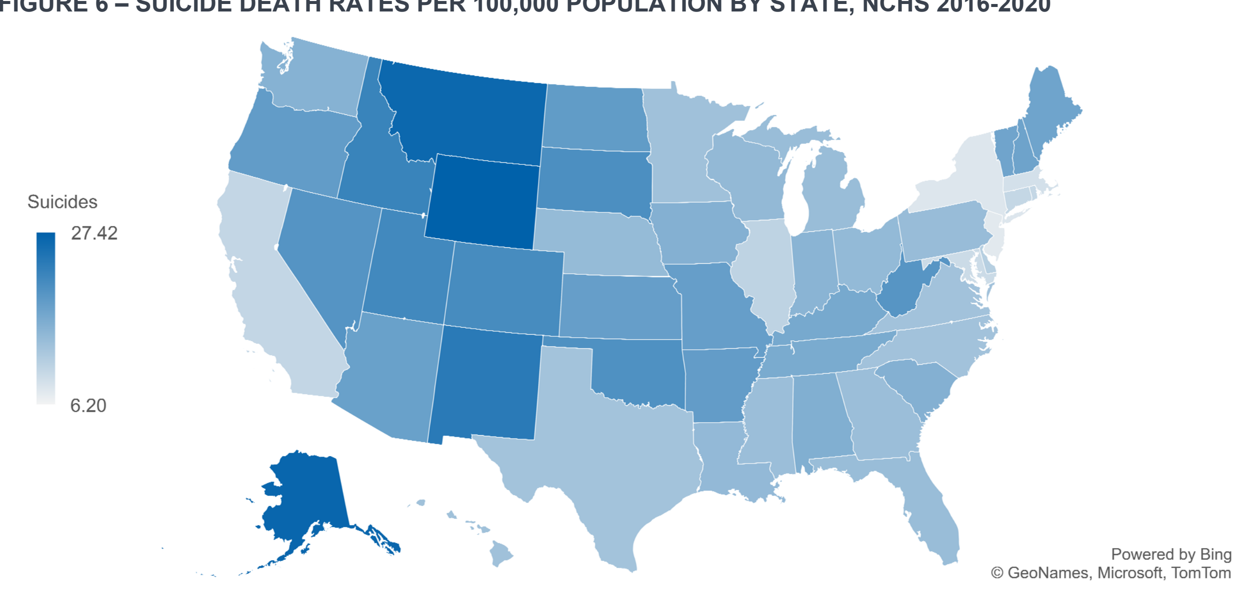
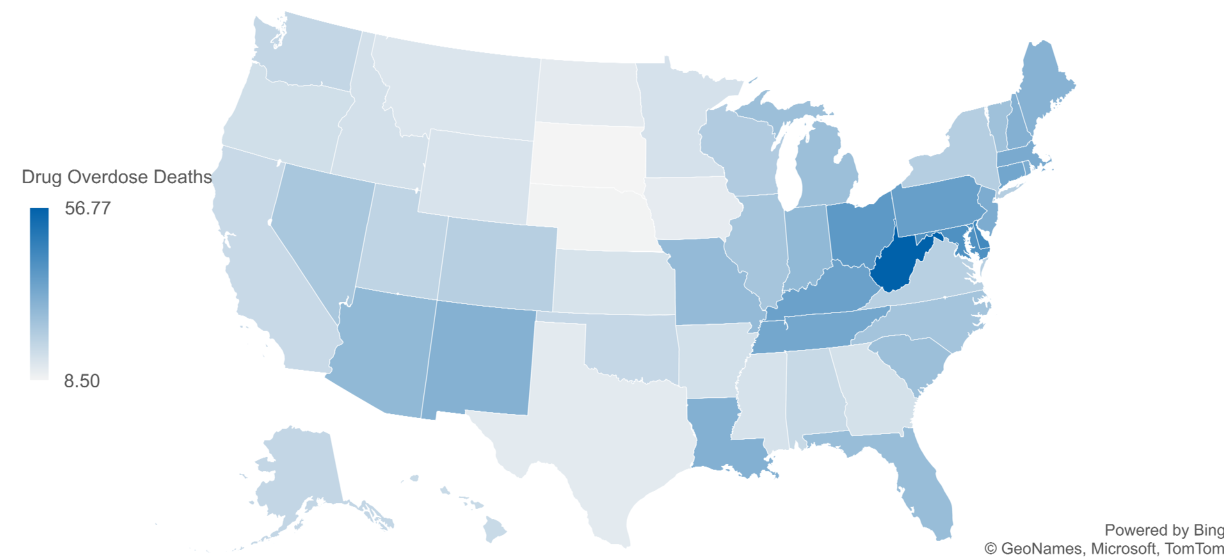


FIGURE 7 – DRUG OVERDOSE DEATH RATES PER 100,000 POPULATION BY STATE, NCHS 2018-2020



B. MEASURES OF BEHAVIORAL HEALTH TREATMENT PATTERNS

Measures of the prevalence of behavioral health conditions provide context on the underlying demand for behavioral healthcare, but not how individuals are currently engaging with care. To this end, we selected the following measures to describe variation in behavioral health treatment patterns among states:

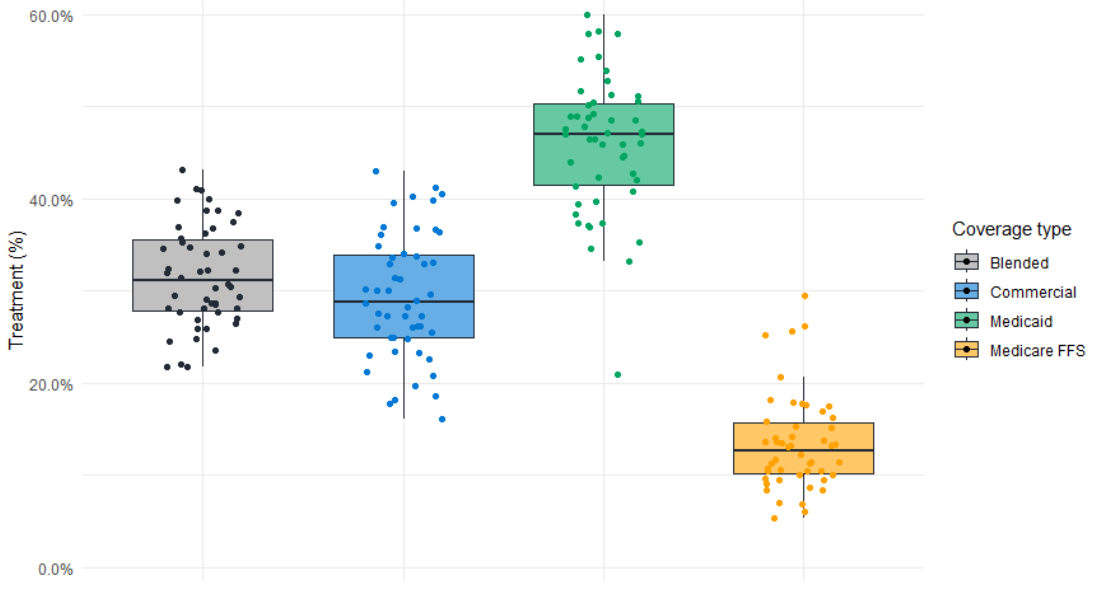
- Percent of individuals with a behavioral health diagnosis that received any specialty behavioral healthcare services.
- Average number of outpatient behavioral health therapy visits in a year for those receiving therapy.
- Percent of emergency department visits with a diagnosis for any behavioral health condition in the first or second position.
- Percent of emergency department visits or inpatient hospitalizations for any behavioral health condition with timely follow-up after discharge.

In the prior section, we describe the prevalence of diagnosed behavioral health conditions based on diagnoses present on claims data, but the presence of a diagnosis code does not necessarily reflect that an individual received any services specifically focused on their behavioral health condition. Further, many individuals may, out of necessity or preference, manage their behavioral health conditions exclusively through a primary care provider or other providers not specializing in behavioral health. Also, when individuals do receive care from a provider specializing in behavioral health, there can be significant variation in the amount or duration of specialty care received. Finally, individuals experiencing hospitalizations or emergency department visits for diagnoses related to behavioral health are often in a state of crisis, and effective follow-up care is critical to a successful discharge and recovery.

Proportion of individuals with a behavioral health diagnosis that received any specialty behavioral healthcare services

Across three major healthcare coverage types in the United States, 33% of individuals who were diagnosed with a behavioral health condition received treatment from a behavioral health specialist within the same year (see the Methodology section for included treatment types). These rates are lowest in Texas where 22% of those with a behavioral health diagnosis received care from a behavioral health specialist. Note that some individuals may appropriately be treated for behavioral health conditions by primary care or other types of providers. We have not attempted to determine or measure adherence to the ideal treatment path for different individuals. Figure 8 below displays variation among states in the percentage of individuals with behavioral health diagnoses that received care from a behavioral health specialist by healthcare coverage type.

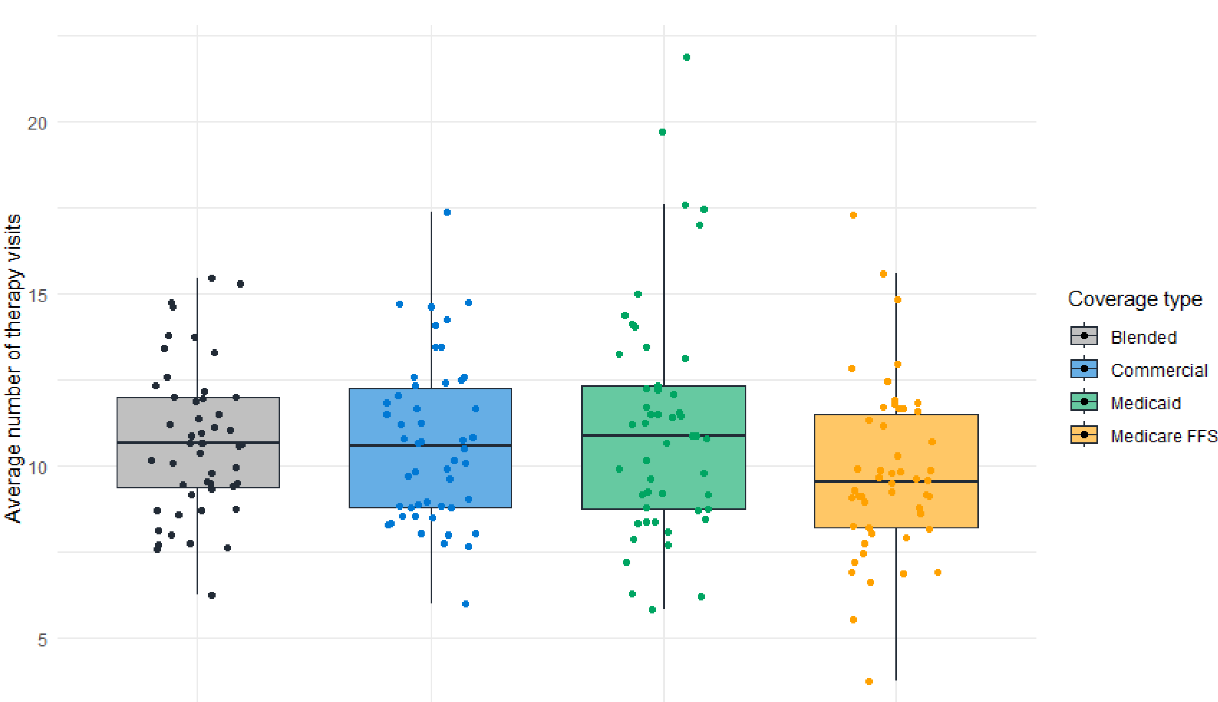
FIGURE 8 – PERCENT OF INDIVIDUALS WITH BEHAVIORAL HEALTH DIAGNOSES RECEIVING CARE FROM A BEHAVIORAL HEALTH SPECIALIST, BY HEALTHCARE COVERAGE TYPE, 2021



Average number of outpatient behavioral health therapy visits in a year for those receiving therapy

Across three major healthcare coverage types in the United States, we found that the population that received any outpatient behavioral health therapy averaged 10.8 therapy visits per year. The average number of therapy visits per year was lowest in Alabama with an average of 6.2 visits per year, and highest in Vermont at 15.5 visits per year. Interestingly, Alabama also has one of the lowest percentages of people with a behavioral health diagnosis receiving specialty treatment (23.6%), but Vermont did not have one of the highest rates and rather fell somewhere in the middle with 30.3% of individuals receiving specialty treatment. Variation between healthcare coverage types was less pronounced for this measure than for many others included in this report. Figure 9 shows the variation in this metric across the nation by healthcare coverage type.

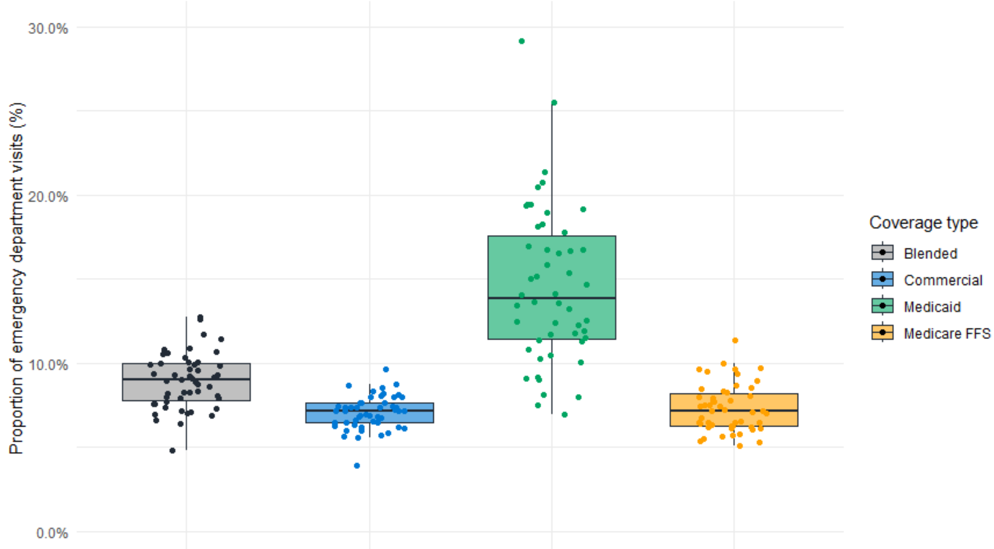
FIGURE 9 – AVERAGE NUMBER OF OUTPATIENT THERAPY VISITS IN A YEAR FOR THOSE RECEIVING THERAPY, BY HEALTHCARE COVERAGE TYPE, 2021



Percent of emergency department visits with a diagnosis for any behavioral health condition in the first or second position

Emergency department (ED) visits are often used as a measure of behavioral health access and quality. Ideally, behavioral health conditions could be managed to avoid emergencies that necessitate visits to emergency departments. However, individuals with under-managed conditions or that face barriers to outpatient care may ultimately end up in the ED for care. Rates of timely follow-up after emergency departments for behavioral health conditions are also included in some schemas that are commonly used to assess the health system performance related to quality of care. Across three major healthcare coverage types, we found that approximately 8% of emergency department visits nationwide were accompanied by a diagnosis for a behavioral health condition in the first or second position. This percentage ranged from approximately 5% (Texas) to 13% (Maine) across the nation. Figure 10 displays the detailed results by state and healthcare coverage type.

FIGURE 10 – PERCENTAGE OF EMERGENCY DEPARTMENT VISITS WITH A DIAGNOSIS FOR ANY BEHAVIORAL HEALTH CONDITION IN THE FIRST OR SECOND POSITION, BY HEALTHCARE COVERAGE TYPE, 2021

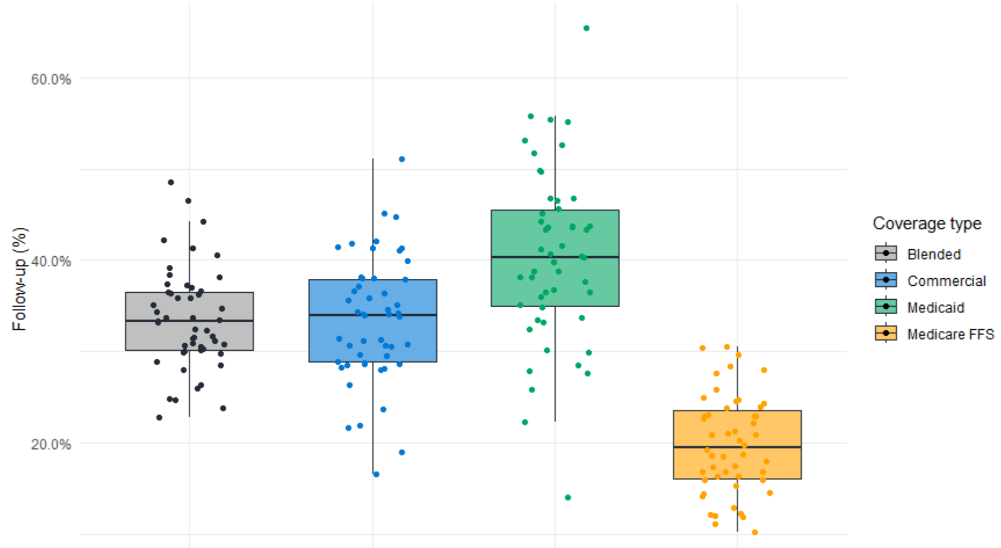


Note that ICD-10-CM coding guidelines specify criteria for identifying the principal or first-listed diagnosis—but sequencing of secondary diagnoses is not necessarily based on order of clinical significance.[21] In some cases, specific payers, performance measurement programs, risk adjustment methodologies, or other factors may introduce incentives that influence sequencing of secondary codes, and in other cases the sequencing is simply alphanumerical. As a result, the percentage of emergency department visits that involve a behavioral health diagnosis in any position is likely higher than reported here, and the percentage of such visits with a principal diagnosis for behavioral health is likely lower than reported here. These results are intended to inform discussions of geographic variation more so than absolute levels.

Percent of emergency department visits or inpatient hospitalizations for any behavioral health condition with timely follow-up after discharge

When inpatient hospitalization or emergency department visits are needed, appropriate outpatient follow-up care is critical to successful discharge and recovery. Timely outpatient follow-up care after discharge is commonly used as an indicator of quality of care. Across three major healthcare coverage types, we found that 34% of inpatient or emergency visits had timely follow up care (within 30 days of discharge) across the United States. Timely follow-up rates vary significantly by healthcare coverage type and state. Figure 11 illustrates the variation in follow-up rates by healthcare coverage type. There is a much narrower range of rates between states for the Medicare FFS and commercially insured populations as compared with the Medicaid population. The Medicaid population in Vermont has the highest rate of timely follow-up rate (65%) while the Medicare FFS population in Oklahoma has the lowest (10%).

FIGURE 11 – PERCENT OF HOSPITALIZATIONS AND EMERGENCY DEPARTMENT VISITS FOR BEHAVIORAL HEALTH CONDITIONS WITH TIMELY FOLLOW-UP CARE, BY HEALTHCARE COVERAGE TYPE, 2021



C. MEASURES OF THE AVAILABILITY AND AFFORDABILITY OF BEHAVIORAL HEALTH PROVIDERS

The lack of available behavioral healthcare providers can be a major barrier to accessing behavioral healthcare across much of the United States. The behavioral healthcare provider shortage in the United States. is well-documented and by some measures behavioral health providers are reimbursed at lower rates for comparable services than their physical health counterparts, which can influence provider insurance acceptance rates and out-of-pocket costs for patients.[22,23] We used the following measures to understand these barriers across the country:

- Percent of population living within a designated Mental Health Provider Shortage Area.
- Percent of psychiatrist need met.
- Ratio of population to mental health providers.
- Therapy access benchmark ratio.
- Percentage of costs for behavioral healthcare that are for services provided out-of-network (for commercial plans with out of network benefits).
- Provider insurance acceptance rates.
- Patient out-of-pocket and self-pay costs for behavioral health services.
- U.S. population insurance coverage.
- U.S. population income levels.

These measures have been selected to provide insights on a variety of factors that influence the availability and affordability of behavioral healthcare in the United States. Where provider shortages exist in a geographic area, individuals may struggle to access care even if affordability is not a concern. For those without healthcare coverage or where many providers do not accept healthcare coverage, access may be a challenge even if the overall supply of providers is adequate.

Percent of population living in designated Mental Health Provider Shortage Areas (HPSA)

Mental Health Provider Shortage Areas (HPSA) are a designation used by the Health Resources and Services Administration (HRSA) to identify geographic areas, population groups, or facilities with a shortage of mental health providers. HRSA uses the ratio of mental health providers to population, the population's need for mental health services, and accessibility of services to determine HPSA designations.[24]

Based on HPSA designations and U.S. Census Bureau data, 174.7 million people (52.7% of the U.S. population) live in counties that are entirely designated as shortage areas, and only 23.7 million people (7.2%) live in counties that are not at all designated as shortage areas. The remaining 132.8 million people (40.1%) live in counties that are partly designated as shortage areas.

FIGURE 12 – PERCENTAGE OF POPULATION LIVING IN MENTAL HEALTH PROFESSIONAL SHORTAGE AREAS, HRSA 2023

Below, we report the percentage of the population in each state that lives in counties that are entirely designated as Mental Health Professional Shortage Areas (Figure 13), that live in counties that are partly designated as Mental Health Professional Shortage Areas (Figure 14), or that live in counties that are not at all designated as Mental Health Professional Shortage Areas (Figure 15). For three states (including Idaho, Montana, and Utah) the entire population

(100%) resides in shortage areas. Vermont is the state least impacted by shortage areas, with over half of its population (51.1%) residing in counties that are not at all designated as shortage areas.

FIGURE 13 – PERCENTAGE OF POPULATION LIVING IN COUNTIES THAT ARE FULLY DESIGNATED AS MENTAL HEALTH PROFESSIONAL SHORTAGE AREAS, 2023

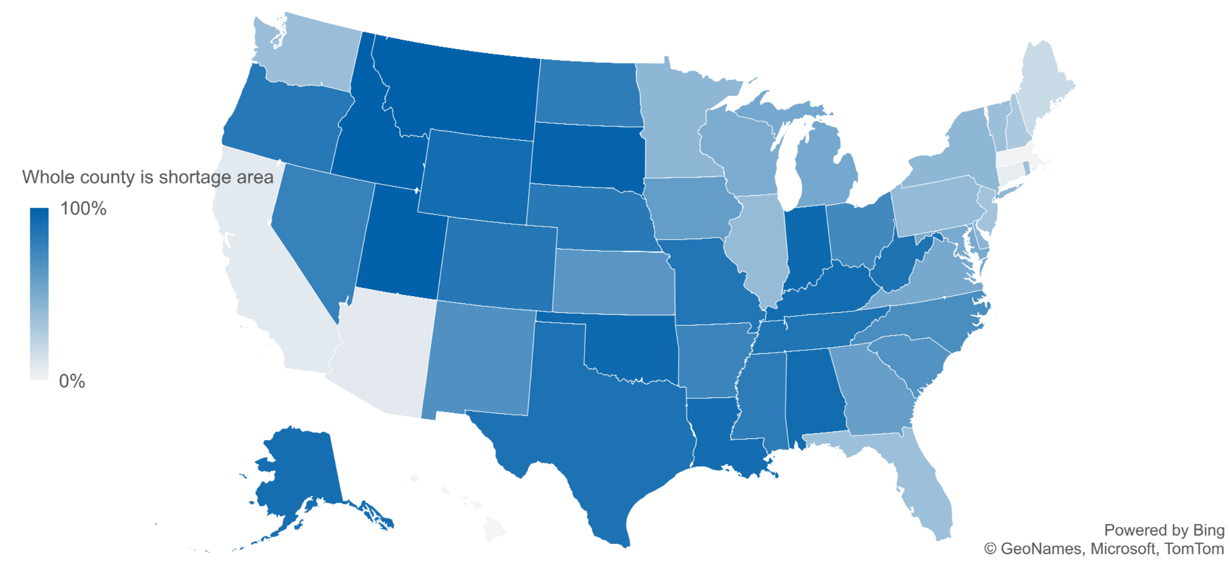


FIGURE 14 – PERCENTAGE OF POPULATION LIVING IN COUNTIES THAT ARE PARTLY DESIGNATED AS MENTAL HEALTH PROFESSIONAL SHORTAGE AREAS, 2023

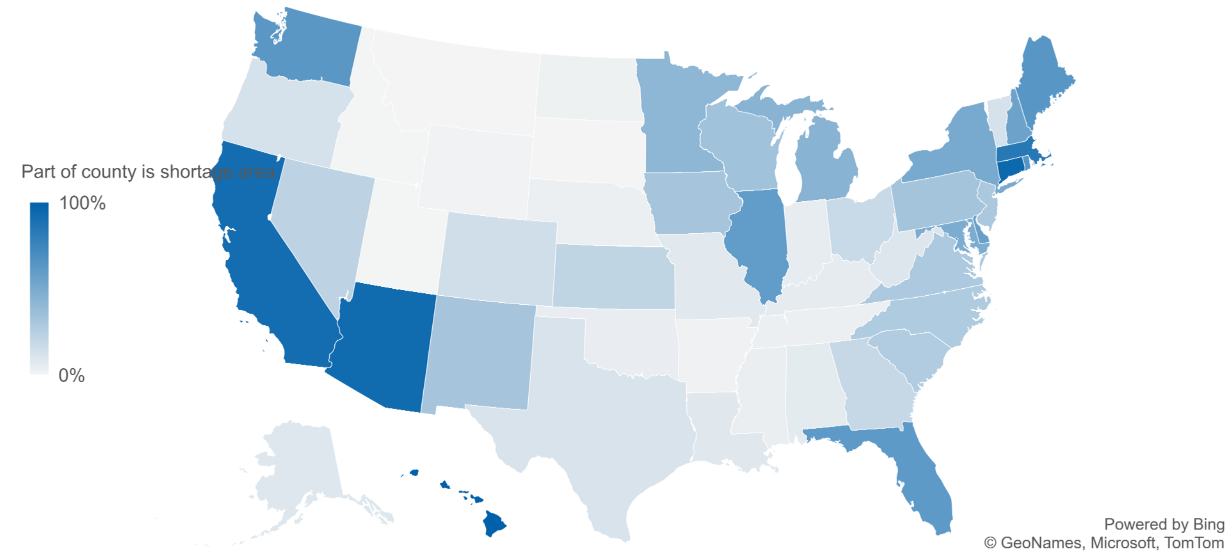
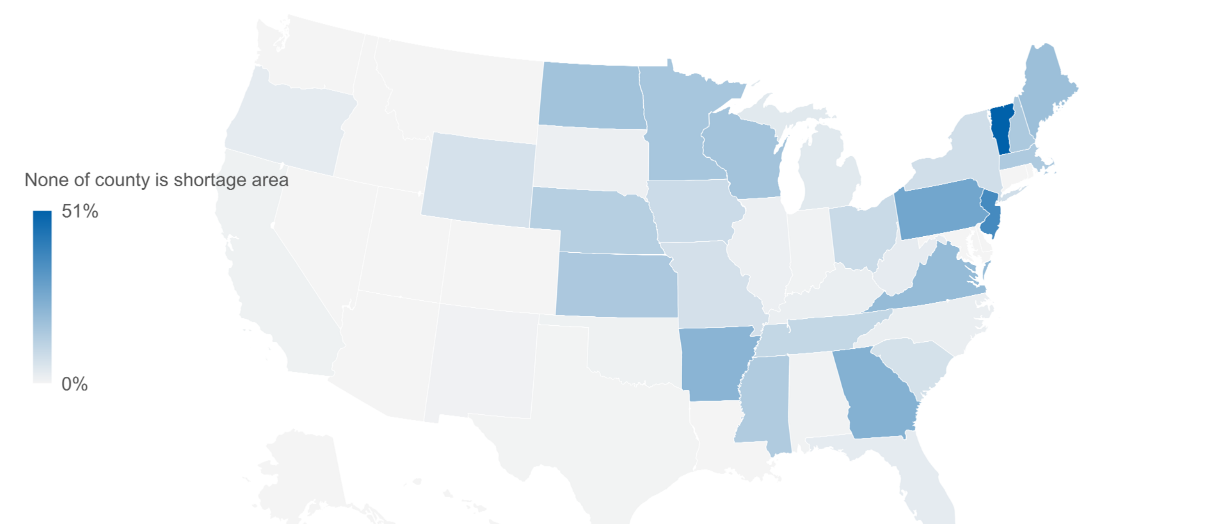


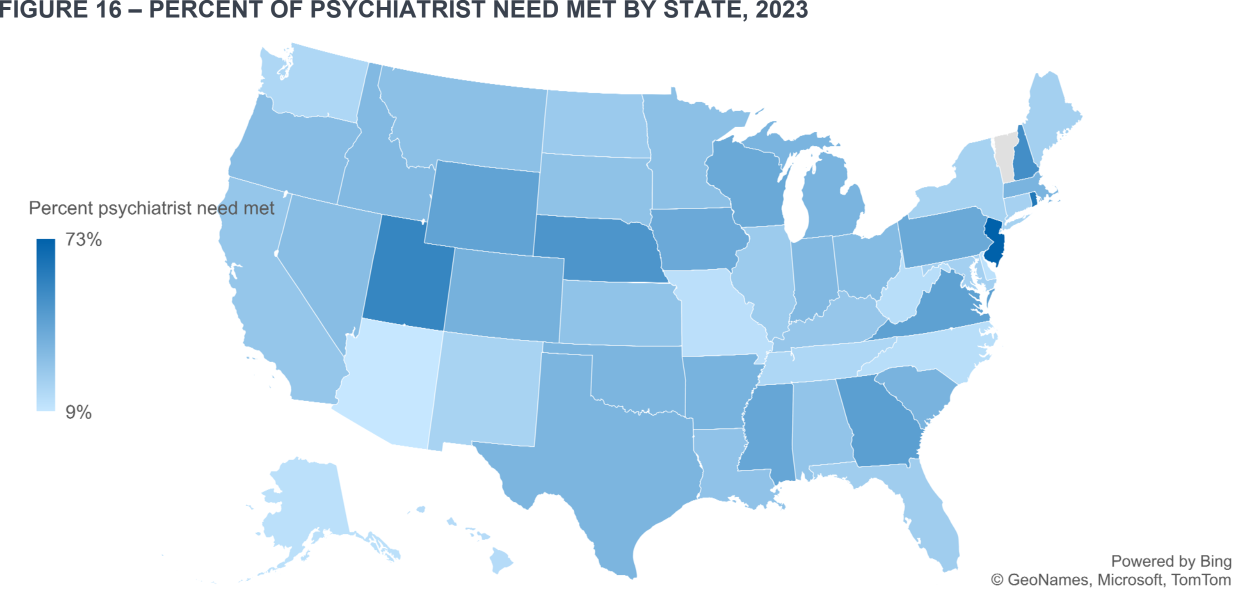
FIGURE 15 – PERCENTAGE OF POPULATION LIVING IN COUNTIES THAT ARE NOT DESIGNATED AS MENTAL HEALTH PROFESSIONAL SHORTAGE AREAS, 2023



Percent of psychiatrist need met

Based on provider ratios used to determine HPSA designations, only 27.7% of psychiatrist need is met across the United States, and psychiatrist need is not fully met in any of the 50 states[25]. Arizona and Delaware have the lowest percentage of psychiatrist need met with 8.5% and 11.6% need met, respectively. New Jersey has the highest level of need met with 72.7% of need met, followed by Rhode Island with 61.9%. Figure 16 below shows the variation in this metric across the nation.

FIGURE 16 – PERCENT OF PSYCHIATRIST NEED MET BY STATE, 2023

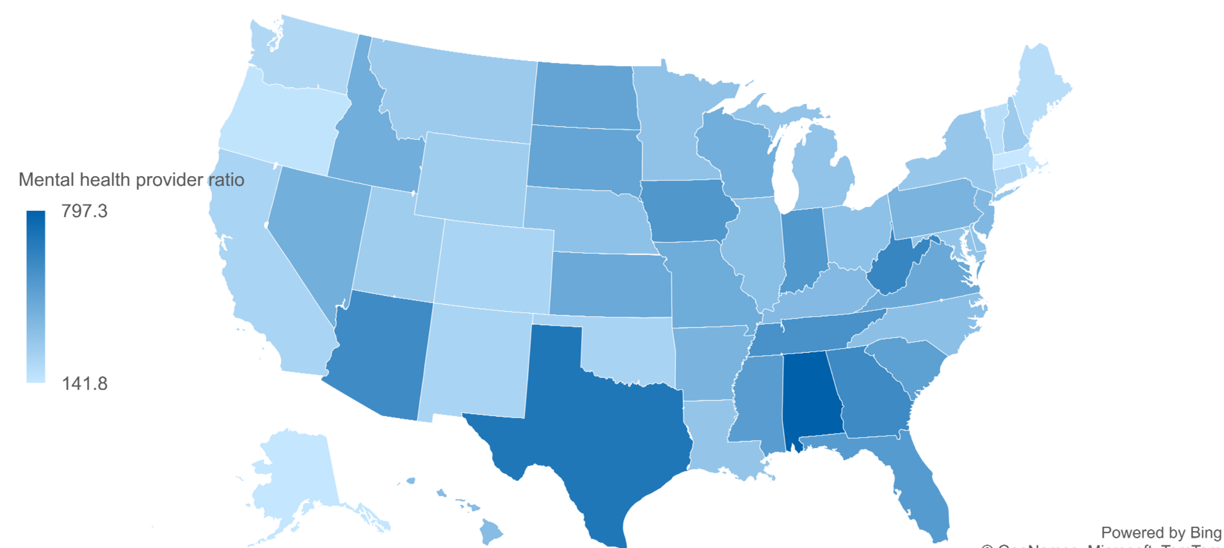


Ratio of population to mental health providers

While the preceding metric focused specifically on psychiatrists (who have medication prescribing privileges) this metric includes a broader range of mental health providers, including psychiatrists, psychologists, licensed clinical social workers, counselors, marriage and family therapists, mental health providers that treat alcohol and other substance

use, and advanced practice nurses specializing in mental healthcare.[26] When looking at the mental health provider workforce more broadly, nationally there are 338.2 people per mental health provider. Mental health provider ratios range from 797.3 people per provider in Alabama to 141.8 people per provider in Massachusetts. Figure 17 below shows the variation in this metric across the nation.

FIGURE 17 – RATIO OF POPULATION TO MENTAL HEALTH PROVIDERS BY STATE, 2022



Therapy Access Ratio

In this report, we introduce the Therapy Access Ratio (TAR), a novel metric designed to illustrate the relationship between provider supply and the use of therapy services across the United States, factoring in regional differences in the prevalence of behavioral health conditions.

The TAR measures how the number of outpatient behavioral health therapy visits that a person with a behavioral health diagnosis uses varies between those living in areas with different levels of behavioral health provider supply. We use the average number of therapy visits per person with a behavioral health diagnosis in Metropolitan Statistical Areas (MSAs) with the highest supply (top decile) of behavioral health providers as a reference point. This rate serves as the reference point for comparison for each other MSA. For each MSA, the TAR is expressed as a percentage, comparing the observed number of therapy visits per person to the reference rate. At the state level, the TAR represents a population-prevalence weighted average of the MSAs within the state. A TAR of 100% indicates that individuals in the region with behavioral health diagnoses receive as many therapy visits per person as those in areas with the highest behavioral health provider supply density, while a TAR of 50% signifies that individuals receive half as many visits.

There is significant variation in this ratio across the United States. Those with behavioral health conditions living in Massachusetts and Florida received 97.9% and 22.9%, respectively, of the therapy visits compared to those in areas with the highest provider density. Figure 18 below summarizes the Therapy Access Ratio across healthcare coverage types. Figure 19 illustrates the national variation in the ratio across three major insurance coverage types combined.

FIGURE 18 – VARIATION AMONG STATES IN THERAPY ACCESS RATIO, BY HEALTHCARE COVERAGE TYPE, 2021

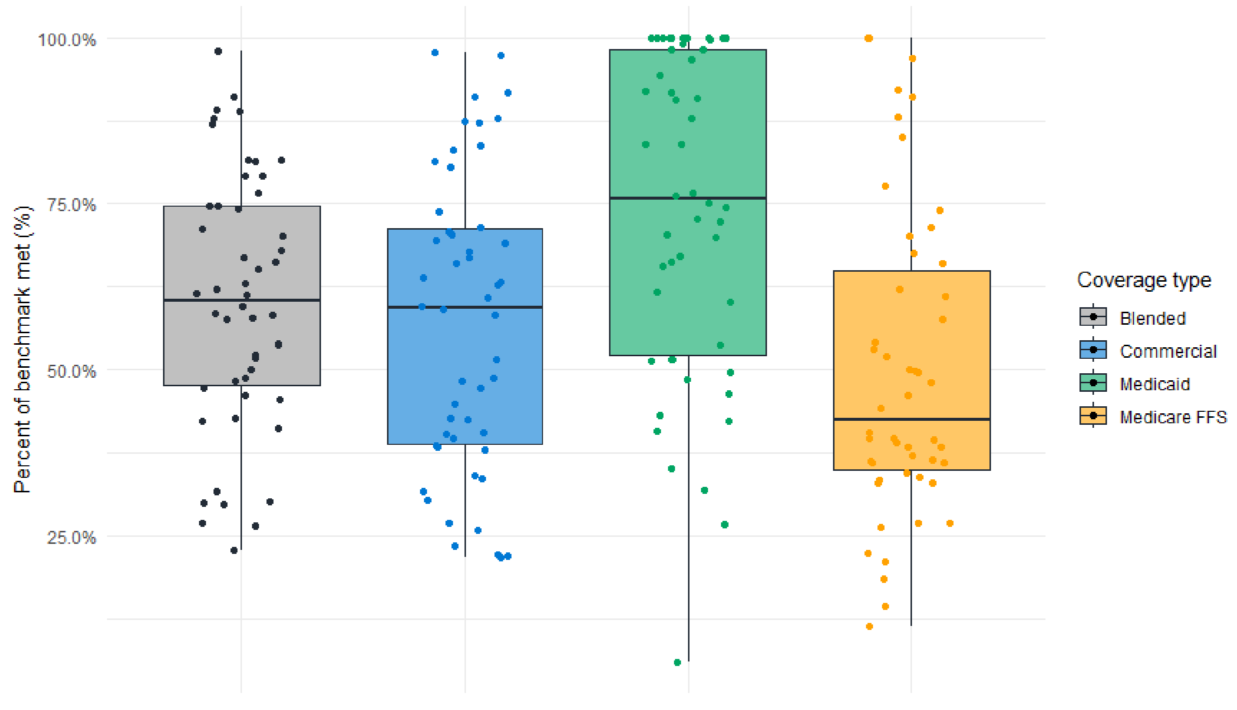
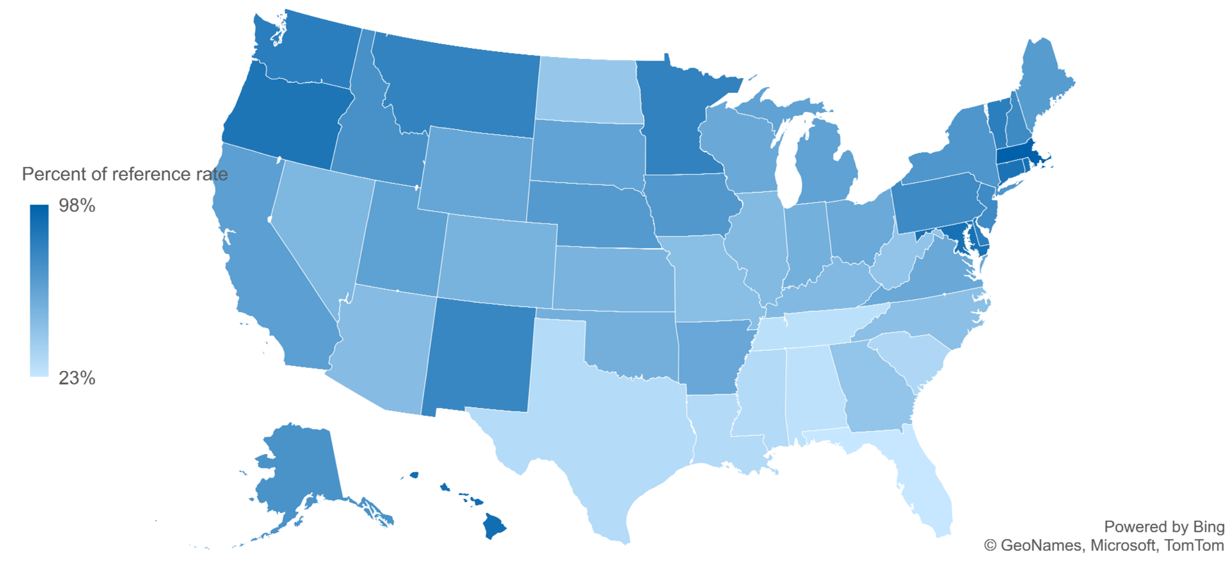


FIGURE 19 – VARIATION AMONG STATES IN THERAPY ACCESS RATIO, MAJOR HEALTHCARE COVERAGE TYPES COMBINED, 2021



Percent of costs for behavioral healthcare that are for services provided out of network

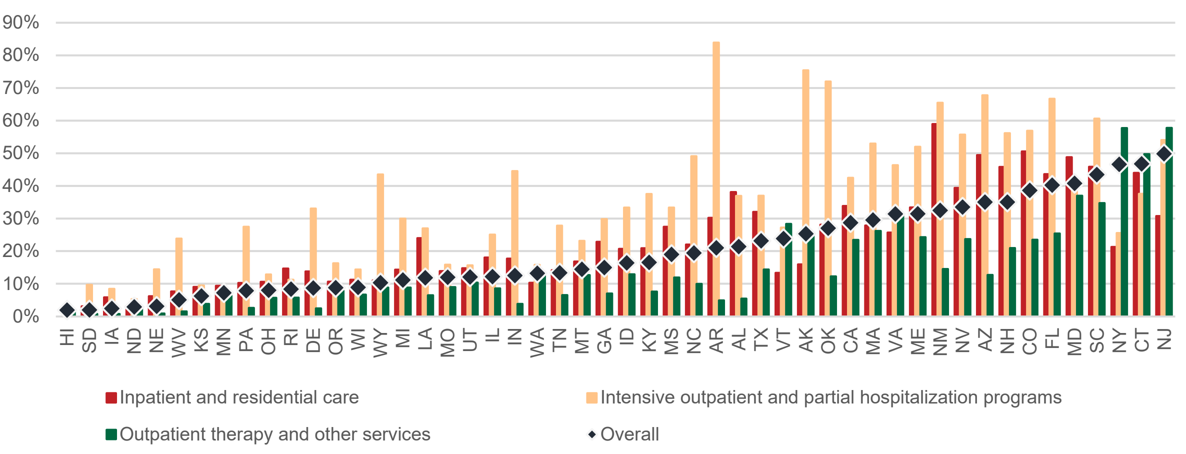
Out-of-network services often come with higher patient cost sharing requirements and may necessitate additional steps for coverage approval. The percentage of care provided out of network may serve as an indicator of the adequacy of commercial insurance networks in providing patients with access to in-network care.

For this study, we analyzed the percentage of costs for behavioral health services that were provided out of network in commercial health plans that offer out-of-network coverage. We divided these services into three broad categories: inpatient and residential care, intensive outpatient and partial hospitalization programs, and outpatient therapy and other services. Note that Medicare, Medicaid, and commercial health plan types that do not typically cover out-of-network care were not included in this measure.

Overall, we found that 16.4% of costs for behavioral health services in these plans was for out-of-network providers. More specifically, 18.4% of costs for inpatient and residential care, 28.3% of costs for intensive outpatient and partial hospitalization programs, and 13.2% of outpatient therapy and other services costs were for out-of-network providers. New Jersey has the highest out of network rate, where 49.9% of all costs for behavioral healthcare were for out-of-network care, and Hawaii and South Dakota had the lowest rates at 1.9% and 2.0%, respectively. Figure 20 displays the percentage of costs for behavioral health services that were for out-of-network care by state and by category of service.

Note that while Milliman has reported extensively on disparities in out-of-network care in past reports, these metrics are not directly comparable to prior publications because this analysis examines out-of-network usage in terms of costs, rather than in terms of visits or units of service. Because out-of-network providers may charge patients different rates than in-network providers, this will not always correlate out-of-network use rates calculated based on visits or units of service, but accurately reflects the impact of out-of-network use on the cost of behavioral healthcare.

FIGURE 20 – PERCENT OF COSTS FOR BEHAVIORAL HEALTH SERVICES PROVIDED OUT-OF-NETWORK IN COMMERCIAL HEALTH INSURANCE PLANS THAT COVER OUT-OF-NETWORK SERVICES, 2021



Provider insurance acceptance rates

Low provider insurance acceptance rates can create financial barriers to care, even when individuals are insured. Nationally, psychiatrists tend to be less likely to accept all major insurance coverage types than other specialties. A recent study conducted by the Kaiser Family Foundation found that in 2019 across all non-pediatric office-based physicians, 89% accepted new Medicare patients and 91% accepted new privately insured patients, but only 60% of psychiatrists accepted new Medicare patients and 59% accepted new privately-insured patients.[27] In a separate report using 2017 survey data, the Medicaid and CHIP Payment and Access Commission (MACPAC) found that 45.5% of psychiatrists accepted new patients with Medicaid as compared to 74.3% across all specialty types.[28]

While insurance acceptance rates may vary from state to state, to our knowledge, state-level information on behavioral health provider insurance acceptance rates has not been reported in the literature.

Patient out-of-pocket and self-pay costs for behavioral health services

We measured affordability of care using patient out-of-pocket costs, patient self-pay costs when uninsured and the uninsured rate. We selected a frequently used service, 60 min Psychotherapy Visit, to demonstrate variation in self-pay and out-of-pocket costs for patients. Nationally, the average self-pay cost for someone without insurance coverage

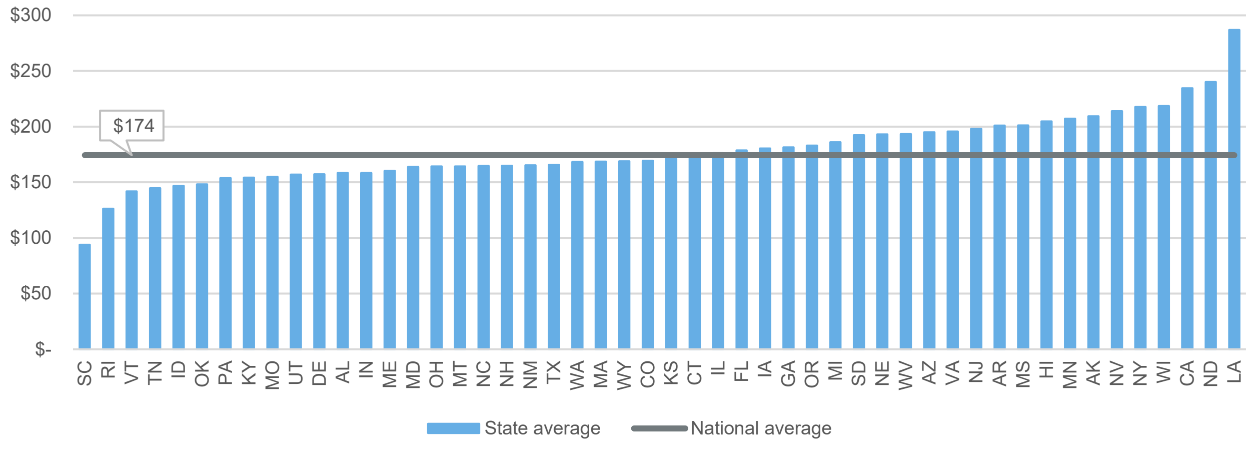
was $174 per visit. On the low end, South Carolina average self-pay costs are $94 per visit and on the high end, Louisiana average self-pay costs are $287 per visit. Among the commercially insured, the average out-of-pocket cost for an in-network visit was $23 (range: $1 - $46) and out-of-network was $53 per visit (range: $24 - $98). Among those with Medicare, the average cost per visit was $29 for Medicare FFS and $14 for Medicare Advantage. Out-of-pocket costs under Medicaid for covered services are generally nominal and are not reported.

FIGURE 21 – AVERAGE OUT-OF-POCKET COSTS FOR A 60 MINUTE PSYCHOTHERAPY VISIT, BY HEALTHCARE COVERAGE TYPE, 2021

	No Coverage	Commercial		Medicare FFS	Medicare Advantage
	Self-pay	In-network providers	Out-of-network providers	Covered providers	Covered providers
Lowest cost state/division*	$93.92	$0.98	$24.08	$25.61	$5.92
National average cost	$174.46	$22.71	$52.87	$29.12	$13.83
Highest cost state/division*	$286.89	$45.50	$97.84	$37.33	$29.92

**Commercial and Medicare FFS ranges are at the state level; Medicare Advantage ranges are at the Census division level*

FIGURE 22 – AVERAGE SELF-PAY COSTS FOR A 60 MINUTE PSYCHOTHERAPY VISIT, 2021

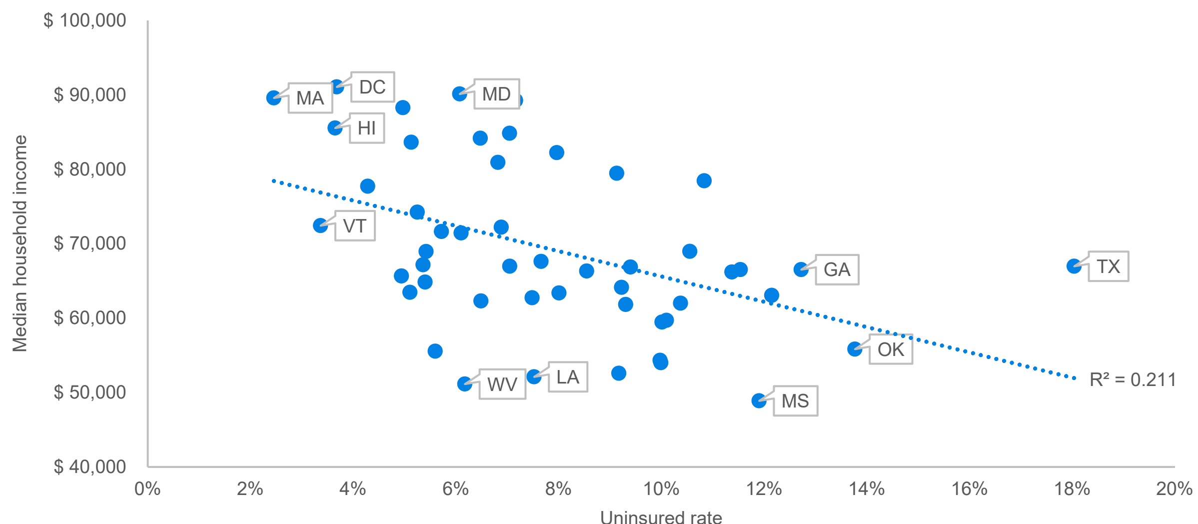


Many other services for behavioral health can be substantially more expensive than a standard psychotherapy visit, however we have focused on costs for this service as therapy visits often serve as an entry point for other types of care, and thus can represent the first financial barrier that many individuals may face when seeking care.

Uninsured rate and median household income

Healthcare coverage can help reduce financial barriers to care, but 8.6% of the U.S. population was uninsured in 2021. At the state level, the uninsured rate ranges from 2.5% in Massachusetts to 18% in Texas. The out-of-pocket costs that individuals face (including either self-pay costs for those without insurance or patient cost sharing amounts for those with insurance) can serve as a barrier to care. As of 2021, 12.6% of the U.S. population lives below the Federal Poverty Level (a measure of household income referenced in many state and federal assistance programs that varies based on family size).[29] By state, the proportion of the population with incomes below the FPL ranges from 7.4% in New Hampshire to 19.4% in Mississippi. Uninsured rates tend to be inversely correlated with median household income by state. Figure 23 displays the relationship between the uninsured rate and median household income across the nation and highlights states that fall in the top 3 or bottom 3 of each metric.

FIGURE 23 – SCATTER PLOT OF UNINSURED RATE VERSUS MEDIAN HOUSEHOLD INCOME, BY STATE, 2021



Discussion

This report highlights the challenges of access to behavioral health services in the United States., a problem highlighted by but not created by the COVID-19 pandemic. The prevalence of behavioral health conditions has increased significantly in recent decades yet many Americans living with these conditions do not receive needed services and live in areas where behavioral health clinicians are in short supply.[30]

Not only is the United States. experiencing an overall shortage of providers, but there is an even greater shortage of culturally or linguistically representative care available. One study found that only 10% of practicing psychiatrists identified as Black or Hispanic, but almost one-third of the U.S. population identifies this way.[31] This shortage limits the ability for people to receive care from providers with which they share important aspects of their identity, which some studies have shown can improve health outcomes and patients' perceptions of their care experience.[32]

This report also underscores the significant geographic variation in access to behavioral health services across the country. The variation in measurement suggests policy solutions should be location and population specific rather than using a one-size-fits-all approach. Place-based context is critical when using these results to design effective solutions. Factors such as differences in behavioral health needs, the supply of behavioral health clinicians, provider networks, socioeconomic conditions, cultural attitudes, and local, state, and federal-level policies all influence the extent to which individuals can access these services. The study provides an overview of behavioral healthcare access measures across all 50 states, including details by healthcare coverage type, to inform the development of policy solutions or targeted interventions. Such policies or interventions should consider the multi-faceted causes of these issues to create effective solutions.

Methodology

DATA SOURCES

Measures for this report were constructed using a variety of data sources. We relied on three large, national research databases with administrative claims and enrollment data to derive diagnosis, cost, and utilization-based measures:

- 2021 Milliman Consolidated Health Cost Guidelines™ Database
  - The Milliman Consolidated Health Cost Guidelines Databases contain healthcare experience primarily for large group commercial members, using data contributed from a number of payers with which Milliman has data purchase or trade agreements. Milliman collects this data from various health plans for use in product development, research, and client projects.
- 2021 CMS 100% Research Identifiable Files (RIF) for Medicare
  - CMS 100% Medicare RIF contains detailed administrative claims data for all patients covered by Medicare FFS, including medical claims paid under Medicare Parts A and B and prescription drug claims paid under Part D.
- 2021 Transformed Medicaid and CHIP Statistical Information System (T-MSIS) data for Medicaid and CHIP
  - T-MSIS contains detailed administrative claims for all patients covered by Medicaid and CHIP.

In cases where metrics are reported as a blend across three major healthcare coverage types, we have weighted each type by total covered population estimates from U.S. Census and other data to normalize for differences between our study sample and the general population.

In addition to detailed administrative claim level datasets, we also utilized public data sources and publications for specific population, demographic, and self-reported health measures. For several of these measures, we relied on public data as compiled by County Health Rankings and Roadmaps, a program of the Robert Wood Johnson Foundation in collaboration with the University of Wisconsin Public Health Institute.[33] County Health Rankings and Roadmaps compiles data across publicly available health data sources including Behavioral Risk Factor Surveillance System (BRFSS), American Community Survey (ACS), and Small Area Health Insurance Estimates (SAHIE) related to health outcomes and risk factors. County Health Rankings data is available as statistically weighted, standardized data ranked by state or raw, unranked data. We used the raw, unranked data for our analysis. The following measures were sourced from the County Health Rankings 2023 report.

- Percent of Adults with frequent mental distress
- Rate of poor mental health days
- Rate of drug overdose deaths
- Rate of suicide deaths
- Mental health providers
- Median household income
- Uninsured rate
- State and county population estimates

Detailed specifications on measures compiled by County Health rankings can be found at countyhealthrankings.org.

We also relied on detailed population statistics from the U.S. Census Bureau American Community Survey (ACS).[34] The American Community Survey is an annual survey conducted on a sample of the U.S. population that describes social, economic, and demographic characteristics. Geographic estimates are produced using statistical techniques and datasets are available for 1- and 5- year estimates. The following measures were sourced from the 2021 American Community Survey 5-year estimates.

- Private insurance: number of people covered.
- Medicare: number of people covered.
- Medicaid: number of people covered.

ACS defines healthcare coverage as follows:

- "Medicaid: Includes those covered by Medicaid, Medical Assistance, Children's Health Insurance Plan (CHIP) or any kind of government-assistance plan for those with low incomes or a disability, as well as those who have both Medicaid and another type of coverage, such as dual eligibles who are also covered by Medicare.
- Medicare: Includes those covered by Medicare, Medicare Advantage, and those who have Medicare and another type of non-Medicaid coverage where Medicare appears to be the primary payer. Excludes seniors who also report employer-sponsored coverage and full-time work, and those covered by Medicare and Medicaid (dual eligibles)."

We also relied on Mental Health Professional Shortage Areas (HPSA) as defined by the Health Resources and Services Administration for parts of this analysis.[35]

SAMPLE SELECTION

For all measures derived from administrative healthcare claims data, we restricted our sample to individuals with 12 months of medical coverage in the 2021 calendar year. Information on the sample size used for this analysis by state and healthcare coverage type can be found in Appendix C.

IDENTIFICATION OF INDIVIDUALS WITH BEHAVIORAL HEALTH CONDITIONS:

Patients were considered to have a behavioral health condition if they met one of the following criteria:

- **Behavioral health conditions.** Codes in the F-series of the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) were considered behavioral, except for codes indicating a history of a condition, conditions in remission, substance use without complications, factors or symptoms associated with other disorders or diseases, individual symptoms that may not alone satisfy diagnostic criteria, etc. Patients were required to have at least one relevant ICD-10-CM code in any position on any claim.
- **Attempted suicide or intentional self-harm.** Individuals were included if they experienced an injury, poisoning by drugs, medications or biological substances, the toxic effects of chiefly nonmedicinal substances, or asphyxiation where the intent was coded as "intentional self-harm". Individuals were also included if they experienced suicidal ideation. For this measure we used ICD-10-CM codes according to the case definition developed by Hedegaard, et. al for an NCHS brief.[36] Patients were required to have at least one relevant ICD-10-CM code in any position on any claim.

IDENTIFICATION OF BEHAVIORAL HEALTH COSTS AND TREATMENT

We defined behavioral health specialty treatment to include the following:

- Inpatient hospitalizations with diagnosis-related-groups (DRG) related to behavioral health.
- Admissions to residential treatment facilities for mental health or substance use disorders.
- Intensive outpatient and partial hospitalization programs.
- Electroconvulsive therapy, transcranial magnetic stimulation, biofeedback, and other related therapies.
- Evaluation and management visits provided by psychiatrists or other psychiatrist-supervised clinicians.
- Outpatient counseling and psychotherapy services.
- Applied behavioral analysis for autism spectrum disorders.
- Behavioral health diagnostic and evaluation services, other than those provided as part of routine preventive screenings.
- Other miscellaneous outpatient services specific to behavioral health.

Primary care providers can sometimes be the first point of contact for some individuals with behavioral health conditions, can prescribe medications for behavioral health conditions, and can provide referrals to behavioral health specialists. Similarly, emergency departments are often used for behavioral healthcare when individuals are in crisis or if other appropriate outpatient care is not available promptly. However, we have not included these provider types in this metric as the intent is to reflect access to professionals and facilities that specialize in behavioral health.

Follow-up care after an inpatient hospitalization or emergency department visit with a diagnosis in the first or second position for a behavioral health condition was defined to include intensive outpatient care, partial hospitalization, or professional outpatient psychiatric visits within 30 days from the date of discharge. Note that related but not identical measures are included in some quality performance measurement initiatives. Our definition is not intended to replicate any particular definition or criteria used in any specific program.

Out-of-pocket costs were defined as the proportion of costs for services described above that were the responsibility of the patient. This does not include any balance billing that may have occurred by providers that sought payment from patients for differences between amounts billed by the provider and allowed by the healthcare payor. Self-pay cost was defined as the amount billed (prior to any negotiated discounts) by providers that also accepted commercial insurance coverage.

The Therapy Access Ratio is calculated as the difference between the average number of therapy visits received by individuals diagnosed with behavioral health conditions in a given MSA relative to the average number of therapy visits received by individuals with behavioral health conditions living in the top decile of MSAs with the highest behavioral health provider supply density. The metric is expressed as a percentage.

We identified 60-minute psychotherapy visits using CPT code 90837.

Caveats and limitations

This report describes measures related to the prevalence of behavioral health conditions, how individuals use behavioral healthcare, and barriers to access and affordability of behavioral healthcare. This study does not and is not intended to establish specific causal links between any of the measures studied. The causes and consequences of behavioral health conditions and challenges in the behavioral healthcare delivery system are myriad and beyond the scope of any individual study.

This study relies on commercial, Medicare FFS, and Medicaid administrative claims data to identify behavioral health conditions. As such, results may not be generalizable to individuals with other types of coverage such as TRICARE or Indian Health Services, or uninsured individuals.

To the extent that behavioral health conditions go unreported in the claims data, our measures based on administrative data might be understated. As the reach of digital behavioral health providers that do not always directly interact with health insurance carriers increases, healthcare claims data may increasingly understate the totality of behavioral health services and diagnoses.

For measures based on administrative claim data, our study only includes individuals with a full year of insurance eligibility, which includes a substantial majority of individuals with healthcare coverage available for study but excludes some individuals who were unable to maintain a full year of employment or who were not eligible for Medicare or Medicaid for the entire year. Due to rules against Medicaid disenrollment that were in place during the COVID-19 Public Health Emergency, the proportion of Medicaid beneficiaries enrolled for less than a full year was likely lower than typical during the timeframe included in this study.

We did not adjust for sex or gender differences across healthcare coverage types or states. Medicaid eligibility criteria also varies across states, meaning differences in Medicaid measures may also reflect different population characteristics.

We also relied on publicly available data sources that include national survey data. Of note, survey data often has limitations due to its reliance on self-reported information, which can lead to inaccuracies due to respondent bias or misunderstanding of questions. Additionally, it may not be fully representative of a population as the methodology can often exclude certain groups such as those without internet or phone access, leading to potential sampling bias. Relatedly Medicaid coverage estimates from the ACS are likely an undercount and research has demonstrated undercounts of Medicaid associated with ACA Medicaid expansions.[37,38] Some of the publicly available measures rely on different data sources published in different years or include data averaged across multiple years. In all cases, the most recent data available at the time of publication was used. Many publicly available sources report small area estimates that are derived from statistical modeling. Smaller population areas, with a lower number of survey responses

will rely more on modeled data than actual rates. Further documentation related to data collection and measures calculations can be found on the websites for individual data sources.

We recognize that there are elements of behavioral health access that could not be captured in this analysis, as the analysis was limited to administrative claims and publicly available data sources.

We have not audited the data sets used for this analysis, but have extensive experience using them, and have found them to be reasonable for these purposes. Any errors or omissions in the data sets could affect the results in this report. Some of the data contributors may use third-party vendors to provide behavioral health services, which could lead to the exclusion of some behavioral healthcare claims from these data sets. We are not able to directly identify coverage levels or use of third-party vendors for behavioral healthcare in the data sets used for this analysis. However, we have carefully inspected the data to identify contributors with claims patterns that may indicate incomplete reporting of behavioral health data and have found that incomplete reporting likely impacts a small minority of contributors. Medicare FFS and Medicaid data are representative of 100% of the plan beneficiaries. However, Medicaid data quality varies by state, and the commercial and Medicare Advantage data represents geographic and demographic mix available in the research databases used for analysis.

Acknowledgements

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Glossary

This glossary describes key terms, as they are used in this report.

- **Behavioral health**: An umbrella term used to describe both mental health and substance use disorders.
- **Behavioral health specialist**: A healthcare facility or professional that specializes in services for the purpose of treating an individual's mental health or substance use disorders. See the Methodology section for the technical specifications used in this analysis.
- **Commercial insurance**: A type of health insurance that is generally purchased or sponsored by employers or purchased on the individual market.
- **Diagnosed prevalence**: The number of cases of a disease that have been diagnosed by a healthcare professional.
- **Emergency department utilization**: The use of emergency departments for healthcare services.
- **Federal poverty level (FPL)**: A measure of income issued every year by the Department of Health and Human Services (HHS). Federal poverty levels are used to determine eligibility for certain programs and benefits.
- **Frequent mental distress**: The percentage of adults who report that their mental health was not good for 14 or more of the past 30 days.
- **In-network**: Physicians, hospitals, or other healthcare providers who have a contract with the health insurance plan to provide services to plan members for specific pre-negotiated rates.
- **Inpatient hospitalization**: When a patient is admitted to the hospital for treatment with the expectation that they will remain in the hospital for 24 hours or more.
- **Intensive outpatient and partial hospitalization programs**: Structured programs that provide care for several hours a day, several days a week, but do not require an overnight stay.
- **Intentional self-harm**: Behaviors where an individual intentionally inflicts harm on themselves.
- **Median household income**: The income amount that divides a population into two equal groups, half having an income above that amount, and half having an income below that amount.
- **Medicaid**: A state and federal program that provides health coverage for some low-income people, families and children, pregnant women, the elderly, and people with disabilities.
- **Medicare**: A federal program that provides health coverage for those aged 65 or older or that have certain qualifying disabilities.
- **Mental Health Care Health Professional Shortage Areas (HPSA)**: Geographic areas, population groups, or facilities designated by the Health Resources and Services Administration (HRSA) as having shortages of primary care, dental care, or mental health providers.
- **Mental health**: In some contexts, this term refers to a range of clinical conditions including depression, anxiety disorders, schizophrenia, and others. In other contexts, the term is also used to refer to a person’s general emotional, psychological, and social well-being.
- **Metropolitan Statistical Areas (MSAs)**: Geographic entities defined by the U.S. Office of Management and Budget for use by federal statistical agencies in collecting, tabulating, and publishing federal statistics.
- **Out-of-network**: Physicians, hospitals, or other healthcare providers who are not part of a health insurer's network of preferred providers. Patients will generally pay more for services received from out-of-network providers.
- **Out-of-pocket costs**: Medical costs that are not covered by insurance and must be paid by the patient.
- **Outpatient therapy**: Behavioral healthcare services that do not require an overnight stay in a hospital or medical facility.
- **Prevalence**: A statistical concept referring to the number of cases of a clinical condition that are present in a particular population at a given time.
- **Provider networks**: Groups of healthcare providers that have contracts with an insurance company to provide services to plan members, generally for specific pre-negotiated rates.

- **Psychiatrist need met**: The percentage of the estimated need for psychiatrists that is being met in a particular area, based on HRSA's criteria for defining Mental Health Professional Shortage Areas.
- **Psychotherapy**: A general term for treating mental health problems by talking with a psychiatrist, psychologist, or other mental health provider.
- **Reimbursement structures**: Methods used by health insurance companies to pay healthcare providers for their services.
- **Self-pay**: Patients who pay for their own medical expenses without the help of insurance.
- **Socioeconomic conditions**: The combination of social and economic factors that influence what positions individuals or groups hold within the structure of a society.
- **Substance use disorders**: Health conditions associated with the use of one or more substances, leading to health issues or problems at work, school, or home.
- **Suicidal ideation**: Thoughts about, or an unusual preoccupation with, suicide.
- **Therapy Access Ratio (TAR)**: A novel metric designed to evaluate the correlation of provider supply and the accessibility of therapy services across the United States, factoring in regional differences in the prevalence of behavioral health conditions.
- **Timely follow-up care**: The care received shortly after a hospital stay or emergency department visit, which is important for successful recovery and preventing readmission to the hospital.
- **Uninsured rate**: The percentage of the population that does not have healthcare coverage.

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Appendix A: Summary of behavioral health access measures by state

For ease of reference, we have summarized the metrics described throughout this report for each state in the figures that follow. Sources or definitions for each metric are described below. Further technical details are provided in the Methodology section of this report.

Measure	Description	Source and year
Prevalence of behavioral health conditions		
Adults with frequent mental distress.	Percent of adults reporting at least 14 days of poor mental health per month.	BRFSS, 2020.
Poor mental health days per month.	Average number of mentally unhealthy days out of the past 30.	BRFSS, 2020.
Drug overdose deaths per 100,000.	Number of drug overdose deaths per 100,000 population.	NCHS – Mortality Files, 2018-2020.
Suicides per 100,000.	Number of suicide deaths per 100,000 population.	NCHS – Mortality Files, 2016-2020.
Individuals with any diagnosed MH/SUD condition.	Percent of individuals that had claims with diagnoses for any behavioral health condition.	CHSD, RIF, and T-MSIS claims datasets, 2021.
Percent of individuals with diagnosed suicidal ideation or intentional self-harm.	Percent of individuals that had claims with diagnoses for suicidal ideation or intentional self-harm.	CHSD, RIF, and T-MSIS claims datasets, 2021.
Behavioral health treatment patterns		
Percent of individuals with any MH/SUD diagnosis that received specialty MH/SUD care.	Percent of individuals with diagnoses for any behavioral health condition that used any services provided by facilities or clinicians specializing in behavioral health.	CHSD, RIF, and T-MSIS claims datasets, 2021.
Average number of sessions per year for those receiving outpatient BH therapy.	Average number of outpatient psychotherapy visits received per year among individuals that received any outpatient psychotherapy.	CHSD, RIF, and T-MSIS claims datasets, 2021.
Percent of emergency department visits with a diagnosis for any MH/SUD condition in the first or second position.	Percent of emergency department visits that had a diagnosis for any behavioral health condition in the first or second position on the claim record.	CHSD, RIF, and T-MSIS claims datasets, 2021.
Percent of MH/SUD emergency department visits or hospitalizations with timely follow-up after discharge.	Percent of hospitalizations or emergency department visits with a principal diagnosis for any behavioral health condition that were followed by outpatient behavioral health care within 30 days of discharge.	CHSD, RIF, and T-MSIS claims datasets, 2021.
Availability of behavioral health providers		
Percent of population living in a county where whole county is shortage area or none of county is shortage area.	Sum of population in counties that are entirely within designated mental health HPSAs, or that include no designated mental health HPSAs.	ACS, HPSA, 2023.
Percent of psychiatrist need met.	Percent of psychiatrists needed to remove all mental health HPSA designations, per HRSA HPSA definitions.	HPSA, 2023.
Percent of MH/SUD care provided out-of-network (for commercial health plans with OON coverage).	The percent of total costs for behavioral healthcare services that were for out-of-network providers (for commercial health insurance plans that cover out-of-network providers).	CHSD, RIF, and T-MSIS claims datasets, 2021.
Therapy Access Ratio.	A novel metric describing the proportion of visits received by those with behavioral health diagnoses compared to the number of visits received by those living in areas with the highest provider supply.	CMS NPI Registry, CHSD, RIF, and T-MSIS claims datasets, 2021.
Affordability of behavioral health services		
Average out of pocket costs for an individual 60-minute psychotherapy visit.	Average cost for which patients are responsible under the terms of their insurance coverage (or average undiscounted billed charge for self-pay patients) for a 60-minute psychotherapy visit.	CHSD and RIF claims datasets, 2021.
Percent of providers accepting insurance coverage.	Percent of psychiatrists that accept each major type of healthcare coverage.	MACPAC, 2017 and KFF, 2017-2019.
Percent of population by healthcare coverage type.	The percent of the total population covered by each major healthcare type.	ACS, 2021, 5Y average.
Median income.	The income level that divides the population in half, where half have higher, and half have lower incomes.	U.S. Census SAIPE, 2021.
Percent of individuals below FPL.	Ther percent of individuals in households with income levels below the Federal Poverty Level.	ACS, 2021, 5Y average.

FIGURE A: BEHAVIORAL HEALTH ACCESS MEASURES NATIONWIDE

Prevalence of behavioral health conditions	Nationwide	Rank	Min	Max
Survey and vital statistics measures				
Adults with frequent mental distress	14.0%		9.7%	18.7%
Poor mental health days per month	4.4		3.2	5.7
Drug overdose deaths per 100,000	23.3		8.5	56.8
Suicides per 100,000	13.8		6.2	27.4
Individuals with any diagnosed MH/SUD condition				
Commercial insurance [1]	22.7%		10.8%	32.8%
Medicare FFS [2]	36.2%		22.4%	42.5%
Dual	54.8%		28.9%	65.9%
Non-Dual	33.0%		21.6%	38.1%
Medicaid	23.6%		13.2%	38.3%
Dual	31.3%		19.4%	56.6%
Non-Dual	24.3%		12.3%	41.6%
Percent of individuals with diagnosed suicidal ideation or intentional self-harm				
Commercial insurance [1]	0.3%		0.1%	0.6%
Medicare FFS	0.1%		0.0%	0.2%
Dual	0.3%		0.0%	1.0%
Non-Dual	0.0%		0.0%	0.1%
Medicaid	0.4%		0.0%	0.9%
Dual	0.1%		0.0%	0.5%
Non-Dual	0.5%		0.0%	1.0%
Behavioral health treatment patterns	**Nationwide**	**Rank**	**Min**	**Max**
Percent of individuals with any MH/SUD diagnosis that received specialty MH/SUD care [3]				
Commercial insurance	30.7%		16.2%	43.0%
Medicare FFS	15.7%		5.4%	29.5%
Dual	25.5%		4.4%	40.5%
Non-Dual	12.9%		5.6%	23.9%
Medicaid	44.3%		21.0%	65.1%
Dual	36.6%		17.3%	59.5%
Non-Dual	45.7%		22.0%	67.6%
Aggregate [4]	32.6%		21.7%	43.1%
Average number of sessions per year for those receiving outpatient BH therapy				
Commercial insurance	10.7		6.0	17.4
Medicare FFS	10.7		3.8	17.3
Dual	11.5		4.1	18.7
Non-Dual	10.2		3.6	16.4
Medicaid	11.2		5.8	21.9
Dual	11.4		5.5	26.4
Non-Dual	11.2		5.5	21.0
Aggregate [4]	10.8		6.2	15.5
Percent of emergency department visits with a diagnosis for any MH/SUD condition in the first or second position				
Commercial insurance	6.9%		3.9%	9.7%
Medicare FFS	7.3%		5.1%	11.3%
Dual	14.4%		8.1%	22.6%
Non-Dual	4.4%		3.4%	5.6%
Medicaid	12.9%		6.9%	29.1%
Dual	12.3%		6.1%	42.3%
Non-Dual	13.0%		7.0%	30.8%
Percent of MH/SUD emergency department visits or hospitalizations with timely follow-up after discharge [5]				
Commercial insurance	34.7%		16.6%	51.1%
Medicare FFS	20.4%		10.3%	30.5%
Medicaid	36.7%		14.1%	65.5%
Aggregate [4]	33.8%		22.7%	48.6%

FIGURE A: BEHAVIORAL HEALTH ACCESS MEASURES NATIONWIDE

Availability of behavioral health providers	Nationwide	Rank	Min	Nationwide	Max
Percent of population living in a county where:					
Whole county is shortage area	52.7%		0.0%		100.0%
None of county is shortage area	7.2%		0.0%		51.1%
Percent of psychiatrist need met[6]	27.7%		8.5%		72.7%
Ratio of population to MH providers	338.2		141.8		797.3
Percent of MH/SUD care provided out-of-network (for commercial health plans with OON coverage)[7]					
Overall	16.4%		2%		50%
Inpatient and residential care	18.4%		0%		59%
Intensive outpatient and partial hospitalization programs	28.3%		1%		84%
Outpatient therapy and other services	13.2%		1%		58%
Therapy Access Ratio[8]					
Commercial insurance	54.4%		21.9%		97.8%
Medicare FFS	54.6%		11.5%		100.0%
Medicaid	66.9%		6.1%		100.0%
Affordability of behavioral health services	**Nationwide**	**Rank**	**Min**	**Nationwide**	**Max**
Average out of pocket costs for an individual 60-minute psychotherapy visit[9]					
No insurance - self pay	$174		$94		$287
Commercial insurance - out-of-network	$53		$24		$98
Commercial insurance - in-network	$23		$1		$46
Medicare FFS	$29		$26		$37
Percent of population by insurance type					
Commercially insured	54.6%		38.4%		68.4%
Medicare	14.3%		8.4%		18.9%
Medicare Advantage	6.2%		0.2%		9.1%
Medicare FFS	8.2%		5.8%		15.9%
Medicaid[10]	21.1%		9.8%		34.4%
Military	1.3%		0.0%		5.3%
Uninsured	8.6%		2.5%		18.0%
Income					
Median income	$70,857		$48,871		$91,072
Percent of individuals below FPL	12.6%		7.4%		19.4%
Legend					
Gradient Interpretation			Adverse / Favorable		Favorable / Adverse

Notes:
1. Kansas uses 2020 prevalence metrics for commercial insurance due to data quality issues with the 2021 data.
2. Medicare Advantage metrics can be found by Census division in Appendix B.
3. Specialty care is defined as care from a behavioral health specialist in an inpatient, outpatient, or professional setting.
4. Aggregate metrics are calculated using the percent of population by insurance type.
5. Timely follow-up is defined as a follow-up visit within 30 days of discharge.
6. "Percent of Need Met" is computed by dividing the number of psychiatrists available to serve the population of the area, group, or facility by the number of psychiatrists that would be necessary to eliminate the mental health HPSA (based on a ratio of 30,000 to 1 (20,000 to 1 where high needs are indicated)).
7. Measured by volume of allowed dollars.
8. Calculated as the average number of therapy visits received by individuals diagnosed with behavioral health conditions in a given MSA, compared against the top decile of MSAs with the highest behavioral health provider supply density. Expressed as a percentage, this ratio illustrates how close an MSA, and by extension a state, is to achieving the reference rate.
9. Defined by HCPCS 90837.
10. Dual-eligible members are reported in the Medicaid category. The Medicare category reflect Medicare-only members.
11. Data for the District of Columbia is not available for all metrics. D.C. is included in rankings only for metrics for which data are available.

FIGURE A-1: BEHAVIORAL HEALTH ACCESS MEASURES FOR ALABAMA

Prevalence of behavioral health conditions	Alabama	Rank	Min	Max
Survey and vital statistics measures				
Adults with frequent mental distress	16.5%	44	9.7%	18.7%
Poor mental health days per month	5.1	45	3.2	5.7
Drug overdose deaths per 100,000	17.5	17	8.5	56.8
Suicides per 100,000	16.2	29	6.2	27.4
Individuals with any diagnosed MH/SUD condition				
Commercial insurance [1]	24.4%	33	10.8%	32.8%
Medicare FFS [2]	39.2%	46	22.4%	42.5%
Dual	51.7%	20	28.9%	65.9%
Non-Dual	37.2%	49	21.6%	38.1%
Medicaid	21.1%	10	13.2%	38.3%
Dual	22.5%	4	19.4%	56.6%
Non-Dual	23.2%	10	12.3%	41.6%
Percent of individuals with diagnosed suicidal ideation or intentional self-harm				
Commercial insurance [1]	0.3%	23	0.1%	0.6%
Medicare FFS	0.0%	13	0.0%	0.2%
Dual	0.0%	11	0.0%	1.0%
Non-Dual	0.0%	20	0.0%	0.1%
Medicaid	0.1%	8	0.0%	0.9%
Dual	0.0%	1	0.0%	0.5%
Non-Dual	0.2%	9	0.0%	1.0%

Behavioral health treatment patterns	Alabama	Rank	Min	Max
Percent of individuals with any MH/SUD diagnosis that received specialty MH/SUD care [3]				
Commercial insurance	20.7%	45	16.2%	43.0%
Medicare FFS	9.5%	43	5.4%	29.5%
Dual	14.8%	39	4.4%	40.5%
Non-Dual	8.3%	40	5.6%	23.9%
Medicaid	37.3%	45	21.0%	65.1%
Dual	30.3%	38	17.3%	59.5%
Non-Dual	38.5%	45	22.0%	67.6%
Aggregate [4]	23.6%	47	21.7%	43.1%
Average number of sessions per year for those receiving outpatient BH therapy				
Commercial insurance	6.0	50	6.0	17.4
Medicare FFS	3.8	51	3.8	17.3
Dual	4.1	51	4.1	18.7
Non-Dual	3.6	51	3.6	16.4
Medicaid	7.9	46	5.8	21.9
Dual	6.4	46	5.5	26.4
Non-Dual	8.1	44	5.5	21.0
Aggregate [4]	6.2	50	6.2	15.5
Percent of emergency department visits with a diagnosis for any MH/SUD condition in the first or second position				
Commercial insurance	7.4%	34	3.9%	9.7%
Medicare FFS	6.3%	15	5.1%	11.3%
Dual	10.9%	3	8.1%	22.6%
Non-Dual	4.7%	38	3.4%	5.6%
Medicaid	17.0%	38	6.9%	29.1%
Dual	20.8%	45	6.1%	42.3%
Non-Dual	16.4%	34	7.0%	30.8%
Percent of MH/SUD emergency department visits or hospitalizations with timely follow-up after discharge [5]				
Commercial insurance	28.7%	40	16.6%	51.1%
Medicare FFS	12.0%	47	10.3%	30.5%
Medicaid	25.8%	49	14.1%	65.5%
Aggregate [4]	26.3%	45	22.7%	48.6%

FIGURE A-1: BEHAVIORAL HEALTH ACCESS MEASURES FOR ALABAMA

Availability of behavioral health providers	Alabama	Rank	Min	Max
Percent of population living in a county where:				
Whole county is shortage area	92.8%	45	0.0%	100.0%
None of county is shortage area	0.8%	34	0.0%	51.1%
Percent of psychiatrist need met[6]	25.4%	31	8.5%	72.7%
Ratio of population to MH providers	797.3	51	141.8	797.3
Percent of MH/SUD care provided out-of-network (for commercial health plans with OON coverage)[7]				
Overall	21.4%	31	2%	50%
Inpatient and residential care	38.1%	41	0%	59%
Intensive outpatient and partial hospitalization programs	37.0%	28	1%	84%
Outpatient therapy and other services	5.4%	12	1%	58%
Therapy Access Ratio[8]				
Commercial insurance	22.2%	48	21.9%	97.8%
Medicare FFS	14.5%	50	11.5%	100.0%
Medicaid	43.1%	45	6.1%	100.0%

Affordability of behavioral health services	Alabama	Rank	Min	Max
Average out of pocket costs for an individual 60-minute psychotherapy visit[9]				
No insurance - self pay	$158	12	$94	$287
Commercial insurance - out-of-network	$80	41	$24	$98
Commercial insurance - in-network	$37	48	$1	$46
Medicare FFS	$29	37	$26	$37
Percent of population by insurance type				
Commercially insured	52.5%		38.4%	68.4%
Medicare	16.2%		8.4%	18.9%
Medicare Advantage	8.2%		0.2%	9.1%
Medicare FFS	8.0%		5.8%	15.9%
Medicaid[10]	19.2%		9.8%	34.4%
Military	2.1%		0.0%	5.3%
Uninsured	10.0%		2.5%	18.0%
Income				
Median income	$53,990	47	$48,871	$91,072
Percent of individuals below FPL	15.8%	45	7.4%	19.4%

Legend		
Gradient Interpretation	Adverse	Favorable
	Favorable	Adverse

Notes:
1. Kansas uses 2020 prevalence metrics for commercial insurance due to data quality issues with the 2021 data.
2. Medicare Advantage metrics can be found by Census division in Appendix B.
3. Specialty care is defined as care from a behavioral health specialist in an inpatient, outpatient, or professional setting.
4. Aggregate metrics are calculated using the percent of population by insurance type.
5. Timely follow-up is defined as a follow-up visit within 30 days of discharge.
6. "Percent of Need Met" is computed by dividing the number of psychiatrists available to serve the population of the area, group, or facility by the number of psychiatrists that would be necessary to eliminate the mental health HPSA (based on a ratio of 30,000 to 1 (20,000 to 1 where high needs are indicated)).
7. Measured by volume of allowed dollars.
8. Calculated as the average number of therapy visits received by individuals diagnosed with behavioral health conditions in a given MSA, compared against the top decile of MSAs with the highest behavioral health provider supply density. Expressed as a percentage, this ratio illustrates how close an MSA, and by extension a state, is to achieving the reference rate.
9. Defined by HCPCS 90837.
10. Dual-eligible members are reported in the Medicaid category. The Medicare category reflect Medicare-only members.
11. Data for the District of Columbia is not available for all metrics. D.C. is included in rankings only for metrics for which data are available.

FIGURE A-2: BEHAVIORAL HEALTH ACCESS MEASURES FOR ALASKA

Prevalence of behavioral health conditions	Alaska	Rank	Min	Max
Survey and vital statistics measures				
Adults with frequent mental distress	9.9%	2	9.7%	18.7%
Poor mental health days per month	3.3	3	3.2	5.7
Drug overdose deaths per 100,000	18.3	20	8.5	56.8
Suicides per 100,000	26.7	50	6.2	27.4
Individuals with any diagnosed MH/SUD condition				
Commercial insurance [1]	20.3%	13	10.8%	32.8%
Medicare FFS [2]	25.1%	2	22.4%	42.5%
Dual	40.0%	5	28.9%	65.9%
Non-Dual	21.9%	3	21.6%	38.1%
Medicaid	19.1%	5	13.2%	38.3%
Dual	29.3%	15	19.4%	56.6%
Non-Dual	25.8%	22	12.3%	41.6%
Percent of individuals with diagnosed suicidal ideation or intentional self-harm				
Commercial insurance [1]	0.4%	40	0.1%	0.6%
Medicare FFS	0.0%	1	0.0%	0.2%
Dual	0.0%	1	0.0%	1.0%
Non-Dual	0.0%	1	0.0%	0.1%
Medicaid	0.2%	14	0.0%	0.9%
Dual	0.0%	1	0.0%	0.5%
Non-Dual	0.3%	19	0.0%	1.0%

Behavioral health treatment patterns	Alaska	Rank	Min	Max
Percent of individuals with any MH/SUD diagnosis that received specialty MH/SUD care [3]				
Commercial insurance	39.6%	6	16.2%	43.0%
Medicare FFS	5.4%	51	5.4%	29.5%
Dual	4.4%	51	4.4%	40.5%
Non-Dual	5.7%	50	5.6%	23.9%
Medicaid	38.3%	43	21.0%	65.1%
Dual	28.0%	44	17.3%	59.5%
Non-Dual	39.6%	44	22.0%	67.6%
Aggregate [4]	34.9%	15	21.7%	43.1%
Average number of sessions per year for those receiving outpatient BH therapy				
Commercial insurance	10.7	25	6.0	17.4
Medicare FFS	9.1	32	3.8	17.3
Dual	9.9	28	4.1	18.7
Non-Dual	8.5	31	3.6	16.4
Medicaid	11.2	24	5.8	21.9
Dual	10.4	25	5.5	26.4
Non-Dual	11.3	23	5.5	21.0
Aggregate [4]	10.6	26	6.2	15.5
Percent of emergency department visits with a diagnosis for any MH/SUD condition in the first or second position				
Commercial insurance	7.6%	38	3.9%	9.7%
Medicare FFS	9.5%	45	5.1%	11.3%
Dual	16.2%	37	8.1%	22.6%
Non-Dual	5.0%	44	3.4%	5.6%
Medicaid	19.3%	44	6.9%	29.1%
Dual	10.6%	15	6.1%	42.3%
Non-Dual	21.1%	47	7.0%	30.8%
Percent of MH/SUD emergency department visits or hospitalizations with timely follow-up after discharge [5]				
Commercial insurance	34.0%	25	16.6%	51.1%
Medicare FFS	12.1%	46	10.3%	30.5%
Medicaid	32.5%	43	14.1%	65.5%
Aggregate [4]	30.8%	34	22.7%	48.6%

FIGURE A-2: BEHAVIORAL HEALTH ACCESS MEASURES FOR ALASKA

Availability of behavioral health providers	Alaska	Rank	Min	Max
Percent of population living in a county where:				
Whole county is shortage area	91.1%	41	0.0%	100.0%
None of county is shortage area	0.0%	37	0.0%	51.1%
Percent of psychiatrist need met[6]	12.1%	48	8.5%	72.7%
Ratio of population to MH providers	148.2	2	141.8	797.3
Percent of MH/SUD care provided out-of-network (for commercial health plans with OON coverage)[7]				
Overall	25.4%	34	2%	50%
Inpatient and residential care	16.0%	22	0%	59%
Intensive outpatient and partial hospitalization programs	75.4%	49	1%	84%
Outpatient therapy and other services	24.9%	41	1%	58%
Therapy Access Ratio[8]				
Commercial insurance	83.0%	9	21.9%	97.8%
Medicare FFS	33.0%	43	11.5%	100.0%
Medicaid	61.8%	36	6.1%	100.0%
Affordability of behavioral health services	**Alaska**	**Rank**	**Min**	**Max**
Average out of pocket costs for an individual 60-minute psychotherapy visit[9]				
No insurance - self pay	$209	44	$94	$287
Commercial insurance - out-of-network	$88	46	$24	$98
Commercial insurance - in-network	$27	33	$1	$46
Medicare FFS	$37	51	$26	$37
Percent of population by insurance type				
Commercially insured	47.4%		38.4%	68.4%
Medicare	10.7%		8.4%	18.9%
Medicare Advantage	0.2%		0.2%	9.1%
Medicare FFS	10.5%		5.8%	15.9%
Medicaid[10]	25.7%		9.8%	34.4%
Military	5.3%		0.0%	5.3%
Uninsured	10.8%		2.5%	18.0%
Income				
Median income	$78,437	13	$48,871	$91,072
Percent of individuals below FPL	10.4%	13	7.4%	19.4%

Legend

Gradient Interpretation		
	Adverse	Favorable
	Favorable	Adverse

Notes:
1. Kansas uses 2020 prevalence metrics for commercial insurance due to data quality issues with the 2021 data.
2. Medicare Advantage metrics can be found by Census division in Appendix B.
3. Specialty care is defined as care from a behavioral health specialist in an inpatient, outpatient, or professional setting.
4. Aggregate metrics are calculated using the percent of population by insurance type.
5. Timely follow-up is defined as a follow-up visit within 30 days of discharge.
6. "Percent of Need Met" is computed by dividing the number of psychiatrists available to serve the population of the area, group, or facility by the number of psychiatrists that would be necessary to eliminate the mental health HPSA (based on a ratio of 30,000 to 1 (20,000 to 1 where high needs are indicated)).
7. Measured by volume of allowed dollars.
8. Calculated as the average number of therapy visits received by individuals diagnosed with behavioral health conditions in a given MSA, compared against the top decile of MSAs with the highest behavioral health provider supply density. Expressed as a percentage, this ratio illustrates how close an MSA, and by extension a state, is to achieving the reference rate.
9. Defined by HCPCS 90837.
10. Dual-eligible members are reported in the Medicaid category. The Medicare category reflect Medicare-only members.
11. Data for the District of Columbia is not available for all metrics. D.C. is included in rankings only for metrics for which data are available.

FIGURE A-3: BEHAVIORAL HEALTH ACCESS MEASURES FOR ARIZONA

Prevalence of behavioral health conditions	Arizona	Rank	Min	Max
Survey and vital statistics measures				
Adults with frequent mental distress	14.0%	28	9.7%	18.7%
Poor mental health days per month	4.4	23	3.2	5.7
Drug overdose deaths per 100,000	28.0	35	8.5	56.8
Suicides per 100,000	18.3	35	6.2	27.4
Individuals with any diagnosed MH/SUD condition				
Commercial insurance [1]	19.7%	12	10.8%	32.8%
Medicare FFS [2]	30.5%	8	22.4%	42.5%
Dual	34.8%	2	28.9%	65.9%
Non-Dual	30.1%	16	21.6%	38.1%
Medicaid	22.8%	14	13.2%	38.3%
Dual	31.3%	20	19.4%	56.6%
Non-Dual	24.2%	17	12.3%	41.6%
Percent of individuals with diagnosed suicidal ideation or intentional self-harm				
Commercial insurance [1]	0.4%	36	0.1%	0.6%
Medicare FFS	0.0%	25	0.0%	0.2%
Dual	0.2%	29	0.0%	1.0%
Non-Dual	0.0%	35	0.0%	0.1%
Medicaid	0.4%	33	0.0%	0.9%
Dual	0.1%	43	0.0%	0.5%
Non-Dual	0.5%	34	0.0%	1.0%

Behavioral health treatment patterns	Arizona	Rank	Min	Max
Percent of individuals with any MH/SUD diagnosis that received specialty MH/SUD care [3]				
Commercial insurance	27.5%	28	16.2%	43.0%
Medicare FFS	11.3%	32	5.4%	29.5%
Dual	10.0%	48	4.4%	40.5%
Non-Dual	11.4%	22	5.6%	23.9%
Medicaid	52.7%	9	21.0%	65.1%
Dual	49.5%	7	17.3%	59.5%
Non-Dual	53.1%	10	22.0%	67.6%
Aggregate [4]	32.4%	20	21.7%	43.1%
Average number of sessions per year for those receiving outpatient BH therapy				
Commercial insurance	8.5	41	6.0	17.4
Medicare FFS	6.9	48	3.8	17.3
Dual	5.7	50	4.1	18.7
Non-Dual	7.0	46	3.6	16.4
Medicaid	7.7	47	5.8	21.9
Dual	7.3	41	5.5	26.4
Non-Dual	7.8	47	5.5	21.0
Aggregate [4]	8.1	44	6.2	15.5
Percent of emergency department visits with a diagnosis for any MH/SUD condition in the first or second position				
Commercial insurance	6.0%	7	3.9%	9.7%
Medicare FFS	5.1%	1	5.1%	11.3%
Dual	14.4%	26	8.1%	22.6%
Non-Dual	3.6%	4	3.4%	5.6%
Medicaid	12.4%	19	6.9%	29.1%
Dual	9.7%	11	6.1%	42.3%
Non-Dual	12.8%	18	7.0%	30.8%
Percent of MH/SUD emergency department visits or hospitalizations with timely follow-up after discharge [5]				
Commercial insurance	30.7%	32	16.6%	51.1%
Medicare FFS	18.7%	27	10.3%	30.5%
Medicaid	45.7%	14	14.1%	65.5%
Aggregate [4]	33.3%	25	22.7%	48.6%

FIGURE A-3: BEHAVIORAL HEALTH ACCESS MEASURES FOR ARIZONA

Availability of behavioral health providers	Arizona	Rank	Min	Max
Percent of population living in a county where:				
Whole county is shortage area	7.1%	5	0.0%	100.0%
None of county is shortage area	0.0%	37	0.0%	51.1%
Percent of psychiatrist need met[6]	8.5%	50	8.5%	72.7%
Ratio of population to MH providers	590.0	47	141.8	797.3
Percent of MH/SUD care provided out-of-network (for commercial health plans with OON coverage)[7]				
Overall	35.0%	42	2%	50%
Inpatient and residential care	49.5%	48	0%	59%
Intensive outpatient and partial hospitalization programs	67.8%	47	1%	84%
Outpatient therapy and other services	12.7%	31	1%	58%
Therapy Access Ratio[8]				
Commercial insurance	38.5%	39	21.9%	97.8%
Medicare FFS	27.0%	45	11.5%	100.0%
Medicaid	76.7%	24	6.1%	100.0%

Affordability of behavioral health services	Arizona	Rank	Min	Max
Average out of pocket costs for an individual 60-minute psychotherapy visit[9]				
No insurance - self pay	$195	37	$94	$287
Commercial insurance - out-of-network	$78	39	$24	$98
Commercial insurance - in-network	$23	23	$1	$46
Medicare FFS	$29	35	$26	$37
Percent of population by insurance type				
Commercially insured	50.4%		38.4%	68.4%
Medicare	16.2%		8.4%	18.9%
Medicare Advantage	7.3%		0.2%	9.1%
Medicare FFS	8.9%		5.8%	15.9%
Medicaid[10]	21.3%		9.8%	34.4%
Military	1.5%		0.0%	5.3%
Uninsured	10.6%		2.5%	18.0%
Income				
Median income	$68,967	21	$48,871	$91,072
Percent of individuals below FPL	13.5%	36	7.4%	19.4%

Legend

Gradient Interpretation: Adverse → Favorable; Favorable → Adverse

Notes:
1. Kansas uses 2020 prevalence metrics for commercial insurance due to data quality issues with the 2021 data.
2. Medicare Advantage metrics can be found by Census division in Appendix B.
3. Specialty care is defined as care from a behavioral health specialist in an inpatient, outpatient, or professional setting.
4. Aggregate metrics are calculated using the percent of population by insurance type.
5. Timely follow-up is defined as a follow-up visit within 30 days of discharge.
6. "Percent of Need Met" is computed by dividing the number of psychiatrists available to serve the population of the area, group, or facility by the number of psychiatrists that would be necessary to eliminate the mental health HPSA (based on a ratio of 30,000 to 1 (20,000 to 1 where high needs are indicated)).
7. Measured by volume of allowed dollars.
8. Calculated as the average number of therapy visits received by individuals diagnosed with behavioral health conditions in a given MSA, compared against the top decile of MSAs with the highest behavioral health provider supply density. Expressed as a percentage, this ratio illustrates how close an MSA, and by extension a state, is to achieving the reference rate.
9. Defined by HCPCS 90837.
10. Dual-eligible members are reported in the Medicaid category. The Medicare category reflect Medicare-only members.
11. Data for the District of Columbia is not available for all metrics. D.C. is included in rankings only for metrics for which data are available.

FIGURE A-4: BEHAVIORAL HEALTH ACCESS MEASURES FOR ARKANSAS

Prevalence of behavioral health conditions	Arkansas	Rank	Min	Max
Survey and vital statistics measures				
Adults with frequent mental distress	18.7%	51	9.7%	18.7%
Poor mental health days per month	5.5	48	3.2	5.7
Drug overdose deaths per 100,000	15.2	13	8.5	56.8
Suicides per 100,000	18.8	38	6.2	27.4
Individuals with any diagnosed MH/SUD condition				
Commercial insurance [1]	22.4%	22	10.8%	32.8%
Medicare FFS [2]	38.4%	38	22.4%	42.5%
Dual	54.7%	27	28.9%	65.9%
Non-Dual	35.7%	43	21.6%	38.1%
Medicaid	20.3%	8	13.2%	38.3%
Dual	32.4%	23	19.4%	56.6%
Non-Dual	19.7%	5	12.3%	41.6%
Percent of individuals with diagnosed suicidal ideation or intentional self-harm				
Commercial insurance [1]	0.2%	12	0.1%	0.6%
Medicare FFS	0.0%	19	0.0%	0.2%
Dual	0.1%	17	0.0%	1.0%
Non-Dual	0.0%	23	0.0%	0.1%
Medicaid	0.2%	12	0.0%	0.9%
Dual	0.0%	1	0.0%	0.5%
Non-Dual	0.2%	10	0.0%	1.0%

Behavioral health treatment patterns	Arkansas	Rank	Min	Max
Percent of individuals with any MH/SUD diagnosis that received specialty MH/SUD care [3]				
Commercial insurance	24.9%	38	16.2%	43.0%
Medicare FFS	10.0%	40	5.4%	29.5%
Dual	21.1%	23	4.4%	40.5%
Non-Dual	7.3%	44	5.6%	23.9%
Medicaid	39.4%	42	21.0%	65.1%
Dual	26.7%	45	17.3%	59.5%
Non-Dual	42.6%	40	22.0%	67.6%
Aggregate [4]	27.7%	38	21.7%	43.1%
Average number of sessions per year for those receiving outpatient BH therapy				
Commercial insurance	9.8	30	6.0	17.4
Medicare FFS	9.9	21	3.8	17.3
Dual	12.3	12	4.1	18.7
Non-Dual	7.4	40	3.6	16.4
Medicaid	14.1	9	5.8	21.9
Dual	11.4	17	5.5	26.4
Non-Dual	14.4	7	5.5	21.0
Aggregate [4]	11.2	18	6.2	15.5
Percent of emergency department visits with a diagnosis for any MH/SUD condition in the first or second position				
Commercial insurance	5.6%	2	3.9%	9.7%
Medicare FFS	6.1%	10	5.1%	11.3%
Dual	11.7%	7	8.1%	22.6%
Non-Dual	4.0%	16	3.4%	5.6%
Medicaid	10.8%	11	6.9%	29.1%
Dual	12.8%	27	6.1%	42.3%
Non-Dual	10.4%	11	7.0%	30.8%
Percent of MH/SUD emergency department visits or hospitalizations with timely follow-up after discharge [5]				
Commercial insurance	38.2%	11	16.6%	51.1%
Medicare FFS	24.3%	11	10.3%	30.5%
Medicaid	38.2%	31	14.1%	65.5%
Aggregate [4]	36.5%	14	22.7%	48.6%

FIGURE A-4: BEHAVIORAL HEALTH ACCESS MEASURES FOR ARKANSAS

Availability of behavioral health providers	Arkansas	Rank	Min	Max
Percent of population living in a county where:				
Whole county is shortage area	75.6%	30	0.0%	100.0%
None of county is shortage area	22.1%	5	0.0%	51.1%
Percent of psychiatrist need met[6]	33.7%	15	8.5%	72.7%
Ratio of population to MH providers	392.7	31	141.8	797.3
Percent of MH/SUD care provided out-of-network (for commercial health plans with OON coverage)[7]				
Overall	21.0%	30	2%	50%
Inpatient and residential care	30.2%	36	0%	59%
Intensive outpatient and partial hospitalization programs	83.9%	50	1%	84%
Outpatient therapy and other services	4.9%	11	1%	58%
Therapy Access Ratio[8]				
Commercial insurance	42.8%	33	21.9%	97.8%
Medicare FFS	36.0%	38	11.5%	100.0%
Medicaid	94.2%	16	6.1%	100.0%

Affordability of behavioral health services	Arkansas	Rank	Min	Max
Average out of pocket costs for an individual 60-minute psychotherapy visit[9]				
No insurance - self pay	$201	40	$94	$287
Commercial insurance - out-of-network	$95	49	$24	$98
Commercial insurance - in-network	$33	43	$1	$46
Medicare FFS	$27	7	$26	$37
Percent of population by insurance type				
Commercially insured	46.6%		38.4%	68.4%
Medicare	15.6%		8.4%	18.9%
Medicare Advantage	5.3%		0.2%	9.1%
Medicare FFS	10.3%		5.8%	15.9%
Medicaid[10]	27.0%		9.8%	34.4%
Military	1.5%		0.0%	5.3%
Uninsured	9.2%		2.5%	18.0%
Income				
Median income	$52,577	48	$48,871	$91,072
Percent of individuals below FPL	16.0%	46	7.4%	19.4%

Legend

Gradient Interpretation: Adverse → Favorable; Favorable → Adverse

Notes:
1. Kansas uses 2020 prevalence metrics for commercial insurance due to data quality issues with the 2021 data.
2. Medicare Advantage metrics can be found by Census division in Appendix B.
3. Specialty care is defined as care from a behavioral health specialist in an inpatient, outpatient, or professional setting.
4. Aggregate metrics are calculated using the percent of population by insurance type.
5. Timely follow-up is defined as a follow-up visit within 30 days of discharge.
6. "Percent of Need Met" is computed by dividing the number of psychiatrists available to serve the population of the area, group, or facility by the number of psychiatrists that would be necessary to eliminate the mental health HPSA (based on a ratio of 30,000 to 1 (20,000 to 1 where high needs are indicated)).
7. Measured by volume of allowed dollars.
8. Calculated as the average number of therapy visits received by individuals diagnosed with behavioral health conditions in a given MSA, compared against the top decile of MSAs with the highest behavioral health provider supply density. Expressed as a percentage, this ratio illustrates how close an MSA, and by extension a state, is to achieving the reference rate.
9. Defined by HCPCS 90837.
10. Dual-eligible members are reported in the Medicaid category. The Medicare category reflect Medicare-only members.
11. Data for the District of Columbia is not available for all metrics. D.C. is included in rankings only for metrics for which data are available.

FIGURE A-5: BEHAVIORAL HEALTH ACCESS MEASURES FOR CALIFORNIA

Prevalence of behavioral health conditions	California	Rank	Min	Max
Survey and vital statistics measures				
Adults with frequent mental distress	12.7%	10	9.7%	18.7%
Poor mental health days per month	4.0	7	3.2	5.7
Drug overdose deaths per 100,000	17.3	16	8.5	56.8
Suicides per 100,000	10.5	8	6.2	27.4
Individuals with any diagnosed MH/SUD condition				
Commercial insurance [1]	13.7%	3	10.8%	32.8%
Medicare FFS [2]	33.6%	17	22.4%	42.5%
Dual	46.7%	10	28.9%	65.9%
Non-Dual	28.6%	8	21.6%	38.1%
Medicaid	16.9%	2	13.2%	38.3%
Dual	22.5%	5	19.4%	56.6%
Non-Dual	17.7%	2	12.3%	41.6%
Percent of individuals with diagnosed suicidal ideation or intentional self-harm				
Commercial insurance [1]	0.2%	5	0.1%	0.6%
Medicare FFS	0.2%	49	0.0%	0.2%
Dual	0.4%	44	0.0%	1.0%
Non-Dual	0.1%	46	0.0%	0.1%
Medicaid	0.4%	35	0.0%	0.9%
Dual	0.1%	45	0.0%	0.5%
Non-Dual	0.5%	37	0.0%	1.0%

Behavioral health treatment patterns	California	Rank	Min	Max
Percent of individuals with any MH/SUD diagnosis that received specialty MH/SUD care [3]				
Commercial insurance	30.0%	23	16.2%	43.0%
Medicare FFS	17.6%	10	5.4%	29.5%
Dual	22.4%	21	4.4%	40.5%
Non-Dual	14.7%	11	5.6%	23.9%
Medicaid	46.0%	30	21.0%	65.1%
Dual	33.3%	29	17.3%	59.5%
Non-Dual	48.0%	28	22.0%	67.6%
Aggregate [4]	34.0%	19	21.7%	43.1%
Average number of sessions per year for those receiving outpatient BH therapy				
Commercial insurance	12.6	10	6.0	17.4
Medicare FFS	11.7	12	3.8	17.3
Dual	11.3	18	4.1	18.7
Non-Dual	11.9	6	3.6	16.4
Medicaid	10.8	27	5.8	21.9
Dual	8.2	38	5.5	26.4
Non-Dual	11.2	26	5.5	21.0
Aggregate [4]	12.0	14	6.2	15.5
Percent of emergency department visits with a diagnosis for any MH/SUD condition in the first or second position				
Commercial insurance	6.6%	17	3.9%	9.7%
Medicare FFS	8.7%	42	5.1%	11.3%
Dual	13.5%	18	8.1%	22.6%
Non-Dual	5.0%	45	3.4%	5.6%
Medicaid	11.5%	14	6.9%	29.1%
Dual	8.8%	7	6.1%	42.3%
Non-Dual	11.8%	15	7.0%	30.8%
Percent of MH/SUD emergency department visits or hospitalizations with timely follow-up after discharge [5]				
Commercial insurance	37.1%	15	16.6%	51.1%
Medicare FFS	20.2%	24	10.3%	30.5%
Medicaid	29.9%	45	14.1%	65.5%
Aggregate [4]	33.7%	23	22.7%	48.6%

FIGURE A-5: BEHAVIORAL HEALTH ACCESS MEASURES FOR CALIFORNIA

Availability of behavioral health providers	California	Rank	Min	Max
Percent of population living in a county where:				
Whole county is shortage area	7.2%	6	0.0%	100.0%
None of county is shortage area	1.2%	32	0.0%	51.1%
Percent of psychiatrist need met[6]	24.3%	32	8.5%	72.7%
Ratio of population to MH providers	235.9	12	141.8	797.3
Percent of MH/SUD care provided out-of-network (for commercial health plans with OON coverage)[7]				
Overall	28.7%	36	2%	50%
Inpatient and residential care	33.9%	40	0%	59%
Intensive outpatient and partial hospitalization programs	42.5%	33	1%	84%
Outpatient therapy and other services	23.5%	37	1%	58%
Therapy Access Ratio[8]				
Commercial insurance	70.7%	14	21.9%	97.8%
Medicare FFS	67.5%	13	11.5%	100.0%
Medicaid	46.4%	44	6.1%	100.0%

Affordability of behavioral health services	California	Rank	Min	Max
Average out of pocket costs for an individual 60-minute psychotherapy visit[9]				
No insurance - self pay	$235	48	$94	$287
Commercial insurance - out-of-network	$68	29	$24	$98
Commercial insurance - in-network	$24	26	$1	$46
Medicare FFS	$31	50	$26	$37
Percent of population by insurance type				
Commercially insured	54.0%		38.4%	68.4%
Medicare	11.7%		8.4%	18.9%
Medicare Advantage	5.5%		0.2%	9.1%
Medicare FFS	6.2%		5.8%	15.9%
Medicaid[10]	26.5%		9.8%	34.4%
Military	0.8%		0.0%	5.3%
Uninsured	7.0%		2.5%	18.0%
Income				
Median income	$84,831	7	$48,871	$91,072
Percent of individuals below FPL	12.3%	27	7.4%	19.4%

Legend

Gradient Interpretation	Min side	Max side
	Adverse	Favorable
	Favorable	Adverse

Notes:
1. Kansas uses 2020 prevalence metrics for commercial insurance due to data quality issues with the 2021 data.
2. Medicare Advantage metrics can be found by Census division in Appendix B.
3. Specialty care is defined as care from a behavioral health specialist in an inpatient, outpatient, or professional setting.
4. Aggregate metrics are calculated using the percent of population by insurance type.
5. Timely follow-up is defined as a follow-up visit within 30 days of discharge.
6. "Percent of Need Met" is computed by dividing the number of psychiatrists available to serve the population of the area, group, or facility by the number of psychiatrists that would be necessary to eliminate the mental health HPSA (based on a ratio of 30,000 to 1 (20,000 to 1 where high needs are indicated)).
7. Measured by volume of allowed dollars.
8. Calculated as the average number of therapy visits received by individuals diagnosed with behavioral health conditions in a given MSA, compared against the top decile of MSAs with the highest behavioral health provider supply density. Expressed as a percentage, this ratio illustrates how close an MSA, and by extension a state, is to achieving the reference rate.
9. Defined by HCPCS 90837.
10. Dual-eligible members are reported in the Medicaid category. The Medicare category reflect Medicare-only members.
11. Data for the District of Columbia is not available for all metrics. D.C. is included in rankings only for metrics for which data are available.

FIGURE A-6: BEHAVIORAL HEALTH ACCESS MEASURES FOR COLORADO

Prevalence of behavioral health conditions	Colorado	Rank	Min	Max
Survey and vital statistics measures				
Adults with frequent mental distress	13.1%	18	9.7%	18.7%
Poor mental health days per month	4.3	20	3.2	5.7
Drug overdose deaths per 100,000	20.7	23	8.5	56.8
Suicides per 100,000	21.3	45	6.2	27.4
Individuals with any diagnosed MH/SUD condition				
Commercial insurance [1]	18.4%	9	10.8%	32.8%
Medicare FFS [2]	31.9%	11	22.4%	42.5%
Dual	49.0%	15	28.9%	65.9%
Non-Dual	29.6%	12	21.6%	38.1%
Medicaid	23.3%	18	13.2%	38.3%
Dual	27.7%	11	19.4%	56.6%
Non-Dual	23.6%	13	12.3%	41.6%
Percent of individuals with diagnosed suicidal ideation or intentional self-harm				
Commercial insurance [1]	0.3%	16	0.1%	0.6%
Medicare FFS	0.0%	27	0.0%	0.2%
Dual	0.1%	22	0.0%	1.0%
Non-Dual	0.0%	36	0.0%	0.1%
Medicaid	0.4%	31	0.0%	0.9%
Dual	0.0%	32	0.0%	0.5%
Non-Dual	0.4%	27	0.0%	1.0%

Behavioral health treatment patterns	Colorado	Rank	Min	Max
Percent of individuals with any MH/SUD diagnosis that received specialty MH/SUD care [3]				
Commercial insurance	25.4%	36	16.2%	43.0%
Medicare FFS	13.3%	23	5.4%	29.5%
Dual	18.6%	32	4.4%	40.5%
Non-Dual	12.1%	19	5.6%	23.9%
Medicaid	43.9%	35	21.0%	65.1%
Dual	36.3%	23	17.3%	59.5%
Non-Dual	44.8%	36	22.0%	67.6%
Aggregate [4]	28.5%	34	21.7%	43.1%
Average number of sessions per year for those receiving outpatient BH therapy				
Commercial insurance	10.5	26	6.0	17.4
Medicare FFS	10.7	16	3.8	17.3
Dual	10.8	21	4.1	18.7
Non-Dual	10.6	14	3.6	16.4
Medicaid	7.2	48	5.8	21.9
Dual	5.8	50	5.5	26.4
Non-Dual	7.3	48	5.5	21.0
Aggregate [4]	9.8	32	6.2	15.5
Percent of emergency department visits with a diagnosis for any MH/SUD condition in the first or second position				
Commercial insurance	7.2%	28	3.9%	9.7%
Medicare FFS	7.2%	26	5.1%	11.3%
Dual	16.3%	38	8.1%	22.6%
Non-Dual	3.8%	7	3.4%	5.6%
Medicaid	14.1%	27	6.9%	29.1%
Dual	12.3%	26	6.1%	42.3%
Non-Dual	14.2%	26	7.0%	30.8%
Percent of MH/SUD emergency department visits or hospitalizations with timely follow-up after discharge [5]				
Commercial insurance	34.2%	23	16.6%	51.1%
Medicare FFS	17.9%	30	10.3%	30.5%
Medicaid	22.2%	50	14.1%	65.5%
Aggregate [4]	30.2%	38	22.7%	48.6%

FIGURE A-6: BEHAVIORAL HEALTH ACCESS MEASURES FOR COLORADO

Availability of behavioral health providers	Colorado	Rank	Min	Max
Percent of population living in a county where:				
Whole county is shortage area	84.8%	36	0.0%	100.0%
None of county is shortage area	0.0%	37	0.0%	51.1%
Percent of psychiatrist need met[6]	34.6%	14	8.5%	72.7%
Ratio of population to MH providers	233.6	10	141.8	797.3
Percent of MH/SUD care provided out-of-network (for commercial health plans with OON coverage)[7]				
Overall	38.6%	44	2%	50%
Inpatient and residential care	50.6%	49	0%	59%
Intensive outpatient and partial hospitalization programs	56.9%	43	1%	84%
Outpatient therapy and other services	23.5%	38	1%	58%
Therapy Access Ratio[8]				
Commercial insurance	51.5%	28	21.9%	97.8%
Medicare FFS	61.2%	16	11.5%	100.0%
Medicaid	51.3%	41	6.1%	100.0%
Affordability of behavioral health services	**Colorado**	**Rank**	**Min**	**Max**
Average out of pocket costs for an individual 60-minute psychotherapy visit[9]				
No insurance - self pay	$169	25	$94	$287
Commercial insurance - out-of-network	$69	31	$24	$98
Commercial insurance - in-network	$24	25	$1	$46
Medicare FFS	$28	26	$26	$37
Percent of population by insurance type				
Commercially insured	58.3%		38.4%	68.4%
Medicare	13.1%		8.4%	18.9%
Medicare Advantage	6.0%		0.2%	9.1%
Medicare FFS	7.1%		5.8%	15.9%
Medicaid[10]	18.5%		9.8%	34.4%
Military	2.2%		0.0%	5.3%
Uninsured	8.0%		2.5%	18.0%
Income				
Median income	$82,228	10	$48,871	$91,072
Percent of individuals below FPL	9.6%	6	7.4%	19.4%

Legend

Gradient Interpretation	
Adverse	Favorable
Favorable	Adverse

Notes:
1. Kansas uses 2020 prevalence metrics for commercial insurance due to data quality issues with the 2021 data.
2. Medicare Advantage metrics can be found by Census division in Appendix B.
3. Specialty care is defined as care from a behavioral health specialist in an inpatient, outpatient, or professional setting.
4. Aggregate metrics are calculated using the percent of population by insurance type.
5. Timely follow-up is defined as a follow-up visit within 30 days of discharge.
6. "Percent of Need Met" is computed by dividing the number of psychiatrists available to serve the population of the area, group, or facility by the number of psychiatrists that would be necessary to eliminate the mental health HPSA (based on a ratio of 30,000 to 1 (20,000 to 1 where high needs are indicated)).
7. Measured by volume of allowed dollars.
8. Calculated as the average number of therapy visits received by individuals diagnosed with behavioral health conditions in a given MSA, compared against the top decile of MSAs with the highest behavioral health provider supply density. Expressed as a percentage, this ratio illustrates how close an MSA, and by extension a state, is to achieving the reference rate.
9. Defined by HCPCS 90837.
10. Dual-eligible members are reported in the Medicaid category. The Medicare category reflect Medicare-only members.
11. Data for the District of Columbia is not available for all metrics. D.C. is included in rankings only for metrics for which data are available.

FIGURE A-7: BEHAVIORAL HEALTH ACCESS MEASURES FOR CONNECTICUT

Prevalence of behavioral health conditions	Connecticut	Rank	Min	Max
Survey and vital statistics measures				
Adults with frequent mental distress	13.5%	22	9.7%	18.7%
Poor mental health days per month	4.3	21	3.2	5.7
Drug overdose deaths per 100,000	34.2	44	8.5	56.8
Suicides per 100,000	10.4	7	6.2	27.4
Individuals with any diagnosed MH/SUD condition				
Commercial insurance [1]	22.8%	25	10.8%	32.8%
Medicare FFS [2]	37.4%	34	22.4%	42.5%
Dual	53.4%	25	28.9%	65.9%
Non-Dual	32.5%	27	21.6%	38.1%
Medicaid	27.8%	35	13.2%	38.3%
Dual	29.9%	16	19.4%	56.6%
Non-Dual	28.0%	32	12.3%	41.6%
Percent of individuals with diagnosed suicidal ideation or intentional self-harm				
Commercial insurance [1]	0.3%	19	0.1%	0.6%
Medicare FFS	0.0%	33	0.0%	0.2%
Dual	0.2%	27	0.0%	1.0%
Non-Dual	0.0%	25	0.0%	0.1%
Medicaid	0.4%	38	0.0%	0.9%
Dual	0.0%	1	0.0%	0.5%
Non-Dual	0.5%	39	0.0%	1.0%

Behavioral health treatment patterns	Connecticut	Rank	Min	Max
Percent of individuals with any MH/SUD diagnosis that received specialty MH/SUD care [3]				
Commercial insurance	30.0%	22	16.2%	43.0%
Medicare FFS	25.2%	4	5.4%	29.5%
Dual	32.8%	5	4.4%	40.5%
Non-Dual	21.4%	4	5.6%	23.9%
Medicaid	57.9%	4	21.0%	65.1%
Dual	32.5%	33	17.3%	59.5%
Non-Dual	62.9%	2	22.0%	67.6%
Aggregate [4]	36.9%	10	21.7%	43.1%
Average number of sessions per year for those receiving outpatient BH therapy				
Commercial insurance	14.7	3	6.0	17.4
Medicare FFS	12.8	5	3.8	17.3
Dual	14.5	5	4.1	18.7
Non-Dual	11.1	12	3.6	16.4
Medicaid	11.7	17	5.8	21.9
Dual	8.9	36	5.5	26.4
Non-Dual	12.3	13	5.5	21.0
Aggregate [4]	13.8	5	6.2	15.5
Percent of emergency department visits with a diagnosis for any MH/SUD condition in the first or second position				
Commercial insurance	7.1%	26	3.9%	9.7%
Medicare FFS	9.6%	48	5.1%	11.3%
Dual	15.7%	34	8.1%	22.6%
Non-Dual	4.9%	42	3.4%	5.6%
Medicaid	20.5%	47	6.9%	29.1%
Dual	42.3%	51	6.1%	42.3%
Non-Dual	19.4%	44	7.0%	30.8%
Percent of MH/SUD emergency department visits or hospitalizations with timely follow-up after discharge [5]				
Commercial insurance	35.7%	19	16.6%	51.1%
Medicare FFS	30.4%	2	10.3%	30.5%
Medicaid	44.2%	16	14.1%	65.5%
Aggregate [4]	37.4%	10	22.7%	48.6%

FIGURE A-7: BEHAVIORAL HEALTH ACCESS MEASURES FOR CONNECTICUT

Availability of behavioral health providers	Connecticut	Rank	Min	Max
Percent of population living in a county where:				
Whole county is shortage area	5.1%	4	0.0%	100.0%
None of county is shortage area	0.0%	37	0.0%	51.1%
Percent of psychiatrist need met[6]	19.0%	39	8.5%	72.7%
Ratio of population to MH providers	218.5	8	141.8	797.3
Percent of MH/SUD care provided out-of-network (for commercial health plans with OON coverage)[7]				
Overall	46.8%	49	2%	50%
Inpatient and residential care	44.0%	44	0%	59%
Intensive outpatient and partial hospitalization programs	37.6%	31	1%	84%
Outpatient therapy and other services	49.7%	48	1%	58%
Therapy Access Ratio[8]				
Commercial insurance	81.4%	10	21.9%	97.8%
Medicare FFS	100.0%	2	11.5%	100.0%
Medicaid	100.0%	1	6.1%	100.0%

Affordability of behavioral health services	Connecticut	Rank	Min	Max
Average out of pocket costs for an individual 60-minute psychotherapy visit[9]				
No insurance - self pay	$173	27	$94	$287
Commercial insurance - out-of-network	$69	30	$24	$98
Commercial insurance - in-network	$19	12	$1	$46
Medicare FFS	$28	25	$26	$37
Percent of population by insurance type				
Commercially insured	57.4%		38.4%	68.4%
Medicare	14.1%		8.4%	18.9%
Medicare Advantage	6.8%		0.2%	9.1%
Medicare FFS	7.3%		5.8%	15.9%
Medicaid[10]	22.6%		9.8%	34.4%
Military	0.7%		0.0%	5.3%
Uninsured	5.1%		2.5%	18.0%
Income				
Median income	$83,628	9	$48,871	$91,072
Percent of individuals below FPL	10.0%	10	7.4%	19.4%

Legend

Gradient Interpretation	Min	Max
	Adverse	Favorable
	Favorable	Adverse

Notes:

1. Kansas uses 2020 prevalence metrics for commercial insurance due to data quality issues with the 2021 data.
2. Medicare Advantage metrics can be found by Census division in Appendix B.
3. Specialty care is defined as care from a behavioral health specialist in an inpatient, outpatient, or professional setting.
4. Aggregate metrics are calculated using the percent of population by insurance type.
5. Timely follow-up is defined as a follow-up visit within 30 days of discharge.
6. "Percent of Need Met" is computed by dividing the number of psychiatrists available to serve the population of the area, group, or facility by the number of psychiatrists that would be necessary to eliminate the mental health HPSA (based on a ratio of 30,000 to 1 (20,000 to 1 where high needs are indicated)).
7. Measured by volume of allowed dollars.
8. Calculated as the average number of therapy visits received by individuals diagnosed with behavioral health conditions in a given MSA, compared against the top decile of MSAs with the highest behavioral health provider supply density. Expressed as a percentage, this ratio illustrates how close an MSA, and by extension a state, is to achieving the reference rate.
9. Defined by HCPCS 90837.
10. Dual-eligible members are reported in the Medicaid category. The Medicare category reflect Medicare-only members.
11. Data for the District of Columbia is not available for all metrics. D.C. is included in rankings only for metrics for which data are available.

FIGURE A-8: BEHAVIORAL HEALTH ACCESS MEASURES FOR DELAWARE

Prevalence of behavioral health conditions	Delaware	Rank	Min	Max
Survey and vital statistics measures				
Adults with frequent mental distress	13.0%	14	9.7%	18.7%
Poor mental health days per month	4.2	17	3.2	5.7
Drug overdose deaths per 100,000	43.7	49	8.5	56.8
Suicides per 100,000	11.6	10	6.2	27.4
Individuals with any diagnosed MH/SUD condition				
Commercial insurance [1]	27.4%	45	10.8%	32.8%
Medicare FFS [2]	34.3%	21	22.4%	42.5%
Dual	46.2%	8	28.9%	65.9%
Non-Dual	33.1%	31	21.6%	38.1%
Medicaid	26.3%	30	13.2%	38.3%
Dual	28.7%	13	19.4%	56.6%
Non-Dual	28.6%	35	12.3%	41.6%
Percent of individuals with diagnosed suicidal ideation or intentional self-harm				
Commercial insurance [1]	0.3%	34	0.1%	0.6%
Medicare FFS	0.0%	1	0.0%	0.2%
Dual	0.0%	1	0.0%	1.0%
Non-Dual	0.0%	1	0.0%	0.1%
Medicaid	0.0%	4	0.0%	0.9%
Dual	0.0%	1	0.0%	0.5%
Non-Dual	0.1%	3	0.0%	1.0%

Behavioral health treatment patterns	Delaware	Rank	Min	Max
Percent of individuals with any MH/SUD diagnosis that received specialty MH/SUD care [3]				
Commercial insurance	40.6%	3	16.2%	43.0%
Medicare FFS	15.2%	16	5.4%	29.5%
Dual	20.8%	24	4.4%	40.5%
Non-Dual	14.3%	13	5.6%	23.9%
Medicaid	47.9%	22	21.0%	65.1%
Dual	28.5%	43	17.3%	59.5%
Non-Dual	49.4%	23	22.0%	67.6%
Aggregate [4]	38.4%	8	21.7%	43.1%
Average number of sessions per year for those receiving outpatient BH therapy				
Commercial insurance	11.7	16	6.0	17.4
Medicare FFS	8.2	40	3.8	17.3
Dual	8.0	40	4.1	18.7
Non-Dual	8.2	34	3.6	16.4
Medicaid	9.2	36	5.8	21.9
Dual	7.5	40	5.5	26.4
Non-Dual	9.4	35	5.5	21.0
Aggregate [4]	10.6	27	6.2	15.5
Percent of emergency department visits with a diagnosis for any MH/SUD condition in the first or second position				
Commercial insurance	6.1%	8	3.9%	9.7%
Medicare FFS	6.5%	17	5.1%	11.3%
Dual	14.1%	22	8.1%	22.6%
Non-Dual	4.1%	19	3.4%	5.6%
Medicaid	13.7%	25	6.9%	29.1%
Dual	12.1%	25	6.1%	42.3%
Non-Dual	13.8%	24	7.0%	30.8%
Percent of MH/SUD emergency department visits or hospitalizations with timely follow-up after discharge [5]				
Commercial insurance	39.9%	10	16.6%	51.1%
Medicare FFS	15.9%	39	10.3%	30.5%
Medicaid	33.4%	41	14.1%	65.5%
Aggregate [4]	34.8%	20	22.7%	48.6%

FIGURE A-8: BEHAVIORAL HEALTH ACCESS MEASURES FOR DELAWARE

Availability of behavioral health providers	Delaware	Rank	Min	Max
Percent of population living in a county where:				
Whole county is shortage area	43.0%	18	0.0%	100.0%
None of county is shortage area	0.0%	37	0.0%	51.1%
Percent of psychiatrist need met[6]	11.6%	49	8.5%	72.7%
Ratio of population to MH providers	322.8	23	141.8	797.3
Percent of MH/SUD care provided out-of-network (for commercial health plans with OON coverage)[7]				
Overall	8.7%	12	2%	50%
Inpatient and residential care	13.8%	16	0%	59%
Intensive outpatient and partial hospitalization programs	33.1%	25	1%	84%
Outpatient therapy and other services	2.5%	6	1%	58%
Therapy Access Ratio[8]				
Commercial insurance	91.8%	3	21.9%	97.8%
Medicare FFS	57.6%	17	11.5%	100.0%
Medicaid	70.3%	31	6.1%	100.0%

Affordability of behavioral health services	Delaware	Rank	Min	Max
Average out of pocket costs for an individual 60-minute psychotherapy visit[9]				
No insurance - self pay	$157	11	$94	$287
Commercial insurance - out-of-network	$45	10	$24	$98
Commercial insurance - in-network	$12	5	$1	$46
Medicare FFS	$27	14	$26	$37
Percent of population by insurance type				
Commercially insured	54.9%		38.4%	68.4%
Medicare	17.6%		8.4%	18.9%
Medicare Advantage	4.1%		0.2%	9.1%
Medicare FFS	13.5%		5.8%	15.9%
Medicaid[10]	20.6%		9.8%	34.4%
Military	1.2%		0.0%	5.3%
Uninsured	5.7%		2.5%	18.0%
Income				
Median income	$71,636	19	$48,871	$91,072
Percent of individuals below FPL	11.4%	21	7.4%	19.4%

Legend

Gradient Interpretation: Adverse — Favorable; Favorable — Adverse

Notes:
1. Kansas uses 2020 prevalence metrics for commercial insurance due to data quality issues with the 2021 data.
2. Medicare Advantage metrics can be found by Census division in Appendix B.
3. Specialty care is defined as care from a behavioral health specialist in an inpatient, outpatient, or professional setting.
4. Aggregate metrics are calculated using the percent of population by insurance type.
5. Timely follow-up is defined as a follow-up visit within 30 days of discharge.
6. "Percent of Need Met" is computed by dividing the number of psychiatrists available to serve the population of the area, group, or facility by the number of psychiatrists that would be necessary to eliminate the mental health HPSA (based on a ratio of 30,000 to 1 (20,000 to 1 where high needs are indicated)).
7. Measured by volume of allowed dollars.
8. Calculated as the average number of therapy visits received by individuals diagnosed with behavioral health conditions in a given MSA, compared against the top decile of MSAs with the highest behavioral health provider supply density. Expressed as a percentage, this ratio illustrates how close an MSA, and by extension a state, is to achieving the reference rate.
9. Defined by HCPCS 90837.
10. Dual-eligible members are reported in the Medicaid category. The Medicare category reflect Medicare-only members.
11. Data for the District of Columbia is not available for all metrics. D.C. is included in rankings only for metrics for which data are available.

FIGURE A-9: BEHAVIORAL HEALTH ACCESS MEASURES FOR DISTRICT OF COLUMBIA

Prevalence of behavioral health conditions	District Of Columbia	Rank	Min	Max
Survey and vital statistics measures				
Adults with frequent mental distress	14.4%	32	9.7%	18.7%
Poor mental health days per month	5.0	41	3.2	5.7
Drug overdose deaths per 100,000	46.6	50	8.5	56.8
Suicides per 100,000	6.2	1	6.2	27.4
Individuals with any diagnosed MH/SUD condition				
Commercial insurance [1]	N/A	N/A	10.8%	32.8%
Medicare FFS [2]	25.8%	3	22.4%	42.5%
Dual	36.0%	3	28.9%	65.9%
Non-Dual	21.6%	1	21.6%	38.1%
Medicaid	21.0%	9	13.2%	38.3%
Dual	24.4%	7	19.4%	56.6%
Non-Dual	20.5%	6	12.3%	41.6%
Percent of individuals with diagnosed suicidal ideation or intentional self-harm				
Commercial insurance [1]	N/A	N/A	0.1%	0.6%
Medicare FFS	0.0%	29	0.0%	0.2%
Dual	0.1%	18	0.0%	1.0%
Non-Dual	0.0%	1	0.0%	0.1%
Medicaid	0.0%	1	0.0%	0.9%
Dual	0.0%	1	0.0%	0.5%
Non-Dual	0.0%	1	0.0%	1.0%

Behavioral health treatment patterns	District Of Columbia	Rank	Min	Max
Percent of individuals with any MH/SUD diagnosis that received specialty MH/SUD care [3]				
Commercial insurance	N/A	N/A	16.2%	43.0%
Medicare FFS	18.3%	6	5.4%	29.5%
Dual	20.1%	27	4.4%	40.5%
Non-Dual	17.0%	6	5.6%	23.9%
Medicaid	65.1%	1	21.0%	65.1%
Dual	57.9%	2	17.3%	59.5%
Non-Dual	67.6%	1	22.0%	67.6%
Aggregate [4]	N/A	N/A	21.7%	43.1%
Average number of sessions per year for those receiving outpatient BH therapy				
Commercial insurance	N/A	N/A	6.0	17.4
Medicare FFS	10.1	18	3.8	17.3
Dual	7.3	45	4.1	18.7
Non-Dual	13.7	3	3.6	16.4
Medicaid	10.8	28	5.8	21.9
Dual	7.9	39	5.5	26.4
Non-Dual	11.3	24	5.5	21.0
Aggregate [4]	N/A	N/A	6.2	15.5
Percent of emergency department visits with a diagnosis for any MH/SUD condition in the first or second position				
Commercial insurance	N/A	N/A	3.9%	9.7%
Medicare FFS	9.6%	46	5.1%	11.3%
Dual	14.1%	21	8.1%	22.6%
Non-Dual	3.4%	1	3.4%	5.6%
Medicaid	13.8%	26	6.9%	29.1%
Dual	26.1%	50	6.1%	42.3%
Non-Dual	13.1%	20	7.0%	30.8%
Percent of MH/SUD emergency department visits or hospitalizations with timely follow-up after discharge [5]				
Commercial insurance	N/A	N/A	16.6%	51.1%
Medicare FFS	11.6%	49	10.3%	30.5%
Medicaid	55.1%	5	14.1%	65.5%
Aggregate [4]	N/A	N/A	22.7%	48.6%

FIGURE A-9: BEHAVIORAL HEALTH ACCESS MEASURES FOR DISTRICT OF COLUMBIA

Availability of behavioral health providers	District Of Columbia	Rank	Min	Max
Percent of population living in a county where:				
Whole county is shortage area	0.0%	1	0.0%	100.0%
None of county is shortage area	0.0%	37	0.0%	51.1%
Percent of psychiatrist need met[6]	39.3%	10	8.5%	72.7%
Ratio of population to MH providers	159.9	4	141.8	797.3
Percent of MH/SUD care provided out-of-network (for commercial health plans with OON coverage)[7]				
Overall	N/A	N/A	2%	50%
Inpatient and residential care	N/A	N/A	0%	59%
Intensive outpatient and partial hospitalization programs	N/A	N/A	1%	84%
Outpatient therapy and other services	N/A	N/A	1%	58%
Therapy Access Ratio[8]				
Commercial insurance	N/A	N/A	21.9%	97.8%
Medicare FFS	78.4%	8	11.5%	100.0%
Medicaid	72.8%	29	6.1%	100.0%

Affordability of behavioral health services	District Of Columbia	Rank	Min	Max
Average out of pocket costs for an individual 60-minute psychotherapy visit[9]				
No insurance - self pay	N/A	N/A	$94	$287
Commercial insurance - out-of-network	N/A	N/A	$24	$98
Commercial insurance - in-network	N/A	N/A	$1	$46
Medicare FFS	$29	43	$26	$37
Percent of population by insurance type				
Commercially insured	61.8%		38.4%	68.4%
Medicare	8.4%		8.4%	18.9%
Medicare Advantage	2.1%		0.2%	9.1%
Medicare FFS	6.3%		5.8%	15.9%
Medicaid[10]	24.9%		9.8%	34.4%
Military	1.2%		0.0%	5.3%
Uninsured	3.7%		2.5%	18.0%
Income				
Median income	$91,072	1	$48,871	$91,072
Percent of individuals below FPL	15.4%	44	7.4%	19.4%

Legend		
Gradient Interpretation	Adverse	Favorable
	Favorable	Adverse

Notes:
1. Kansas uses 2020 prevalence metrics for commercial insurance due to data quality issues with the 2021 data.
2. Medicare Advantage metrics can be found by Census division in Appendix B.
3. Specialty care is defined as care from a behavioral health specialist in an inpatient, outpatient, or professional setting.
4. Aggregate metrics are calculated using the percent of population by insurance type.
5. Timely follow-up is defined as a follow-up visit within 30 days of discharge.
6. "Percent of Need Met" is computed by dividing the number of psychiatrists available to serve the population of the area, group, or facility by the number of psychiatrists that would be necessary to eliminate the mental health HPSA (based on a ratio of 30,000 to 1 (20,000 to 1 where high needs are indicated)).
7. Measured by volume of allowed dollars.
8. Calculated as the average number of therapy visits received by individuals diagnosed with behavioral health conditions in a given MSA, compared against the top decile of MSAs with the highest behavioral health provider supply density. Expressed as a percentage, this ratio illustrates how close an MSA, and by extension a state, is to achieving the reference rate.
9. Defined by HCPCS 90837.
10. Dual-eligible members are reported in the Medicaid category. The Medicare category reflect Medicare-only members.
11. Data for the District of Columbia is not available for all metrics. D.C. is included in rankings only for metrics for which data are available.

FIGURE A-10: BEHAVIORAL HEALTH ACCESS MEASURES FOR FLORIDA

Prevalence of behavioral health conditions	Florida	Rank	Min	Max
Survey and vital statistics measures				
Adults with frequent mental distress	12.9%	13	9.7%	18.7%
Poor mental health days per month	4.2	18	3.2	5.7
Drug overdose deaths per 100,000	26.7	32	8.5	56.8
Suicides per 100,000	14.1	18	6.2	27.4
Individuals with any diagnosed MH/SUD condition				
Commercial insurance [1]	20.7%	15	10.8%	32.8%
Medicare FFS [2]	39.3%	47	22.4%	42.5%
Dual	60.2%	43	28.9%	65.9%
Non-Dual	36.7%	47	21.6%	38.1%
Medicaid	19.9%	6	13.2%	38.3%
Dual	19.4%	1	19.4%	56.6%
Non-Dual	21.0%	7	12.3%	41.6%
Percent of individuals with diagnosed suicidal ideation or intentional self-harm				
Commercial insurance [1]	0.3%	13	0.1%	0.6%
Medicare FFS	0.1%	46	0.0%	0.2%
Dual	0.3%	36	0.0%	1.0%
Non-Dual	0.1%	51	0.0%	0.1%
Medicaid	0.3%	27	0.0%	0.9%
Dual	0.0%	29	0.0%	0.5%
Non-Dual	0.4%	30	0.0%	1.0%

Behavioral health treatment patterns	Florida	Rank	Min	Max
Percent of individuals with any MH/SUD diagnosis that received specialty MH/SUD care [3]				
Commercial insurance	18.2%	48	16.2%	43.0%
Medicare FFS	18.2%	7	5.4%	29.5%
Dual	33.5%	4	4.4%	40.5%
Non-Dual	15.0%	9	5.6%	23.9%
Medicaid	46.5%	28	21.0%	65.1%
Dual	55.3%	3	17.3%	59.5%
Non-Dual	44.9%	35	22.0%	67.6%
Aggregate [4]	24.7%	45	21.7%	43.1%
Average number of sessions per year for those receiving outpatient BH therapy				
Commercial insurance	8.0	45	6.0	17.4
Medicare FFS	9.9	19	3.8	17.3
Dual	11.9	16	4.1	18.7
Non-Dual	9.2	24	3.6	16.4
Medicaid	5.8	51	5.8	21.9
Dual	7.1	42	5.5	26.4
Non-Dual	5.5	51	5.5	21.0
Aggregate [4]	7.7	46	6.2	15.5
Percent of emergency department visits with a diagnosis for any MH/SUD condition in the first or second position				
Commercial insurance	6.0%	6	3.9%	9.7%
Medicare FFS	5.5%	4	5.1%	11.3%
Dual	11.5%	6	8.1%	22.6%
Non-Dual	3.8%	10	3.4%	5.6%
Medicaid	8.1%	4	6.9%	29.1%
Dual	9.6%	10	6.1%	42.3%
Non-Dual	8.0%	4	7.0%	30.8%
Percent of MH/SUD emergency department visits or hospitalizations with timely follow-up after discharge [5]				
Commercial insurance	28.8%	38	16.6%	51.1%
Medicare FFS	19.3%	26	10.3%	30.5%
Medicaid	30.1%	44	14.1%	65.5%
Aggregate [4]	28.0%	44	22.7%	48.6%

FIGURE A-10: BEHAVIORAL HEALTH ACCESS MEASURES FOR FLORIDA

Availability of behavioral health providers	Florida	Rank	Min	Max
Percent of population living in a county where:				
Whole county is shortage area	35.6%	11	0.0%	100.0%
None of county is shortage area	3.1%	24	0.0%	51.1%
Percent of psychiatrist need met[6]	21.0%	36	8.5%	72.7%
Ratio of population to MH providers	514.0	43	141.8	797.3
Percent of MH/SUD care provided out-of-network (for commercial health plans with OON coverage)[7]				
Overall	40.2%	45	2%	50%
Inpatient and residential care	43.6%	43	0%	59%
Intensive outpatient and partial hospitalization programs	66.7%	46	1%	84%
Outpatient therapy and other services	25.4%	42	1%	58%
Therapy Access Ratio[8]				
Commercial insurance	23.6%	47	21.9%	97.8%
Medicare FFS	53.2%	19	11.5%	100.0%
Medicaid	6.1%	51	6.1%	100.0%

Affordability of behavioral health services	Florida	Rank	Min	Max
Average out of pocket costs for an individual 60-minute psychotherapy visit[9]				
No insurance - self pay	$179	29	$94	$287
Commercial insurance - out-of-network	$57	20	$24	$98
Commercial insurance - in-network	$22	20	$1	$46
Medicare FFS	$29	38	$26	$37
Percent of population by insurance type				
Commercially insured	50.4%		38.4%	68.4%
Medicare	17.9%		8.4%	18.9%
Medicare Advantage	9.1%		0.2%	9.1%
Medicare FFS	8.8%		5.8%	15.9%
Medicaid[10]	17.8%		9.8%	34.4%
Military	1.7%		0.0%	5.3%
Uninsured	12.1%		2.5%	18.0%
Income				
Median income	$63,054	37	$48,871	$91,072
Percent of individuals below FPL	13.1%	33	7.4%	19.4%

Legend

Gradient Interpretation: Adverse → Favorable; Favorable → Adverse

Notes:
1. Kansas uses 2020 prevalence metrics for commercial insurance due to data quality issues with the 2021 data.
2. Medicare Advantage metrics can be found by Census division in Appendix B.
3. Specialty care is defined as care from a behavioral health specialist in an inpatient, outpatient, or professional setting.
4. Aggregate metrics are calculated using the percent of population by insurance type.
5. Timely follow-up is defined as a follow-up visit within 30 days of discharge.
6. "Percent of Need Met" is computed by dividing the number of psychiatrists available to serve the population of the area, group, or facility by the number of psychiatrists that would be necessary to eliminate the mental health HPSA (based on a ratio of 30,000 to 1 (20,000 to 1 where high needs are indicated)).
7. Measured by volume of allowed dollars.
8. Calculated as the average number of therapy visits received by individuals diagnosed with behavioral health conditions in a given MSA, compared against the top decile of MSAs with the highest behavioral health provider supply density. Expressed as a percentage, this ratio illustrates how close an MSA, and by extension a state, is to achieving the reference rate.
9. Defined by HCPCS 90837.
10. Dual-eligible members are reported in the Medicaid category. The Medicare category reflect Medicare-only members.
11. Data for the District of Columbia is not available for all metrics. D.C. is included in rankings only for metrics for which data are available.

FIGURE A-11: BEHAVIORAL HEALTH ACCESS MEASURES FOR GEORGIA

Prevalence of behavioral health conditions	Georgia	Rank	Min	Max
Survey and vital statistics measures				
Adults with frequent mental distress	14.7%	35	9.7%	18.7%
Poor mental health days per month	4.5	31	3.2	5.7
Drug overdose deaths per 100,000	14.8	11	8.5	56.8
Suicides per 100,000	14.0	17	6.2	27.4
Individuals with any diagnosed MH/SUD condition				
Commercial insurance [1]	19.0%	11	10.8%	32.8%
Medicare FFS [2]	37.0%	31	22.4%	42.5%
Dual	52.2%	21	28.9%	65.9%
Non-Dual	34.9%	36	21.6%	38.1%
Medicaid	18.6%	4	13.2%	38.3%
Dual	27.4%	10	19.4%	56.6%
Non-Dual	18.9%	4	12.3%	41.6%
Percent of individuals with diagnosed suicidal ideation or intentional self-harm				
Commercial insurance [1]	0.2%	8	0.1%	0.6%
Medicare FFS	0.0%	17	0.0%	0.2%
Dual	0.1%	15	0.0%	1.0%
Non-Dual	0.0%	24	0.0%	0.1%
Medicaid	0.2%	17	0.0%	0.9%
Dual	0.0%	27	0.0%	0.5%
Non-Dual	0.3%	16	0.0%	1.0%

Behavioral health treatment patterns	Georgia	Rank	Min	Max
Percent of individuals with any MH/SUD diagnosis that received specialty MH/SUD care [3]				
Commercial insurance	27.3%	29	16.2%	43.0%
Medicare FFS	11.3%	31	5.4%	29.5%
Dual	21.1%	22	4.4%	40.5%
Non-Dual	9.4%	35	5.6%	23.9%
Medicaid	36.9%	47	21.0%	65.1%
Dual	17.9%	50	17.3%	59.5%
Non-Dual	40.0%	43	22.0%	67.6%
Aggregate [4]	28.1%	36	21.7%	43.1%
Average number of sessions per year for those receiving outpatient BH therapy				
Commercial insurance	8.8	39	6.0	17.4
Medicare FFS	7.9	42	3.8	17.3
Dual	9.4	35	4.1	18.7
Non-Dual	7.2	43	3.6	16.4
Medicaid	8.8	38	5.8	21.9
Dual	5.5	51	5.5	26.4
Non-Dual	9.1	37	5.5	21.0
Aggregate [4]	8.7	41	6.2	15.5
Percent of emergency department visits with a diagnosis for any MH/SUD condition in the first or second position				
Commercial insurance	6.3%	12	3.9%	9.7%
Medicare FFS	6.6%	21	5.1%	11.3%
Dual	12.4%	13	8.1%	22.6%
Non-Dual	4.6%	32	3.4%	5.6%
Medicaid	9.0%	5	6.9%	29.1%
Dual	11.5%	20	6.1%	42.3%
Non-Dual	8.6%	5	7.0%	30.8%
Percent of MH/SUD emergency department visits or hospitalizations with timely follow-up after discharge [5]				
Commercial insurance	34.3%	22	16.6%	51.1%
Medicare FFS	19.7%	25	10.3%	30.5%
Medicaid	34.9%	39	14.1%	65.5%
Aggregate [4]	33.2%	26	22.7%	48.6%

FIGURE A-11: BEHAVIORAL HEALTH ACCESS MEASURES FOR GEORGIA

Availability of behavioral health providers	Georgia	Rank	Min	Max
Percent of population living in a county where:				
Whole county is shortage area	57.9%	23	0.0%	100.0%
None of county is shortage area	23.4%	4	0.0%	51.1%
Percent of psychiatrist need met[6]	43.2%	6	8.5%	72.7%
Ratio of population to MH providers	596.2	48	141.8	797.3
Percent of MH/SUD care provided out-of-network (for commercial health plans with OON coverage)[7]				
Overall	15.0%	25	2%	50%
Inpatient and residential care	22.9%	30	0%	59%
Intensive outpatient and partial hospitalization programs	29.8%	23	1%	84%
Outpatient therapy and other services	7.0%	19	1%	58%
Therapy Access Ratio[8]				
Commercial insurance	40.3%	36	21.9%	97.8%
Medicare FFS	33.9%	40	11.5%	100.0%
Medicaid	51.6%	39	6.1%	100.0%

Affordability of behavioral health services	Georgia	Rank	Min	Max
Average out of pocket costs for an individual 60-minute psychotherapy visit[9]				
No insurance - self pay	$181	31	$94	$287
Commercial insurance - out-of-network	$75	36	$24	$98
Commercial insurance - in-network	$8	2	$1	$46
Medicare FFS	$27	18	$26	$37
Percent of population by insurance type				
Commercially insured	54.4%		38.4%	68.4%
Medicare	12.7%		8.4%	18.9%
Medicare Advantage	6.0%		0.2%	9.1%
Medicare FFS	6.7%		5.8%	15.9%
Medicaid[10]	18.0%		9.8%	34.4%
Military	2.2%		0.0%	5.3%
Uninsured	12.7%		2.5%	18.0%
Income				
Median income	$66,507	29	$48,871	$91,072
Percent of individuals below FPL	13.9%	39	7.4%	19.4%

Legend

Gradient Interpretation — Adverse → Favorable; Favorable → Adverse

Notes:
1. Kansas uses 2020 prevalence metrics for commercial insurance due to data quality issues with the 2021 data.
2. Medicare Advantage metrics can be found by Census division in Appendix B.
3. Specialty care is defined as care from a behavioral health specialist in an inpatient, outpatient, or professional setting.
4. Aggregate metrics are calculated using the percent of population by insurance type.
5. Timely follow-up is defined as a follow-up visit within 30 days of discharge.
6. "Percent of Need Met" is computed by dividing the number of psychiatrists available to serve the population of the area, group, or facility by the number of psychiatrists that would be necessary to eliminate the mental health HPSA (based on a ratio of 30,000 to 1 (20,000 to 1 where high needs are indicated)).
7. Measured by volume of allowed dollars.
8. Calculated as the average number of therapy visits received by individuals diagnosed with behavioral health conditions in a given MSA, compared against the top decile of MSAs with the highest behavioral health provider supply density. Expressed as a percentage, this ratio illustrates how close an MSA, and by extension a state, is to achieving the reference rate.
9. Defined by HCPCS 90837.
10. Dual-eligible members are reported in the Medicaid category. The Medicare category reflect Medicare-only members.
11. Data for the District of Columbia is not available for all metrics. D.C. is included in rankings only for metrics for which data are available.

FIGURE A-12: BEHAVIORAL HEALTH ACCESS MEASURES FOR HAWAII

Prevalence of behavioral health conditions	Hawaii	Rank	Min	Max
Survey and vital statistics measures				
Adults with frequent mental distress	11.1%	4	9.7%	18.7%
Poor mental health days per month	3.6	4	3.2	5.7
Drug overdose deaths per 100,000	17.2	15	8.5	56.8
Suicides per 100,000	13.5	15	6.2	27.4
Individuals with any diagnosed MH/SUD condition				
Commercial insurance [1]	16.9%	6	10.8%	32.8%
Medicare FFS [2]	22.4%	1	22.4%	42.5%
Dual	28.9%	1	28.9%	65.9%
Non-Dual	21.9%	2	21.6%	38.1%
Medicaid	13.2%	1	13.2%	38.3%
Dual	21.7%	3	19.4%	56.6%
Non-Dual	12.3%	1	12.3%	41.6%
Percent of individuals with diagnosed suicidal ideation or intentional self-harm				
Commercial insurance [1]	0.2%	2	0.1%	0.6%
Medicare FFS	0.0%	1	0.0%	0.2%
Dual	0.0%	1	0.0%	1.0%
Non-Dual	0.0%	1	0.0%	0.1%
Medicaid	0.0%	2	0.0%	0.9%
Dual	0.0%	1	0.0%	0.5%
Non-Dual	0.0%	2	0.0%	1.0%

Behavioral health treatment patterns	Hawaii	Rank	Min	Max
Percent of individuals with any MH/SUD diagnosis that received specialty MH/SUD care [3]				
Commercial insurance	43.0%	1	16.2%	43.0%
Medicare FFS	13.5%	22	5.4%	29.5%
Dual	14.6%	40	4.4%	40.5%
Non-Dual	13.4%	15	5.6%	23.9%
Medicaid	47.1%	25	21.0%	65.1%
Dual	43.7%	16	17.3%	59.5%
Non-Dual	48.0%	29	22.0%	67.6%
Aggregate [4]	41.1%	2	21.7%	43.1%
Average number of sessions per year for those receiving outpatient BH therapy				
Commercial insurance	12.0	14	6.0	17.4
Medicare FFS	8.1	41	3.8	17.3
Dual	8.6	39	4.1	18.7
Non-Dual	7.9	36	3.6	16.4
Medicaid	8.1	45	5.8	21.9
Dual	9.2	35	5.5	26.4
Non-Dual	7.9	46	5.5	21.0
Aggregate [4]	10.7	23	6.2	15.5
Percent of emergency department visits with a diagnosis for any MH/SUD condition in the first or second position				
Commercial insurance	5.7%	3	3.9%	9.7%
Medicare FFS	7.7%	32	5.1%	11.3%
Dual	21.8%	50	8.1%	22.6%
Non-Dual	4.5%	28	3.4%	5.6%
Medicaid	14.1%	28	6.9%	29.1%
Dual	11.8%	23	6.1%	42.3%
Non-Dual	14.6%	28	7.0%	30.8%
Percent of MH/SUD emergency department visits or hospitalizations with timely follow-up after discharge [5]				
Commercial insurance	28.5%	41	16.6%	51.1%
Medicare FFS	16.3%	36	10.3%	30.5%
Medicaid	38.8%	30	14.1%	65.5%
Aggregate [4]	29.8%	40	22.7%	48.6%

FIGURE A-12: BEHAVIORAL HEALTH ACCESS MEASURES FOR HAWAII

Availability of behavioral health providers	Hawaii	Rank	Min	Max
Percent of population living in a county where:				
Whole county is shortage area	0.0%	1	0.0%	100.0%
None of county is shortage area	0.0%	37	0.0%	51.1%
Percent of psychiatrist need met[6]	14.1%	44	8.5%	72.7%
Ratio of population to MH providers	351.9	28	141.8	797.3
Percent of MH/SUD care provided out-of-network (for commercial health plans with OON coverage)[7]				
Overall	1.9%	1	2%	50%
Inpatient and residential care	0.0%	1	0%	59%
Intensive outpatient and partial hospitalization programs	1.0%	1	1%	84%
Outpatient therapy and other services	2.2%	5	1%	58%
Therapy Access Ratio[8]				
Commercial insurance	97.8%	1	21.9%	97.8%
Medicare FFS	52.1%	20	11.5%	100.0%
Medicaid	87.9%	21	6.1%	100.0%
Affordability of behavioral health services	**Hawaii**	**Rank**	**Min**	**Max**
Average out of pocket costs for an individual 60-minute psychotherapy visit[9]				
No insurance - self pay	$205	42	$94	$287
Commercial insurance - out-of-network	$34	3	$24	$98
Commercial insurance - in-network	$1	1	$1	$46
Medicare FFS	$31	49	$26	$37
Percent of population by insurance type				
Commercially insured	55.5%		38.4%	68.4%
Medicare	16.1%		8.4%	18.9%
Medicare Advantage	8.0%		0.2%	9.1%
Medicare FFS	8.1%		5.8%	15.9%
Medicaid[10]	20.4%		9.8%	34.4%
Military	4.4%		0.0%	5.3%
Uninsured	3.6%		2.5%	18.0%
Income				
Median income	$85,547	6	$48,871	$91,072
Percent of individuals below FPL	9.5%	5	7.4%	19.4%

Legend

Gradient Interpretation: Adverse → Favorable; Favorable → Adverse

Notes:

1. Kansas uses 2020 prevalence metrics for commercial insurance due to data quality issues with the 2021 data.
2. Medicare Advantage metrics can be found by Census division in Appendix B.
3. Specialty care is defined as care from a behavioral health specialist in an inpatient, outpatient, or professional setting.
4. Aggregate metrics are calculated using the percent of population by insurance type.
5. Timely follow-up is defined as a follow-up visit within 30 days of discharge.
6. "Percent of Need Met" is computed by dividing the number of psychiatrists available to serve the population of the area, group, or facility by the number of psychiatrists that would be necessary to eliminate the mental health HPSA (based on a ratio of 30,000 to 1 (20,000 to 1 where high needs are indicated)).
7. Measured by volume of allowed dollars.
8. Calculated as the average number of therapy visits received by individuals diagnosed with behavioral health conditions in a given MSA, compared against the top decile of MSAs with the highest behavioral health provider supply density. Expressed as a percentage, this ratio illustrates how close an MSA, and by extension a state, is to achieving the reference rate.
9. Defined by HCPCS 90837.
10. Dual-eligible members are reported in the Medicaid category. The Medicare category reflect Medicare-only members.
11. Data for the District of Columbia is not available for all metrics. D.C. is included in rankings only for metrics for which data are available.

FIGURE A-13: BEHAVIORAL HEALTH ACCESS MEASURES FOR IDAHO

Prevalence of behavioral health conditions	Idaho	Rank	Min	Max
Survey and vital statistics measures				
Adults with frequent mental distress	13.0%	15	9.7%	18.7%
Poor mental health days per month	4.1	8	3.2	5.7
Drug overdose deaths per 100,000	14.9	12	8.5	56.8
Suicides per 100,000	22.4	47	6.2	27.4
Individuals with any diagnosed MH/SUD condition				
Commercial insurance [1]	24.0%	30	10.8%	32.8%
Medicare FFS [2]	31.3%	10	22.4%	42.5%
Dual	46.5%	9	28.9%	65.9%
Non-Dual	29.4%	11	21.6%	38.1%
Medicaid	31.1%	44	13.2%	38.3%
Dual	33.8%	24	19.4%	56.6%
Non-Dual	31.4%	43	12.3%	41.6%
Percent of individuals with diagnosed suicidal ideation or intentional self-harm				
Commercial insurance [1]	0.5%	49	0.1%	0.6%
Medicare FFS	0.0%	1	0.0%	0.2%
Dual	0.0%	1	0.0%	1.0%
Non-Dual	0.0%	1	0.0%	0.1%
Medicaid	0.2%	16	0.0%	0.9%
Dual	0.0%	1	0.0%	0.5%
Non-Dual	0.3%	13	0.0%	1.0%

Behavioral health treatment patterns	Idaho	Rank	Min	Max
Percent of individuals with any MH/SUD diagnosis that received specialty MH/SUD care [3]				
Commercial insurance	31.4%	19	16.2%	43.0%
Medicare FFS	6.0%	50	5.4%	29.5%
Dual	7.0%	50	4.4%	40.5%
Non-Dual	5.8%	49	5.6%	23.9%
Medicaid	44.5%	34	21.0%	65.1%
Dual	35.9%	25	17.3%	59.5%
Non-Dual	46.7%	31	22.0%	67.6%
Aggregate [4]	31.9%	24	21.7%	43.1%
Average number of sessions per year for those receiving outpatient BH therapy				
Commercial insurance	10.7	24	6.0	17.4
Medicare FFS	10.3	17	3.8	17.3
Dual	12.2	13	4.1	18.7
Non-Dual	9.0	27	3.6	16.4
Medicaid	17.6	3	5.8	21.9
Dual	19.2	3	5.5	26.4
Non-Dual	17.7	3	5.5	21.0
Aggregate [4]	12.3	10	6.2	15.5
Percent of emergency department visits with a diagnosis for any MH/SUD condition in the first or second position				
Commercial insurance	7.6%	37	3.9%	9.7%
Medicare FFS	6.5%	18	5.1%	11.3%
Dual	14.3%	24	8.1%	22.6%
Non-Dual	4.0%	13	3.4%	5.6%
Medicaid	15.4%	32	6.9%	29.1%
Dual	13.6%	29	6.1%	42.3%
Non-Dual	15.7%	32	7.0%	30.8%
Percent of MH/SUD emergency department visits or hospitalizations with timely follow-up after discharge [5]				
Commercial insurance	34.0%	26	16.6%	51.1%
Medicare FFS	16.3%	37	10.3%	30.5%
Medicaid	43.6%	20	14.1%	65.5%
Aggregate [4]	34.4%	21	22.7%	48.6%

FIGURE A-13: BEHAVIORAL HEALTH ACCESS MEASURES FOR IDAHO

Availability of behavioral health providers	Idaho	Rank	Min	Max
Percent of population living in a county where:				
Whole county is shortage area	99.8%	50	0.0%	100.0%
None of county is shortage area	0.0%	37	0.0%	51.1%
Percent of psychiatrist need met[6]	30.4%	22	8.5%	72.7%
Ratio of population to MH providers	420.9	34	141.8	797.3
Percent of MH/SUD care provided out-of-network (for commercial health plans with OON coverage)[7]				
Overall	16.4%	26	2%	50%
Inpatient and residential care	20.7%	26	0%	59%
Intensive outpatient and partial hospitalization programs	33.4%	27	1%	84%
Outpatient therapy and other services	12.9%	32	1%	58%
Therapy Access Ratio[8]				
Commercial insurance	66.1%	20	21.9%	97.8%
Medicare FFS	37.0%	34	11.5%	100.0%
Medicaid	100.0%	1	6.1%	100.0%
Affordability of behavioral health services	**Idaho**	**Rank**	**Min**	**Max**
Average out of pocket costs for an individual 60-minute psychotherapy visit[9]				
No insurance - self pay	$147	5	$94	$287
Commercial insurance - out-of-network	$54	16	$24	$98
Commercial insurance - in-network	$29	38	$1	$46
Medicare FFS	$26	3	$26	$37
Percent of population by insurance type				
Commercially insured	54.5%		38.4%	68.4%
Medicare	14.9%		8.4%	18.9%
Medicare Advantage	6.0%		0.2%	9.1%
Medicare FFS	8.9%		5.8%	15.9%
Medicaid[10]	20.1%		9.8%	34.4%
Military	1.8%		0.0%	5.3%
Uninsured	8.5%		2.5%	18.0%
Income				
Median income	$66,318	30	$48,871	$91,072
Percent of individuals below FPL	11.4%	21	7.4%	19.4%

Legend

Gradient Interpretation: Adverse → Favorable; Favorable → Adverse

Notes:
1. Kansas uses 2020 prevalence metrics for commercial insurance due to data quality issues with the 2021 data.
2. Medicare Advantage metrics can be found by Census division in Appendix B.
3. Specialty care is defined as care from a behavioral health specialist in an inpatient, outpatient, or professional setting.
4. Aggregate metrics are calculated using the percent of population by insurance type.
5. Timely follow-up is defined as a follow-up visit within 30 days of discharge.
6. "Percent of Need Met" is computed by dividing the number of psychiatrists available to serve the population of the area, group, or facility by the number of psychiatrists that would be necessary to eliminate the mental health HPSA (based on a ratio of 30,000 to 1 (20,000 to 1 where high needs are indicated)).
7. Measured by volume of allowed dollars.
8. Calculated as the average number of therapy visits received by individuals diagnosed with behavioral health conditions in a given MSA, compared against the top decile of MSAs with the highest behavioral health provider supply density. Expressed as a percentage, this ratio illustrates how close an MSA, and by extension a state, is to achieving the reference rate.
9. Defined by HCPCS 90837.
10. Dual-eligible members are reported in the Medicaid category. The Medicare category reflect Medicare-only members.
11. Data for the District of Columbia is not available for all metrics. D.C. is included in rankings only for metrics for which data are available.

FIGURE A-14: BEHAVIORAL HEALTH ACCESS MEASURES FOR ILLINOIS

Prevalence of behavioral health conditions	Illinois	Rank	Min	Max
Survey and vital statistics measures				
Adults with frequent mental distress	10.2%	3	9.7%	18.7%
Poor mental health days per month	3.2	1	3.2	5.7
Drug overdose deaths per 100,000	23.8	27	8.5	56.8
Suicides per 100,000	10.9	9	6.2	27.4
Individuals with any diagnosed MH/SUD condition				
Commercial insurance [1]	18.6%	10	10.8%	32.8%
Medicare FFS [2]	34.4%	22	22.4%	42.5%
Dual	56.2%	31	28.9%	65.9%
Non-Dual	31.1%	22	21.6%	38.1%
Medicaid	24.4%	20	13.2%	38.3%
Dual	36.3%	32	19.4%	56.6%
Non-Dual	24.6%	18	12.3%	41.6%
Percent of individuals with diagnosed suicidal ideation or intentional self-harm				
Commercial insurance [1]	0.3%	28	0.1%	0.6%
Medicare FFS	0.1%	43	0.0%	0.2%
Dual	0.3%	42	0.0%	1.0%
Non-Dual	0.1%	47	0.0%	0.1%
Medicaid	0.6%	43	0.0%	0.9%
Dual	0.1%	47	0.0%	0.5%
Non-Dual	0.7%	42	0.0%	1.0%

Behavioral health treatment patterns	Illinois	Rank	Min	Max
Percent of individuals with any MH/SUD diagnosis that received specialty MH/SUD care [3]				
Commercial insurance	23.4%	40	16.2%	43.0%
Medicare FFS	17.8%	9	5.4%	29.5%
Dual	25.8%	12	4.4%	40.5%
Non-Dual	15.6%	7	5.6%	23.9%
Medicaid	37.4%	44	21.0%	65.1%
Dual	33.2%	30	17.3%	59.5%
Non-Dual	38.5%	46	22.0%	67.6%
Aggregate [4]	26.0%	43	21.7%	43.1%
Average number of sessions per year for those receiving outpatient BH therapy				
Commercial insurance	11.3	19	6.0	17.4
Medicare FFS	11.9	7	3.8	17.3
Dual	13.1	11	4.1	18.7
Non-Dual	11.4	10	3.6	16.4
Medicaid	9.2	35	5.8	21.9
Dual	10.9	21	5.5	26.4
Non-Dual	9.1	38	5.5	21.0
Aggregate [4]	10.9	22	6.2	15.5
Percent of emergency department visits with a diagnosis for any MH/SUD condition in the first or second position				
Commercial insurance	6.2%	10	3.9%	9.7%
Medicare FFS	6.2%	13	5.1%	11.3%
Dual	11.8%	8	8.1%	22.6%
Non-Dual	4.2%	23	3.4%	5.6%
Medicaid	10.5%	10	6.9%	29.1%
Dual	7.3%	2	6.1%	42.3%
Non-Dual	10.9%	12	7.0%	30.8%
Percent of MH/SUD emergency department visits or hospitalizations with timely follow-up after discharge [5]				
Commercial insurance	28.7%	39	16.6%	51.1%
Medicare FFS	24.5%	10	10.3%	30.5%
Medicaid	39.7%	28	14.1%	65.5%
Aggregate [4]	30.7%	35	22.7%	48.6%

FIGURE A-14: BEHAVIORAL HEALTH ACCESS MEASURES FOR ILLINOIS

Availability of behavioral health providers	Illinois	Rank	Min	Max
Percent of population living in a county where:				
Whole county is shortage area	38.6%	14	0.0%	100.0%
None of county is shortage area	1.7%	30	0.0%	51.1%
Percent of psychiatrist need met[6]	22.0%	35	8.5%	72.7%
Ratio of population to MH providers	344.4	27	141.8	797.3
Percent of MH/SUD care provided out-of-network (for commercial health plans with OON coverage)[7]				
Overall	12.2%	20	2%	50%
Inpatient and residential care	18.0%	25	0%	59%
Intensive outpatient and partial hospitalization programs	25.1%	17	1%	84%
Outpatient therapy and other services	8.6%	22	1%	58%
Therapy Access Ratio[8]				
Commercial insurance	44.8%	32	21.9%	97.8%
Medicare FFS	70.2%	12	11.5%	100.0%
Medicaid	48.6%	43	6.1%	100.0%

Affordability of behavioral health services	Illinois	Rank	Min	Max
Average out of pocket costs for an individual 60-minute psychotherapy visit[9]				
No insurance - self pay	$176	28	$94	$287
Commercial insurance - out-of-network	$43	5	$24	$98
Commercial insurance - in-network	$21	16	$1	$46
Medicare FFS	$29	41	$26	$37
Percent of population by insurance type				
Commercially insured	58.4%		38.4%	68.4%
Medicare	14.3%		8.4%	18.9%
Medicare Advantage	4.9%		0.2%	9.1%
Medicare FFS	9.4%		5.8%	15.9%
Medicaid[10]	19.8%		9.8%	34.4%
Military	0.7%		0.0%	5.3%
Uninsured	6.9%		2.5%	18.0%
Income				
Median income	$72,215	18	$48,871	$91,072
Percent of individuals below FPL	11.8%	24	7.4%	19.4%

Legend

Gradient Interpretation: Adverse → Favorable; Favorable → Adverse

Notes:
1. Kansas uses 2020 prevalence metrics for commercial insurance due to data quality issues with the 2021 data.
2. Medicare Advantage metrics can be found by Census division in Appendix B.
3. Specialty care is defined as care from a behavioral health specialist in an inpatient, outpatient, or professional setting.
4. Aggregate metrics are calculated using the percent of population by insurance type.
5. Timely follow-up is defined as a follow-up visit within 30 days of discharge.
6. "Percent of Need Met" is computed by dividing the number of psychiatrists available to serve the population of the area, group, or facility by the number of psychiatrists that would be necessary to eliminate the mental health HPSA (based on a ratio of 30,000 to 1 (20,000 to 1 where high needs are indicated)).
7. Measured by volume of allowed dollars.
8. Calculated as the average number of therapy visits received by individuals diagnosed with behavioral health conditions in a given MSA, compared against the top decile of MSAs with the highest behavioral health provider supply density. Expressed as a percentage, this ratio illustrates how close an MSA, and by extension a state, is to achieving the reference rate.
9. Defined by HCPCS 90837.
10. Dual-eligible members are reported in the Medicaid category. The Medicare category reflect Medicare-only members.
11. Data for the District of Columbia is not available for all metrics. D.C. is included in rankings only for metrics for which data are available.

FIGURE A-15: BEHAVIORAL HEALTH ACCESS MEASURES FOR INDIANA

Prevalence of behavioral health conditions	Indiana	Rank	Min	Max
Survey and vital statistics measures				
Adults with frequent mental distress	15.8%	40	9.7%	18.7%
Poor mental health days per month	4.9	39	3.2	5.7
Drug overdose deaths per 100,000	28.0	34	8.5	56.8
Suicides per 100,000	15.4	25	6.2	27.4
Individuals with any diagnosed MH/SUD condition				
Commercial insurance [1]	25.0%	35	10.8%	32.8%
Medicare FFS [2]	38.9%	42	22.4%	42.5%
Dual	64.3%	49	28.9%	65.9%
Non-Dual	34.6%	33	21.6%	38.1%
Medicaid	25.0%	23	13.2%	38.3%
Dual	32.4%	22	19.4%	56.6%
Non-Dual	24.9%	20	12.3%	41.6%
Percent of individuals with diagnosed suicidal ideation or intentional self-harm				
Commercial insurance [1]	0.4%	38	0.1%	0.6%
Medicare FFS	0.1%	36	0.0%	0.2%
Dual	0.3%	37	0.0%	1.0%
Non-Dual	0.0%	34	0.0%	0.1%
Medicaid	0.5%	40	0.0%	0.9%
Dual	0.0%	36	0.0%	0.5%
Non-Dual	0.6%	40	0.0%	1.0%

Behavioral health treatment patterns	Indiana	Rank	Min	Max
Percent of individuals with any MH/SUD diagnosis that received specialty MH/SUD care [3]				
Commercial insurance	26.2%	32	16.2%	43.0%
Medicare FFS	13.7%	19	5.4%	29.5%
Dual	27.3%	10	4.4%	40.5%
Non-Dual	9.5%	33	5.6%	23.9%
Medicaid	57.8%	5	21.0%	65.1%
Dual	54.5%	5	17.3%	59.5%
Non-Dual	58.5%	5	22.0%	67.6%
Aggregate [4]	32.2%	21	21.7%	43.1%
Average number of sessions per year for those receiving outpatient BH therapy				
Commercial insurance	9.6	32	6.0	17.4
Medicare FFS	8.6	37	3.8	17.3
Dual	9.7	31	4.1	18.7
Non-Dual	7.4	39	3.6	16.4
Medicaid	11.5	18	5.8	21.9
Dual	11.0	20	5.5	26.4
Non-Dual	11.7	18	5.5	21.0
Aggregate [4]	10.0	31	6.2	15.5
Percent of emergency department visits with a diagnosis for any MH/SUD condition in the first or second position				
Commercial insurance	7.6%	39	3.9%	9.7%
Medicare FFS	6.1%	8	5.1%	11.3%
Dual	11.9%	9	8.1%	22.6%
Non-Dual	3.6%	2	3.4%	5.6%
Medicaid	6.9%	1	6.9%	29.1%
Dual	6.1%	1	6.1%	42.3%
Non-Dual	7.0%	1	7.0%	30.8%
Percent of MH/SUD emergency department visits or hospitalizations with timely follow-up after discharge [5]				
Commercial insurance	34.6%	21	16.6%	51.1%
Medicare FFS	22.9%	17	10.3%	30.5%
Medicaid	55.1%	4	14.1%	65.5%
Aggregate [4]	38.2%	9	22.7%	48.6%

FIGURE A-15: BEHAVIORAL HEALTH ACCESS MEASURES FOR INDIANA

Availability of behavioral health providers	Indiana	Rank	Min	Max
Percent of population living in a county where:				
Whole county is shortage area	94.1%	46	0.0%	100.0%
None of county is shortage area	0.8%	35	0.0%	51.1%
Percent of psychiatrist need met[6]	31.1%	21	8.5%	72.7%
Ratio of population to MH providers	528.7	44	141.8	797.3
Percent of MH/SUD care provided out-of-network (for commercial health plans with OON coverage)[7]				
Overall	12.5%	21	2%	50%
Inpatient and residential care	17.7%	24	0%	59%
Intensive outpatient and partial hospitalization programs	44.5%	35	1%	84%
Outpatient therapy and other services	3.8%	10	1%	58%
Therapy Access Ratio[8]				
Commercial insurance	40.7%	35	21.9%	97.8%
Medicare FFS	39.5%	30	11.5%	100.0%
Medicaid	98.1%	14	6.1%	100.0%
Affordability of behavioral health services	**Indiana**	**Rank**	**Min**	**Max**
Average out of pocket costs for an individual 60-minute psychotherapy visit[9]				
No insurance - self pay	$158	13	$94	$287
Commercial insurance - out-of-network	$74	34	$24	$98
Commercial insurance - in-network	$26	30	$1	$46
Medicare FFS	$27	15	$26	$37
Percent of population by insurance type				
Commercially insured	57.0%		38.4%	68.4%
Medicare	14.8%		8.4%	18.9%
Medicare Advantage	6.0%		0.2%	9.1%
Medicare FFS	8.8%		5.8%	15.9%
Medicaid[10]	19.8%		9.8%	34.4%
Military	0.9%		0.0%	5.3%
Uninsured	7.5%		2.5%	18.0%
Income				
Median income	$62,723	38	$48,871	$91,072
Percent of individuals below FPL	12.5%	28	7.4%	19.4%

Legend

Gradient Interpretation: Adverse — Favorable; Favorable — Adverse

Notes:
1. Kansas uses 2020 prevalence metrics for commercial insurance due to data quality issues with the 2021 data.
2. Medicare Advantage metrics can be found by Census division in Appendix B.
3. Specialty care is defined as care from a behavioral health specialist in an inpatient, outpatient, or professional setting.
4. Aggregate metrics are calculated using the percent of population by insurance type.
5. Timely follow-up is defined as a follow-up visit within 30 days of discharge.
6. "Percent of Need Met" is computed by dividing the number of psychiatrists available to serve the population of the area, group, or facility by the number of psychiatrists that would be necessary to eliminate the mental health HPSA (based on a ratio of 30,000 to 1 (20,000 to 1 where high needs are indicated)).
7. Measured by volume of allowed dollars.
8. Calculated as the average number of therapy visits received by individuals diagnosed with behavioral health conditions in a given MSA, compared against the top decile of MSAs with the highest behavioral health provider supply density. Expressed as a percentage, this ratio illustrates how close an MSA, and by extension a state, is to achieving the reference rate.
9. Defined by HCPCS 90837.
10. Dual-eligible members are reported in the Medicaid category. The Medicare category reflect Medicare-only members.
11. Data for the District of Columbia is not available for all metrics. D.C. is included in rankings only for metrics for which data are available.

FIGURE A-16: BEHAVIORAL HEALTH ACCESS MEASURES FOR IOWA

Prevalence of behavioral health conditions	Iowa	Rank	Min	Max
Survey and vital statistics measures				
Adults with frequent mental distress	13.6%	23	9.7%	18.7%
Poor mental health days per month	4.4	25	3.2	5.7
Drug overdose deaths per 100,000	11.3	3	8.5	56.8
Suicides per 100,000	16.0	27	6.2	27.4
Individuals with any diagnosed MH/SUD condition				
Commercial insurance [1]	27.4%	44	10.8%	32.8%
Medicare FFS [2]	34.1%	19	22.4%	42.5%
Dual	61.4%	45	28.9%	65.9%
Non-Dual	31.0%	20	21.6%	38.1%
Medicaid	28.9%	39	13.2%	38.3%
Dual	42.6%	45	19.4%	56.6%
Non-Dual	30.6%	41	12.3%	41.6%
Percent of individuals with diagnosed suicidal ideation or intentional self-harm				
Commercial insurance [1]	0.4%	44	0.1%	0.6%
Medicare FFS	0.0%	26	0.0%	0.2%
Dual	0.3%	39	0.0%	1.0%
Non-Dual	0.0%	1	0.0%	0.1%
Medicaid	0.6%	41	0.0%	0.9%
Dual	0.1%	41	0.0%	0.5%
Non-Dual	0.7%	43	0.0%	1.0%

Behavioral health treatment patterns	Iowa	Rank	Min	Max
Percent of individuals with any MH/SUD diagnosis that received specialty MH/SUD care [3]				
Commercial insurance	36.4%	10	16.2%	43.0%
Medicare FFS	12.2%	28	5.4%	29.5%
Dual	24.9%	15	4.4%	40.5%
Non-Dual	9.3%	36	5.6%	23.9%
Medicaid	49.2%	16	21.0%	65.1%
Dual	44.5%	13	17.3%	59.5%
Non-Dual	50.1%	20	22.0%	67.6%
Aggregate [4]	36.2%	12	21.7%	43.1%
Average number of sessions per year for those receiving outpatient BH therapy				
Commercial insurance	10.8	21	6.0	17.4
Medicare FFS	9.3	29	3.8	17.3
Dual	10.4	25	4.1	18.7
Non-Dual	8.4	33	3.6	16.4
Medicaid	9.6	33	5.8	21.9
Dual	9.7	29	5.5	26.4
Non-Dual	9.7	33	5.5	21.0
Aggregate [4]	10.4	28	6.2	15.5
Percent of emergency department visits with a diagnosis for any MH/SUD condition in the first or second position				
Commercial insurance	8.0%	42	3.9%	9.7%
Medicare FFS	6.1%	9	5.1%	11.3%
Dual	14.8%	27	8.1%	22.6%
Non-Dual	3.6%	3	3.4%	5.6%
Medicaid	18.3%	41	6.9%	29.1%
Dual	19.2%	44	6.1%	42.3%
Non-Dual	18.1%	39	7.0%	30.8%
Percent of MH/SUD emergency department visits or hospitalizations with timely follow-up after discharge [5]				
Commercial insurance	37.8%	14	16.6%	51.1%
Medicare FFS	21.3%	20	10.3%	30.5%
Medicaid	43.4%	22	14.1%	65.5%
Aggregate [4]	37.0%	12	22.7%	48.6%

FIGURE A-16: BEHAVIORAL HEALTH ACCESS MEASURES FOR IOWA

Availability of behavioral health providers	Iowa	Rank	Min	Max
Percent of population living in a county where:				
Whole county is shortage area	59.4%	24	0.0%	100.0%
None of county is shortage area	8.6%	18	0.0%	51.1%
Percent of psychiatrist need met[6]	38.2%	13	8.5%	72.7%
Ratio of population to MH providers	532.1	45	141.8	797.3
Percent of MH/SUD care provided out-of-network (for commercial health plans with OON coverage)[7]				
Overall	2.4%	3	2%	50%
Inpatient and residential care	5.8%	4	0%	59%
Intensive outpatient and partial hospitalization programs	8.4%	4	1%	84%
Outpatient therapy and other services	0.8%	2	1%	58%
Therapy Access Ratio[8]				
Commercial insurance	69.1%	17	21.9%	97.8%
Medicare FFS	38.5%	32	11.5%	100.0%
Medicaid	76.2%	25	6.1%	100.0%

Affordability of behavioral health services	Iowa	Rank	Min	Max
Average out of pocket costs for an individual 60-minute psychotherapy visit[9]				
No insurance - self pay	$180	30	$94	$287
Commercial insurance - out-of-network	$45	9	$24	$98
Commercial insurance - in-network	$21	17	$1	$46
Medicare FFS	$27	9	$26	$37
Percent of population by insurance type				
Commercially insured	58.6%		38.4%	68.4%
Medicare	15.6%		8.4%	18.9%
Medicare Advantage	4.4%		0.2%	9.1%
Medicare FFS	11.3%		5.8%	15.9%
Medicaid[10]	20.0%		9.8%	34.4%
Military	0.8%		0.0%	5.3%
Uninsured	4.9%		2.5%	18.0%
Income				
Median income	$65,645	32	$48,871	$91,072
Percent of individuals below FPL	11.0%	18	7.4%	19.4%

Legend

Gradient Interpretation: Adverse → Favorable; Favorable → Adverse

Notes:
1. Kansas uses 2020 prevalence metrics for commercial insurance due to data quality issues with the 2021 data.
2. Medicare Advantage metrics can be found by Census division in Appendix B.
3. Specialty care is defined as care from a behavioral health specialist in an inpatient, outpatient, or professional setting.
4. Aggregate metrics are calculated using the percent of population by insurance type.
5. Timely follow-up is defined as a follow-up visit within 30 days of discharge.
6. "Percent of Need Met" is computed by dividing the number of psychiatrists available to serve the population of the area, group, or facility by the number of psychiatrists that would be necessary to eliminate the mental health HPSA (based on a ratio of 30,000 to 1 (20,000 to 1 where high needs are indicated)).
7. Measured by volume of allowed dollars.
8. Calculated as the average number of therapy visits received by individuals diagnosed with behavioral health conditions in a given MSA, compared against the top decile of MSAs with the highest behavioral health provider supply density. Expressed as a percentage, this ratio illustrates how close an MSA, and by extension a state, is to achieving the reference rate.
9. Defined by HCPCS 90837.
10. Dual-eligible members are reported in the Medicaid category. The Medicare category reflect Medicare-only members.
11. Data for the District of Columbia is not available for all metrics. D.C. is included in rankings only for metrics for which data are available.

FIGURE A-17: BEHAVIORAL HEALTH ACCESS MEASURES FOR KANSAS

Prevalence of behavioral health conditions	Kansas	Rank	Min	Max
Survey and vital statistics measures				
Adults with frequent mental distress	14.3%	30	9.7%	18.7%
Poor mental health days per month	4.4	27	3.2	5.7
Drug overdose deaths per 100,000	14.2	8	8.5	56.8
Suicides per 100,000	18.6	37	6.2	27.4
Individuals with any diagnosed MH/SUD condition				
Commercial insurance [1]	21.4%	16	10.8%	32.8%
Medicare FFS [2]	35.1%	26	22.4%	42.5%
Dual	58.8%	38	28.9%	65.9%
Non-Dual	32.7%	29	21.6%	38.1%
Medicaid	29.6%	40	13.2%	38.3%
Dual	38.5%	37	19.4%	56.6%
Non-Dual	29.9%	37	12.3%	41.6%
Percent of individuals with diagnosed suicidal ideation or intentional self-harm				
Commercial insurance [1]	0.3%	33	0.1%	0.6%
Medicare FFS	0.0%	20	0.0%	0.2%
Dual	0.1%	24	0.0%	1.0%
Non-Dual	0.0%	26	0.0%	0.1%
Medicaid	0.3%	24	0.0%	0.9%
Dual	0.0%	1	0.0%	0.5%
Non-Dual	0.4%	25	0.0%	1.0%

Behavioral health treatment patterns	Kansas	Rank	Min	Max
Percent of individuals with any MH/SUD diagnosis that received specialty MH/SUD care [3]				
Commercial insurance	27.2%	31	16.2%	43.0%
Medicare FFS	12.3%	27	5.4%	29.5%
Dual	20.1%	26	4.4%	40.5%
Non-Dual	10.9%	26	5.6%	23.9%
Medicaid	46.5%	29	21.0%	65.1%
Dual	32.0%	35	17.3%	59.5%
Non-Dual	49.1%	24	22.0%	67.6%
Aggregate [4]	28.7%	32	21.7%	43.1%
Average number of sessions per year for those receiving outpatient BH therapy				
Commercial insurance	8.5	42	6.0	17.4
Medicare FFS	9.8	23	3.8	17.3
Dual	10.6	22	4.1	18.7
Non-Dual	9.4	23	3.6	16.4
Medicaid	12.3	14	5.8	21.9
Dual	12.5	12	5.5	26.4
Non-Dual	12.3	15	5.5	21.0
Aggregate [4]	9.4	38	6.2	15.5
Percent of emergency department visits with a diagnosis for any MH/SUD condition in the first or second position				
Commercial insurance	8.0%	41	3.9%	9.7%
Medicare FFS	6.3%	14	5.1%	11.3%
Dual	13.8%	20	8.1%	22.6%
Non-Dual	4.2%	21	3.4%	5.6%
Medicaid	11.4%	13	6.9%	29.1%
Dual	17.6%	42	6.1%	42.3%
Non-Dual	10.4%	10	7.0%	30.8%
Percent of MH/SUD emergency department visits or hospitalizations with timely follow-up after discharge [5]				
Commercial insurance	38.0%	13	16.6%	51.1%
Medicare FFS	17.4%	31	10.3%	30.5%
Medicaid	45.1%	15	14.1%	65.5%
Aggregate [4]	36.6%	13	22.7%	48.6%

FIGURE A-17: BEHAVIORAL HEALTH ACCESS MEASURES FOR KANSAS

Availability of behavioral health providers	Kansas	Rank	Min	Max
Percent of population living in a county where:				
Whole county is shortage area	63.7%	25	0.0%	100.0%
None of county is shortage area	15.1%	11	0.0%	51.1%
Percent of psychiatrist need met[6]	26.0%	30	8.5%	72.7%
Ratio of population to MH providers	446.3	37	141.8	797.3
Percent of MH/SUD care provided out-of-network (for commercial health plans with OON coverage)[7]				
Overall	6.3%	7	2%	50%
Inpatient and residential care	9.0%	7	0%	59%
Intensive outpatient and partial hospitalization programs	9.5%	5	1%	84%
Outpatient therapy and other services	3.8%	9	1%	58%
Therapy Access Ratio[8]				
Commercial insurance	42.6%	34	21.9%	97.8%
Medicare FFS	46.1%	25	11.5%	100.0%
Medicaid	91.7%	18	6.1%	100.0%
Affordability of behavioral health services	**Kansas**	**Rank**	**Min**	**Max**
Average out of pocket costs for an individual 60-minute psychotherapy visit[9]				
No insurance - self pay	$171	26	$94	$287
Commercial insurance - out-of-network	$82	44	$24	$98
Commercial insurance - in-network	$35	46	$1	$46
Medicare FFS	$27	16	$26	$37
Percent of population by insurance type				
Commercially insured	59.0%		38.4%	68.4%
Medicare	14.7%		8.4%	18.9%
Medicare Advantage	3.7%		0.2%	9.1%
Medicare FFS	11.0%		5.8%	15.9%
Medicaid[10]	15.2%		9.8%	34.4%
Military	1.9%		0.0%	5.3%
Uninsured	9.2%		2.5%	18.0%
Income				
Median income	$64,128	34	$48,871	$91,072
Percent of individuals below FPL	11.5%	23	7.4%	19.4%

Legend

Gradient Interpretation		
	Adverse	Favorable
	Favorable	Adverse

Notes:
1. Kansas uses 2020 prevalence metrics for commercial insurance due to data quality issues with the 2021 data.
2. Medicare Advantage metrics can be found by Census division in Appendix B.
3. Specialty care is defined as care from a behavioral health specialist in an inpatient, outpatient, or professional setting.
4. Aggregate metrics are calculated using the percent of population by insurance type.
5. Timely follow-up is defined as a follow-up visit within 30 days of discharge.
6. "Percent of Need Met" is computed by dividing the number of psychiatrists available to serve the population of the area, group, or facility by the number of psychiatrists that would be necessary to eliminate the mental health HPSA (based on a ratio of 30,000 to 1 (20,000 to 1 where high needs are indicated)).
7. Measured by volume of allowed dollars.
8. Calculated as the average number of therapy visits received by individuals diagnosed with behavioral health conditions in a given MSA, compared against the top decile of MSAs with the highest behavioral health provider supply density. Expressed as a percentage, this ratio illustrates how close an MSA, and by extension a state, is to achieving the reference rate.
9. Defined by HCPCS 90837.
10. Dual-eligible members are reported in the Medicaid category. The Medicare category reflect Medicare-only members.
11. Data for the District of Columbia is not available for all metrics. D.C. is included in rankings only for metrics for which data are available.

FIGURE A-18: BEHAVIORAL HEALTH ACCESS MEASURES FOR KENTUCKY

Prevalence of behavioral health conditions	Kentucky	Rank	Min	Max
Survey and vital statistics measures				
Adults with frequent mental distress	18.0%	47	9.7%	18.7%
Poor mental health days per month	5.5	47	3.2	5.7
Drug overdose deaths per 100,000	35.6	45	8.5	56.8
Suicides per 100,000	17.1	31	6.2	27.4
Individuals with any diagnosed MH/SUD condition				
Commercial insurance [1]	21.5%	18	10.8%	32.8%
Medicare FFS [2]	41.9%	50	22.4%	42.5%
Dual	59.8%	41	28.9%	65.9%
Non-Dual	38.1%	51	21.6%	38.1%
Medicaid	34.1%	49	13.2%	38.3%
Dual	37.9%	34	19.4%	56.6%
Non-Dual	35.0%	48	12.3%	41.6%
Percent of individuals with diagnosed suicidal ideation or intentional self-harm				
Commercial insurance [1]	0.3%	15	0.1%	0.6%
Medicare FFS	0.0%	18	0.0%	0.2%
Dual	0.1%	13	0.0%	1.0%
Non-Dual	0.0%	29	0.0%	0.1%
Medicaid	0.3%	25	0.0%	0.9%
Dual	0.0%	1	0.0%	0.5%
Non-Dual	0.4%	23	0.0%	1.0%

Behavioral health treatment patterns	Kentucky	Rank	Min	Max
Percent of individuals with any MH/SUD diagnosis that received specialty MH/SUD care [3]				
Commercial insurance	21.2%	44	16.2%	43.0%
Medicare FFS	11.5%	30	5.4%	29.5%
Dual	20.3%	25	4.4%	40.5%
Non-Dual	8.6%	38	5.6%	23.9%
Medicaid	47.5%	23	21.0%	65.1%
Dual	28.8%	41	17.3%	59.5%
Non-Dual	50.3%	18	22.0%	67.6%
Aggregate [4]	29.0%	31	21.7%	43.1%
Average number of sessions per year for those receiving outpatient BH therapy				
Commercial insurance	8.3	44	6.0	17.4
Medicare FFS	6.9	46	3.8	17.3
Dual	7.5	43	4.1	18.7
Non-Dual	6.4	49	3.6	16.4
Medicaid	9.9	31	5.8	21.9
Dual	9.7	32	5.5	26.4
Non-Dual	10.0	31	5.5	21.0
Aggregate [4]	8.7	42	6.2	15.5
Percent of emergency department visits with a diagnosis for any MH/SUD condition in the first or second position				
Commercial insurance	7.1%	27	3.9%	9.7%
Medicare FFS	7.0%	23	5.1%	11.3%
Dual	12.2%	10	8.1%	22.6%
Non-Dual	4.6%	37	3.4%	5.6%
Medicaid	13.4%	23	6.9%	29.1%
Dual	11.4%	19	6.1%	42.3%
Non-Dual	13.6%	23	7.0%	30.8%
Percent of MH/SUD emergency department visits or hospitalizations with timely follow-up after discharge [5]				
Commercial insurance	31.4%	28	16.6%	51.1%
Medicare FFS	14.6%	41	10.3%	30.5%
Medicaid	35.1%	38	14.1%	65.5%
Aggregate [4]	31.0%	33	22.7%	48.6%

FIGURE A-18: BEHAVIORAL HEALTH ACCESS MEASURES FOR KENTUCKY

Availability of behavioral health providers	Kentucky	Rank	Min	Max
Percent of population living in a county where:				
Whole county is shortage area	92.1%	44	0.0%	100.0%
None of county is shortage area	2.1%	28	0.0%	51.1%
Percent of psychiatrist need met[6]	24.2%	33	8.5%	72.7%
Ratio of population to MH providers	365.2	29	141.8	797.3
Percent of MH/SUD care provided out-of-network (for commercial health plans with OON coverage)[7]				
Overall	16.5%	27	2%	50%
Inpatient and residential care	20.9%	27	0%	59%
Intensive outpatient and partial hospitalization programs	37.5%	30	1%	84%
Outpatient therapy and other services	7.6%	20	1%	58%
Therapy Access Ratio[8]				
Commercial insurance	31.7%	43	21.9%	97.8%
Medicare FFS	27.0%	44	11.5%	100.0%
Medicaid	84.0%	22	6.1%	100.0%

Affordability of behavioral health services	Kentucky	Rank	Min	Max
Average out of pocket costs for an individual 60-minute psychotherapy visit[9]				
No insurance - self pay	$154	8	$94	$287
Commercial insurance - out-of-network	$51	14	$24	$98
Commercial insurance - in-network	$28	37	$1	$46
Medicare FFS	$27	6	$26	$37
Percent of population by insurance type				
Commercially insured	48.9%		38.4%	68.4%
Medicare	15.4%		8.4%	18.9%
Medicare Advantage	6.7%		0.2%	9.1%
Medicare FFS	8.7%		5.8%	15.9%
Medicaid[10]	28.9%		9.8%	34.4%
Military	1.2%		0.0%	5.3%
Uninsured	5.6%		2.5%	18.0%
Income				
Median income	$55,532	45	$48,871	$91,072
Percent of individuals below FPL	16.3%	47	7.4%	19.4%

Legend

Gradient Interpretation: Adverse → Favorable; Favorable → Adverse

Notes:
1. Kansas uses 2020 prevalence metrics for commercial insurance due to data quality issues with the 2021 data.
2. Medicare Advantage metrics can be found by Census division in Appendix B.
3. Specialty care is defined as care from a behavioral health specialist in an inpatient, outpatient, or professional setting.
4. Aggregate metrics are calculated using the percent of population by insurance type.
5. Timely follow-up is defined as a follow-up visit within 30 days of discharge.
6. "Percent of Need Met" is computed by dividing the number of psychiatrists available to serve the population of the area, group, or facility by the number of psychiatrists that would be necessary to eliminate the mental health HPSA (based on a ratio of 30,000 to 1 (20,000 to 1 where high needs are indicated)).
7. Measured by volume of allowed dollars.
8. Calculated as the average number of therapy visits received by individuals diagnosed with behavioral health conditions in a given MSA, compared against the top decile of MSAs with the highest behavioral health provider supply density. Expressed as a percentage, this ratio illustrates how close an MSA, and by extension a state, is to achieving the reference rate.
9. Defined by HCPCS 90837.
10. Dual-eligible members are reported in the Medicaid category. The Medicare category reflect Medicare-only members.
11. Data for the District of Columbia is not available for all metrics. D.C. is included in rankings only for metrics for which data are available.

FIGURE A-19: BEHAVIORAL HEALTH ACCESS MEASURES FOR LOUISIANA

Prevalence of behavioral health conditions	Louisiana	Rank	Min	Max
Survey and vital statistics measures				
Adults with frequent mental distress	18.2%	49	9.7%	18.7%
Poor mental health days per month	5.7	51	3.2	5.7
Drug overdose deaths per 100,000	30.8	39	8.5	56.8
Suicides per 100,000	14.6	23	6.2	27.4
Individuals with any diagnosed MH/SUD condition				
Commercial insurance [1]	28.2%	48	10.8%	32.8%
Medicare FFS [2]	39.0%	45	22.4%	42.5%
Dual	52.7%	23	28.9%	65.9%
Non-Dual	35.4%	38	21.6%	38.1%
Medicaid	25.4%	26	13.2%	38.3%
Dual	25.1%	8	19.4%	56.6%
Non-Dual	26.5%	27	12.3%	41.6%
Percent of individuals with diagnosed suicidal ideation or intentional self-harm				
Commercial insurance [1]	0.3%	14	0.1%	0.6%
Medicare FFS	0.1%	39	0.0%	0.2%
Dual	0.3%	41	0.0%	1.0%
Non-Dual	0.0%	21	0.0%	0.1%
Medicaid	0.6%	48	0.0%	0.9%
Dual	0.0%	38	0.0%	0.5%
Non-Dual	0.7%	47	0.0%	1.0%

Behavioral health treatment patterns	Louisiana	Rank	Min	Max
Percent of individuals with any MH/SUD diagnosis that received specialty MH/SUD care [3]				
Commercial insurance	26.1%	34	16.2%	43.0%
Medicare FFS	10.6%	35	5.4%	29.5%
Dual	19.4%	29	4.4%	40.5%
Non-Dual	7.2%	45	5.6%	23.9%
Medicaid	42.0%	38	21.0%	65.1%
Dual	29.6%	39	17.3%	59.5%
Non-Dual	43.5%	39	22.0%	67.6%
Aggregate [4]	30.8%	26	21.7%	43.1%
Average number of sessions per year for those receiving outpatient BH therapy				
Commercial insurance	8.8	36	6.0	17.4
Medicare FFS	6.6	49	3.8	17.3
Dual	5.7	49	4.1	18.7
Non-Dual	7.3	42	3.6	16.4
Medicaid	6.2	50	5.8	21.9
Dual	6.3	47	5.5	26.4
Non-Dual	6.2	50	5.5	21.0
Aggregate [4]	7.6	48	6.2	15.5
Percent of emergency department visits with a diagnosis for any MH/SUD condition in the first or second position				
Commercial insurance	6.8%	19	3.9%	9.7%
Medicare FFS	7.9%	35	5.1%	11.3%
Dual	13.3%	16	8.1%	22.6%
Non-Dual	4.4%	26	3.4%	5.6%
Medicaid	11.3%	12	6.9%	29.1%
Dual	10.5%	14	6.1%	42.3%
Non-Dual	11.4%	13	7.0%	30.8%
Percent of MH/SUD emergency department visits or hospitalizations with timely follow-up after discharge [5]				
Commercial insurance	28.1%	44	16.6%	51.1%
Medicare FFS	27.6%	6	10.3%	30.5%
Medicaid	37.7%	33	14.1%	65.5%
Aggregate [4]	31.6%	29	22.7%	48.6%

FIGURE A-19: BEHAVIORAL HEALTH ACCESS MEASURES FOR LOUISIANA

Availability of behavioral health providers	Louisiana	Rank	Min	Max
Percent of population living in a county where:				
Whole county is shortage area	91.8%	42	0.0%	100.0%
None of county is shortage area	0.0%	37	0.0%	51.1%
Percent of psychiatrist need met[6]	26.2%	29	8.5%	72.7%
Ratio of population to MH providers	307.9	19	141.8	797.3
Percent of MH/SUD care provided out-of-network (for commercial health plans with OON coverage)[7]				
Overall	11.9%	17	2%	50%
Inpatient and residential care	24.0%	31	0%	59%
Intensive outpatient and partial hospitalization programs	27.0%	19	1%	84%
Outpatient therapy and other services	6.5%	16	1%	58%
Therapy Access Ratio[8]				
Commercial insurance	34.1%	41	21.9%	97.8%
Medicare FFS	21.2%	48	11.5%	100.0%
Medicaid	26.7%	50	6.1%	100.0%

Affordability of behavioral health services	Louisiana	Rank	Min	Max
Average out of pocket costs for an individual 60-minute psychotherapy visit[9]				
No insurance - self pay	$287	50	$94	$287
Commercial insurance - out-of-network	$82	43	$24	$98
Commercial insurance - in-network	$31	39	$1	$46
Medicare FFS	$26	2	$26	$37
Percent of population by insurance type				
Commercially insured	45.4%		38.4%	68.4%
Medicare	13.6%		8.4%	18.9%
Medicare Advantage	6.4%		0.2%	9.1%
Medicare FFS	7.2%		5.8%	15.9%
Medicaid[10]	32.0%		9.8%	34.4%
Military	1.5%		0.0%	5.3%
Uninsured	7.5%		2.5%	18.0%
Income				
Median income	$52,090	49	$48,871	$91,072
Percent of individuals below FPL	18.8%	50	7.4%	19.4%

Legend

Gradient Interpretation: Adverse → Favorable; Favorable → Adverse

Notes:
1. Kansas uses 2020 prevalence metrics for commercial insurance due to data quality issues with the 2021 data.
2. Medicare Advantage metrics can be found by Census division in Appendix B.
3. Specialty care is defined as care from a behavioral health specialist in an inpatient, outpatient, or professional setting.
4. Aggregate metrics are calculated using the percent of population by insurance type.
5. Timely follow-up is defined as a follow-up visit within 30 days of discharge.
6. "Percent of Need Met" is computed by dividing the number of psychiatrists available to serve the population of the area, group, or facility by the number of psychiatrists that would be necessary to eliminate the mental health HPSA (based on a ratio of 30,000 to 1 (20,000 to 1 where high needs are indicated)).
7. Measured by volume of allowed dollars.
8. Calculated as the average number of therapy visits received by individuals diagnosed with behavioral health conditions in a given MSA, compared against the top decile of MSAs with the highest behavioral health provider supply density. Expressed as a percentage, this ratio illustrates how close an MSA, and by extension a state, is to achieving the reference rate.
9. Defined by HCPCS 90837.
10. Dual-eligible members are reported in the Medicaid category. The Medicare category reflect Medicare-only members.
11. Data for the District of Columbia is not available for all metrics. D.C. is included in rankings only for metrics for which data are available.

FIGURE A-20: BEHAVIORAL HEALTH ACCESS MEASURES FOR MAINE

Prevalence of behavioral health conditions	Maine	Rank	Min	Max
Survey and vital statistics measures				
Adults with frequent mental distress	13.6%	25	9.7%	18.7%
Poor mental health days per month	4.4	22	3.2	5.7
Drug overdose deaths per 100,000	30.1	36	8.5	56.8
Suicides per 100,000	17.8	33	6.2	27.4
Individuals with any diagnosed MH/SUD condition				
Commercial insurance [1]	26.7%	43	10.8%	32.8%
Medicare FFS [2]	36.5%	30	22.4%	42.5%
Dual	55.0%	29	28.9%	65.9%
Non-Dual	30.4%	17	21.6%	38.1%
Medicaid	34.0%	48	13.2%	38.3%
Dual	41.3%	43	19.4%	56.6%
Non-Dual	41.5%	50	12.3%	41.6%
Percent of individuals with diagnosed suicidal ideation or intentional self-harm				
Commercial insurance [1]	0.3%	18	0.1%	0.6%
Medicare FFS	0.0%	1	0.0%	0.2%
Dual	0.0%	1	0.0%	1.0%
Non-Dual	0.0%	1	0.0%	0.1%
Medicaid	0.2%	11	0.0%	0.9%
Dual	0.0%	1	0.0%	0.5%
Non-Dual	0.3%	14	0.0%	1.0%

Behavioral health treatment patterns	Maine	Rank	Min	Max
Percent of individuals with any MH/SUD diagnosis that received specialty MH/SUD care [3]				
Commercial insurance	22.6%	43	16.2%	43.0%
Medicare FFS	14.1%	17	5.4%	29.5%
Dual	16.9%	34	4.4%	40.5%
Non-Dual	12.5%	18	5.6%	23.9%
Medicaid	48.9%	18	21.0%	65.1%
Dual	35.7%	26	17.3%	59.5%
Non-Dual	52.4%	12	22.0%	67.6%
Aggregate [4]	27.7%	39	21.7%	43.1%
Average number of sessions per year for those receiving outpatient BH therapy				
Commercial insurance	12.5	11	6.0	17.4
Medicare FFS	15.6	2	3.8	17.3
Dual	17.7	2	4.1	18.7
Non-Dual	13.4	4	3.6	16.4
Medicaid	14.4	7	5.8	21.9
Dual	15.0	8	5.5	26.4
Non-Dual	14.3	8	5.5	21.0
Aggregate [4]	13.3	8	6.2	15.5
Percent of emergency department visits with a diagnosis for any MH/SUD condition in the first or second position				
Commercial insurance	7.4%	36	3.9%	9.7%
Medicare FFS	9.9%	50	5.1%	11.3%
Dual	16.4%	39	8.1%	22.6%
Non-Dual	4.6%	33	3.4%	5.6%
Medicaid	29.1%	51	6.9%	29.1%
Dual	24.9%	48	6.1%	42.3%
Non-Dual	30.8%	51	7.0%	30.8%
Percent of MH/SUD emergency department visits or hospitalizations with timely follow-up after discharge [5]				
Commercial insurance	44.7%	3	16.6%	51.1%
Medicare FFS	23.8%	13	10.3%	30.5%
Medicaid	53.1%	6	14.1%	65.5%
Aggregate [4]	44.2%	3	22.7%	48.6%

FIGURE A-20: BEHAVIORAL HEALTH ACCESS MEASURES FOR MAINE

Availability of behavioral health providers	Maine	Rank	Min	Max
Percent of population living in a county where:				
Whole county is shortage area	17.8%	7	0.0%	100.0%
None of county is shortage area	18.3%	7	0.0%	51.1%
Percent of psychiatrist need met[6]	19.7%	37	8.5%	72.7%
Ratio of population to MH providers	189.2	5	141.8	797.3
Percent of MH/SUD care provided out-of-network (for commercial health plans with OON coverage)[7]				
Overall	31.5%	39	2%	50%
Inpatient and residential care	33.4%	39	0%	59%
Intensive outpatient and partial hospitalization programs	52.0%	38	1%	84%
Outpatient therapy and other services	24.3%	40	1%	58%
Therapy Access Ratio[8]				
Commercial insurance	48.8%	29	21.9%	97.8%
Medicare FFS	87.9%	6	11.5%	100.0%
Medicaid	100.0%	1	6.1%	100.0%
Affordability of behavioral health services	**Maine**	**Rank**	**Min**	**Max**
Average out of pocket costs for an individual 60-minute psychotherapy visit[9]				
No insurance - self pay	$160	14	$94	$287
Commercial insurance - out-of-network	$55	18	$24	$98
Commercial insurance - in-network	$32	41	$1	$46
Medicare FFS	$26	1	$26	$37
Percent of population by insurance type				
Commercially insured	55.3%		38.4%	68.4%
Medicare	18.5%		8.4%	18.9%
Medicare Advantage	8.8%		0.2%	9.1%
Medicare FFS	9.7%		5.8%	15.9%
Medicaid[10]	19.5%		9.8%	34.4%
Military	1.4%		0.0%	5.3%
Uninsured	5.4%		2.5%	18.0%
Income				
Median income	$64,823	33	$48,871	$91,072
Percent of individuals below FPL	11.0%	18	7.4%	19.4%

Legend

Gradient Interpretation: Adverse → Favorable; Favorable → Adverse

Notes:
1. Kansas uses 2020 prevalence metrics for commercial insurance due to data quality issues with the 2021 data.
2. Medicare Advantage metrics can be found by Census division in Appendix B.
3. Specialty care is defined as care from a behavioral health specialist in an inpatient, outpatient, or professional setting.
4. Aggregate metrics are calculated using the percent of population by insurance type.
5. Timely follow-up is defined as a follow-up visit within 30 days of discharge.
6. "Percent of Need Met" is computed by dividing the number of psychiatrists available to serve the population of the area, group, or facility by the number of psychiatrists that would be necessary to eliminate the mental health HPSA (based on a ratio of 30,000 to 1 (20,000 to 1 where high needs are indicated)).
7. Measured by volume of allowed dollars.
8. Calculated as the average number of therapy visits received by individuals diagnosed with behavioral health conditions in a given MSA, compared against the top decile of MSAs with the highest behavioral health provider supply density. Expressed as a percentage, this ratio illustrates how close an MSA, and by extension a state, is to achieving the reference rate.
9. Defined by HCPCS 90837.
10. Dual-eligible members are reported in the Medicaid category. The Medicare category reflect Medicare-only members.
11. Data for the District of Columbia is not available for all metrics. D.C. is included in rankings only for metrics for which data are available.

FIGURE A-21: BEHAVIORAL HEALTH ACCESS MEASURES FOR MARYLAND

Prevalence of behavioral health conditions	Maryland	Rank	Min	Max
Survey and vital statistics measures				
Adults with frequent mental distress	12.7%	9	9.7%	18.7%
Poor mental health days per month	4.1	13	3.2	5.7
Drug overdose deaths per 100,000	41.1	48	8.5	56.8
Suicides per 100,000	9.8	5	6.2	27.4
Individuals with any diagnosed MH/SUD condition				
Commercial insurance [1]	23.0%	26	10.8%	32.8%
Medicare FFS [2]	34.3%	20	22.4%	42.5%
Dual	50.5%	18	28.9%	65.9%
Non-Dual	31.5%	23	21.6%	38.1%
Medicaid	26.6%	32	13.2%	38.3%
Dual	40.5%	42	19.4%	56.6%
Non-Dual	26.8%	29	12.3%	41.6%
Percent of individuals with diagnosed suicidal ideation or intentional self-harm				
Commercial insurance [1]	0.3%	17	0.1%	0.6%
Medicare FFS	0.1%	37	0.0%	0.2%
Dual	0.2%	28	0.0%	1.0%
Non-Dual	0.0%	41	0.0%	0.1%
Medicaid	0.4%	32	0.0%	0.9%
Dual	0.0%	31	0.0%	0.5%
Non-Dual	0.4%	28	0.0%	1.0%

Behavioral health treatment patterns	Maryland	Rank	Min	Max
Percent of individuals with any MH/SUD diagnosis that received specialty MH/SUD care [3]				
Commercial insurance	34.0%	13	16.2%	43.0%
Medicare FFS	20.7%	5	5.4%	29.5%
Dual	32.0%	6	4.4%	40.5%
Non-Dual	17.5%	5	5.6%	23.9%
Medicaid	48.5%	21	21.0%	65.1%
Dual	38.4%	21	17.3%	59.5%
Non-Dual	49.8%	22	22.0%	67.6%
Aggregate [4]	35.7%	13	21.7%	43.1%
Average number of sessions per year for those receiving outpatient BH therapy				
Commercial insurance	14.6	4	6.0	17.4
Medicare FFS	11.4	14	3.8	17.3
Dual	11.3	19	4.1	18.7
Non-Dual	11.4	11	3.6	16.4
Medicaid	17.0	5	5.8	21.9
Dual	11.4	18	5.5	26.4
Non-Dual	17.5	4	5.5	21.0
Aggregate [4]	14.8	3	6.2	15.5
Percent of emergency department visits with a diagnosis for any MH/SUD condition in the first or second position				
Commercial insurance	6.9%	21	3.9%	9.7%
Medicare FFS	7.8%	34	5.1%	11.3%
Dual	14.3%	25	8.1%	22.6%
Non-Dual	4.9%	41	3.4%	5.6%
Medicaid	10.1%	8	6.9%	29.1%
Dual	10.6%	16	6.1%	42.3%
Non-Dual	9.9%	8	7.0%	30.8%
Percent of MH/SUD emergency department visits or hospitalizations with timely follow-up after discharge [5]				
Commercial insurance	41.3%	8	16.6%	51.1%
Medicare FFS	25.8%	7	10.3%	30.5%
Medicaid	40.3%	27	14.1%	65.5%
Aggregate [4]	39.2%	7	22.7%	48.6%

FIGURE A-21: BEHAVIORAL HEALTH ACCESS MEASURES FOR MARYLAND

Availability of behavioral health providers	Maryland	Rank	Min	Max
Percent of population living in a county where:				
Whole county is shortage area	50.9%	20	0.0%	100.0%
None of county is shortage area	0.0%	37	0.0%	51.1%
Percent of psychiatrist need met[6]	19.4%	38	8.5%	72.7%
Ratio of population to MH providers	314.5	20	141.8	797.3
Percent of MH/SUD care provided out-of-network (for commercial health plans with OON coverage)[7]				
Overall	40.8%	46	2%	50%
Inpatient and residential care	48.8%	47	0%	59%
Intensive outpatient and partial hospitalization programs	40.7%	32	1%	84%
Outpatient therapy and other services	37.0%	47	1%	58%
Therapy Access Ratio[8]				
Commercial insurance	87.5%	6	21.9%	97.8%
Medicare FFS	77.8%	9	11.5%	100.0%
Medicaid	99.9%	10	6.1%	100.0%

Affordability of behavioral health services	Maryland	Rank	Min	Max
Average out of pocket costs for an individual 60-minute psychotherapy visit[9]				
No insurance - self pay	$164	15	$94	$287
Commercial insurance - out-of-network	$59	21	$24	$98
Commercial insurance - in-network	$19	13	$1	$46
Medicare FFS	$29	36	$26	$37
Percent of population by insurance type				
Commercially insured	58.6%		38.4%	68.4%
Medicare	13.2%		8.4%	18.9%
Medicare Advantage	2.2%		0.2%	9.1%
Medicare FFS	11.0%		5.8%	15.9%
Medicaid[10]	20.3%		9.8%	34.4%
Military	1.9%		0.0%	5.3%
Uninsured	6.1%		2.5%	18.0%
Income				
Median income	$90,129	2	$48,871	$91,072
Percent of individuals below FPL	9.2%	3	7.4%	19.4%

Legend

Gradient Interpretation: Adverse → Favorable; Favorable → Adverse

Notes:
1. Kansas uses 2020 prevalence metrics for commercial insurance due to data quality issues with the 2021 data.
2. Medicare Advantage metrics can be found by Census division in Appendix B.
3. Specialty care is defined as care from a behavioral health specialist in an inpatient, outpatient, or professional setting.
4. Aggregate metrics are calculated using the percent of population by insurance type.
5. Timely follow-up is defined as a follow-up visit within 30 days of discharge.
6. "Percent of Need Met" is computed by dividing the number of psychiatrists available to serve the population of the area, group, or facility by the number of psychiatrists that would be necessary to eliminate the mental health HPSA (based on a ratio of 30,000 to 1 (20,000 to 1 where high needs are indicated)).
7. Measured by volume of allowed dollars.
8. Calculated as the average number of therapy visits received by individuals diagnosed with behavioral health conditions in a given MSA, compared against the top decile of MSAs with the highest behavioral health provider supply density. Expressed as a percentage, this ratio illustrates how close an MSA, and by extension a state, is to achieving the reference rate.
9. Defined by HCPCS 90837.
10. Dual-eligible members are reported in the Medicaid category. The Medicare category reflect Medicare-only members.
11. Data for the District of Columbia is not available for all metrics. D.C. is included in rankings only for metrics for which data are available.

FIGURE A-22: BEHAVIORAL HEALTH ACCESS MEASURES FOR MASSACHUSETTS

Prevalence of behavioral health conditions	Massachusetts	Rank	Min	Max
Survey and vital statistics measures				
Adults with frequent mental distress	13.4%	21	9.7%	18.7%
Poor mental health days per month	4.5	29	3.2	5.7
Drug overdose deaths per 100,000	32.6	42	8.5	56.8
Suicides per 100,000	9.0	4	6.2	27.4
Individuals with any diagnosed MH/SUD condition				
Commercial insurance [1]	28.0%	47	10.8%	32.8%
Medicare FFS [2]	42.5%	51	22.4%	42.5%
Dual	64.2%	48	28.9%	65.9%
Non-Dual	36.3%	46	21.6%	38.1%
Medicaid	31.0%	43	13.2%	38.3%
Dual	52.0%	49	19.4%	56.6%
Non-Dual	30.1%	38	12.3%	41.6%
Percent of individuals with diagnosed suicidal ideation or intentional self-harm				
Commercial insurance [1]	0.2%	10	0.1%	0.6%
Medicare FFS	0.2%	51	0.0%	0.2%
Dual	0.8%	50	0.0%	1.0%
Non-Dual	0.1%	48	0.0%	0.1%
Medicaid	0.6%	46	0.0%	0.9%
Dual	0.5%	51	0.0%	0.5%
Non-Dual	0.7%	46	0.0%	1.0%

Behavioral health treatment patterns	Massachusetts	Rank	Min	Max
Percent of individuals with any MH/SUD diagnosis that received specialty MH/SUD care [3]				
Commercial insurance	41.2%	2	16.2%	43.0%
Medicare FFS	26.2%	2	5.4%	29.5%
Dual	35.3%	3	4.4%	40.5%
Non-Dual	21.6%	3	5.6%	23.9%
Medicaid	55.1%	7	21.0%	65.1%
Dual	48.9%	8	17.3%	59.5%
Non-Dual	57.7%	7	22.0%	67.6%
Aggregate [4]	43.1%	1	21.7%	43.1%
Average number of sessions per year for those receiving outpatient BH therapy				
Commercial insurance	14.7	2	6.0	17.4
Medicare FFS	12.9	4	3.8	17.3
Dual	13.6	9	4.1	18.7
Non-Dual	12.4	5	3.6	16.4
Medicaid	15.0	6	5.8	21.9
Dual	16.6	5	5.5	26.4
Non-Dual	14.5	6	5.5	21.0
Aggregate [4]	14.6	4	6.2	15.5
Percent of emergency department visits with a diagnosis for any MH/SUD condition in the first or second position				
Commercial insurance	7.1%	24	3.9%	9.7%
Medicare FFS	11.3%	51	5.1%	11.3%
Dual	20.1%	49	8.1%	22.6%
Non-Dual	5.5%	49	3.4%	5.6%
Medicaid	19.4%	46	6.9%	29.1%
Dual	16.9%	41	6.1%	42.3%
Non-Dual	20.6%	46	7.0%	30.8%
Percent of MH/SUD emergency department visits or hospitalizations with timely follow-up after discharge [5]				
Commercial insurance	51.1%	1	16.6%	51.1%
Medicare FFS	24.7%	9	10.3%	30.5%
Medicaid	51.7%	8	14.1%	65.5%
Aggregate [4]	48.6%	1	22.7%	48.6%

FIGURE A-22: BEHAVIORAL HEALTH ACCESS MEASURES FOR MASSACHUSETTS

Availability of behavioral health providers	Massachusetts	Rank	Min	Max
Percent of population living in a county where:				
Whole county is shortage area	1.3%	3	0.0%	100.0%
None of county is shortage area	14.7%	13	0.0%	51.1%
Percent of psychiatrist need met[6]	33.0%	18	8.5%	72.7%
Ratio of population to MH providers	141.8	1	141.8	797.3
Percent of MH/SUD care provided out-of-network (for commercial health plans with OON coverage)[7]				
Overall	29.6%	37	2%	50%
Inpatient and residential care	27.9%	34	0%	59%
Intensive outpatient and partial hospitalization programs	53.0%	39	1%	84%
Outpatient therapy and other services	26.2%	43	1%	58%
Therapy Access Ratio[8]				
Commercial insurance	97.3%	2	21.9%	97.8%
Medicare FFS	96.8%	3	11.5%	100.0%
Medicaid	100.0%	1	6.1%	100.0%

Affordability of behavioral health services	Massachusetts	Rank	Min	Max
Average out of pocket costs for an individual 60-minute psychotherapy visit[9]				
No insurance - self pay	$169	23	$94	$287
Commercial insurance - out-of-network	$24	1	$24	$98
Commercial insurance - in-network	$11	3	$1	$46
Medicare FFS	$28	29	$26	$37
Percent of population by insurance type				
Commercially insured	60.6%		38.4%	68.4%
Medicare	13.4%		8.4%	18.9%
Medicare Advantage	3.9%		0.2%	9.1%
Medicare FFS	9.5%		5.8%	15.9%
Medicaid[10]	23.2%		9.8%	34.4%
Military	0.4%		0.0%	5.3%
Uninsured	2.5%		2.5%	18.0%
Income				
Median income	$89,577	3	$48,871	$91,072
Percent of individuals below FPL	9.9%	8	7.4%	19.4%

Legend

Gradient Interpretation: Adverse → Favorable; Favorable → Adverse

Notes:
1. Kansas uses 2020 prevalence metrics for commercial insurance due to data quality issues with the 2021 data.
2. Medicare Advantage metrics can be found by Census division in Appendix B.
3. Specialty care is defined as care from a behavioral health specialist in an inpatient, outpatient, or professional setting.
4. Aggregate metrics are calculated using the percent of population by insurance type.
5. Timely follow-up is defined as a follow-up visit within 30 days of discharge.
6. "Percent of Need Met" is computed by dividing the number of psychiatrists available to serve the population of the area, group, or facility by the number of psychiatrists that would be necessary to eliminate the mental health HPSA (based on a ratio of 30,000 to 1 (20,000 to 1 where high needs are indicated)).
7. Measured by volume of allowed dollars.
8. Calculated as the average number of therapy visits received by individuals diagnosed with behavioral health conditions in a given MSA, compared against the top decile of MSAs with the highest behavioral health provider supply density. Expressed as a percentage, this ratio illustrates how close an MSA, and by extension a state, is to achieving the reference rate.
9. Defined by HCPCS 90837.
10. Dual-eligible members are reported in the Medicaid category. The Medicare category reflect Medicare-only members.
11. Data for the District of Columbia is not available for all metrics. D.C. is included in rankings only for metrics for which data are available.

FIGURE A-23: BEHAVIORAL HEALTH ACCESS MEASURES FOR MICHIGAN

Prevalence of behavioral health conditions	Michigan	Rank	Min	Max
Survey and vital statistics measures				
Adults with frequent mental distress	16.6%	45	9.7%	18.7%
Poor mental health days per month	5.3	46	3.2	5.7
Drug overdose deaths per 100,000	25.8	30	8.5	56.8
Suicides per 100,000	14.1	19	6.2	27.4
Individuals with any diagnosed MH/SUD condition				
Commercial insurance [1]	22.3%	21	10.8%	32.8%
Medicare FFS [2]	40.2%	48	22.4%	42.5%
Dual	61.3%	44	28.9%	65.9%
Non-Dual	35.7%	44	21.6%	38.1%
Medicaid	25.9%	28	13.2%	38.3%
Dual	28.1%	12	19.4%	56.6%
Non-Dual	26.0%	23	12.3%	41.6%
Percent of individuals with diagnosed suicidal ideation or intentional self-harm				
Commercial insurance [1]	0.3%	27	0.1%	0.6%
Medicare FFS	0.1%	48	0.0%	0.2%
Dual	0.5%	47	0.0%	1.0%
Non-Dual	0.0%	43	0.0%	0.1%
Medicaid	0.6%	42	0.0%	0.9%
Dual	0.0%	28	0.0%	0.5%
Non-Dual	0.7%	41	0.0%	1.0%

Behavioral health treatment patterns	Michigan	Rank	Min	Max
Percent of individuals with any MH/SUD diagnosis that received specialty MH/SUD care[3]				
Commercial insurance	29.7%	24	16.2%	43.0%
Medicare FFS	16.9%	12	5.4%	29.5%
Dual	25.9%	11	4.4%	40.5%
Non-Dual	13.6%	14	5.6%	23.9%
Medicaid	51.6%	10	21.0%	65.1%
Dual	59.5%	1	17.3%	59.5%
Non-Dual	50.2%	19	22.0%	67.6%
Aggregate [4]	34.5%	17	21.7%	43.1%
Average number of sessions per year for those receiving outpatient BH therapy				
Commercial insurance	10.8	23	6.0	17.4
Medicare FFS	11.8	8	3.8	17.3
Dual	12.0	15	4.1	18.7
Non-Dual	11.8	7	3.6	16.4
Medicaid	8.3	44	5.8	21.9
Dual	6.1	48	5.5	26.4
Non-Dual	8.7	41	5.5	21.0
Aggregate [4]	10.2	29	6.2	15.5
Percent of emergency department visits with a diagnosis for any MH/SUD condition in the first or second position				
Commercial insurance	8.0%	40	3.9%	9.7%
Medicare FFS	8.6%	41	5.1%	11.3%
Dual	15.9%	35	8.1%	22.6%
Non-Dual	4.9%	40	3.4%	5.6%
Medicaid	15.0%	30	6.9%	29.1%
Dual	15.7%	35	6.1%	42.3%
Non-Dual	15.0%	30	7.0%	30.8%
Percent of MH/SUD emergency department visits or hospitalizations with timely follow-up after discharge[5]				
Commercial insurance	35.1%	20	16.6%	51.1%
Medicare FFS	23.0%	16	10.3%	30.5%
Medicaid	38.8%	29	14.1%	65.5%
Aggregate [4]	35.1%	19	22.7%	48.6%

FIGURE A-23: BEHAVIORAL HEALTH ACCESS MEASURES FOR MICHIGAN

Availability of behavioral health providers	Michigan	Rank	Min	Max
Percent of population living in a county where:				
Whole county is shortage area	51.9%	22	0.0%	100.0%
None of county is shortage area	3.9%	23	0.0%	51.1%
Percent of psychiatrist need met[6]	33.1%	17	8.5%	72.7%
Ratio of population to MH providers	315.6	21	141.8	797.3
Percent of MH/SUD care provided out-of-network (for commercial health plans with OON coverage)[7]				
Overall	11.2%	16	2%	50%
Inpatient and residential care	14.3%	19	0%	59%
Intensive outpatient and partial hospitalization programs	30.0%	24	1%	84%
Outpatient therapy and other services	8.8%	23	1%	58%
Therapy Access Ratio[8]				
Commercial insurance	58.2%	27	21.9%	97.8%
Medicare FFS	71.4%	11	11.5%	100.0%
Medicaid	65.6%	35	6.1%	100.0%
Affordability of behavioral health services	**Michigan**	**Rank**	**Min**	**Max**
Average out of pocket costs for an individual 60-minute psychotherapy visit[9]				
No insurance - self pay	$186	33	$94	$287
Commercial insurance - out-of-network	$26	2	$24	$98
Commercial insurance - in-network	$19	11	$1	$46
Medicare FFS	$28	23	$26	$37
Percent of population by insurance type				
Commercially insured	54.9%		38.4%	68.4%
Medicare	15.9%		8.4%	18.9%
Medicare Advantage	8.3%		0.2%	9.1%
Medicare FFS	7.7%		5.8%	15.9%
Medicaid[10]	23.5%		9.8%	34.4%
Military	0.5%		0.0%	5.3%
Uninsured	5.1%		2.5%	18.0%
Income				
Median income	$63,444	35	$48,871	$91,072
Percent of individuals below FPL	13.3%	34	7.4%	19.4%

Legend

Gradient Interpretation	Min	Max
	Adverse	Favorable
	Favorable	Adverse

Notes:
1. Kansas uses 2020 prevalence metrics for commercial insurance due to data quality issues with the 2021 data.
2. Medicare Advantage metrics can be found by Census division in Appendix B.
3. Specialty care is defined as care from a behavioral health specialist in an inpatient, outpatient, or professional setting.
4. Aggregate metrics are calculated using the percent of population by insurance type.
5. Timely follow-up is defined as a follow-up visit within 30 days of discharge.
6. "Percent of Need Met" is computed by dividing the number of psychiatrists available to serve the population of the area, group, or facility by the number of psychiatrists that would be necessary to eliminate the mental health HPSA (based on a ratio of 30,000 to 1 (20,000 to 1 where high needs are indicated)).
7. Measured by volume of allowed dollars.
8. Calculated as the average number of therapy visits received by individuals diagnosed with behavioral health conditions in a given MSA, compared against the top decile of MSAs with the highest behavioral health provider supply density. Expressed as a percentage, this ratio illustrates how close an MSA, and by extension a state, is to achieving the reference rate.
9. Defined by HCPCS 90837.
10. Dual-eligible members are reported in the Medicaid category. The Medicare category reflect Medicare-only members.
11. Data for the District of Columbia is not available for all metrics. D.C. is included in rankings only for metrics for which data are available.

FIGURE A-24: BEHAVIORAL HEALTH ACCESS MEASURES FOR MINNESOTA

Prevalence of behavioral health conditions	Minnesota	Rank	Min	Max
Survey and vital statistics measures				
Adults with frequent mental distress	12.8%	12	9.7%	18.7%
Poor mental health days per month	4.1	15	3.2	5.7
Drug overdose deaths per 100,000	14.7	10	8.5	56.8
Suicides per 100,000	13.5	14	6.2	27.4
Individuals with any diagnosed MH/SUD condition				
Commercial insurance [1]	22.6%	23	10.8%	32.8%
Medicare FFS [2]	37.1%	32	22.4%	42.5%
Dual	65.9%	51	28.9%	65.9%
Non-Dual	32.2%	25	21.6%	38.1%
Medicaid	32.8%	46	13.2%	38.3%
Dual	56.6%	51	19.4%	56.6%
Non-Dual	32.2%	46	12.3%	41.6%
Percent of individuals with diagnosed suicidal ideation or intentional self-harm				
Commercial insurance [1]	0.3%	32	0.1%	0.6%
Medicare FFS	0.2%	50	0.0%	0.2%
Dual	1.0%	51	0.0%	1.0%
Non-Dual	0.0%	37	0.0%	0.1%
Medicaid	0.7%	49	0.0%	0.9%
Dual	0.4%	50	0.0%	0.5%
Non-Dual	0.8%	49	0.0%	1.0%

Behavioral health treatment patterns	Minnesota	Rank	Min	Max
Percent of individuals with any MH/SUD diagnosis that received specialty MH/SUD care [3]				
Commercial insurance	36.1%	11	16.2%	43.0%
Medicare FFS	17.4%	11	5.4%	29.5%
Dual	29.6%	8	4.4%	40.5%
Non-Dual	13.1%	16	5.6%	23.9%
Medicaid	55.5%	6	21.0%	65.1%
Dual	47.7%	9	17.3%	59.5%
Non-Dual	57.0%	8	22.0%	67.6%
Aggregate [4]	38.7%	7	21.7%	43.1%
Average number of sessions per year for those receiving outpatient BH therapy				
Commercial insurance	10.8	22	6.0	17.4
Medicare FFS	9.2	30	3.8	17.3
Dual	9.3	37	4.1	18.7
Non-Dual	9.0	29	3.6	16.4
Medicaid	12.3	13	5.8	21.9
Dual	12.7	11	5.5	26.4
Non-Dual	12.3	14	5.5	21.0
Aggregate [4]	11.0	21	6.2	15.5
Percent of emergency department visits with a diagnosis for any MH/SUD condition in the first or second position				
Commercial insurance	8.7%	48	3.9%	9.7%
Medicare FFS	9.0%	43	5.1%	11.3%
Dual	19.1%	48	8.1%	22.6%
Non-Dual	4.2%	22	3.4%	5.6%
Medicaid	18.9%	42	6.9%	29.1%
Dual	16.8%	39	6.1%	42.3%
Non-Dual	19.4%	43	7.0%	30.8%
Percent of MH/SUD emergency department visits or hospitalizations with timely follow-up after discharge [5]				
Commercial insurance	41.8%	5	16.6%	51.1%
Medicare FFS	24.0%	12	10.3%	30.5%
Medicaid	46.8%	12	14.1%	65.5%
Aggregate [4]	41.4%	5	22.7%	48.6%

FIGURE A-24: BEHAVIORAL HEALTH ACCESS MEASURES FOR MINNESOTA

Availability of behavioral health providers	Minnesota	Rank	Min	Max
Percent of population living in a county where:				
Whole county is shortage area	41.9%	17	0.0%	100.0%
None of county is shortage area	16.1%	10	0.0%	51.1%
Percent of psychiatrist need met[6]	27.3%	26	8.5%	72.7%
Ratio of population to MH providers	321.6	22	141.8	797.3
Percent of MH/SUD care provided out-of-network (for commercial health plans with OON coverage)[7]				
Overall	7.3%	8	2%	50%
Inpatient and residential care	9.4%	8	0%	59%
Intensive outpatient and partial hospitalization programs	6.5%	3	1%	84%
Outpatient therapy and other services	6.3%	15	1%	58%
Therapy Access Ratio[8]				
Commercial insurance	73.9%	12	21.9%	97.8%
Medicare FFS	74.1%	10	11.5%	100.0%
Medicaid	99.0%	12	6.1%	100.0%

Affordability of behavioral health services	Minnesota	Rank	Min	Max
Average out of pocket costs for an individual 60-minute psychotherapy visit[9]				
No insurance - self pay	$207	43	$94	$287
Commercial insurance - out-of-network	$44	7	$24	$98
Commercial insurance - in-network	$23	24	$1	$46
Medicare FFS	$28	33	$26	$37
Percent of population by insurance type				
Commercially insured	61.3%		38.4%	68.4%
Medicare	15.3%		8.4%	18.9%
Medicare Advantage	8.0%		0.2%	9.1%
Medicare FFS	7.3%		5.8%	15.9%
Medicaid[10]	18.5%		9.8%	34.4%
Military	0.6%		0.0%	5.3%
Uninsured	4.3%		2.5%	18.0%
Income				
Median income	$77,712	14	$48,871	$91,072
Percent of individuals below FPL	9.2%	3	7.4%	19.4%

Legend		
Gradient Interpretation	Adverse	Favorable
	Favorable	Adverse

Notes:
1. Kansas uses 2020 prevalence metrics for commercial insurance due to data quality issues with the 2021 data.
2. Medicare Advantage metrics can be found by Census division in Appendix B.
3. Specialty care is defined as care from a behavioral health specialist in an inpatient, outpatient, or professional setting.
4. Aggregate metrics are calculated using the percent of population by insurance type.
5. Timely follow-up is defined as a follow-up visit within 30 days of discharge.
6. "Percent of Need Met" is computed by dividing the number of psychiatrists available to serve the population of the area, group, or facility by the number of psychiatrists that would be necessary to eliminate the mental health HPSA (based on a ratio of 30,000 to 1 (20,000 to 1 where high needs are indicated)).
7. Measured by volume of allowed dollars.
8. Calculated as the average number of therapy visits received by individuals diagnosed with behavioral health conditions in a given MSA, compared against the top decile of MSAs with the highest behavioral health provider supply density. Expressed as a percentage, this ratio illustrates how close an MSA, and by extension a state, is to achieving the reference rate.
9. Defined by HCPCS 90837.
10. Dual-eligible members are reported in the Medicaid category. The Medicare category reflect Medicare-only members.
11. Data for the District of Columbia is not available for all metrics. D.C. is included in rankings only for metrics for which data are available.

FIGURE A-25: BEHAVIORAL HEALTH ACCESS MEASURES FOR MISSISSIPPI

Prevalence of behavioral health conditions	Mississippi	Rank	Min	Max
Survey and vital statistics measures				
Adults with frequent mental distress	14.6%	34	9.7%	18.7%
Poor mental health days per month	4.4	24	3.2	5.7
Drug overdose deaths per 100,000	14.4	9	8.5	56.8
Suicides per 100,000	13.9	16	6.2	27.4
Individuals with any diagnosed MH/SUD condition				
Commercial insurance [1]	24.1%	31	10.8%	32.8%
Medicare FFS [2]	38.9%	43	22.4%	42.5%
Dual	52.6%	22	28.9%	65.9%
Non-Dual	35.4%	39	21.6%	38.1%
Medicaid	22.2%	11	13.2%	38.3%
Dual	33.9%	25	19.4%	56.6%
Non-Dual	22.8%	9	12.3%	41.6%
Percent of individuals with diagnosed suicidal ideation or intentional self-harm				
Commercial insurance [1]	0.2%	9	0.1%	0.6%
Medicare FFS	0.0%	16	0.0%	0.2%
Dual	0.1%	14	0.0%	1.0%
Non-Dual	0.0%	22	0.0%	0.1%
Medicaid	0.1%	6	0.0%	0.9%
Dual	0.0%	1	0.0%	0.5%
Non-Dual	0.1%	6	0.0%	1.0%

Behavioral health treatment patterns	Mississippi	Rank	Min	Max
Percent of individuals with any MH/SUD diagnosis that received specialty MH/SUD care [3]				
Commercial insurance	18.5%	47	16.2%	43.0%
Medicare FFS	9.0%	44	5.4%	29.5%
Dual	16.8%	35	4.4%	40.5%
Non-Dual	6.2%	47	5.6%	23.9%
Medicaid	42.7%	36	21.0%	65.1%
Dual	32.4%	34	17.3%	59.5%
Non-Dual	46.1%	32	22.0%	67.6%
Aggregate [4]	24.4%	46	21.7%	43.1%
Average number of sessions per year for those receiving outpatient BH therapy				
Commercial insurance	7.7	49	6.0	17.4
Medicare FFS	5.5	50	3.8	17.3
Dual	6.6	48	4.1	18.7
Non-Dual	4.9	50	3.6	16.4
Medicaid	8.7	40	5.8	21.9
Dual	6.5	45	5.5	26.4
Non-Dual	9.2	36	5.5	21.0
Aggregate [4]	7.7	47	6.2	15.5
Percent of emergency department visits with a diagnosis for any MH/SUD condition in the first or second position				
Commercial insurance	6.2%	9	3.9%	9.7%
Medicare FFS	5.4%	3	5.1%	11.3%
Dual	8.1%	1	8.1%	22.6%
Non-Dual	3.7%	6	3.4%	5.6%
Medicaid	8.0%	3	6.9%	29.1%
Dual	8.7%	6	6.1%	42.3%
Non-Dual	7.7%	3	7.0%	30.8%
Percent of MH/SUD emergency department visits or hospitalizations with timely follow-up after discharge [5]				
Commercial insurance	19.0%	49	16.6%	51.1%
Medicare FFS	14.4%	42	10.3%	30.5%
Medicaid	33.7%	40	14.1%	65.5%
Aggregate [4]	22.7%	50	22.7%	48.6%

FIGURE A-25: BEHAVIORAL HEALTH ACCESS MEASURES FOR MISSISSIPPI

Availability of behavioral health providers	Mississippi	Rank	Min	Max
Percent of population living in a county where:				
Whole county is shortage area	81.7%	33	0.0%	100.0%
None of county is shortage area	14.2%	14	0.0%	51.1%
Percent of psychiatrist need met[6]	39.5%	9	8.5%	72.7%
Ratio of population to MH providers	502.2	42	141.8	797.3
Percent of MH/SUD care provided out-of-network (for commercial health plans with OON coverage)[7]				
Overall	19.0%	28	2%	50%
Inpatient and residential care	27.5%	33	0%	59%
Intensive outpatient and partial hospitalization programs	33.4%	26	1%	84%
Outpatient therapy and other services	11.9%	28	1%	58%
Therapy Access Ratio[8]				
Commercial insurance	21.9%	50	21.9%	97.8%
Medicare FFS	11.5%	51	11.5%	100.0%
Medicaid	53.8%	38	6.1%	100.0%

Affordability of behavioral health services	Mississippi	Rank	Min	Max
Average out of pocket costs for an individual 60-minute psychotherapy visit[9]				
No insurance - self pay	$201	41	$94	$287
Commercial insurance - out-of-network	$87	45	$24	$98
Commercial insurance - in-network	$33	42	$1	$46
Medicare FFS	$30	45	$26	$37
Percent of population by insurance type				
Commercially insured	47.6%		38.4%	68.4%
Medicare	14.5%		8.4%	18.9%
Medicare Advantage	4.3%		0.2%	9.1%
Medicare FFS	10.2%		5.8%	15.9%
Medicaid[10]	24.0%		9.8%	34.4%
Military	2.0%		0.0%	5.3%
Uninsured	11.9%		2.5%	18.0%
Income				
Median income	$48,871	51	$48,871	$91,072
Percent of individuals below FPL	19.4%	51	7.4%	19.4%

Legend

Gradient Interpretation: Adverse → Favorable; Favorable → Adverse

Notes:
1. Kansas uses 2020 prevalence metrics for commercial insurance due to data quality issues with the 2021 data.
2. Medicare Advantage metrics can be found by Census division in Appendix B.
3. Specialty care is defined as care from a behavioral health specialist in an inpatient, outpatient, or professional setting.
4. Aggregate metrics are calculated using the percent of population by insurance type.
5. Timely follow-up is defined as a follow-up visit within 30 days of discharge.
6. "Percent of Need Met" is computed by dividing the number of psychiatrists available to serve the population of the area, group, or facility by the number of psychiatrists that would be necessary to eliminate the mental health HPSA (based on a ratio of 30,000 to 1 (20,000 to 1 where high needs are indicated)).
7. Measured by volume of allowed dollars.
8. Calculated as the average number of therapy visits received by individuals diagnosed with behavioral health conditions in a given MSA, compared against the top decile of MSAs with the highest behavioral health provider supply density. Expressed as a percentage, this ratio illustrates how close an MSA, and by extension a state, is to achieving the reference rate.
9. Defined by HCPCS 90837.
10. Dual-eligible members are reported in the Medicaid category. The Medicare category reflect Medicare-only members.
11. Data for the District of Columbia is not available for all metrics. D.C. is included in rankings only for metrics for which data are available.

FIGURE A-26: BEHAVIORAL HEALTH ACCESS MEASURES FOR MISSOURI

Prevalence of behavioral health conditions	Missouri	Rank	Min	Max
Survey and vital statistics measures				
Adults with frequent mental distress	15.9%	41	9.7%	18.7%
Poor mental health days per month	4.9	38	3.2	5.7
Drug overdose deaths per 100,000	27.5	33	8.5	56.8
Suicides per 100,000	18.6	36	6.2	27.4
Individuals with any diagnosed MH/SUD condition				
Commercial insurance [1]	23.1%	27	10.8%	32.8%
Medicare FFS [2]	38.5%	40	22.4%	42.5%
Dual	64.7%	50	28.9%	65.9%
Non-Dual	34.9%	35	21.6%	38.1%
Medicaid	27.5%	34	13.2%	38.3%
Dual	43.7%	46	19.4%	56.6%
Non-Dual	26.3%	26	12.3%	41.6%
Percent of individuals with diagnosed suicidal ideation or intentional self-harm				
Commercial insurance [1]	0.4%	47	0.1%	0.6%
Medicare FFS	0.1%	45	0.0%	0.2%
Dual	0.6%	49	0.0%	1.0%
Non-Dual	0.0%	39	0.0%	0.1%
Medicaid	0.8%	50	0.0%	0.9%
Dual	0.3%	49	0.0%	0.5%
Non-Dual	1.0%	50	0.0%	1.0%

Behavioral health treatment patterns	Missouri	Rank	Min	Max
Percent of individuals with any MH/SUD diagnosis that received specialty MH/SUD care [3]				
Commercial insurance	23.2%	41	16.2%	43.0%
Medicare FFS	13.1%	26	5.4%	29.5%
Dual	25.6%	13	4.4%	40.5%
Non-Dual	9.8%	31	5.6%	23.9%
Medicaid	44.7%	33	21.0%	65.1%
Dual	42.1%	17	17.3%	59.5%
Non-Dual	45.5%	34	22.0%	67.6%
Aggregate [4]	25.9%	44	21.7%	43.1%
Average number of sessions per year for those receiving outpatient BH therapy				
Commercial insurance	8.0	47	6.0	17.4
Medicare FFS	9.7	24	3.8	17.3
Dual	10.4	24	4.1	18.7
Non-Dual	9.1	26	3.6	16.4
Medicaid	21.9	1	5.8	21.9
Dual	26.4	1	5.5	26.4
Non-Dual	21.0	1	5.5	21.0
Aggregate [4]	10.7	24	6.2	15.5
Percent of emergency department visits with a diagnosis for any MH/SUD condition in the first or second position				
Commercial insurance	8.2%	45	3.9%	9.7%
Medicare FFS	7.4%	28	5.1%	11.3%
Dual	15.5%	32	8.1%	22.6%
Non-Dual	4.4%	27	3.4%	5.6%
Medicaid	16.7%	35	6.9%	29.1%
Dual	16.4%	37	6.1%	42.3%
Non-Dual	16.7%	36	7.0%	30.8%
Percent of MH/SUD emergency department visits or hospitalizations with timely follow-up after discharge [5]				
Commercial insurance	29.5%	36	16.6%	51.1%
Medicare FFS	18.5%	29	10.3%	30.5%
Medicaid	46.8%	11	14.1%	65.5%
Aggregate [4]	31.4%	31	22.7%	48.6%

FIGURE A-26: BEHAVIORAL HEALTH ACCESS MEASURES FOR MISSOURI

Availability of behavioral health providers	Missouri	Rank	Min	Max
Percent of population living in a county where:				
Whole county is shortage area	85.5%	37	0.0%	100.0%
None of county is shortage area	6.8%	20	0.0%	51.1%
Percent of psychiatrist need met[6]	12.2%	47	8.5%	72.7%
Ratio of population to MH providers	432.8	36	141.8	797.3
Percent of MH/SUD care provided out-of-network (for commercial health plans with OON coverage)[7]				
Overall	12.0%	18	2%	50%
Inpatient and residential care	13.9%	17	0%	59%
Intensive outpatient and partial hospitalization programs	15.9%	13	1%	84%
Outpatient therapy and other services	9.0%	25	1%	58%
Therapy Access Ratio[8]				
Commercial insurance	33.6%	42	21.9%	97.8%
Medicare FFS	39.7%	29	11.5%	100.0%
Medicaid	99.7%	11	6.1%	100.0%

Affordability of behavioral health services	Missouri	Rank	Min	Max
Average out of pocket costs for an individual 60-minute psychotherapy visit[9]				
No insurance - self pay	$155	9	$94	$287
Commercial insurance - out-of-network	$79	40	$24	$98
Commercial insurance - in-network	$22	19	$1	$46
Medicare FFS	$27	11	$26	$37
Percent of population by insurance type				
Commercially insured	58.3%		38.4%	68.4%
Medicare	16.4%		8.4%	18.9%
Medicare Advantage	7.2%		0.2%	9.1%
Medicare FFS	9.2%		5.8%	15.9%
Medicaid[10]	14.7%		9.8%	34.4%
Military	1.3%		0.0%	5.3%
Uninsured	9.3%		2.5%	18.0%
Income				
Median income	$61,815	41	$48,871	$91,072
Percent of individuals below FPL	12.8%	31	7.4%	19.4%

Legend

Gradient Interpretation — Adverse → Favorable; Favorable → Adverse

Notes:
1. Kansas uses 2020 prevalence metrics for commercial insurance due to data quality issues with the 2021 data.
2. Medicare Advantage metrics can be found by Census division in Appendix B.
3. Specialty care is defined as care from a behavioral health specialist in an inpatient, outpatient, or professional setting.
4. Aggregate metrics are calculated using the percent of population by insurance type.
5. Timely follow-up is defined as a follow-up visit within 30 days of discharge.
6. "Percent of Need Met" is computed by dividing the number of psychiatrists available to serve the population of the area, group, or facility by the number of psychiatrists that would be necessary to eliminate the mental health HPSA (based on a ratio of 30,000 to 1 (20,000 to 1 where high needs are indicated)).
7. Measured by volume of allowed dollars.
8. Calculated as the average number of therapy visits received by individuals diagnosed with behavioral health conditions in a given MSA, compared against the top decile of MSAs with the highest behavioral health provider supply density. Expressed as a percentage, this ratio illustrates how close an MSA, and by extension a state, is to achieving the reference rate.
9. Defined by HCPCS 90837.
10. Dual-eligible members are reported in the Medicaid category. The Medicare category reflect Medicare-only members.
11. Data for the District of Columbia is not available for all metrics. D.C. is included in rankings only for metrics for which data are available.

FIGURE A-27: BEHAVIORAL HEALTH ACCESS MEASURES FOR MONTANA

Prevalence of behavioral health conditions	Montana	Rank	Min	Max
Survey and vital statistics measures				
Adults with frequent mental distress	13.9%	27	9.7%	18.7%
Poor mental health days per month	4.5	30	3.2	5.7
Drug overdose deaths per 100,000	13.4	6	8.5	56.8
Suicides per 100,000	26.4	49	6.2	27.4
Individuals with any diagnosed MH/SUD condition				
Commercial insurance [1]	18.1%	7	10.8%	32.8%
Medicare FFS [2]	32.6%	14	22.4%	42.5%
Dual	48.0%	14	28.9%	65.9%
Non-Dual	31.0%	21	21.6%	38.1%
Medicaid	31.9%	45	13.2%	38.3%
Dual	39.0%	38	19.4%	56.6%
Non-Dual	32.1%	45	12.3%	41.6%
Percent of individuals with diagnosed suicidal ideation or intentional self-harm				
Commercial insurance [1]	0.4%	46	0.1%	0.6%
Medicare FFS	0.0%	1	0.0%	0.2%
Dual	0.0%	1	0.0%	1.0%
Non-Dual	0.0%	1	0.0%	0.1%
Medicaid	0.4%	37	0.0%	0.9%
Dual	0.0%	1	0.0%	0.5%
Non-Dual	0.5%	36	0.0%	1.0%

Behavioral health treatment patterns	Montana	Rank	Min	Max
Percent of individuals with any MH/SUD diagnosis that received specialty MH/SUD care[3]				
Commercial insurance	32.9%	18	16.2%	43.0%
Medicare FFS	10.5%	38	5.4%	29.5%
Dual	11.7%	44	4.4%	40.5%
Non-Dual	10.2%	29	5.6%	23.9%
Medicaid	53.8%	8	21.0%	65.1%
Dual	32.9%	32	17.3%	59.5%
Non-Dual	55.9%	9	22.0%	67.6%
Aggregate [4]	34.2%	18	21.7%	43.1%
Average number of sessions per year for those receiving outpatient BH therapy				
Commercial insurance	12.3	13	6.0	17.4
Medicare FFS	9.6	25	3.8	17.3
Dual	10.9	20	4.1	18.7
Non-Dual	9.0	28	3.6	16.4
Medicaid	10.7	29	5.8	21.9
Dual	11.2	19	5.5	26.4
Non-Dual	10.8	29	5.5	21.0
Aggregate [4]	11.5	16	6.2	15.5
Percent of emergency department visits with a diagnosis for any MH/SUD condition in the first or second position				
Commercial insurance	7.4%	32	3.9%	9.7%
Medicare FFS	8.1%	37	5.1%	11.3%
Dual	18.7%	46	8.1%	22.6%
Non-Dual	4.6%	36	3.4%	5.6%
Medicaid	25.5%	50	6.9%	29.1%
Dual	23.2%	47	6.1%	42.3%
Non-Dual	25.7%	50	7.0%	30.8%
Percent of MH/SUD emergency department visits or hospitalizations with timely follow-up after discharge[5]				
Commercial insurance	29.6%	35	16.6%	51.1%
Medicare FFS	22.1%	19	10.3%	30.5%
Medicaid	46.5%	13	14.1%	65.5%
Aggregate [4]	32.3%	28	22.7%	48.6%

FIGURE A-27: BEHAVIORAL HEALTH ACCESS MEASURES FOR MONTANA

Availability of behavioral health providers	Montana	Rank	Min	Max
Percent of population living in a county where:				
Whole county is shortage area	100.0%	51	0.0%	100.0%
None of county is shortage area	0.0%	37	0.0%	51.1%
Percent of psychiatrist need met[6]	27.3%	27	8.5%	72.7%
Ratio of population to MH providers	281.6	17	141.8	797.3
Percent of MH/SUD care provided out-of-network (for commercial health plans with OON coverage)[7]				
Overall	14.5%	24	2%	50%
Inpatient and residential care	16.9%	23	0%	59%
Intensive outpatient and partial hospitalization programs	23.2%	15	1%	84%
Outpatient therapy and other services	12.7%	30	1%	58%
Therapy Access Ratio[8]				
Commercial insurance	80.6%	11	21.9%	97.8%
Medicare FFS	48.2%	24	11.5%	100.0%
Medicaid	96.6%	15	6.1%	100.0%
Affordability of behavioral health services	**Montana**	**Rank**	**Min**	**Max**
Average out of pocket costs for an individual 60-minute psychotherapy visit[9]				
No insurance - self pay	$164	17	$94	$287
Commercial insurance - out-of-network	$56	19	$24	$98
Commercial insurance - in-network	$28	34	$1	$46
Medicare FFS	$27	8	$26	$37
Percent of population by insurance type				
Commercially insured	52.1%		38.4%	68.4%
Medicare	17.6%		8.4%	18.9%
Medicare Advantage	4.0%		0.2%	9.1%
Medicare FFS	13.6%		5.8%	15.9%
Medicaid[10]	19.8%		9.8%	34.4%
Military	2.5%		0.0%	5.3%
Uninsured	8.0%		2.5%	18.0%
Income				
Median income	$63,357	36	$48,871	$91,072
Percent of individuals below FPL	12.5%	28	7.4%	19.4%

Legend

Gradient Interpretation: Adverse → Favorable; Favorable → Adverse

Notes:
1. Kansas uses 2020 prevalence metrics for commercial insurance due to data quality issues with the 2021 data.
2. Medicare Advantage metrics can be found by Census division in Appendix B.
3. Specialty care is defined as care from a behavioral health specialist in an inpatient, outpatient, or professional setting.
4. Aggregate metrics are calculated using the percent of population by insurance type.
5. Timely follow-up is defined as a follow-up visit within 30 days of discharge.
6. "Percent of Need Met" is computed by dividing the number of psychiatrists available to serve the population of the area, group, or facility by the number of psychiatrists that would be necessary to eliminate the mental health HPSA (based on a ratio of 30,000 to 1 (20,000 to 1 where high needs are indicated)).
7. Measured by volume of allowed dollars.
8. Calculated as the average number of therapy visits received by individuals diagnosed with behavioral health conditions in a given MSA, compared against the top decile of MSAs with the highest behavioral health provider supply density. Expressed as a percentage, this ratio illustrates how close an MSA, and by extension a state, is to achieving the reference rate.
9. Defined by HCPCS 90837.
10. Dual-eligible members are reported in the Medicaid category. The Medicare category reflect Medicare-only members.
11. Data for the District of Columbia is not available for all metrics. D.C. is included in rankings only for metrics for which data are available.

FIGURE A-28: BEHAVIORAL HEALTH ACCESS MEASURES FOR NEBRASKA

Prevalence of behavioral health conditions	Nebraska	Rank	Min	Max
Survey and vital statistics measures				
Adults with frequent mental distress	12.3%	6	9.7%	18.7%
Poor mental health days per month	3.9	6	3.2	5.7
Drug overdose deaths per 100,000	8.8	2	8.5	56.8
Suicides per 100,000	14.4	21	6.2	27.4
Individuals with any diagnosed MH/SUD condition				
Commercial insurance [1]	21.8%	19	10.8%	32.8%
Medicare FFS [2]	31.0%	9	22.4%	42.5%
Dual	53.2%	24	28.9%	65.9%
Non-Dual	28.9%	9	21.6%	38.1%
Medicaid	25.0%	22	13.2%	38.3%
Dual	30.9%	18	19.4%	56.6%
Non-Dual	24.7%	19	12.3%	41.6%
Percent of individuals with diagnosed suicidal ideation or intentional self-harm				
Commercial insurance [1]	0.3%	30	0.1%	0.6%
Medicare FFS	0.0%	10	0.0%	0.2%
Dual	0.1%	16	0.0%	1.0%
Non-Dual	0.0%	1	0.0%	0.1%
Medicaid	0.3%	22	0.0%	0.9%
Dual	0.0%	1	0.0%	0.5%
Non-Dual	0.3%	21	0.0%	1.0%

Behavioral health treatment patterns	Nebraska	Rank	Min	Max
Percent of individuals with any MH/SUD diagnosis that received specialty MH/SUD care [3]				
Commercial insurance	36.7%	9	16.2%	43.0%
Medicare FFS	10.5%	37	5.4%	29.5%
Dual	17.5%	33	4.4%	40.5%
Non-Dual	9.3%	37	5.6%	23.9%
Medicaid	60.0%	2	21.0%	65.1%
Dual	55.3%	4	17.3%	59.5%
Non-Dual	60.6%	3	22.0%	67.6%
Aggregate [4]	37.5%	9	21.7%	43.1%
Average number of sessions per year for those receiving outpatient BH therapy				
Commercial insurance	9.0	33	6.0	17.4
Medicare FFS	9.3	28	3.8	17.3
Dual	9.0	38	4.1	18.7
Non-Dual	9.4	21	3.6	16.4
Medicaid	11.3	23	5.8	21.9
Dual	11.9	14	5.5	26.4
Non-Dual	11.3	25	5.5	21.0
Aggregate [4]	9.4	37	6.2	15.5
Percent of emergency department visits with a diagnosis for any MH/SUD condition in the first or second position				
Commercial insurance	8.1%	44	3.9%	9.7%
Medicare FFS	6.7%	22	5.1%	11.3%
Dual	15.3%	30	8.1%	22.6%
Non-Dual	4.4%	25	3.4%	5.6%
Medicaid	15.1%	31	6.9%	29.1%
Dual	11.9%	24	6.1%	42.3%
Non-Dual	15.8%	33	7.0%	30.8%
Percent of MH/SUD emergency department visits or hospitalizations with timely follow-up after discharge [5]				
Commercial insurance	41.4%	7	16.6%	51.1%
Medicare FFS	23.0%	15	10.3%	30.5%
Medicaid	49.9%	9	14.1%	65.5%
Aggregate [4]	40.6%	6	22.7%	48.6%

FIGURE A-28: BEHAVIORAL HEALTH ACCESS MEASURES FOR NEBRASKA

Availability of behavioral health providers	Nebraska	Rank	Min	Max
Percent of population living in a county where:				
Whole county is shortage area	83.6%	34	0.0%	100.0%
None of county is shortage area	13.0%	15	0.0%	51.1%
Percent of psychiatrist need met[6]	47.9%	5	8.5%	72.7%
Ratio of population to MH providers	328.6	24	141.8	797.3
Percent of MH/SUD care provided out-of-network (for commercial health plans with OON coverage)[7]				
Overall	3.1%	5	2%	50%
Inpatient and residential care	6.2%	5	0%	59%
Intensive outpatient and partial hospitalization programs	14.4%	10	1%	84%
Outpatient therapy and other services	0.9%	3	1%	58%
Therapy Access Ratio[8]				
Commercial insurance	63.2%	22	21.9%	97.8%
Medicare FFS	36.3%	36	11.5%	100.0%
Medicaid	100.0%	1	6.1%	100.0%

Affordability of behavioral health services	Nebraska	Rank	Min	Max
Average out of pocket costs for an individual 60-minute psychotherapy visit[9]				
No insurance - self pay	$193	35	$94	$287
Commercial insurance - out-of-network	$95	48	$24	$98
Commercial insurance - in-network	$46	50	$1	$46
Medicare FFS	$27	4	$26	$37
Percent of population by insurance type				
Commercially insured	62.0%		38.4%	68.4%
Medicare	14.2%		8.4%	18.9%
Medicare Advantage	3.5%		0.2%	9.1%
Medicare FFS	10.7%		5.8%	15.9%
Medicaid[10]	14.9%		9.8%	34.4%
Military	1.8%		0.0%	5.3%
Uninsured	7.0%		2.5%	18.0%
Income				
Median income	$66,949	26	$48,871	$91,072
Percent of individuals below FPL	10.3%	12	7.4%	19.4%

Legend

Gradient Interpretation	Adverse	Favorable
	Favorable	Adverse

Notes:
1. Kansas uses 2020 prevalence metrics for commercial insurance due to data quality issues with the 2021 data.
2. Medicare Advantage metrics can be found by Census division in Appendix B.
3. Specialty care is defined as care from a behavioral health specialist in an inpatient, outpatient, or professional setting.
4. Aggregate metrics are calculated using the percent of population by insurance type.
5. Timely follow-up is defined as a follow-up visit within 30 days of discharge.
6. "Percent of Need Met" is computed by dividing the number of psychiatrists available to serve the population of the area, group, or facility by the number of psychiatrists that would be necessary to eliminate the mental health HPSA (based on a ratio of 30,000 to 1 (20,000 to 1 where high needs are indicated)).
7. Measured by volume of allowed dollars.
8. Calculated as the average number of therapy visits received by individuals diagnosed with behavioral health conditions in a given MSA, compared against the top decile of MSAs with the highest behavioral health provider supply density. Expressed as a percentage, this ratio illustrates how close an MSA, and by extension a state, is to achieving the reference rate.
9. Defined by HCPCS 90837.
10. Dual-eligible members are reported in the Medicaid category. The Medicare category reflect Medicare-only members.
11. Data for the District of Columbia is not available for all metrics. D.C. is included in rankings only for metrics for which data are available.

FIGURE A-29: BEHAVIORAL HEALTH ACCESS MEASURES FOR NEVADA

Prevalence of behavioral health conditions	Nevada	Rank	Min	Max
Survey and vital statistics measures				
Adults with frequent mental distress	18.2%	48	9.7%	18.7%
Poor mental health days per month	5.6	49	3.2	5.7
Drug overdose deaths per 100,000	23.4	26	8.5	56.8
Suicides per 100,000	20.0	42	6.2	27.4
Individuals with any diagnosed MH/SUD condition				
Commercial insurance [1]	18.3%	8	10.8%	32.8%
Medicare FFS [2]	30.1%	7	22.4%	42.5%
Dual	42.1%	6	28.9%	65.9%
Non-Dual	28.3%	7	21.6%	38.1%
Medicaid	23.2%	16	13.2%	38.3%
Dual	28.8%	14	19.4%	56.6%
Non-Dual	23.6%	14	12.3%	41.6%
Percent of individuals with diagnosed suicidal ideation or intentional self-harm				
Commercial insurance [1]	0.4%	41	0.1%	0.6%
Medicare FFS	0.1%	38	0.0%	0.2%
Dual	0.5%	46	0.0%	1.0%
Non-Dual	0.0%	30	0.0%	0.1%
Medicaid	0.4%	36	0.0%	0.9%
Dual	0.1%	39	0.0%	0.5%
Non-Dual	0.4%	32	0.0%	1.0%

Behavioral health treatment patterns	Nevada	Rank	Min	Max
Percent of individuals with any MH/SUD diagnosis that received specialty MH/SUD care [3]				
Commercial insurance	26.0%	35	16.2%	43.0%
Medicare FFS	10.7%	34	5.4%	29.5%
Dual	16.6%	36	4.4%	40.5%
Non-Dual	9.4%	34	5.6%	23.9%
Medicaid	42.3%	37	21.0%	65.1%
Dual	41.4%	19	17.3%	59.5%
Non-Dual	41.8%	41	22.0%	67.6%
Aggregate [4]	28.7%	33	21.7%	43.1%
Average number of sessions per year for those receiving outpatient BH therapy				
Commercial insurance	8.8	37	6.0	17.4
Medicare FFS	7.2	45	3.8	17.3
Dual	6.7	47	4.1	18.7
Non-Dual	7.6	37	3.6	16.4
Medicaid	12.2	15	5.8	21.9
Dual	15.7	7	5.5	26.4
Non-Dual	12.1	16	5.5	21.0
Aggregate [4]	9.5	33	6.2	15.5
Percent of emergency department visits with a diagnosis for any MH/SUD condition in the first or second position				
Commercial insurance	7.4%	33	3.9%	9.7%
Medicare FFS	8.5%	40	5.1%	11.3%
Dual	17.0%	41	8.1%	22.6%
Non-Dual	5.1%	46	3.4%	5.6%
Medicaid	16.7%	36	6.9%	29.1%
Dual	14.1%	32	6.1%	42.3%
Non-Dual	17.0%	38	7.0%	30.8%
Percent of MH/SUD emergency department visits or hospitalizations with timely follow-up after discharge [5]				
Commercial insurance	21.6%	48	16.6%	51.1%
Medicare FFS	16.0%	38	10.3%	30.5%
Medicaid	40.6%	25	14.1%	65.5%
Aggregate [4]	25.9%	46	22.7%	48.6%

FIGURE A-29: BEHAVIORAL HEALTH ACCESS MEASURES FOR NEVADA

Availability of behavioral health providers	Nevada	Rank	Min	Max
Percent of population living in a county where:				
Whole county is shortage area	77.5%	31	0.0%	100.0%
None of county is shortage area	0.0%	37	0.0%	51.1%
Percent of psychiatrist need met[6]	28.6%	25	8.5%	72.7%
Ratio of population to MH providers	416.4	33	141.8	797.3
Percent of MH/SUD care provided out-of-network (for commercial health plans with OON coverage)[7]				
Overall	33.5%	41	2%	50%
Inpatient and residential care	39.4%	42	0%	59%
Intensive outpatient and partial hospitalization programs	55.7%	41	1%	84%
Outpatient therapy and other services	23.7%	39	1%	58%
Therapy Access Ratio[8]				
Commercial insurance	38.7%	38	21.9%	97.8%
Medicare FFS	36.0%	37	11.5%	100.0%
Medicaid	84.0%	23	6.1%	100.0%
Affordability of behavioral health services	**Nevada**	**Rank**	**Min**	**Max**
Average out of pocket costs for an individual 60-minute psychotherapy visit[9]				
No insurance - self pay	$214	45	$94	$287
Commercial insurance - out-of-network	$77	38	$24	$98
Commercial insurance - in-network	$24	27	$1	$46
Medicare FFS	$28	31	$26	$37
Percent of population by insurance type				
Commercially insured	52.3%		38.4%	68.4%
Medicare	14.1%		8.4%	18.9%
Medicare Advantage	6.1%		0.2%	9.1%
Medicare FFS	7.9%		5.8%	15.9%
Medicaid[10]	20.8%		9.8%	34.4%
Military	1.5%		0.0%	5.3%
Uninsured	11.4%		2.5%	18.0%
Income				
Median income	$66,194	31	$48,871	$91,072
Percent of individuals below FPL	12.9%	32	7.4%	19.4%

Legend

	Min	Max
Gradient Interpretation	Adverse	Favorable
	Favorable	Adverse

Notes:
1. Kansas uses 2020 prevalence metrics for commercial insurance due to data quality issues with the 2021 data.
2. Medicare Advantage metrics can be found by Census division in Appendix B.
3. Specialty care is defined as care from a behavioral health specialist in an inpatient, outpatient, or professional setting.
4. Aggregate metrics are calculated using the percent of population by insurance type.
5. Timely follow-up is defined as a follow-up visit within 30 days of discharge.
6. "Percent of Need Met" is computed by dividing the number of psychiatrists available to serve the population of the area, group, or facility by the number of psychiatrists that would be necessary to eliminate the mental health HPSA (based on a ratio of 30,000 to 1 (20,000 to 1 where high needs are indicated)).
7. Measured by volume of allowed dollars.
8. Calculated as the average number of therapy visits received by individuals diagnosed with behavioral health conditions in a given MSA, compared against the top decile of MSAs with the highest behavioral health provider supply density. Expressed as a percentage, this ratio illustrates how close an MSA, and by extension a state, is to achieving the reference rate.
9. Defined by HCPCS 90837.
10. Dual-eligible members are reported in the Medicaid category. The Medicare category reflect Medicare-only members.
11. Data for the District of Columbia is not available for all metrics. D.C. is included in rankings only for metrics for which data are available.

FIGURE A-30: BEHAVIORAL HEALTH ACCESS MEASURES FOR NEW HAMPSHIRE

Prevalence of behavioral health conditions	New Hampshire	Rank	Min	Max
Survey and vital statistics measures				
Adults with frequent mental distress	14.8%	36	9.7%	18.7%
Poor mental health days per month	4.8	36	3.2	5.7
Drug overdose deaths per 100,000	30.7	38	8.5	56.8
Suicides per 100,000	17.9	34	6.2	27.4
Individuals with any diagnosed MH/SUD condition				
Commercial insurance [1]	27.8%	46	10.8%	32.8%
Medicare FFS [2]	34.7%	24	22.4%	42.5%
Dual	58.9%	39	28.9%	65.9%
Non-Dual	32.1%	24	21.6%	38.1%
Medicaid	33.2%	47	13.2%	38.3%
Dual	50.0%	48	19.4%	56.6%
Non-Dual	32.7%	47	12.3%	41.6%
Percent of individuals with diagnosed suicidal ideation or intentional self-harm				
Commercial insurance [1]	0.4%	45	0.1%	0.6%
Medicare FFS	0.0%	14	0.0%	0.2%
Dual	0.1%	21	0.0%	1.0%
Non-Dual	0.0%	1	0.0%	0.1%
Medicaid	0.2%	15	0.0%	0.9%
Dual	0.0%	1	0.0%	0.5%
Non-Dual	0.3%	15	0.0%	1.0%

Behavioral health treatment patterns	New Hampshire	Rank	Min	Max
Percent of individuals with any MH/SUD diagnosis that received specialty MH/SUD care [3]				
Commercial insurance	28.3%	27	16.2%	43.0%
Medicare FFS	15.3%	15	5.4%	29.5%
Dual	27.3%	9	4.4%	40.5%
Non-Dual	13.0%	17	5.6%	23.9%
Medicaid	49.0%	17	21.0%	65.1%
Dual	39.6%	20	17.3%	59.5%
Non-Dual	48.8%	26	22.0%	67.6%
Aggregate [4]	29.5%	29	21.7%	43.1%
Average number of sessions per year for those receiving outpatient BH therapy				
Commercial insurance	13.5	8	6.0	17.4
Medicare FFS	12.5	6	3.8	17.3
Dual	13.7	8	4.1	18.7
Non-Dual	11.7	8	3.6	16.4
Medicaid	14.1	8	5.8	21.9
Dual	14.4	9	5.5	26.4
Non-Dual	14.2	9	5.5	21.0
Aggregate [4]	13.4	7	6.2	15.5
Percent of emergency department visits with a diagnosis for any MH/SUD condition in the first or second position				
Commercial insurance	8.3%	46	3.9%	9.7%
Medicare FFS	8.2%	38	5.1%	11.3%
Dual	17.7%	44	8.1%	22.6%
Non-Dual	5.2%	47	3.4%	5.6%
Medicaid	19.4%	45	6.9%	29.1%
Dual	18.8%	43	6.1%	42.3%
Non-Dual	19.6%	45	7.0%	30.8%
Percent of MH/SUD emergency department visits or hospitalizations with timely follow-up after discharge [5]				
Commercial insurance	42.1%	4	16.6%	51.1%
Medicare FFS	28.4%	4	10.3%	30.5%
Medicaid	55.8%	2	14.1%	65.5%
Aggregate [4]	42.2%	4	22.7%	48.6%

FIGURE A-30: BEHAVIORAL HEALTH ACCESS MEASURES FOR NEW HAMPSHIRE

Availability of behavioral health providers	New Hampshire	Rank	Min	Max
Percent of population living in a county where:				
Whole county is shortage area	29.7%	8	0.0%	100.0%
None of county is shortage area	15.1%	12	0.0%	51.1%
Percent of psychiatrist need met[6]	51.1%	4	8.5%	72.7%
Ratio of population to MH providers	276.9	16	141.8	797.3
Percent of MH/SUD care provided out-of-network (for commercial health plans with OON coverage)[7]				
Overall	35.1%	43	2%	50%
Inpatient and residential care	45.8%	45	0%	59%
Intensive outpatient and partial hospitalization programs	56.2%	42	1%	84%
Outpatient therapy and other services	20.9%	36	1%	58%
Therapy Access Ratio[8]				
Commercial insurance	66.9%	19	21.9%	97.8%
Medicare FFS	85.1%	7	11.5%	100.0%
Medicaid	100.0%	1	6.1%	100.0%

Affordability of behavioral health services	New Hampshire	Rank	Min	Max
Average out of pocket costs for an individual 60-minute psychotherapy visit[9]				
No insurance - self pay	$165	19	$94	$287
Commercial insurance - out-of-network	$45	8	$24	$98
Commercial insurance - in-network	$18	9	$1	$46
Medicare FFS	$29	44	$26	$37
Percent of population by insurance type				
Commercially insured	62.7%		38.4%	68.4%
Medicare	17.6%		8.4%	18.9%
Medicare Advantage	4.6%		0.2%	9.1%
Medicare FFS	13.1%		5.8%	15.9%
Medicaid[10]	13.5%		9.8%	34.4%
Military	1.2%		0.0%	5.3%
Uninsured	5.0%		2.5%	18.0%
Income				
Median income	$88,268	5	$48,871	$91,072
Percent of individuals below FPL	7.4%	1	7.4%	19.4%

Legend

Gradient Interpretation: Adverse → Favorable; Favorable → Adverse

Notes:
1. Kansas uses 2020 prevalence metrics for commercial insurance due to data quality issues with the 2021 data.
2. Medicare Advantage metrics can be found by Census division in Appendix B.
3. Specialty care is defined as care from a behavioral health specialist in an inpatient, outpatient, or professional setting.
4. Aggregate metrics are calculated using the percent of population by insurance type.
5. Timely follow-up is defined as a follow-up visit within 30 days of discharge.
6. "Percent of Need Met" is computed by dividing the number of psychiatrists available to serve the population of the area, group, or facility by the number of psychiatrists that would be necessary to eliminate the mental health HPSA (based on a ratio of 30,000 to 1 (20,000 to 1 where high needs are indicated)).
7. Measured by volume of allowed dollars.
8. Calculated as the average number of therapy visits received by individuals diagnosed with behavioral health conditions in a given MSA, compared against the top decile of MSAs with the highest behavioral health provider supply density. Expressed as a percentage, this ratio illustrates how close an MSA, and by extension a state, is to achieving the reference rate.
9. Defined by HCPCS 90837.
10. Dual-eligible members are reported in the Medicaid category. The Medicare category reflect Medicare-only members.
11. Data for the District of Columbia is not available for all metrics. D.C. is included in rankings only for metrics for which data are available.

FIGURE A-31: BEHAVIORAL HEALTH ACCESS MEASURES FOR NEW JERSEY

Prevalence of behavioral health conditions	New Jersey	Rank	Min	Max
Survey and vital statistics measures				
Adults with frequent mental distress	12.7%	11	9.7%	18.7%
Poor mental health days per month	4.1	9	3.2	5.7
Drug overdose deaths per 100,000	32.0	40	8.5	56.8
Suicides per 100,000	7.8	2	6.2	27.4
Individuals with any diagnosed MH/SUD condition				
Commercial insurance [1]	16.9%	5	10.8%	32.8%
Medicare FFS [2]	34.8%	25	22.4%	42.5%
Dual	53.9%	26	28.9%	65.9%
Non-Dual	32.4%	26	21.6%	38.1%
Medicaid	22.9%	15	13.2%	38.3%
Dual	37.2%	33	19.4%	56.6%
Non-Dual	21.2%	8	12.3%	41.6%
Percent of individuals with diagnosed suicidal ideation or intentional self-harm				
Commercial insurance [1]	0.2%	7	0.1%	0.6%
Medicare FFS	0.1%	40	0.0%	0.2%
Dual	0.3%	34	0.0%	1.0%
Non-Dual	0.1%	45	0.0%	0.1%
Medicaid	0.4%	29	0.0%	0.9%
Dual	0.1%	42	0.0%	0.5%
Non-Dual	0.4%	24	0.0%	1.0%

Behavioral health treatment patterns	New Jersey	Rank	Min	Max
Percent of individuals with any MH/SUD diagnosis that received specialty MH/SUD care [3]				
Commercial insurance	28.9%	25	16.2%	43.0%
Medicare FFS	25.6%	3	5.4%	29.5%
Dual	38.3%	2	4.4%	40.5%
Non-Dual	23.0%	2	5.6%	23.9%
Medicaid	45.9%	31	21.0%	65.1%
Dual	45.9%	12	17.3%	59.5%
Non-Dual	45.9%	33	22.0%	67.6%
Aggregate [4]	32.1%	23	21.7%	43.1%
Average number of sessions per year for those receiving outpatient BH therapy				
Commercial insurance	14.2	5	6.0	17.4
Medicare FFS	11.7	10	3.8	17.3
Dual	12.0	14	4.1	18.7
Non-Dual	11.6	9	3.6	16.4
Medicaid	13.1	12	5.8	21.9
Dual	13.4	10	5.5	26.4
Non-Dual	13.1	12	5.5	21.0
Aggregate [4]	13.8	6	6.2	15.5
Percent of emergency department visits with a diagnosis for any MH/SUD condition in the first or second position				
Commercial insurance	6.7%	18	3.9%	9.7%
Medicare FFS	8.3%	39	5.1%	11.3%
Dual	17.5%	43	8.1%	22.6%
Non-Dual	5.6%	51	3.4%	5.6%
Medicaid	13.2%	22	6.9%	29.1%
Dual	11.7%	21	6.1%	42.3%
Non-Dual	13.6%	22	7.0%	30.8%
Percent of MH/SUD emergency department visits or hospitalizations with timely follow-up after discharge [5]				
Commercial insurance	36.4%	17	16.6%	51.1%
Medicare FFS	30.5%	1	10.3%	30.5%
Medicaid	43.7%	17	14.1%	65.5%
Aggregate [4]	37.3%	11	22.7%	48.6%

FIGURE A-31: BEHAVIORAL HEALTH ACCESS MEASURES FOR NEW JERSEY

Availability of behavioral health providers	New Jersey	Rank	Min	Max
Percent of population living in a county where:				
Whole county is shortage area	33.3%	9	0.0%	100.0%
None of county is shortage area	36.8%	2	0.0%	51.1%
Percent of psychiatrist need met[6]	72.7%	1	8.5%	72.7%
Ratio of population to MH providers	370.3	30	141.8	797.3
Percent of MH/SUD care provided out-of-network (for commercial health plans with OON coverage)[7]				
Overall	49.9%	50	2%	50%
Inpatient and residential care	30.8%	37	0%	59%
Intensive outpatient and partial hospitalization programs	54.0%	40	1%	84%
Outpatient therapy and other services	57.8%	50	1%	58%
Therapy Access Ratio[8]				
Commercial insurance	71.3%	13	21.9%	97.8%
Medicare FFS	92.1%	4	11.5%	100.0%
Medicaid	75.1%	26	6.1%	100.0%

Affordability of behavioral health services	New Jersey	Rank	Min	Max
Average out of pocket costs for an individual 60-minute psychotherapy visit[9]				
No insurance - self pay	$198	39	$94	$287
Commercial insurance - out-of-network	$76	37	$24	$98
Commercial insurance - in-network	$20	14	$1	$46
Medicare FFS	$28	34	$26	$37
Percent of population by insurance type				
Commercially insured	60.3%		38.4%	68.4%
Medicare	13.8%		8.4%	18.9%
Medicare Advantage	4.8%		0.2%	9.1%
Medicare FFS	8.9%		5.8%	15.9%
Medicaid[10]	18.4%		9.8%	34.4%
Military	0.4%		0.0%	5.3%
Uninsured	7.2%		2.5%	18.0%
Income				
Median income	$89,227	4	$48,871	$91,072
Percent of individuals below FPL	9.8%	7	7.4%	19.4%

Legend

Gradient Interpretation: Adverse → Favorable; Favorable → Adverse

Notes:
1. Kansas uses 2020 prevalence metrics for commercial insurance due to data quality issues with the 2021 data.
2. Medicare Advantage metrics can be found by Census division in Appendix B.
3. Specialty care is defined as care from a behavioral health specialist in an inpatient, outpatient, or professional setting.
4. Aggregate metrics are calculated using the percent of population by insurance type.
5. Timely follow-up is defined as a follow-up visit within 30 days of discharge.
6. "Percent of Need Met" is computed by dividing the number of psychiatrists available to serve the population of the area, group, or facility by the number of psychiatrists that would be necessary to eliminate the mental health HPSA (based on a ratio of 30,000 to 1 (20,000 to 1 where high needs are indicated)).
7. Measured by volume of allowed dollars.
8. Calculated as the average number of therapy visits received by individuals diagnosed with behavioral health conditions in a given MSA, compared against the top decile of MSAs with the highest behavioral health provider supply density. Expressed as a percentage, this ratio illustrates how close an MSA, and by extension a state, is to achieving the reference rate.
9. Defined by HCPCS 90837.
10. Dual-eligible members are reported in the Medicaid category. The Medicare category reflect Medicare-only members.
11. Data for the District of Columbia is not available for all metrics. D.C. is included in rankings only for metrics for which data are available.

FIGURE A-32: BEHAVIORAL HEALTH ACCESS MEASURES FOR NEW MEXICO

Prevalence of behavioral health conditions	New Mexico	Rank	Min	Max
Survey and vital statistics measures				
Adults with frequent mental distress	13.6%	24	9.7%	18.7%
Poor mental health days per month	4.3	19	3.2	5.7
Drug overdose deaths per 100,000	30.5	37	8.5	56.8
Suicides per 100,000	23.8	48	6.2	27.4
Individuals with any diagnosed MH/SUD condition				
Commercial insurance [1]	10.8%	1	10.8%	32.8%
Medicare FFS [2]	29.2%	5	22.4%	42.5%
Dual	37.8%	4	28.9%	65.9%
Non-Dual	27.4%	6	21.6%	38.1%
Medicaid	24.1%	19	13.2%	38.3%
Dual	25.1%	9	19.4%	56.6%
Non-Dual	25.7%	21	12.3%	41.6%
Percent of individuals with diagnosed suicidal ideation or intentional self-harm				
Commercial insurance [1]	0.2%	4	0.1%	0.6%
Medicare FFS	0.0%	24	0.0%	0.2%
Dual	0.2%	25	0.0%	1.0%
Non-Dual	0.0%	1	0.0%	0.1%
Medicaid	0.3%	20	0.0%	0.9%
Dual	0.0%	1	0.0%	0.5%
Non-Dual	0.3%	18	0.0%	1.0%

Behavioral health treatment patterns	New Mexico	Rank	Min	Max
Percent of individuals with any MH/SUD diagnosis that received specialty MH/SUD care [3]				
Commercial insurance	34.8%	12	16.2%	43.0%
Medicare FFS	11.3%	33	5.4%	29.5%
Dual	14.5%	41	4.4%	40.5%
Non-Dual	10.4%	28	5.6%	23.9%
Medicaid	50.4%	14	21.0%	65.1%
Dual	34.7%	28	17.3%	59.5%
Non-Dual	51.1%	16	22.0%	67.6%
Aggregate [4]	38.8%	6	21.7%	43.1%
Average number of sessions per year for those receiving outpatient BH therapy				
Commercial insurance	11.2	20	6.0	17.4
Medicare FFS	9.1	33	3.8	17.3
Dual	7.7	41	4.1	18.7
Non-Dual	10.0	16	3.6	16.4
Medicaid	11.5	20	5.8	21.9
Dual	9.4	33	5.5	26.4
Non-Dual	11.8	17	5.5	21.0
Aggregate [4]	11.1	19	6.2	15.5
Percent of emergency department visits with a diagnosis for any MH/SUD condition in the first or second position				
Commercial insurance	6.5%	13	3.9%	9.7%
Medicare FFS	7.5%	31	5.1%	11.3%
Dual	15.1%	28	8.1%	22.6%
Non-Dual	4.3%	24	3.4%	5.6%
Medicaid	20.7%	48	6.9%	29.1%
Dual	13.7%	30	6.1%	42.3%
Non-Dual	21.9%	48	7.0%	30.8%
Percent of MH/SUD emergency department visits or hospitalizations with timely follow-up after discharge [5]				
Commercial insurance	26.3%	45	16.6%	51.1%
Medicare FFS	23.0%	14	10.3%	30.5%
Medicaid	36.5%	35	14.1%	65.5%
Aggregate [4]	30.3%	37	22.7%	48.6%

FIGURE A-32: BEHAVIORAL HEALTH ACCESS MEASURES FOR NEW MEXICO

Availability of behavioral health providers	New Mexico	Rank	Min	Max
Percent of population living in a county where:				
Whole county is shortage area	67.2%	27	0.0%	100.0%
None of county is shortage area	0.9%	33	0.0%	51.1%
Percent of psychiatrist need met[6]	18.2%	41	8.5%	72.7%
Ratio of population to MH providers	234.0	11	141.8	797.3
Percent of MH/SUD care provided out-of-network (for commercial health plans with OON coverage)[7]				
Overall	32.5%	40	2%	50%
Inpatient and residential care	58.9%	50	0%	59%
Intensive outpatient and partial hospitalization programs	65.5%	45	1%	84%
Outpatient therapy and other services	14.6%	35	1%	58%
Therapy Access Ratio[8]				
Commercial insurance	69.5%	16	21.9%	97.8%
Medicare FFS	54.2%	18	11.5%	100.0%
Medicaid	90.5%	20	6.1%	100.0%

Affordability of behavioral health services	New Mexico	Rank	Min	Max
Average out of pocket costs for an individual 60-minute psychotherapy visit[9]				
No insurance - self pay	$165	20	$94	$287
Commercial insurance - out-of-network	$74	35	$24	$98
Commercial insurance - in-network	$27	31	$1	$46
Medicare FFS	$27	20	$26	$37
Percent of population by insurance type				
Commercially insured	38.4%		38.4%	68.4%
Medicare	15.6%		8.4%	18.9%
Medicare Advantage	6.6%		0.2%	9.1%
Medicare FFS	9.0%		5.8%	15.9%
Medicaid[10]	34.4%		9.8%	34.4%
Military	1.6%		0.0%	5.3%
Uninsured	10.0%		2.5%	18.0%
Income				
Median income	$54,304	46	$48,871	$91,072
Percent of individuals below FPL	18.3%	49	7.4%	19.4%

Legend		
Gradient Interpretation	Adverse	Favorable
	Favorable	Adverse

Notes:
1. Kansas uses 2020 prevalence metrics for commercial insurance due to data quality issues with the 2021 data.
2. Medicare Advantage metrics can be found by Census division in Appendix B.
3. Specialty care is defined as care from a behavioral health specialist in an inpatient, outpatient, or professional setting.
4. Aggregate metrics are calculated using the percent of population by insurance type.
5. Timely follow-up is defined as a follow-up visit within 30 days of discharge.
6. "Percent of Need Met" is computed by dividing the number of psychiatrists available to serve the population of the area, group, or facility by the number of psychiatrists that would be necessary to eliminate the mental health HPSA (based on a ratio of 30,000 to 1 (20,000 to 1 where high needs are indicated)).
7. Measured by volume of allowed dollars.
8. Calculated as the average number of therapy visits received by individuals diagnosed with behavioral health conditions in a given MSA, compared against the top decile of MSAs with the highest behavioral health provider supply density. Expressed as a percentage, this ratio illustrates how close an MSA, and by extension a state, is to achieving the reference rate.
9. Defined by HCPCS 90837.
10. Dual-eligible members are reported in the Medicaid category. The Medicare category reflect Medicare-only members.
11. Data for the District of Columbia is not available for all metrics. D.C. is included in rankings only for metrics for which data are available.

FIGURE A-33: BEHAVIORAL HEALTH ACCESS MEASURES FOR NEW YORK

Prevalence of behavioral health conditions	New York	Rank	Min	Max
Survey and vital statistics measures				
Adults with frequent mental distress	13.1%	16	9.7%	18.7%
Poor mental health days per month	4.1	12	3.2	5.7
Drug overdose deaths per 100,000	21.0	24	8.5	56.8
Suicides per 100,000	8.2	3	6.2	27.4
Individuals with any diagnosed MH/SUD condition				
Commercial insurance [1]	15.9%	4	10.8%	32.8%
Medicare FFS [2]	36.3%	29	22.4%	42.5%
Dual	57.6%	35	28.9%	65.9%
Non-Dual	30.5%	18	21.6%	38.1%
Medicaid	22.6%	12	13.2%	38.3%
Dual	34.1%	26	19.4%	56.6%
Non-Dual	23.5%	12	12.3%	41.6%
Percent of individuals with diagnosed suicidal ideation or intentional self-harm				
Commercial insurance [1]	0.1%	1	0.1%	0.6%
Medicare FFS	0.1%	44	0.0%	0.2%
Dual	0.3%	38	0.0%	1.0%
Non-Dual	0.0%	44	0.0%	0.1%
Medicaid	0.4%	30	0.0%	0.9%
Dual	0.1%	46	0.0%	0.5%
Non-Dual	0.4%	33	0.0%	1.0%

Behavioral health treatment patterns	New York	Rank	Min	Max
Percent of individuals with any MH/SUD diagnosis that received specialty MH/SUD care [3]				
Commercial insurance	33.7%	14	16.2%	43.0%
Medicare FFS	29.5%	1	5.4%	29.5%
Dual	40.5%	1	4.4%	40.5%
Non-Dual	23.9%	1	5.6%	23.9%
Medicaid	21.0%	51	21.0%	65.1%
Dual	17.3%	51	17.3%	59.5%
Non-Dual	22.0%	51	22.0%	67.6%
Aggregate [4]	29.4%	30	21.7%	43.1%
Average number of sessions per year for those receiving outpatient BH therapy				
Commercial insurance	17.4	1	6.0	17.4
Medicare FFS	14.8	3	3.8	17.3
Dual	14.4	6	4.1	18.7
Non-Dual	15.2	2	3.6	16.4
Medicaid	11.4	21	5.8	21.9
Dual	10.6	23	5.5	26.4
Non-Dual	11.7	19	5.5	21.0
Aggregate [4]	15.3	2	6.2	15.5
Percent of emergency department visits with a diagnosis for any MH/SUD condition in the first or second position				
Commercial insurance	5.7%	4	3.9%	9.7%
Medicare FFS	9.6%	47	5.1%	11.3%
Dual	17.8%	45	8.1%	22.6%
Non-Dual	4.8%	39	3.4%	5.6%
Medicaid	17.8%	39	6.9%	29.1%
Dual	14.2%	33	6.1%	42.3%
Non-Dual	18.4%	40	7.0%	30.8%
Percent of MH/SUD emergency department visits or hospitalizations with timely follow-up after discharge [5]				
Commercial insurance	28.1%	43	16.6%	51.1%
Medicare FFS	29.6%	3	10.3%	30.5%
Medicaid	14.1%	51	14.1%	65.5%
Aggregate [4]	23.8%	49	22.7%	48.6%

FIGURE A-33: BEHAVIORAL HEALTH ACCESS MEASURES FOR NEW YORK

Availability of behavioral health providers	New York	Rank	Min	Max
Percent of population living in a county where:				
Whole county is shortage area	41.6%	16	0.0%	100.0%
None of county is shortage area	7.6%	19	0.0%	51.1%
Percent of psychiatrist need met[6]	18.8%	40	8.5%	72.7%
Ratio of population to MH providers	299.4	18	141.8	797.3
Percent of MH/SUD care provided out-of-network (for commercial health plans with OON coverage)[7]				
Overall	46.6%	48	2%	50%
Inpatient and residential care	21.3%	28	0%	59%
Intensive outpatient and partial hospitalization programs	25.6%	18	1%	84%
Outpatient therapy and other services	57.7%	49	1%	58%
Therapy Access Ratio[8]				
Commercial insurance	83.7%	8	21.9%	97.8%
Medicare FFS	91.0%	5	11.5%	100.0%
Medicaid	31.9%	49	6.1%	100.0%

Affordability of behavioral health services	New York	Rank	Min	Max
Average out of pocket costs for an individual 60-minute psychotherapy visit[9]				
No insurance - self pay	$218	46	$94	$287
Commercial insurance - out-of-network	$49	12	$24	$98
Commercial insurance - in-network	$12	4	$1	$46
Medicare FFS	$29	42	$26	$37
Percent of population by insurance type				
Commercially insured	53.5%		38.4%	68.4%
Medicare	13.3%		8.4%	18.9%
Medicare Advantage	6.1%		0.2%	9.1%
Medicare FFS	7.1%		5.8%	15.9%
Medicaid[10]	27.6%		9.8%	34.4%
Military	0.4%		0.0%	5.3%
Uninsured	5.2%		2.5%	18.0%
Income				
Median income	$74,230	15	$48,871	$91,072
Percent of individuals below FPL	13.5%	36	7.4%	19.4%

Legend		
Gradient Interpretation	Adverse	Favorable
	Favorable	Adverse

Notes:
1. Kansas uses 2020 prevalence metrics for commercial insurance due to data quality issues with the 2021 data.
2. Medicare Advantage metrics can be found by Census division in Appendix B.
3. Specialty care is defined as care from a behavioral health specialist in an inpatient, outpatient, or professional setting.
4. Aggregate metrics are calculated using the percent of population by insurance type.
5. Timely follow-up is defined as a follow-up visit within 30 days of discharge.
6. "Percent of Need Met" is computed by dividing the number of psychiatrists available to serve the population of the area, group, or facility by the number of psychiatrists that would be necessary to eliminate the mental health HPSA (based on a ratio of 30,000 to 1 (20,000 to 1 where high needs are indicated)).
7. Measured by volume of allowed dollars.
8. Calculated as the average number of therapy visits received by individuals diagnosed with behavioral health conditions in a given MSA, compared against the top decile of MSAs with the highest behavioral health provider supply density. Expressed as a percentage, this ratio illustrates how close an MSA, and by extension a state, is to achieving the reference rate.
9. Defined by HCPCS 90837.
10. Dual-eligible members are reported in the Medicaid category. The Medicare category reflect Medicare-only members.
11. Data for the District of Columbia is not available for all metrics. D.C. is included in rankings only for metrics for which data are available.

FIGURE A-34: BEHAVIORAL HEALTH ACCESS MEASURES FOR NORTH CAROLINA

Prevalence of behavioral health conditions	North Carolina	Rank	Min	Max
Survey and vital statistics measures				
Adults with frequent mental distress	13.1%	17	9.7%	18.7%
Poor mental health days per month	4.1	10	3.2	5.7
Drug overdose deaths per 100,000	24.4	28	8.5	56.8
Suicides per 100,000	13.4	12	6.2	27.4
Individuals with any diagnosed MH/SUD condition				
Commercial insurance [1]	24.3%	32	10.8%	32.8%
Medicare FFS [2]	38.7%	41	22.4%	42.5%
Dual	58.4%	37	28.9%	65.9%
Non-Dual	35.6%	41	21.6%	38.1%
Medicaid	23.3%	17	13.2%	38.3%
Dual	34.9%	28	19.4%	56.6%
Non-Dual	26.9%	30	12.3%	41.6%
Percent of individuals with diagnosed suicidal ideation or intentional self-harm				
Commercial insurance [1]	0.3%	20	0.1%	0.6%
Medicare FFS	0.1%	35	0.0%	0.2%
Dual	0.3%	40	0.0%	1.0%
Non-Dual	0.0%	33	0.0%	0.1%
Medicaid	0.3%	23	0.0%	0.9%
Dual	0.0%	34	0.0%	0.5%
Non-Dual	0.5%	35	0.0%	1.0%

Behavioral health treatment patterns	North Carolina	Rank	Min	Max
Percent of individuals with any MH/SUD diagnosis that received specialty MH/SUD care [3]				
Commercial insurance	26.2%	33	16.2%	43.0%
Medicare FFS	13.7%	20	5.4%	29.5%
Dual	22.9%	20	4.4%	40.5%
Non-Dual	11.4%	23	5.6%	23.9%
Medicaid	35.3%	48	21.0%	65.1%
Dual	24.8%	47	17.3%	59.5%
Non-Dual	37.4%	47	22.0%	67.6%
Aggregate [4]	27.0%	40	21.7%	43.1%
Average number of sessions per year for those receiving outpatient BH therapy				
Commercial insurance	9.9	29	6.0	17.4
Medicare FFS	9.1	34	3.8	17.3
Dual	10.3	26	4.1	18.7
Non-Dual	8.5	32	3.6	16.4
Medicaid	8.5	41	5.8	21.9
Dual	5.9	49	5.5	26.4
Non-Dual	8.8	40	5.5	21.0
Aggregate [4]	9.5	35	6.2	15.5
Percent of emergency department visits with a diagnosis for any MH/SUD condition in the first or second position				
Commercial insurance	8.5%	47	3.9%	9.7%
Medicare FFS	8.0%	36	5.1%	11.3%
Dual	15.5%	33	8.1%	22.6%
Non-Dual	4.9%	43	3.4%	5.6%
Medicaid	11.9%	17	6.9%	29.1%
Dual	10.9%	17	6.1%	42.3%
Non-Dual	12.1%	17	7.0%	30.8%
Percent of MH/SUD emergency department visits or hospitalizations with timely follow-up after discharge [5]				
Commercial insurance	30.7%	33	16.6%	51.1%
Medicare FFS	16.8%	34	10.3%	30.5%
Medicaid	27.6%	48	14.1%	65.5%
Aggregate [4]	28.5%	43	22.7%	48.6%

FIGURE A-34: BEHAVIORAL HEALTH ACCESS MEASURES FOR NORTH CAROLINA

Availability of behavioral health providers	North Carolina	Rank	Min	Max
Percent of population living in a county where:				
Whole county is shortage area	69.6%	28	0.0%	100.0%
None of county is shortage area	2.2%	27	0.0%	51.1%
Percent of psychiatrist need met[6]	13.0%	46	8.5%	72.7%
Ratio of population to MH providers	336.2	26	141.8	797.3
Percent of MH/SUD care provided out-of-network (for commercial health plans with OON coverage)[7]				
Overall	19.5%	29	2%	50%
Inpatient and residential care	22.0%	29	0%	59%
Intensive outpatient and partial hospitalization programs	49.1%	37	1%	84%
Outpatient therapy and other services	10.0%	26	1%	58%
Therapy Access Ratio[8]				
Commercial insurance	47.3%	31	21.9%	97.8%
Medicare FFS	40.6%	27	11.5%	100.0%
Medicaid	42.4%	46	6.1%	100.0%

Affordability of behavioral health services	North Carolina	Rank	Min	Max
Average out of pocket costs for an individual 60-minute psychotherapy visit[9]				
No insurance - self pay	$165	18	$94	$287
Commercial insurance - out-of-network	$70	32	$24	$98
Commercial insurance - in-network	$28	35	$1	$46
Medicare FFS	$28	22	$26	$37
Percent of population by insurance type				
Commercially insured	52.9%		38.4%	68.4%
Medicare	15.5%		8.4%	18.9%
Medicare Advantage	6.9%		0.2%	9.1%
Medicare FFS	8.5%		5.8%	15.9%
Medicaid[10]	18.8%		9.8%	34.4%
Military	2.5%		0.0%	5.3%
Uninsured	10.4%		2.5%	18.0%
Income				
Median income	$61,997	40	$48,871	$91,072
Percent of individuals below FPL	13.7%	38	7.4%	19.4%

Legend

Gradient Interpretation: Adverse (Min) – Favorable (Max); Favorable (Min) – Adverse (Max)

Notes:
1. Kansas uses 2020 prevalence metrics for commercial insurance due to data quality issues with the 2021 data.
2. Medicare Advantage metrics can be found by Census division in Appendix B.
3. Specialty care is defined as care from a behavioral health specialist in an inpatient, outpatient, or professional setting.
4. Aggregate metrics are calculated using the percent of population by insurance type.
5. Timely follow-up is defined as a follow-up visit within 30 days of discharge.
6. "Percent of Need Met" is computed by dividing the number of psychiatrists available to serve the population of the area, group, or facility by the number of psychiatrists that would be necessary to eliminate the mental health HPSA (based on a ratio of 30,000 to 1 (20,000 to 1 where high needs are indicated)).
7. Measured by volume of allowed dollars.
8. Calculated as the average number of therapy visits received by individuals diagnosed with behavioral health conditions in a given MSA, compared against the top decile of MSAs with the highest behavioral health provider supply density. Expressed as a percentage, this ratio illustrates how close an MSA, and by extension a state, is to achieving the reference rate.
9. Defined by HCPCS 90837.
10. Dual-eligible members are reported in the Medicaid category. The Medicare category reflect Medicare-only members.
11. Data for the District of Columbia is not available for all metrics. D.C. is included in rankings only for metrics for which data are available.

FIGURE A-35: BEHAVIORAL HEALTH ACCESS MEASURES FOR NORTH DAKOTA

Prevalence of behavioral health conditions	North Dakota	Rank	Min	Max
Survey and vital statistics measures				
Adults with frequent mental distress	11.5%	5	9.7%	18.7%
Poor mental health days per month	3.6	5	3.2	5.7
Drug overdose deaths per 100,000	11.6	4	8.5	56.8
Suicides per 100,000	19.0	40	6.2	27.4
Individuals with any diagnosed MH/SUD condition				
Commercial insurance [1]	23.8%	29	10.8%	32.8%
Medicare FFS [2]	32.2%	12	22.4%	42.5%
Dual	54.8%	28	28.9%	65.9%
Non-Dual	29.6%	13	21.6%	38.1%
Medicaid	25.2%	25	13.2%	38.3%
Dual	39.2%	39	19.4%	56.6%
Non-Dual	30.4%	40	12.3%	41.6%
Percent of individuals with diagnosed suicidal ideation or intentional self-harm				
Commercial insurance [1]	0.4%	43	0.1%	0.6%
Medicare FFS	0.0%	15	0.0%	0.2%
Dual	0.1%	20	0.0%	1.0%
Non-Dual	0.0%	1	0.0%	0.1%
Medicaid	0.1%	5	0.0%	0.9%
Dual	0.0%	1	0.0%	0.5%
Non-Dual	0.1%	5	0.0%	1.0%

Behavioral health treatment patterns	North Dakota	Rank	Min	Max
Percent of individuals with any MH/SUD diagnosis that received specialty MH/SUD care [3]				
Commercial insurance	27.3%	30	16.2%	43.0%
Medicare FFS	9.5%	42	5.4%	29.5%
Dual	16.2%	37	4.4%	40.5%
Non-Dual	8.1%	41	5.6%	23.9%
Medicaid	39.7%	41	21.0%	65.1%
Dual	28.6%	42	17.3%	59.5%
Non-Dual	40.4%	42	22.0%	67.6%
Aggregate [4]	26.4%	42	21.7%	43.1%
Average number of sessions per year for those receiving outpatient BH therapy				
Commercial insurance	8.8	38	6.0	17.4
Medicare FFS	8.8	36	3.8	17.3
Dual	9.7	30	4.1	18.7
Non-Dual	8.1	35	3.6	16.4
Medicaid	8.4	43	5.8	21.9
Dual	8.2	37	5.5	26.4
Non-Dual	8.4	43	5.5	21.0
Aggregate [4]	8.8	40	6.2	15.5
Percent of emergency department visits with a diagnosis for any MH/SUD condition in the first or second position				
Commercial insurance	9.7%	50	3.9%	9.7%
Medicare FFS	7.1%	24	5.1%	11.3%
Dual	16.0%	36	8.1%	22.6%
Non-Dual	4.0%	14	3.4%	5.6%
Medicaid	21.3%	49	6.9%	29.1%
Dual	16.9%	40	6.1%	42.3%
Non-Dual	22.4%	49	7.0%	30.8%
Percent of MH/SUD emergency department visits or hospitalizations with timely follow-up after discharge [5]				
Commercial insurance	34.1%	24	16.6%	51.1%
Medicare FFS	20.9%	22	10.3%	30.5%
Medicaid	43.6%	19	14.1%	65.5%
Aggregate [4]	33.5%	24	22.7%	48.6%

FIGURE A-35: BEHAVIORAL HEALTH ACCESS MEASURES FOR NORTH DAKOTA

Availability of behavioral health providers	North Dakota	Rank	Min	Max
Percent of population living in a county where:				
Whole county is shortage area	80.6%	32	0.0%	100.0%
None of county is shortage area	17.1%	8	0.0%	51.1%
Percent of psychiatrist need met[6]	22.3%	34	8.5%	72.7%
Ratio of population to MH providers	470.5	40	141.8	797.3
Percent of MH/SUD care provided out-of-network (for commercial health plans with OON coverage)[7]				
Overall	2.9%	4	2%	50%
Inpatient and residential care	2.4%	2	0%	59%
Intensive outpatient and partial hospitalization programs	5.3%	2	1%	84%
Outpatient therapy and other services	2.5%	7	1%	58%
Therapy Access Ratio[8]				
Commercial insurance	38.0%	40	21.9%	97.8%
Medicare FFS	36.5%	35	11.5%	100.0%
Medicaid	67.0%	33	6.1%	100.0%
Affordability of behavioral health services	**North Dakota**	**Rank**	**Min**	**Max**
Average out of pocket costs for an individual 60-minute psychotherapy visit[9]				
No insurance - self pay	$240	49	$94	$287
Commercial insurance - out-of-network	$61	23	$24	$98
Commercial insurance - in-network	$23	21	$1	$46
Medicare FFS	$29	39	$26	$37
Percent of population by insurance type				
Commercially insured	65.4%		38.4%	68.4%
Medicare	14.4%		8.4%	18.9%
Medicare Advantage	3.3%		0.2%	9.1%
Medicare FFS	11.1%		5.8%	15.9%
Medicaid[10]	9.8%		9.8%	34.4%
Military	2.7%		0.0%	5.3%
Uninsured	7.7%		2.5%	18.0%
Income				
Median income	$67,603	23	$48,871	$91,072
Percent of individuals below FPL	10.7%	15	7.4%	19.4%

Legend

Gradient Interpretation		
	Adverse	Favorable
	Favorable	Adverse

Notes:
1. Kansas uses 2020 prevalence metrics for commercial insurance due to data quality issues with the 2021 data.
2. Medicare Advantage metrics can be found by Census division in Appendix B.
3. Specialty care is defined as care from a behavioral health specialist in an inpatient, outpatient, or professional setting.
4. Aggregate metrics are calculated using the percent of population by insurance type.
5. Timely follow-up is defined as a follow-up visit within 30 days of discharge.
6. "Percent of Need Met" is computed by dividing the number of psychiatrists available to serve the population of the area, group, or facility by the number of psychiatrists that would be necessary to eliminate the mental health HPSA (based on a ratio of 30,000 to 1 (20,000 to 1 where high needs are indicated)).
7. Measured by volume of allowed dollars.
8. Calculated as the average number of therapy visits received by individuals diagnosed with behavioral health conditions in a given MSA, compared against the top decile of MSAs with the highest behavioral health provider supply density. Expressed as a percentage, this ratio illustrates how close an MSA, and by extension a state, is to achieving the reference rate.
9. Defined by HCPCS 90837.
10. Dual-eligible members are reported in the Medicaid category. The Medicare category reflect Medicare-only members.
11. Data for the District of Columbia is not available for all metrics. D.C. is included in rankings only for metrics for which data are available.

FIGURE A-36: BEHAVIORAL HEALTH ACCESS MEASURES FOR OHIO

Prevalence of behavioral health conditions	Ohio	Rank	Min	Max
Survey and vital statistics measures				
Adults with frequent mental distress	16.1%	42	9.7%	18.7%
Poor mental health days per month	5.0	42	3.2	5.7
Drug overdose deaths per 100,000	38.3	47	8.5	56.8
Suicides per 100,000	14.6	22	6.2	27.4
Individuals with any diagnosed MH/SUD condition				
Commercial insurance [1]	26.0%	41	10.8%	32.8%
Medicare FFS [2]	38.4%	39	22.4%	42.5%
Dual	63.9%	47	28.9%	65.9%
Non-Dual	35.0%	37	21.6%	38.1%
Medicaid	38.3%	51	13.2%	38.3%
Dual	55.8%	50	19.4%	56.6%
Non-Dual	37.9%	49	12.3%	41.6%
Percent of individuals with diagnosed suicidal ideation or intentional self-harm				
Commercial insurance [1]	0.4%	37	0.1%	0.6%
Medicare FFS	0.1%	41	0.0%	0.2%
Dual	0.3%	43	0.0%	1.0%
Non-Dual	0.0%	42	0.0%	0.1%
Medicaid	0.9%	51	0.0%	0.9%
Dual	0.2%	48	0.0%	0.5%
Non-Dual	1.0%	51	0.0%	1.0%

Behavioral health treatment patterns	Ohio	Rank	Min	Max
Percent of individuals with any MH/SUD diagnosis that received specialty MH/SUD care [3]				
Commercial insurance	31.3%	20	16.2%	43.0%
Medicare FFS	14.1%	18	5.4%	29.5%
Dual	25.4%	14	4.4%	40.5%
Non-Dual	11.3%	24	5.6%	23.9%
Medicaid	51.2%	11	21.0%	65.1%
Dual	43.8%	14	17.3%	59.5%
Non-Dual	52.5%	11	22.0%	67.6%
Aggregate [4]	34.7%	16	21.7%	43.1%
Average number of sessions per year for those receiving outpatient BH therapy				
Commercial insurance	9.0	34	6.0	17.4
Medicare FFS	7.5	44	3.8	17.3
Dual	7.5	42	4.1	18.7
Non-Dual	7.4	38	3.6	16.4
Medicaid	11.4	22	5.8	21.9
Dual	9.7	30	5.5	26.4
Non-Dual	11.6	21	5.5	21.0
Aggregate [4]	9.4	36	6.2	15.5
Percent of emergency department visits with a diagnosis for any MH/SUD condition in the first or second position				
Commercial insurance	7.0%	23	3.9%	9.7%
Medicare FFS	6.2%	12	5.1%	11.3%
Dual	13.5%	17	8.1%	22.6%
Non-Dual	3.9%	11	3.4%	5.6%
Medicaid	16.5%	34	6.9%	29.1%
Dual	15.3%	34	6.1%	42.3%
Non-Dual	16.7%	35	7.0%	30.8%
Percent of MH/SUD emergency department visits or hospitalizations with timely follow-up after discharge [5]				
Commercial insurance	35.8%	18	16.6%	51.1%
Medicare FFS	20.9%	23	10.3%	30.5%
Medicaid	41.6%	23	14.1%	65.5%
Aggregate [4]	35.9%	18	22.7%	48.6%

FIGURE A-36: BEHAVIORAL HEALTH ACCESS MEASURES FOR OHIO

Availability of behavioral health providers	Ohio	Rank	Min	Max
Percent of population living in a county where:				
Whole county is shortage area	73.0%	29	0.0%	100.0%
None of county is shortage area	8.9%	17	0.0%	51.1%
Percent of psychiatrist need met[6]	29.8%	23	8.5%	72.7%
Ratio of population to MH providers	328.9	25	141.8	797.3
Percent of MH/SUD care provided out-of-network (for commercial health plans with OON coverage)[7]				
Overall	8.0%	10	2%	50%
Inpatient and residential care	10.6%	11	0%	59%
Intensive outpatient and partial hospitalization programs	12.8%	8	1%	84%
Outpatient therapy and other services	5.7%	13	1%	58%
Therapy Access Ratio[8]				
Commercial insurance	48.3%	30	21.9%	97.8%
Medicare FFS	33.5%	41	11.5%	100.0%
Medicaid	90.7%	19	6.1%	100.0%

Affordability of behavioral health services	Ohio	Rank	Min	Max
Average out of pocket costs for an individual 60-minute psychotherapy visit[9]				
No insurance - self pay	$164	16	$94	$287
Commercial insurance - out-of-network	$55	17	$24	$98
Commercial insurance - in-network	$28	36	$1	$46
Medicare FFS	$28	32	$26	$37
Percent of population by insurance type				
Commercially insured	55.1%		38.4%	68.4%
Medicare	16.0%		8.4%	18.9%
Medicare Advantage	7.8%		0.2%	9.1%
Medicare FFS	8.1%		5.8%	15.9%
Medicaid[10]	21.6%		9.8%	34.4%
Military	0.8%		0.0%	5.3%
Uninsured	6.5%		2.5%	18.0%
Income				
Median income	$62,286	39	$48,871	$91,072
Percent of individuals below FPL	13.4%	35	7.4%	19.4%

Legend

	Min	Max
Gradient Interpretation	Adverse	Favorable
	Favorable	Adverse

Notes:
1. Kansas uses 2020 prevalence metrics for commercial insurance due to data quality issues with the 2021 data.
2. Medicare Advantage metrics can be found by Census division in Appendix B.
3. Specialty care is defined as care from a behavioral health specialist in an inpatient, outpatient, or professional setting.
4. Aggregate metrics are calculated using the percent of population by insurance type.
5. Timely follow-up is defined as a follow-up visit within 30 days of discharge.
6. "Percent of Need Met" is computed by dividing the number of psychiatrists available to serve the population of the area, group, or facility by the number of psychiatrists that would be necessary to eliminate the mental health HPSA (based on a ratio of 30,000 to 1 (20,000 to 1 where high needs are indicated)).
7. Measured by volume of allowed dollars.
8. Calculated as the average number of therapy visits received by individuals diagnosed with behavioral health conditions in a given MSA, compared against the top decile of MSAs with the highest behavioral health provider supply density. Expressed as a percentage, this ratio illustrates how close an MSA, and by extension a state, is to achieving the reference rate.
9. Defined by HCPCS 90837.
10. Dual-eligible members are reported in the Medicaid category. The Medicare category reflect Medicare-only members.
11. Data for the District of Columbia is not available for all metrics. D.C. is included in rankings only for metrics for which data are available.

FIGURE A-37: BEHAVIORAL HEALTH ACCESS MEASURES FOR OKLAHOMA

Prevalence of behavioral health conditions	Oklahoma	Rank	Min	Max
Survey and vital statistics measures				
Adults with frequent mental distress	16.3%	43	9.7%	18.7%
Poor mental health days per month	5.0	43	3.2	5.7
Drug overdose deaths per 100,000	17.9	18	8.5	56.8
Suicides per 100,000	20.5	43	6.2	27.4
Individuals with any diagnosed MH/SUD condition				
Commercial insurance [1]	22.7%	24	10.8%	32.8%
Medicare FFS [2]	39.0%	44	22.4%	42.5%
Dual	60.1%	42	28.9%	65.9%
Non-Dual	35.6%	40	21.6%	38.1%
Medicaid	26.4%	31	13.2%	38.3%
Dual	38.0%	35	19.4%	56.6%
Non-Dual	26.6%	28	12.3%	41.6%
Percent of individuals with diagnosed suicidal ideation or intentional self-harm				
Commercial insurance [1]	0.4%	48	0.1%	0.6%
Medicare FFS	0.0%	21	0.0%	0.2%
Dual	0.1%	23	0.0%	1.0%
Non-Dual	0.0%	19	0.0%	0.1%
Medicaid	0.1%	9	0.0%	0.9%
Dual	0.0%	1	0.0%	0.5%
Non-Dual	0.2%	8	0.0%	1.0%

Behavioral health treatment patterns	Oklahoma	Rank	Min	Max
Percent of individuals with any MH/SUD diagnosis that received specialty MH/SUD care [3]				
Commercial insurance	25.0%	37	16.2%	43.0%
Medicare FFS	8.4%	46	5.4%	29.5%
Dual	14.1%	42	4.4%	40.5%
Non-Dual	6.9%	46	5.6%	23.9%
Medicaid	45.9%	32	21.0%	65.1%
Dual	37.9%	22	17.3%	59.5%
Non-Dual	48.5%	27	22.0%	67.6%
Aggregate [4]	28.0%	37	21.7%	43.1%
Average number of sessions per year for those receiving outpatient BH therapy				
Commercial insurance	8.9	35	6.0	17.4
Medicare FFS	11.6	13	3.8	17.3
Dual	15.1	4	4.1	18.7
Non-Dual	9.4	22	3.6	16.4
Medicaid	19.7	2	5.8	21.9
Dual	25.6	2	5.5	26.4
Non-Dual	18.7	2	5.5	21.0
Aggregate [4]	12.0	13	6.2	15.5
Percent of emergency department visits with a diagnosis for any MH/SUD condition in the first or second position				
Commercial insurance	6.9%	22	3.9%	9.7%
Medicare FFS	6.2%	11	5.1%	11.3%
Dual	11.3%	5	8.1%	22.6%
Non-Dual	4.1%	20	3.4%	5.6%
Medicaid	11.7%	15	6.9%	29.1%
Dual	11.7%	22	6.1%	42.3%
Non-Dual	11.7%	14	7.0%	30.8%
Percent of MH/SUD emergency department visits or hospitalizations with timely follow-up after discharge [5]				
Commercial insurance	31.2%	30	16.6%	51.1%
Medicare FFS	10.3%	51	10.3%	30.5%
Medicaid	36.7%	34	14.1%	65.5%
Aggregate [4]	29.8%	41	22.7%	48.6%

FIGURE A-37: BEHAVIORAL HEALTH ACCESS MEASURES FOR OKLAHOMA

Availability of behavioral health providers	Oklahoma	Rank	Min	Max
Percent of population living in a county where:				
Whole county is shortage area	94.3%	47	0.0%	100.0%
None of county is shortage area	1.2%	31	0.0%	51.1%
Percent of psychiatrist need met[6]	32.5%	20	8.5%	72.7%
Ratio of population to MH providers	237.8	13	141.8	797.3
Percent of MH/SUD care provided out-of-network (for commercial health plans with OON coverage)[7]				
Overall	27.1%	35	2%	50%
Inpatient and residential care	28.1%	35	0%	59%
Intensive outpatient and partial hospitalization programs	72.0%	48	1%	84%
Outpatient therapy and other services	12.3%	29	1%	58%
Therapy Access Ratio[8]				
Commercial insurance	39.6%	37	21.9%	97.8%
Medicare FFS	33.0%	42	11.5%	100.0%
Medicaid	100.0%	1	6.1%	100.0%

Affordability of behavioral health services	Oklahoma	Rank	Min	Max
Average out of pocket costs for an individual 60-minute psychotherapy visit[9]				
No insurance - self pay	$148	6	$94	$287
Commercial insurance - out-of-network	$81	42	$24	$98
Commercial insurance - in-network	$26	29	$1	$46
Medicare FFS	$27	5	$26	$37
Percent of population by insurance type				
Commercially insured	48.4%		38.4%	68.4%
Medicare	15.5%		8.4%	18.9%
Medicare Advantage	4.8%		0.2%	9.1%
Medicare FFS	10.7%		5.8%	15.9%
Medicaid[10]	20.1%		9.8%	34.4%
Military	2.3%		0.0%	5.3%
Uninsured	13.8%		2.5%	18.0%
Income				
Median income	$55,829	44	$48,871	$91,072
Percent of individuals below FPL	15.2%	43	7.4%	19.4%

Legend

Gradient Interpretation	Min	Max
	Adverse	Favorable
	Favorable	Adverse

Notes:
1. Kansas uses 2020 prevalence metrics for commercial insurance due to data quality issues with the 2021 data.
2. Medicare Advantage metrics can be found by Census division in Appendix B.
3. Specialty care is defined as care from a behavioral health specialist in an inpatient, outpatient, or professional setting.
4. Aggregate metrics are calculated using the percent of population by insurance type.
5. Timely follow-up is defined as a follow-up visit within 30 days of discharge.
6. "Percent of Need Met" is computed by dividing the number of psychiatrists available to serve the population of the area, group, or facility by the number of psychiatrists that would be necessary to eliminate the mental health HPSA (based on a ratio of 30,000 to 1 (20,000 to 1 where high needs are indicated)).
7. Measured by volume of allowed dollars.
8. Calculated as the average number of therapy visits received by individuals diagnosed with behavioral health conditions in a given MSA, compared against the top decile of MSAs with the highest behavioral health provider supply density. Expressed as a percentage, this ratio illustrates how close an MSA, and by extension a state, is to achieving the reference rate.
9. Defined by HCPCS 90837.
10. Dual-eligible members are reported in the Medicaid category. The Medicare category reflect Medicare-only members.
11. Data for the District of Columbia is not available for all metrics. D.C. is included in rankings only for metrics for which data are available.

FIGURE A-38: BEHAVIORAL HEALTH ACCESS MEASURES FOR OREGON

Prevalence of behavioral health conditions	Oregon	Rank	Min	Max
Survey and vital statistics measures				
Adults with frequent mental distress	14.4%	31	9.7%	18.7%
Poor mental health days per month	4.6	33	3.2	5.7
Drug overdose deaths per 100,000	15.5	14	8.5	56.8
Suicides per 100,000	18.9	39	6.2	27.4
Individuals with any diagnosed MH/SUD condition				
Commercial insurance [1]	25.7%	38	10.8%	32.8%
Medicare FFS [2]	33.5%	16	22.4%	42.5%
Dual	47.3%	12	28.9%	65.9%
Non-Dual	30.7%	19	21.6%	38.1%
Medicaid	27.3%	33	13.2%	38.3%
Dual	30.6%	17	19.4%	56.6%
Non-Dual	29.1%	36	12.3%	41.6%
Percent of individuals with diagnosed suicidal ideation or intentional self-harm				
Commercial insurance [1]	0.3%	31	0.1%	0.6%
Medicare FFS	0.0%	12	0.0%	0.2%
Dual	0.0%	12	0.0%	1.0%
Non-Dual	0.0%	1	0.0%	0.1%
Medicaid	0.2%	18	0.0%	0.9%
Dual	0.0%	1	0.0%	0.5%
Non-Dual	0.3%	17	0.0%	1.0%

Behavioral health treatment patterns	Oregon	Rank	Min	Max
Percent of individuals with any MH/SUD diagnosis that received specialty MH/SUD care [3]				
Commercial insurance	39.8%	5	16.2%	43.0%
Medicare FFS	10.5%	36	5.4%	29.5%
Dual	9.1%	49	4.4%	40.5%
Non-Dual	11.0%	25	5.6%	23.9%
Medicaid	50.2%	15	21.0%	65.1%
Dual	33.0%	31	17.3%	59.5%
Non-Dual	51.0%	17	22.0%	67.6%
Aggregate [4]	39.9%	5	21.7%	43.1%
Average number of sessions per year for those receiving outpatient BH therapy				
Commercial insurance	12.6	9	6.0	17.4
Medicare FFS	9.8	22	3.8	17.3
Dual	9.9	29	4.1	18.7
Non-Dual	9.8	17	3.6	16.4
Medicaid	13.5	10	5.8	21.9
Dual	11.8	15	5.5	26.4
Non-Dual	13.6	10	5.5	21.0
Aggregate [4]	12.6	9	6.2	15.5
Percent of emergency department visits with a diagnosis for any MH/SUD condition in the first or second position				
Commercial insurance	7.3%	29	3.9%	9.7%
Medicare FFS	9.4%	44	5.1%	11.3%
Dual	17.4%	42	8.1%	22.6%
Non-Dual	5.3%	48	3.4%	5.6%
Medicaid	18.1%	40	6.9%	29.1%
Dual	14.0%	31	6.1%	42.3%
Non-Dual	18.6%	41	7.0%	30.8%
Percent of MH/SUD emergency department visits or hospitalizations with timely follow-up after discharge [5]				
Commercial insurance	33.8%	27	16.6%	51.1%
Medicare FFS	12.2%	45	10.3%	30.5%
Medicaid	41.2%	24	14.1%	65.5%
Aggregate [4]	33.8%	22	22.7%	48.6%

FIGURE A-38: BEHAVIORAL HEALTH ACCESS MEASURES FOR OREGON

Availability of behavioral health providers	Oregon	Rank	Min	Max
Percent of population living in a county where:				
Whole county is shortage area	84.3%	35	0.0%	100.0%
None of county is shortage area	3.1%	25	0.0%	51.1%
Percent of psychiatrist need met[6]	29.1%	24	8.5%	72.7%
Ratio of population to MH providers	158.2	3	141.8	797.3
Percent of MH/SUD care provided out-of-network (for commercial health plans with OON coverage)[7]				
Overall	8.8%	13	2%	50%
Inpatient and residential care	10.6%	12	0%	59%
Intensive outpatient and partial hospitalization programs	16.3%	14	1%	84%
Outpatient therapy and other services	7.8%	21	1%	58%
Therapy Access Ratio[8]				
Commercial insurance	87.8%	5	21.9%	97.8%
Medicare FFS	49.8%	22	11.5%	100.0%
Medicaid	98.1%	13	6.1%	100.0%
Affordability of behavioral health services	**Oregon**	**Rank**	**Min**	**Max**
Average out of pocket costs for an individual 60-minute psychotherapy visit[9]				
No insurance - self pay	$183	32	$94	$287
Commercial insurance - out-of-network	$62	25	$24	$98
Commercial insurance - in-network	$21	15	$1	$46
Medicare FFS	$28	30	$26	$37
Percent of population by insurance type				
Commercially insured	52.8%		38.4%	68.4%
Medicare	16.3%		8.4%	18.9%
Medicare Advantage	8.0%		0.2%	9.1%
Medicare FFS	8.3%		5.8%	15.9%
Medicaid[10]	23.8%		9.8%	34.4%
Military	0.9%		0.0%	5.3%
Uninsured	6.1%		2.5%	18.0%
Income				
Median income	$71,441	20	$48,871	$91,072
Percent of individuals below FPL	12.1%	26	7.4%	19.4%

Legend		
Gradient Interpretation	Adverse	Favorable
	Favorable	Adverse

Notes:
1. Kansas uses 2020 prevalence metrics for commercial insurance due to data quality issues with the 2021 data.
2. Medicare Advantage metrics can be found by Census division in Appendix B.
3. Specialty care is defined as care from a behavioral health specialist in an inpatient, outpatient, or professional setting.
4. Aggregate metrics are calculated using the percent of population by insurance type.
5. Timely follow-up is defined as a follow-up visit within 30 days of discharge.
6. "Percent of Need Met" is computed by dividing the number of psychiatrists available to serve the population of the area, group, or facility by the number of psychiatrists that would be necessary to eliminate the mental health HPSA (based on a ratio of 30,000 to 1 (20,000 to 1 where high needs are indicated)).
7. Measured by volume of allowed dollars.
8. Calculated as the average number of therapy visits received by individuals diagnosed with behavioral health conditions in a given MSA, compared against the top decile of MSAs with the highest behavioral health provider supply density. Expressed as a percentage, this ratio illustrates how close an MSA, and by extension a state, is to achieving the reference rate.
9. Defined by HCPCS 90837.
10. Dual-eligible members are reported in the Medicaid category. The Medicare category reflect Medicare-only members.
11. Data for the District of Columbia is not available for all metrics. D.C. is included in rankings only for metrics for which data are available.

FIGURE A-39: BEHAVIORAL HEALTH ACCESS MEASURES FOR PENNSYLVANIA

Prevalence of behavioral health conditions	Pennsylvania	Rank	Min	Max
Survey and vital statistics measures				
Adults with frequent mental distress	15.2%	37	9.7%	18.7%
Poor mental health days per month	4.8	35	3.2	5.7
Drug overdose deaths per 100,000	36.4	46	8.5	56.8
Suicides per 100,000	14.2	20	6.2	27.4
Individuals with any diagnosed MH/SUD condition				
Commercial insurance [1]	23.4%	28	10.8%	32.8%
Medicare FFS [2]	37.9%	36	22.4%	42.5%
Dual	59.4%	40	28.9%	65.9%
Non-Dual	34.7%	34	21.6%	38.1%
Medicaid	30.3%	41	13.2%	38.3%
Dual	32.1%	21	19.4%	56.6%
Non-Dual	30.9%	42	12.3%	41.6%
Percent of individuals with diagnosed suicidal ideation or intentional self-harm				
Commercial insurance [1]	0.3%	21	0.1%	0.6%
Medicare FFS	0.1%	47	0.0%	0.2%
Dual	0.4%	45	0.0%	1.0%
Non-Dual	0.1%	50	0.0%	0.1%
Medicaid	0.6%	45	0.0%	0.9%
Dual	0.0%	37	0.0%	0.5%
Non-Dual	0.7%	45	0.0%	1.0%

Behavioral health treatment patterns	Pennsylvania	Rank	Min	Max
Percent of individuals with any MH/SUD diagnosis that received specialty MH/SUD care [3]				
Commercial insurance	33.6%	15	16.2%	43.0%
Medicare FFS	17.9%	8	5.4%	29.5%
Dual	31.0%	7	4.4%	40.5%
Non-Dual	14.5%	12	5.6%	23.9%
Medicaid	46.9%	27	21.0%	65.1%
Dual	29.1%	40	17.3%	59.5%
Non-Dual	49.8%	21	22.0%	67.6%
Aggregate [4]	35.3%	14	21.7%	43.1%
Average number of sessions per year for those receiving outpatient BH therapy				
Commercial insurance	11.7	17	6.0	17.4
Medicare FFS	11.2	15	3.8	17.3
Dual	11.6	17	4.1	18.7
Non-Dual	10.9	13	3.6	16.4
Medicaid	13.2	11	5.8	21.9
Dual	10.3	26	5.5	26.4
Non-Dual	13.5	11	5.5	21.0
Aggregate [4]	12.0	12	6.2	15.5
Percent of emergency department visits with a diagnosis for any MH/SUD condition in the first or second position				
Commercial insurance	6.8%	20	3.9%	9.7%
Medicare FFS	7.2%	27	5.1%	11.3%
Dual	15.2%	29	8.1%	22.6%
Non-Dual	4.5%	30	3.4%	5.6%
Medicaid	12.5%	20	6.9%	29.1%
Dual	9.3%	9	6.1%	42.3%
Non-Dual	12.8%	19	7.0%	30.8%
Percent of MH/SUD emergency department visits or hospitalizations with timely follow-up after discharge [5]				
Commercial insurance	38.0%	12	16.6%	51.1%
Medicare FFS	21.0%	21	10.3%	30.5%
Medicaid	38.2%	32	14.1%	65.5%
Aggregate [4]	36.3%	15	22.7%	48.6%

FIGURE A-39: BEHAVIORAL HEALTH ACCESS MEASURES FOR PENNSYLVANIA

Availability of behavioral health providers	Pennsylvania	Rank	Min	Max
Percent of population living in a county where:				
Whole county is shortage area	39.7%	15	0.0%	100.0%
None of county is shortage area	27.3%	3	0.0%	51.1%
Percent of psychiatrist need met[6]	38.4%	12	8.5%	72.7%
Ratio of population to MH providers	397.1	32	141.8	797.3
Percent of MH/SUD care provided out-of-network (for commercial health plans with OON coverage)[7]				
Overall	7.9%	9	2%	50%
Inpatient and residential care	10.3%	9	0%	59%
Intensive outpatient and partial hospitalization programs	27.5%	21	1%	84%
Outpatient therapy and other services	2.6%	8	1%	58%
Therapy Access Ratio[8]				
Commercial insurance	70.4%	15	21.9%	97.8%
Medicare FFS	62.1%	15	11.5%	100.0%
Medicaid	91.9%	17	6.1%	100.0%

Affordability of behavioral health services	Pennsylvania	Rank	Min	Max
Average out of pocket costs for an individual 60-minute psychotherapy visit[9]				
No insurance - self pay	$154	7	$94	$287
Commercial insurance - out-of-network	$62	24	$24	$98
Commercial insurance - in-network	$19	10	$1	$46
Medicare FFS	$30	47	$26	$37
Percent of population by insurance type				
Commercially insured	56.9%		38.4%	68.4%
Medicare	16.3%		8.4%	18.9%
Medicare Advantage	7.6%		0.2%	9.1%
Medicare FFS	8.7%		5.8%	15.9%
Medicaid[10]	20.8%		9.8%	34.4%
Military	0.5%		0.0%	5.3%
Uninsured	5.4%		2.5%	18.0%
Income				
Median income	$68,931	22	$48,871	$91,072
Percent of individuals below FPL	11.8%	24	7.4%	19.4%

Legend

Gradient Interpretation: Adverse → Favorable; Favorable → Adverse

Notes:
1. Kansas uses 2020 prevalence metrics for commercial insurance due to data quality issues with the 2021 data.
2. Medicare Advantage metrics can be found by Census division in Appendix B.
3. Specialty care is defined as care from a behavioral health specialist in an inpatient, outpatient, or professional setting.
4. Aggregate metrics are calculated using the percent of population by insurance type.
5. Timely follow-up is defined as a follow-up visit within 30 days of discharge.
6. "Percent of Need Met" is computed by dividing the number of psychiatrists available to serve the population of the area, group, or facility by the number of psychiatrists that would be necessary to eliminate the mental health HPSA (based on a ratio of 30,000 to 1 (20,000 to 1 where high needs are indicated)).
7. Measured by volume of allowed dollars.
8. Calculated as the average number of therapy visits received by individuals diagnosed with behavioral health conditions in a given MSA, compared against the top decile of MSAs with the highest behavioral health provider supply density. Expressed as a percentage, this ratio illustrates how close an MSA, and by extension a state, is to achieving the reference rate.
9. Defined by HCPCS 90837.
10. Dual-eligible members are reported in the Medicaid category. The Medicare category reflect Medicare-only members.
11. Data for the District of Columbia is not available for all metrics. D.C. is included in rankings only for metrics for which data are available.

FIGURE A-40: BEHAVIORAL HEALTH ACCESS MEASURES FOR RHODE ISLAND

Prevalence of behavioral health conditions	Rhode Island	Rank	Min	Max
Survey and vital statistics measures				
Adults with frequent mental distress	13.9%	26	9.7%	18.7%
Poor mental health days per month	4.5	28	3.2	5.7
Drug overdose deaths per 100,000	32.2	41	8.5	56.8
Suicides per 100,000	10.4	6	6.2	27.4
Individuals with any diagnosed MH/SUD condition				
Commercial insurance [1]	32.8%	50	10.8%	32.8%
Medicare FFS [2]	37.8%	35	22.4%	42.5%
Dual	45.0%	7	28.9%	65.9%
Non-Dual	37.0%	48	21.6%	38.1%
Medicaid	28.4%	36	13.2%	38.3%
Dual	34.6%	27	19.4%	56.6%
Non-Dual	30.4%	39	12.3%	41.6%
Percent of individuals with diagnosed suicidal ideation or intentional self-harm				
Commercial insurance [1]	0.2%	6	0.1%	0.6%
Medicare FFS	0.1%	34	0.0%	0.2%
Dual	0.5%	48	0.0%	1.0%
Non-Dual	0.0%	1	0.0%	0.1%
Medicaid	0.2%	13	0.0%	0.9%
Dual	0.0%	35	0.0%	0.5%
Non-Dual	0.3%	12	0.0%	1.0%

Behavioral health treatment patterns	Rhode Island	Rank	Min	Max
Percent of individuals with any MH/SUD diagnosis that received specialty MH/SUD care [3]				
Commercial insurance	36.8%	8	16.2%	43.0%
Medicare FFS	16.2%	13	5.4%	29.5%
Dual	23.4%	18	4.4%	40.5%
Non-Dual	15.2%	8	5.6%	23.9%
Medicaid	58.2%	3	21.0%	65.1%
Dual	49.6%	6	17.3%	59.5%
Non-Dual	59.3%	4	22.0%	67.6%
Aggregate [4]	40.9%	3	21.7%	43.1%
Average number of sessions per year for those receiving outpatient BH therapy				
Commercial insurance	12.4	12	6.0	17.4
Medicare FFS	9.1	31	3.8	17.3
Dual	7.5	44	4.1	18.7
Non-Dual	9.8	19	3.6	16.4
Medicaid	11.5	19	5.8	21.9
Dual	10.9	22	5.5	26.4
Non-Dual	11.6	20	5.5	21.0
Aggregate [4]	11.9	15	6.2	15.5
Percent of emergency department visits with a diagnosis for any MH/SUD condition in the first or second position				
Commercial insurance	8.0%	43	3.9%	9.7%
Medicare FFS	9.7%	49	5.1%	11.3%
Dual	22.6%	51	8.1%	22.6%
Non-Dual	5.5%	50	3.4%	5.6%
Medicaid	15.8%	33	6.9%	29.1%
Dual	25.7%	49	6.1%	42.3%
Non-Dual	14.8%	29	7.0%	30.8%
Percent of MH/SUD emergency department visits or hospitalizations with timely follow-up after discharge [5]				
Commercial insurance	45.2%	2	16.6%	51.1%
Medicare FFS	28.0%	5	10.3%	30.5%
Medicaid	55.4%	3	14.1%	65.5%
Aggregate [4]	46.5%	2	22.7%	48.6%

FIGURE A-40: BEHAVIORAL HEALTH ACCESS MEASURES FOR RHODE ISLAND

Availability of behavioral health providers	Rhode Island	Rank	Min	Max
Percent of population living in a county where:				
Whole county is shortage area	35.3%	10	0.0%	100.0%
None of county is shortage area	0.0%	37	0.0%	51.1%
Percent of psychiatrist need met[6]	61.9%	2	8.5%	72.7%
Ratio of population to MH providers	220.8	9	141.8	797.3
Percent of MH/SUD care provided out-of-network (for commercial health plans with OON coverage)[7]				
Overall	8.4%	11	2%	50%
Inpatient and residential care	14.7%	20	0%	59%
Intensive outpatient and partial hospitalization programs	11.2%	7	1%	84%
Outpatient therapy and other services	5.8%	14	1%	58%
Therapy Access Ratio[8]				
Commercial insurance	87.2%	7	21.9%	97.8%
Medicare FFS	66.0%	14	11.5%	100.0%
Medicaid	100.0%	1	6.1%	100.0%

Affordability of behavioral health services	Rhode Island	Rank	Min	Max
Average out of pocket costs for an individual 60-minute psychotherapy visit[9]				
No insurance - self pay	$126	2	$94	$287
Commercial insurance - out-of-network	$43	6	$24	$98
Commercial insurance - in-network	$23	22	$1	$46
Medicare FFS	$27	10	$26	$37
Percent of population by insurance type				
Commercially insured	56.2%		38.4%	68.4%
Medicare	15.1%		8.4%	18.9%
Medicare Advantage	7.7%		0.2%	9.1%
Medicare FFS	7.4%		5.8%	15.9%
Medicaid[10]	23.9%		9.8%	34.4%
Military	0.5%		0.0%	5.3%
Uninsured	4.3%		2.5%	18.0%
Income				
Median income	$73,324	16	$48,871	$91,072
Percent of individuals below FPL	11.3%	20	7.4%	19.4%

Legend

Gradient Interpretation — Adverse → Favorable; Favorable → Adverse

Notes:
1. Kansas uses 2020 prevalence metrics for commercial insurance due to data quality issues with the 2021 data.
2. Medicare Advantage metrics can be found by Census division in Appendix B.
3. Specialty care is defined as care from a behavioral health specialist in an inpatient, outpatient, or professional setting.
4. Aggregate metrics are calculated using the percent of population by insurance type.
5. Timely follow-up is defined as a follow-up visit within 30 days of discharge.
6. "Percent of Need Met" is computed by dividing the number of psychiatrists available to serve the population of the area, group, or facility by the number of psychiatrists that would be necessary to eliminate the mental health HPSA (based on a ratio of 30,000 to 1 (20,000 to 1 where high needs are indicated)).
7. Measured by volume of allowed dollars.
8. Calculated as the average number of therapy visits received by individuals diagnosed with behavioral health conditions in a given MSA, compared against the top decile of MSAs with the highest behavioral health provider supply density. Expressed as a percentage, this ratio illustrates how close an MSA, and by extension a state, is to achieving the reference rate.
9. Defined by HCPCS 90837.
10. Dual-eligible members are reported in the Medicaid category. The Medicare category reflect Medicare-only members.
11. Data for the District of Columbia is not available for all metrics. D.C. is included in rankings only for metrics for which data are available.

FIGURE A-41: BEHAVIORAL HEALTH ACCESS MEASURES FOR SOUTH CAROLINA

Prevalence of behavioral health conditions	South Carolina	Rank	Min	Max
Survey and vital statistics measures				
Adults with frequent mental distress	15.6%	39	9.7%	18.7%
Poor mental health days per month	4.9	37	3.2	5.7
Drug overdose deaths per 100,000	25.8	31	8.5	56.8
Suicides per 100,000	16.0	28	6.2	27.4
Individuals with any diagnosed MH/SUD condition				
Commercial insurance [1]	21.4%	17	10.8%	32.8%
Medicare FFS [2]	37.4%	33	22.4%	42.5%
Dual	56.6%	33	28.9%	65.9%
Non-Dual	36.0%	45	21.6%	38.1%
Medicaid	20.2%	7	13.2%	38.3%
Dual	20.5%	2	19.4%	56.6%
Non-Dual	23.7%	15	12.3%	41.6%
Percent of individuals with diagnosed suicidal ideation or intentional self-harm				
Commercial insurance [1]	0.2%	11	0.1%	0.6%
Medicare FFS	0.0%	22	0.0%	0.2%
Dual	0.1%	19	0.0%	1.0%
Non-Dual	0.0%	32	0.0%	0.1%
Medicaid	0.3%	19	0.0%	0.9%
Dual	0.0%	1	0.0%	0.5%
Non-Dual	0.4%	22	0.0%	1.0%

Behavioral health treatment patterns	South Carolina	Rank	Min	Max
Percent of individuals with any MH/SUD diagnosis that received specialty MH/SUD care [3]				
Commercial insurance	19.6%	46	16.2%	43.0%
Medicare FFS	9.6%	41	5.4%	29.5%
Dual	20.1%	28	4.4%	40.5%
Non-Dual	8.5%	39	5.6%	23.9%
Medicaid	34.6%	49	21.0%	65.1%
Dual	22.2%	48	17.3%	59.5%
Non-Dual	36.3%	49	22.0%	67.6%
Aggregate [4]	22.0%	48	21.7%	43.1%
Average number of sessions per year for those receiving outpatient BH therapy				
Commercial insurance	7.8	48	6.0	17.4
Medicare FFS	6.9	47	3.8	17.3
Dual	7.1	46	4.1	18.7
Non-Dual	6.8	47	3.6	16.4
Medicaid	9.3	34	5.8	21.9
Dual	7.1	43	5.5	26.4
Non-Dual	9.5	34	5.5	21.0
Aggregate [4]	8.0	45	6.2	15.5
Percent of emergency department visits with a diagnosis for any MH/SUD condition in the first or second position				
Commercial insurance	7.4%	31	3.9%	9.7%
Medicare FFS	6.5%	19	5.1%	11.3%
Dual	15.5%	31	8.1%	22.6%
Non-Dual	4.6%	35	3.4%	5.6%
Medicaid	10.3%	9	6.9%	29.1%
Dual	16.4%	36	6.1%	42.3%
Non-Dual	10.0%	9	7.0%	30.8%
Percent of MH/SUD emergency department visits or hospitalizations with timely follow-up after discharge [5]				
Commercial insurance	23.7%	46	16.6%	51.1%
Medicare FFS	14.2%	43	10.3%	30.5%
Medicaid	33.1%	42	14.1%	65.5%
Aggregate [4]	24.8%	47	22.7%	48.6%

FIGURE A-41: BEHAVIORAL HEALTH ACCESS MEASURES FOR SOUTH CAROLINA

Availability of behavioral health providers	South Carolina	Rank	Min	Max
Percent of population living in a county where:				
Whole county is shortage area	66.0%	26	0.0%	100.0%
None of county is shortage area	6.6%	21	0.0%	51.1%
Percent of psychiatrist need met[6]	33.6%	16	8.5%	72.7%
Ratio of population to MH providers	488.1	41	141.8	797.3
Percent of MH/SUD care provided out-of-network (for commercial health plans with OON coverage)[7]				
Overall	43.5%	47	2%	50%
Inpatient and residential care	45.9%	46	0%	59%
Intensive outpatient and partial hospitalization programs	60.6%	44	1%	84%
Outpatient therapy and other services	34.7%	46	1%	58%
Therapy Access Ratio[8]				
Commercial insurance	25.9%	46	21.9%	97.8%
Medicare FFS	22.6%	47	11.5%	100.0%
Medicaid	51.6%	40	6.1%	100.0%

Affordability of behavioral health services	South Carolina	Rank	Min	Max
Average out of pocket costs for an individual 60-minute psychotherapy visit[9]				
No insurance - self pay	$94	1	$94	$287
Commercial insurance - out-of-network	$36	4	$24	$98
Commercial insurance - in-network	$16	6	$1	$46
Medicare FFS	$27	21	$26	$37
Percent of population by insurance type				
Commercially insured	50.7%		38.4%	68.4%
Medicare	17.0%		8.4%	18.9%
Medicare Advantage	6.3%		0.2%	9.1%
Medicare FFS	10.7%		5.8%	15.9%
Medicaid[10]	20.1%		9.8%	34.4%
Military	2.2%		0.0%	5.3%
Uninsured	10.0%		2.5%	18.0%
Income				
Median income	$59,447	43	$48,871	$91,072
Percent of individuals below FPL	14.5%	42	7.4%	19.4%

Legend		
Gradient Interpretation	Adverse	Favorable
	Favorable	Adverse

Notes:
1. Kansas uses 2020 prevalence metrics for commercial insurance due to data quality issues with the 2021 data.
2. Medicare Advantage metrics can be found by Census division in Appendix B.
3. Specialty care is defined as care from a behavioral health specialist in an inpatient, outpatient, or professional setting.
4. Aggregate metrics are calculated using the percent of population by insurance type.
5. Timely follow-up is defined as a follow-up visit within 30 days of discharge.
6. "Percent of Need Met" is computed by dividing the number of psychiatrists available to serve the population of the area, group, or facility by the number of psychiatrists that would be necessary to eliminate the mental health HPSA (based on a ratio of 30,000 to 1 (20,000 to 1 where high needs are indicated)).
7. Measured by volume of allowed dollars.
8. Calculated as the average number of therapy visits received by individuals diagnosed with behavioral health conditions in a given MSA, compared against the top decile of MSAs with the highest behavioral health provider supply density. Expressed as a percentage, this ratio illustrates how close an MSA, and by extension a state, is to achieving the reference rate.
9. Defined by HCPCS 90837.
10. Dual-eligible members are reported in the Medicaid category. The Medicare category reflect Medicare-only members.
11. Data for the District of Columbia is not available for all metrics. D.C. is included in rankings only for metrics for which data are available.

FIGURE A-42: BEHAVIORAL HEALTH ACCESS MEASURES FOR SOUTH DAKOTA

Prevalence of behavioral health conditions	South Dakota	Rank	Min	Max
Survey and vital statistics measures				
Adults with frequent mental distress	9.7%	1	9.7%	18.7%
Poor mental health days per month	3.3	2	3.2	5.7
Drug overdose deaths per 100,000	8.5	1	8.5	56.8
Suicides per 100,000	20.8	44	6.2	27.4
Individuals with any diagnosed MH/SUD condition				
Commercial insurance [1]	20.6%	14	10.8%	32.8%
Medicare FFS [2]	29.2%	6	22.4%	42.5%
Dual	47.5%	13	28.9%	65.9%
Non-Dual	27.1%	5	21.6%	38.1%
Medicaid	22.7%	13	13.2%	38.3%
Dual	39.5%	40	19.4%	56.6%
Non-Dual	23.4%	11	12.3%	41.6%
Percent of individuals with diagnosed suicidal ideation or intentional self-harm				
Commercial insurance [1]	0.3%	26	0.1%	0.6%
Medicare FFS	0.0%	1	0.0%	0.2%
Dual	0.0%	1	0.0%	1.0%
Non-Dual	0.0%	1	0.0%	0.1%
Medicaid	0.2%	10	0.0%	0.9%
Dual	0.0%	1	0.0%	0.5%
Non-Dual	0.2%	11	0.0%	1.0%

Behavioral health treatment patterns	South Dakota	Rank	Min	Max
Percent of individuals with any MH/SUD diagnosis that received specialty MH/SUD care [3]				
Commercial insurance	33.0%	17	16.2%	43.0%
Medicare FFS	8.6%	45	5.4%	29.5%
Dual	13.3%	43	4.4%	40.5%
Non-Dual	7.6%	42	5.6%	23.9%
Medicaid	48.5%	20	21.0%	65.1%
Dual	36.1%	24	17.3%	59.5%
Non-Dual	51.4%	13	22.0%	67.6%
Aggregate [4]	32.2%	22	21.7%	43.1%
Average number of sessions per year for those receiving outpatient BH therapy				
Commercial insurance	10.2	27	6.0	17.4
Medicare FFS	11.7	11	3.8	17.3
Dual	15.5	3	4.1	18.7
Non-Dual	9.2	25	3.6	16.4
Medicaid	12.1	16	5.8	21.9
Dual	16.1	6	5.5	26.4
Non-Dual	11.3	22	5.5	21.0
Aggregate [4]	10.7	25	6.2	15.5
Percent of emergency department visits with a diagnosis for any MH/SUD condition in the first or second position				
Commercial insurance	5.8%	5	3.9%	9.7%
Medicare FFS	5.8%	7	5.1%	11.3%
Dual	12.2%	11	8.1%	22.6%
Non-Dual	3.7%	5	3.4%	5.6%
Medicaid	13.6%	24	6.9%	29.1%
Dual	10.4%	13	6.1%	42.3%
Non-Dual	14.5%	27	7.0%	30.8%
Percent of MH/SUD emergency department visits or hospitalizations with timely follow-up after discharge [5]				
Commercial insurance	30.5%	34	16.6%	51.1%
Medicare FFS	11.9%	48	10.3%	30.5%
Medicaid	52.7%	7	14.1%	65.5%
Aggregate [4]	31.6%	30	22.7%	48.6%

FIGURE A-42: BEHAVIORAL HEALTH ACCESS MEASURES FOR SOUTH DAKOTA

Availability of behavioral health providers	South Dakota	Rank	Min	Max
Percent of population living in a county where:				
Whole county is shortage area	98.3%	48	0.0%	100.0%
None of county is shortage area	1.7%	29	0.0%	51.1%
Percent of psychiatrist need met[6]	26.4%	28	8.5%	72.7%
Ratio of population to MH providers	464.9	39	141.8	797.3
Percent of MH/SUD care provided out-of-network (for commercial health plans with OON coverage)[7]				
Overall	2.0%	2	2%	50%
Inpatient and residential care	3.1%	3	0%	59%
Intensive outpatient and partial hospitalization programs	9.7%	6	1%	84%
Outpatient therapy and other services	0.7%	1	1%	58%
Therapy Access Ratio[8]				
Commercial insurance	60.8%	24	21.9%	97.8%
Medicare FFS	49.5%	23	11.5%	100.0%
Medicaid	72.8%	28	6.1%	100.0%

Affordability of behavioral health services	South Dakota	Rank	Min	Max
Average out of pocket costs for an individual 60-minute psychotherapy visit[9]				
No insurance - self pay	$192	34	$94	$287
Commercial insurance - out-of-network	$98	50	$24	$98
Commercial insurance - in-network	$31	40	$1	$46
Medicare FFS	$28	27	$26	$37
Percent of population by insurance type				
Commercially insured	58.6%		38.4%	68.4%
Medicare	15.5%		8.4%	18.9%
Medicare Advantage	4.0%		0.2%	9.1%
Medicare FFS	11.5%		5.8%	15.9%
Medicaid[10]	13.8%		9.8%	34.4%
Military	2.7%		0.0%	5.3%
Uninsured	9.4%		2.5%	18.0%
Income				
Median income	$66,843	27	$48,871	$91,072
Percent of individuals below FPL	12.5%	28	7.4%	19.4%

Legend		
Gradient Interpretation	Adverse	Favorable
	Favorable	Adverse

Notes:
1. Kansas uses 2020 prevalence metrics for commercial insurance due to data quality issues with the 2021 data.
2. Medicare Advantage metrics can be found by Census division in Appendix B.
3. Specialty care is defined as care from a behavioral health specialist in an inpatient, outpatient, or professional setting.
4. Aggregate metrics are calculated using the percent of population by insurance type.
5. Timely follow-up is defined as a follow-up visit within 30 days of discharge.
6. "Percent of Need Met" is computed by dividing the number of psychiatrists available to serve the population of the area, group, or facility by the number of psychiatrists that would be necessary to eliminate the mental health HPSA (based on a ratio of 30,000 to 1 (20,000 to 1 where high needs are indicated)).
7. Measured by volume of allowed dollars.
8. Calculated as the average number of therapy visits received by individuals diagnosed with behavioral health conditions in a given MSA, compared against the top decile of MSAs with the highest behavioral health provider supply density. Expressed as a percentage, this ratio illustrates how close an MSA, and by extension a state, is to achieving the reference rate.
9. Defined by HCPCS 90837.
10. Dual-eligible members are reported in the Medicaid category. The Medicare category reflect Medicare-only members.
11. Data for the District of Columbia is not available for all metrics. D.C. is included in rankings only for metrics for which data are available.

FIGURE A-43: BEHAVIORAL HEALTH ACCESS MEASURES FOR TENNESSEE

Prevalence of behavioral health conditions	Tennessee	Rank	Min	Max
Survey and vital statistics measures				
Adults with frequent mental distress	16.7%	46	9.7%	18.7%
Poor mental health days per month	5.0	44	3.2	5.7
Drug overdose deaths per 100,000	33.9	43	8.5	56.8
Suicides per 100,000	16.8	30	6.2	27.4
Individuals with any diagnosed MH/SUD condition				
Commercial insurance [1]	25.8%	39	10.8%	32.8%
Medicare FFS [2]	38.0%	37	22.4%	42.5%
Dual	57.9%	36	28.9%	65.9%
Non-Dual	35.7%	42	21.6%	38.1%
Medicaid	24.7%	21	13.2%	38.3%
Dual	36.2%	31	19.4%	56.6%
Non-Dual	24.0%	16	12.3%	41.6%
Percent of individuals with diagnosed suicidal ideation or intentional self-harm				
Commercial insurance [1]	0.3%	24	0.1%	0.6%
Medicare FFS	0.0%	28	0.0%	0.2%
Dual	0.2%	31	0.0%	1.0%
Non-Dual	0.0%	31	0.0%	0.1%
Medicaid	0.3%	26	0.0%	0.9%
Dual	0.0%	30	0.0%	0.5%
Non-Dual	0.4%	26	0.0%	1.0%

Behavioral health treatment patterns	Tennessee	Rank	Min	Max
Percent of individuals with any MH/SUD diagnosis that received specialty MH/SUD care [3]				
Commercial insurance	16.2%	50	16.2%	43.0%
Medicare FFS	11.7%	29	5.4%	29.5%
Dual	22.9%	19	4.4%	40.5%
Non-Dual	9.5%	32	5.6%	23.9%
Medicaid	41.4%	39	21.0%	65.1%
Dual	30.7%	37	17.3%	59.5%
Non-Dual	44.0%	37	22.0%	67.6%
Aggregate [4]	21.8%	49	21.7%	43.1%
Average number of sessions per year for those receiving outpatient BH therapy				
Commercial insurance	8.0	46	6.0	17.4
Medicare FFS	7.8	43	3.8	17.3
Dual	9.6	32	4.1	18.7
Non-Dual	6.7	48	3.6	16.4
Medicaid	6.3	49	5.8	21.9
Dual	6.8	44	5.5	26.4
Non-Dual	6.2	49	5.5	21.0
Aggregate [4]	7.6	49	6.2	15.5
Percent of emergency department visits with a diagnosis for any MH/SUD condition in the first or second position				
Commercial insurance	7.1%	25	3.9%	9.7%
Medicare FFS	6.5%	20	5.1%	11.3%
Dual	13.0%	14	8.1%	22.6%
Non-Dual	4.5%	29	3.4%	5.6%
Medicaid	9.1%	6	6.9%	29.1%
Dual	11.3%	18	6.1%	42.3%
Non-Dual	8.7%	6	7.0%	30.8%
Percent of MH/SUD emergency department visits or hospitalizations with timely follow-up after discharge [5]				
Commercial insurance	30.8%	31	16.6%	51.1%
Medicare FFS	18.6%	28	10.3%	30.5%
Medicaid	27.9%	47	14.1%	65.5%
Aggregate [4]	28.9%	42	22.7%	48.6%

FIGURE A-43: BEHAVIORAL HEALTH ACCESS MEASURES FOR TENNESSEE

Availability of behavioral health providers	Tennessee	Rank	Min	Max
Percent of population living in a county where:				
Whole county is shortage area	86.7%	38	0.0%	100.0%
None of county is shortage area	10.2%	16	0.0%	51.1%
Percent of psychiatrist need met[6]	16.3%	42	8.5%	72.7%
Ratio of population to MH providers	560.5	46	141.8	797.3
Percent of MH/SUD care provided out-of-network (for commercial health plans with OON coverage)[7]				
Overall	13.4%	23	2%	50%
Inpatient and residential care	14.2%	18	0%	59%
Intensive outpatient and partial hospitalization programs	27.8%	22	1%	84%
Outpatient therapy and other services	6.5%	17	1%	58%
Therapy Access Ratio[8]				
Commercial insurance	22.0%	49	21.9%	97.8%
Medicare FFS	26.3%	46	11.5%	100.0%
Medicaid	40.8%	47	6.1%	100.0%

Affordability of behavioral health services	Tennessee	Rank	Min	Max
Average out of pocket costs for an individual 60-minute psychotherapy visit[9]				
No insurance - self pay	$145	4	$94	$287
Commercial insurance - out-of-network	$60	22	$24	$98
Commercial insurance - in-network	$34	44	$1	$46
Medicare FFS	$27	17	$26	$37
Percent of population by insurance type				
Commercially insured	53.5%		38.4%	68.4%
Medicare	15.0%		8.4%	18.9%
Medicare Advantage	6.8%		0.2%	9.1%
Medicare FFS	8.2%		5.8%	15.9%
Medicaid[10]	19.6%		9.8%	34.4%
Military	1.7%		0.0%	5.3%
Uninsured	10.1%		2.5%	18.0%
Income				
Median income	$59,698	42	$48,871	$91,072
Percent of individuals below FPL	14.3%	41	7.4%	19.4%

Legend

Gradient Interpretation: Adverse — Favorable; Favorable — Adverse

Notes:
1. Kansas uses 2020 prevalence metrics for commercial insurance due to data quality issues with the 2021 data.
2. Medicare Advantage metrics can be found by Census division in Appendix B.
3. Specialty care is defined as care from a behavioral health specialist in an inpatient, outpatient, or professional setting.
4. Aggregate metrics are calculated using the percent of population by insurance type.
5. Timely follow-up is defined as a follow-up visit within 30 days of discharge.
6. "Percent of Need Met" is computed by dividing the number of psychiatrists available to serve the population of the area, group, or facility by the number of psychiatrists that would be necessary to eliminate the mental health HPSA (based on a ratio of 30,000 to 1 (20,000 to 1 where high needs are indicated)).
7. Measured by volume of allowed dollars.
8. Calculated as the average number of therapy visits received by individuals diagnosed with behavioral health conditions in a given MSA, compared against the top decile of MSAs with the highest behavioral health provider supply density. Expressed as a percentage, this ratio illustrates how close an MSA, and by extension a state, is to achieving the reference rate.
9. Defined by HCPCS 90837.
10. Dual-eligible members are reported in the Medicaid category. The Medicare category reflect Medicare-only members.
11. Data for the District of Columbia is not available for all metrics. D.C. is included in rankings only for metrics for which data are available.

FIGURE A-44: BEHAVIORAL HEALTH ACCESS MEASURES FOR TEXAS

Prevalence of behavioral health conditions	Texas	Rank	Min	Max
Survey and vital statistics measures				
Adults with frequent mental distress	13.3%	20	9.7%	18.7%
Poor mental health days per month	4.2	16	3.2	5.7
Drug overdose deaths per 100,000	11.8	5	8.5	56.8
Suicides per 100,000	13.3	11	6.2	27.4
Individuals with any diagnosed MH/SUD condition				
Commercial insurance [1]	12.4%	2	10.8%	32.8%
Medicare FFS [2]	36.3%	28	22.4%	42.5%
Dual	56.3%	32	28.9%	65.9%
Non-Dual	33.7%	32	21.6%	38.1%
Medicaid	17.3%	3	13.2%	38.3%
Dual	24.1%	6	19.4%	56.6%
Non-Dual	18.3%	3	12.3%	41.6%
Percent of individuals with diagnosed suicidal ideation or intentional self-harm				
Commercial insurance [1]	0.2%	3	0.1%	0.6%
Medicare FFS	0.1%	42	0.0%	0.2%
Dual	0.3%	35	0.0%	1.0%
Non-Dual	0.1%	49	0.0%	0.1%
Medicaid	0.3%	28	0.0%	0.9%
Dual	0.0%	33	0.0%	0.5%
Non-Dual	0.4%	29	0.0%	1.0%

Behavioral health treatment patterns	Texas	Rank	Min	Max
Percent of individuals with any MH/SUD diagnosis that received specialty MH/SUD care [3]				
Commercial insurance	17.7%	49	16.2%	43.0%
Medicare FFS	13.2%	25	5.4%	29.5%
Dual	24.4%	16	4.4%	40.5%
Non-Dual	10.8%	27	5.6%	23.9%
Medicaid	37.1%	46	21.0%	65.1%
Dual	34.9%	27	17.3%	59.5%
Non-Dual	37.3%	48	22.0%	67.6%
Aggregate [4]	21.7%	50	21.7%	43.1%
Average number of sessions per year for those receiving outpatient BH therapy				
Commercial insurance	8.5	40	6.0	17.4
Medicare FFS	9.6	26	3.8	17.3
Dual	14.0	7	4.1	18.7
Non-Dual	7.4	41	3.6	16.4
Medicaid	8.4	42	5.8	21.9
Dual	12.2	13	5.5	26.4
Non-Dual	8.0	45	5.5	21.0
Aggregate [4]	8.6	43	6.2	15.5
Percent of emergency department visits with a diagnosis for any MH/SUD condition in the first or second position				
Commercial insurance	3.9%	1	3.9%	9.7%
Medicare FFS	5.3%	2	5.1%	11.3%
Dual	10.6%	2	8.1%	22.6%
Non-Dual	3.8%	8	3.4%	5.6%
Medicaid	7.5%	2	6.9%	29.1%
Dual	8.1%	3	6.1%	42.3%
Non-Dual	7.4%	2	7.0%	30.8%
Percent of MH/SUD emergency department visits or hospitalizations with timely follow-up after discharge [5]				
Commercial insurance	21.9%	47	16.6%	51.1%
Medicare FFS	16.8%	35	10.3%	30.5%
Medicaid	36.0%	37	14.1%	65.5%
Aggregate [4]	24.7%	48	22.7%	48.6%

FIGURE A-44: BEHAVIORAL HEALTH ACCESS MEASURES FOR TEXAS

Availability of behavioral health providers	Texas	Rank	Min	Max
Percent of population living in a county where:				
Whole county is shortage area	88.2%	40	0.0%	100.0%
None of county is shortage area	0.4%	36	0.0%	51.1%
Percent of psychiatrist need met[6]	32.5%	19	8.5%	72.7%
Ratio of population to MH providers	690.7	50	141.8	797.3
Percent of MH/SUD care provided out-of-network (for commercial health plans with OON coverage)[7]				
Overall	23.2%	32	2%	50%
Inpatient and residential care	32.0%	38	0%	59%
Intensive outpatient and partial hospitalization programs	37.0%	29	1%	84%
Outpatient therapy and other services	14.4%	34	1%	58%
Therapy Access Ratio[8]				
Commercial insurance	26.9%	45	21.9%	97.8%
Medicare FFS	38.4%	33	11.5%	100.0%
Medicaid	35.3%	48	6.1%	100.0%
Affordability of behavioral health services	**Texas**	**Rank**	**Min**	**Max**
Average out of pocket costs for an individual 60-minute psychotherapy visit[9]				
No insurance - self pay	$166	21	$94	$287
Commercial insurance - out-of-network	$68	28	$24	$98
Commercial insurance - in-network	$22	18	$1	$46
Medicare FFS	$28	24	$26	$37
Percent of population by insurance type				
Commercially insured	52.2%		38.4%	68.4%
Medicare	11.1%		8.4%	18.9%
Medicare Advantage	5.2%		0.2%	9.1%
Medicare FFS	5.9%		5.8%	15.9%
Medicaid[10]	16.9%		9.8%	34.4%
Military	1.8%		0.0%	5.3%
Uninsured	18.0%		2.5%	18.0%
Income				
Median income	$66,959	25	$48,871	$91,072
Percent of individuals below FPL	14.0%	40	7.4%	19.4%

Legend

Gradient Interpretation: Adverse → Favorable; Favorable → Adverse

Notes:
1. Kansas uses 2020 prevalence metrics for commercial insurance due to data quality issues with the 2021 data.
2. Medicare Advantage metrics can be found by Census division in Appendix B.
3. Specialty care is defined as care from a behavioral health specialist in an inpatient, outpatient, or professional setting.
4. Aggregate metrics are calculated using the percent of population by insurance type.
5. Timely follow-up is defined as a follow-up visit within 30 days of discharge.
6. "Percent of Need Met" is computed by dividing the number of psychiatrists available to serve the population of the area, group, or facility by the number of psychiatrists that would be necessary to eliminate the mental health HPSA (based on a ratio of 30,000 to 1 (20,000 to 1 where high needs are indicated)).
7. Measured by volume of allowed dollars.
8. Calculated as the average number of therapy visits received by individuals diagnosed with behavioral health conditions in a given MSA, compared against the top decile of MSAs with the highest behavioral health provider supply density. Expressed as a percentage, this ratio illustrates how close an MSA, and by extension a state, is to achieving the reference rate.
9. Defined by HCPCS 90837.
10. Dual-eligible members are reported in the Medicaid category. The Medicare category reflect Medicare-only members.
11. Data for the District of Columbia is not available for all metrics. D.C. is included in rankings only for metrics for which data are available.

FIGURE A-45: BEHAVIORAL HEALTH ACCESS MEASURES FOR UTAH

Prevalence of behavioral health conditions	Utah	Rank	Min	Max
Survey and vital statistics measures				
Adults with frequent mental distress	14.6%	33	9.7%	18.7%
Poor mental health days per month	4.7	34	3.2	5.7
Drug overdose deaths per 100,000	18.9	21	8.5	56.8
Suicides per 100,000	21.7	46	6.2	27.4
Individuals with any diagnosed MH/SUD condition				
Commercial insurance [1]	25.5%	37	10.8%	32.8%
Medicare FFS [2]	34.1%	18	22.4%	42.5%
Dual	49.2%	16	28.9%	65.9%
Non-Dual	32.9%	30	21.6%	38.1%
Medicaid	28.6%	38	13.2%	38.3%
Dual	40.1%	41	19.4%	56.6%
Non-Dual	28.2%	33	12.3%	41.6%
Percent of individuals with diagnosed suicidal ideation or intentional self-harm				
Commercial insurance [1]	0.6%	50	0.1%	0.6%
Medicare FFS	0.0%	23	0.0%	0.2%
Dual	0.3%	33	0.0%	1.0%
Non-Dual	0.0%	28	0.0%	0.1%
Medicaid	0.4%	34	0.0%	0.9%
Dual	0.0%	1	0.0%	0.5%
Non-Dual	0.4%	31	0.0%	1.0%

Behavioral health treatment patterns	Utah	Rank	Min	Max
Percent of individuals with any MH/SUD diagnosis that received specialty MH/SUD care [3]				
Commercial insurance	33.1%	16	16.2%	43.0%
Medicare FFS	8.3%	47	5.4%	29.5%
Dual	15.3%	38	4.4%	40.5%
Non-Dual	7.5%	43	5.6%	23.9%
Medicaid	33.2%	50	21.0%	65.1%
Dual	31.4%	36	17.3%	59.5%
Non-Dual	34.1%	50	22.0%	67.6%
Aggregate [4]	31.5%	25	21.7%	43.1%
Average number of sessions per year for those receiving outpatient BH therapy				
Commercial insurance	10.1	28	6.0	17.4
Medicare FFS	8.3	38	3.8	17.3
Dual	10.5	23	4.1	18.7
Non-Dual	7.2	44	3.6	16.4
Medicaid	10.9	25	5.8	21.9
Dual	9.9	27	5.5	26.4
Non-Dual	11.1	27	5.5	21.0
Aggregate [4]	10.1	30	6.2	15.5
Percent of emergency department visits with a diagnosis for any MH/SUD condition in the first or second position				
Commercial insurance	8.7%	49	3.9%	9.7%
Medicare FFS	6.4%	16	5.1%	11.3%
Dual	18.8%	47	8.1%	22.6%
Non-Dual	3.8%	9	3.4%	5.6%
Medicaid	11.8%	16	6.9%	29.1%
Dual	10.0%	12	6.1%	42.3%
Non-Dual	11.9%	16	7.0%	30.8%
Percent of MH/SUD emergency department visits or hospitalizations with timely follow-up after discharge [5]				
Commercial insurance	41.1%	9	16.6%	51.1%
Medicare FFS	25.0%	8	10.3%	30.5%
Medicaid	28.5%	46	14.1%	65.5%
Aggregate [4]	38.4%	8	22.7%	48.6%

FIGURE A-45: BEHAVIORAL HEALTH ACCESS MEASURES FOR UTAH

Availability of behavioral health providers	Utah	Rank	Min	Max
Percent of population living in a county where:				
Whole county is shortage area	99.7%	49	0.0%	100.0%
None of county is shortage area	0.0%	37	0.0%	51.1%
Percent of psychiatrist need met[6]	55.1%	3	8.5%	72.7%
Ratio of population to MH providers	270.3	15	141.8	797.3
Percent of MH/SUD care provided out-of-network (for commercial health plans with OON coverage)[7]				
Overall	12.1%	19	2%	50%
Inpatient and residential care	14.8%	21	0%	59%
Intensive outpatient and partial hospitalization programs	15.7%	11	1%	84%
Outpatient therapy and other services	10.4%	27	1%	58%
Therapy Access Ratio[8]				
Commercial insurance	62.8%	23	21.9%	97.8%
Medicare FFS	39.8%	28	11.5%	100.0%
Medicaid	70.0%	32	6.1%	100.0%
Affordability of behavioral health services	**Utah**	**Rank**	**Min**	**Max**
Average out of pocket costs for an individual 60-minute psychotherapy visit[9]				
No insurance - self pay	$157	10	$94	$287
Commercial insurance - out-of-network	$46	11	$24	$98
Commercial insurance - in-network	$34	45	$1	$46
Medicare FFS	$27	19	$26	$37
Percent of population by insurance type				
Commercially insured	68.4%		38.4%	68.4%
Medicare	10.2%		8.4%	18.9%
Medicare Advantage	4.4%		0.2%	9.1%
Medicare FFS	5.8%		5.8%	15.9%
Medicaid[10]	11.0%		9.8%	34.4%
Military	1.3%		0.0%	5.3%
Uninsured	9.1%		2.5%	18.0%
Income				
Median income	$79,449	12	$48,871	$91,072
Percent of individuals below FPL	8.8%	2	7.4%	19.4%

Legend

Gradient Interpretation	Adverse	Favorable
	Favorable	Adverse

Notes:
1. Kansas uses 2020 prevalence metrics for commercial insurance due to data quality issues with the 2021 data.
2. Medicare Advantage metrics can be found by Census division in Appendix B.
3. Specialty care is defined as care from a behavioral health specialist in an inpatient, outpatient, or professional setting.
4. Aggregate metrics are calculated using the percent of population by insurance type.
5. Timely follow-up is defined as a follow-up visit within 30 days of discharge.
6. "Percent of Need Met" is computed by dividing the number of psychiatrists available to serve the population of the area, group, or facility by the number of psychiatrists that would be necessary to eliminate the mental health HPSA (based on a ratio of 30,000 to 1 (20,000 to 1 where high needs are indicated)).
7. Measured by volume of allowed dollars.
8. Calculated as the average number of therapy visits received by individuals diagnosed with behavioral health conditions in a given MSA, compared against the top decile of MSAs with the highest behavioral health provider supply density. Expressed as a percentage, this ratio illustrates how close an MSA, and by extension a state, is to achieving the reference rate.
9. Defined by HCPCS 90837.
10. Dual-eligible members are reported in the Medicaid category. The Medicare category reflect Medicare-only members.
11. Data for the District of Columbia is not available for all metrics. D.C. is included in rankings only for metrics for which data are available.

FIGURE A-46: BEHAVIORAL HEALTH ACCESS MEASURES FOR VERMONT

Prevalence of behavioral health conditions	Vermont	Rank	Min	Max
Survey and vital statistics measures				
Adults with frequent mental distress	15.5%	38	9.7%	18.7%
Poor mental health days per month	5.0	40	3.2	5.7
Drug overdose deaths per 100,000	25.4	29	8.5	56.8
Suicides per 100,000	17.7	32	6.2	27.4
Individuals with any diagnosed MH/SUD condition				
Commercial insurance [1]	25.8%	40	10.8%	32.8%
Medicare FFS [2]	33.0%	15	22.4%	42.5%
Dual	51.6%	19	28.9%	65.9%
Non-Dual	29.2%	10	21.6%	38.1%
Medicaid	36.8%	50	13.2%	38.3%
Dual	48.9%	47	19.4%	56.6%
Non-Dual	41.6%	51	12.3%	41.6%
Percent of individuals with diagnosed suicidal ideation or intentional self-harm				
Commercial insurance [1]	0.3%	25	0.1%	0.6%
Medicare FFS	0.0%	1	0.0%	0.2%
Dual	0.0%	1	0.0%	1.0%
Non-Dual	0.0%	1	0.0%	0.1%
Medicaid	0.0%	3	0.0%	0.9%
Dual	0.0%	1	0.0%	0.5%
Non-Dual	0.1%	4	0.0%	1.0%

Behavioral health treatment patterns	Vermont	Rank	Min	Max
Percent of individuals with any MH/SUD diagnosis that received specialty MH/SUD care [3]				
Commercial insurance	24.8%	39	16.2%	43.0%
Medicare FFS	15.9%	14	5.4%	29.5%
Dual	18.6%	31	4.4%	40.5%
Non-Dual	14.8%	10	5.6%	23.9%
Medicaid	50.6%	13	21.0%	65.1%
Dual	46.2%	11	17.3%	59.5%
Non-Dual	57.7%	6	22.0%	67.6%
Aggregate [4]	30.3%	28	21.7%	43.1%
Average number of sessions per year for those receiving outpatient BH therapy				
Commercial insurance	14.1	6	6.0	17.4
Medicare FFS	17.3	1	3.8	17.3
Dual	18.7	1	4.1	18.7
Non-Dual	16.4	1	3.6	16.4
Medicaid	17.5	4	5.8	21.9
Dual	18.5	4	5.5	26.4
Non-Dual	17.3	5	5.5	21.0
Aggregate [4]	15.5	1	6.2	15.5
Percent of emergency department visits with a diagnosis for any MH/SUD condition in the first or second position				
Commercial insurance	6.5%	16	3.9%	9.7%
Medicare FFS	7.4%	29	5.1%	11.3%
Dual	13.6%	19	8.1%	22.6%
Non-Dual	4.0%	17	3.4%	5.6%
Medicaid	19.1%	43	6.9%	29.1%
Dual	20.8%	46	6.1%	42.3%
Non-Dual	18.8%	42	7.0%	30.8%
Percent of MH/SUD emergency department visits or hospitalizations with timely follow-up after discharge [5]				
Commercial insurance	16.6%	50	16.6%	51.1%
Medicare FFS	22.7%	18	10.3%	30.5%
Medicaid	65.5%	1	14.1%	65.5%
Aggregate [4]	30.5%	36	22.7%	48.6%

FIGURE A-46: BEHAVIORAL HEALTH ACCESS MEASURES FOR VERMONT

Availability of behavioral health providers	Vermont	Rank	Min	Max
Percent of population living in a county where:				
Whole county is shortage area	36.2%	12	0.0%	100.0%
None of county is shortage area	51.1%	1	0.0%	51.1%
Percent of psychiatrist need met[6]	N/A	N/A	8.5%	72.7%
Ratio of population to MH providers	193.1	6	141.8	797.3
Percent of MH/SUD care provided out-of-network (for commercial health plans with OON coverage)[7]				
Overall	23.9%	33	2%	50%
Inpatient and residential care	13.4%	15	0%	59%
Intensive outpatient and partial hospitalization programs	27.2%	20	1%	84%
Outpatient therapy and other services	28.4%	44	1%	58%
Therapy Access Ratio[8]				
Commercial insurance	67.8%	18	21.9%	97.8%
Medicare FFS	100.0%	1	11.5%	100.0%
Medicaid	100.0%	1	6.1%	100.0%

Affordability of behavioral health services	Vermont	Rank	Min	Max
Average out of pocket costs for an individual 60-minute psychotherapy visit[9]				
No insurance - self pay	$142	3	$94	$287
Commercial insurance - out-of-network	$51	15	$24	$98
Commercial insurance - in-network	$25	28	$1	$46
Medicare FFS	$27	13	$26	$37
Percent of population by insurance type				
Commercially insured	54.0%		38.4%	68.4%
Medicare	17.8%		8.4%	18.9%
Medicare Advantage	3.5%		0.2%	9.1%
Medicare FFS	14.3%		5.8%	15.9%
Medicaid[10]	24.8%		9.8%	34.4%
Military	0.0%		0.0%	5.3%
Uninsured	3.4%		2.5%	18.0%
Income				
Median income	$72,415	17	$48,871	$91,072
Percent of individuals below FPL	10.5%	14	7.4%	19.4%

Legend

Gradient Interpretation: Adverse → Favorable; Favorable → Adverse

Notes:
1. Kansas uses 2020 prevalence metrics for commercial insurance due to data quality issues with the 2021 data.
2. Medicare Advantage metrics can be found by Census division in Appendix B.
3. Specialty care is defined as care from a behavioral health specialist in an inpatient, outpatient, or professional setting.
4. Aggregate metrics are calculated using the percent of population by insurance type.
5. Timely follow-up is defined as a follow-up visit within 30 days of discharge.
6. "Percent of Need Met" is computed by dividing the number of psychiatrists available to serve the population of the area, group, or facility by the number of psychiatrists that would be necessary to eliminate the mental health HPSA (based on a ratio of 30,000 to 1 (20,000 to 1 where high needs are indicated)).
7. Measured by volume of allowed dollars.
8. Calculated as the average number of therapy visits received by individuals diagnosed with behavioral health conditions in a given MSA, compared against the top decile of MSAs with the highest behavioral health provider supply density. Expressed as a percentage, this ratio illustrates how close an MSA, and by extension a state, is to achieving the reference rate.
9. Defined by HCPCS 90837.
10. Dual-eligible members are reported in the Medicaid category. The Medicare category reflect Medicare-only members.
11. Data for the District of Columbia is not available for all metrics. D.C. is included in rankings only for metrics for which data are available.

FIGURE A-47: BEHAVIORAL HEALTH ACCESS MEASURES FOR VIRGINIA

Prevalence of behavioral health conditions	Virginia	Rank	Min	Max
Survey and vital statistics measures				
Adults with frequent mental distress	12.6%	7	9.7%	18.7%
Poor mental health days per month	4.1	11	3.2	5.7
Drug overdose deaths per 100,000	20.4	22	8.5	56.8
Suicides per 100,000	13.4	13	6.2	27.4
Individuals with any diagnosed MH/SUD condition				
Commercial insurance [1]	24.5%	34	10.8%	32.8%
Medicare FFS [2]	34.6%	23	22.4%	42.5%
Dual	56.0%	30	28.9%	65.9%
Non-Dual	32.7%	28	21.6%	38.1%
Medicaid	25.6%	27	13.2%	38.3%
Dual	35.5%	30	19.4%	56.6%
Non-Dual	26.2%	25	12.3%	41.6%
Percent of individuals with diagnosed suicidal ideation or intentional self-harm				
Commercial insurance [1]	0.3%	22	0.1%	0.6%
Medicare FFS	0.0%	31	0.0%	0.2%
Dual	0.2%	30	0.0%	1.0%
Non-Dual	0.0%	40	0.0%	0.1%
Medicaid	0.6%	47	0.0%	0.9%
Dual	0.1%	40	0.0%	0.5%
Non-Dual	0.8%	48	0.0%	1.0%

Behavioral health treatment patterns	Virginia	Rank	Min	Max
Percent of individuals with any MH/SUD diagnosis that received specialty MH/SUD care [3]				
Commercial insurance	28.7%	26	16.2%	43.0%
Medicare FFS	13.2%	24	5.4%	29.5%
Dual	23.5%	17	4.4%	40.5%
Non-Dual	11.7%	20	5.6%	23.9%
Medicaid	48.8%	19	21.0%	65.1%
Dual	41.9%	18	17.3%	59.5%
Non-Dual	49.1%	25	22.0%	67.6%
Aggregate [4]	30.4%	27	21.7%	43.1%
Average number of sessions per year for those receiving outpatient BH therapy				
Commercial insurance	11.5	18	6.0	17.4
Medicare FFS	9.9	20	3.8	17.3
Dual	10.2	27	4.1	18.7
Non-Dual	9.8	18	3.6	16.4
Medicaid	10.2	30	5.8	21.9
Dual	9.2	34	5.5	26.4
Non-Dual	10.4	30	5.5	21.0
Aggregate [4]	11.1	20	6.2	15.5
Percent of emergency department visits with a diagnosis for any MH/SUD condition in the first or second position				
Commercial insurance	6.5%	15	3.9%	9.7%
Medicare FFS	5.7%	5	5.1%	11.3%
Dual	13.1%	15	8.1%	22.6%
Non-Dual	4.0%	12	3.4%	5.6%
Medicaid	9.2%	7	6.9%	29.1%
Dual	8.4%	4	6.1%	42.3%
Non-Dual	9.3%	7	7.0%	30.8%
Percent of MH/SUD emergency department visits or hospitalizations with timely follow-up after discharge [5]				
Commercial insurance	28.9%	37	16.6%	51.1%
Medicare FFS	16.9%	33	10.3%	30.5%
Medicaid	49.6%	10	14.1%	65.5%
Aggregate [4]	31.2%	32	22.7%	48.6%

FIGURE A-47: BEHAVIORAL HEALTH ACCESS MEASURES FOR VIRGINIA

Availability of behavioral health providers	Virginia	Rank	Min	Max
Percent of population living in a county where:				
Whole county is shortage area	51.2%	21	0.0%	100.0%
None of county is shortage area	19.8%	6	0.0%	51.1%
Percent of psychiatrist need met[6]	42.1%	7	8.5%	72.7%
Ratio of population to MH providers	446.8	38	141.8	797.3
Percent of MH/SUD care provided out-of-network (for commercial health plans with OON coverage)[7]				
Overall	31.4%	38	2%	50%
Inpatient and residential care	25.7%	32	0%	59%
Intensive outpatient and partial hospitalization programs	46.4%	36	1%	84%
Outpatient therapy and other services	31.7%	45	1%	58%
Therapy Access Ratio[8]				
Commercial insurance	59.6%	25	21.9%	97.8%
Medicare FFS	39.2%	31	11.5%	100.0%
Medicaid	66.3%	34	6.1%	100.0%

Affordability of behavioral health services	Virginia	Rank	Min	Max
Average out of pocket costs for an individual 60-minute psychotherapy visit[9]				
No insurance - self pay	$196	38	$94	$287
Commercial insurance - out-of-network	$63	26	$24	$98
Commercial insurance - in-network	$17	7	$1	$46
Medicare FFS	$28	28	$26	$37
Percent of population by insurance type				
Commercially insured	58.7%		38.4%	68.4%
Medicare	14.9%		8.4%	18.9%
Medicare Advantage	4.4%		0.2%	9.1%
Medicare FFS	10.5%		5.8%	15.9%
Medicaid[10]	15.5%		9.8%	34.4%
Military	4.1%		0.0%	5.3%
Uninsured	6.8%		2.5%	18.0%
Income				
Median income	$80,926	11	$48,871	$91,072
Percent of individuals below FPL	9.9%	8	7.4%	19.4%

Legend

Gradient Interpretation: Adverse → Favorable; Favorable → Adverse

Notes:
1. Kansas uses 2020 prevalence metrics for commercial insurance due to data quality issues with the 2021 data.
2. Medicare Advantage metrics can be found by Census division in Appendix B.
3. Specialty care is defined as care from a behavioral health specialist in an inpatient, outpatient, or professional setting.
4. Aggregate metrics are calculated using the percent of population by insurance type.
5. Timely follow-up is defined as a follow-up visit within 30 days of discharge.
6. "Percent of Need Met" is computed by dividing the number of psychiatrists available to serve the population of the area, group, or facility by the number of psychiatrists that would be necessary to eliminate the mental health HPSA (based on a ratio of 30,000 to 1 (20,000 to 1 where high needs are indicated)).
7. Measured by volume of allowed dollars.
8. Calculated as the average number of therapy visits received by individuals diagnosed with behavioral health conditions in a given MSA, compared against the top decile of MSAs with the highest behavioral health provider supply density. Expressed as a percentage, this ratio illustrates how close an MSA, and by extension a state, is to achieving the reference rate.
9. Defined by HCPCS 90837.
10. Dual-eligible members are reported in the Medicaid category. The Medicare category reflect Medicare-only members.
11. Data for the District of Columbia is not available for all metrics. D.C. is included in rankings only for metrics for which data are available.

FIGURE A-48: BEHAVIORAL HEALTH ACCESS MEASURES FOR WASHINGTON

Prevalence of behavioral health conditions	Washington	Rank	Min	Max
Survey and vital statistics measures				
Adults with frequent mental distress	14.1%	29	9.7%	18.7%
Poor mental health days per month	4.5	32	3.2	5.7
Drug overdose deaths per 100,000	18.2	19	8.5	56.8
Suicides per 100,000	15.7	26	6.2	27.4
Individuals with any diagnosed MH/SUD condition				
Commercial insurance [1]	26.1%	42	10.8%	32.8%
Medicare FFS [2]	32.4%	13	22.4%	42.5%
Dual	49.2%	17	28.9%	65.9%
Non-Dual	29.9%	15	21.6%	38.1%
Medicaid	25.9%	29	13.2%	38.3%
Dual	31.2%	19	19.4%	56.6%
Non-Dual	26.1%	24	12.3%	41.6%
Percent of individuals with diagnosed suicidal ideation or intentional self-harm				
Commercial insurance [1]	0.4%	35	0.1%	0.6%
Medicare FFS	0.0%	30	0.0%	0.2%
Dual	0.2%	26	0.0%	1.0%
Non-Dual	0.0%	38	0.0%	0.1%
Medicaid	0.4%	39	0.0%	0.9%
Dual	0.0%	1	0.0%	0.5%
Non-Dual	0.5%	38	0.0%	1.0%

Behavioral health treatment patterns	Washington	Rank	Min	Max
Percent of individuals with any MH/SUD diagnosis that received specialty MH/SUD care [3]				
Commercial insurance	40.2%	4	16.2%	43.0%
Medicare FFS	10.1%	39	5.4%	29.5%
Dual	10.5%	47	4.4%	40.5%
Non-Dual	10.0%	30	5.6%	23.9%
Medicaid	51.1%	12	21.0%	65.1%
Dual	46.8%	10	17.3%	59.5%
Non-Dual	51.4%	14	22.0%	67.6%
Aggregate [4]	40.0%	4	21.7%	43.1%
Average number of sessions per year for those receiving outpatient BH therapy				
Commercial insurance	13.5	7	6.0	17.4
Medicare FFS	9.5	27	3.8	17.3
Dual	9.4	36	4.1	18.7
Non-Dual	9.6	20	3.6	16.4
Medicaid	9.8	32	5.8	21.9
Dual	9.8	28	5.5	26.4
Non-Dual	9.8	32	5.5	21.0
Aggregate [4]	12.2	11	6.2	15.5
Percent of emergency department visits with a diagnosis for any MH/SUD condition in the first or second position				
Commercial insurance	6.5%	14	3.9%	9.7%
Medicare FFS	7.8%	33	5.1%	11.3%
Dual	16.8%	40	8.1%	22.6%
Non-Dual	4.6%	34	3.4%	5.6%
Medicaid	16.8%	37	6.9%	29.1%
Dual	16.4%	38	6.1%	42.3%
Non-Dual	16.8%	37	7.0%	30.8%
Percent of MH/SUD emergency department visits or hospitalizations with timely follow-up after discharge [5]				
Commercial insurance	31.3%	29	16.6%	51.1%
Medicare FFS	12.9%	44	10.3%	30.5%
Medicaid	43.4%	21	14.1%	65.5%
Aggregate [4]	32.5%	27	22.7%	48.6%

FIGURE A-48: BEHAVIORAL HEALTH ACCESS MEASURES FOR WASHINGTON

Availability of behavioral health providers	Washington	Rank	Min	Max
Percent of population living in a county where:				
Whole county is shortage area	37.0%	13	0.0%	100.0%
None of county is shortage area	0.0%	37	0.0%	51.1%
Percent of psychiatrist need met[6]	16.2%	43	8.5%	72.7%
Ratio of population to MH providers	215.4	7	141.8	797.3
Percent of MH/SUD care provided out-of-network (for commercial health plans with OON coverage)[7]				
Overall	13.2%	22	2%	50%
Inpatient and residential care	10.3%	10	0%	59%
Intensive outpatient and partial hospitalization programs	15.8%	12	1%	84%
Outpatient therapy and other services	13.6%	33	1%	58%
Therapy Access Ratio[8]				
Commercial insurance	91.1%	4	21.9%	97.8%
Medicare FFS	34.5%	39	11.5%	100.0%
Medicaid	74.6%	27	6.1%	100.0%
Affordability of behavioral health services	**Washington**	**Rank**	**Min**	**Max**
Average out of pocket costs for an individual 60-minute psychotherapy visit[9]				
No insurance - self pay	$168	22	$94	$287
Commercial insurance - out-of-network	$49	13	$24	$98
Commercial insurance - in-network	$17	8	$1	$46
Medicare FFS	$30	46	$26	$37
Percent of population by insurance type				
Commercially insured	56.8%		38.4%	68.4%
Medicare	13.8%		8.4%	18.9%
Medicare Advantage	5.5%		0.2%	9.1%
Medicare FFS	8.3%		5.8%	15.9%
Medicaid[10]	21.0%		9.8%	34.4%
Military	1.9%		0.0%	5.3%
Uninsured	6.5%		2.5%	18.0%
Income				
Median income	$84,155	8	$48,871	$91,072
Percent of individuals below FPL	10.0%	10	7.4%	19.4%

Legend

Gradient Interpretation: Adverse → Favorable; Favorable → Adverse

Notes:
1. Kansas uses 2020 prevalence metrics for commercial insurance due to data quality issues with the 2021 data.
2. Medicare Advantage metrics can be found by Census division in Appendix B.
3. Specialty care is defined as care from a behavioral health specialist in an inpatient, outpatient, or professional setting.
4. Aggregate metrics are calculated using the percent of population by insurance type.
5. Timely follow-up is defined as a follow-up visit within 30 days of discharge.
6. "Percent of Need Met" is computed by dividing the number of psychiatrists available to serve the population of the area, group, or facility by the number of psychiatrists that would be necessary to eliminate the mental health HPSA (based on a ratio of 30,000 to 1 (20,000 to 1 where high needs are indicated)).
7. Measured by volume of allowed dollars.
8. Calculated as the average number of therapy visits received by individuals diagnosed with behavioral health conditions in a given MSA, compared against the top decile of MSAs with the highest behavioral health provider supply density. Expressed as a percentage, this ratio illustrates how close an MSA, and by extension a state, is to achieving the reference rate.
9. Defined by HCPCS 90837.
10. Dual-eligible members are reported in the Medicaid category. The Medicare category reflect Medicare-only members.
11. Data for the District of Columbia is not available for all metrics. D.C. is included in rankings only for metrics for which data are available.

FIGURE A-49: BEHAVIORAL HEALTH ACCESS MEASURES FOR WEST VIRGINIA

Prevalence of behavioral health conditions	West Virginia	Rank	Min	Max
Survey and vital statistics measures				
Adults with frequent mental distress	18.7%	50	9.7%	18.7%
Poor mental health days per month	5.7	50	3.2	5.7
Drug overdose deaths per 100,000	56.8	51	8.5	56.8
Suicides per 100,000	19.9	41	6.2	27.4
Individuals with any diagnosed MH/SUD condition				
Commercial insurance [1]	29.2%	49	10.8%	32.8%
Medicare FFS [2]	41.5%	49	22.4%	42.5%
Dual	57.0%	34	28.9%	65.9%
Non-Dual	37.8%	50	21.6%	38.1%
Medicaid	30.8%	42	13.2%	38.3%
Dual	35.0%	29	19.4%	56.6%
Non-Dual	31.7%	44	12.3%	41.6%
Percent of individuals with diagnosed suicidal ideation or intentional self-harm				
Commercial insurance [1]	0.3%	29	0.1%	0.6%
Medicare FFS	0.0%	11	0.0%	0.2%
Dual	0.0%	10	0.0%	1.0%
Non-Dual	0.0%	1	0.0%	0.1%
Medicaid	0.3%	21	0.0%	0.9%
Dual	0.0%	1	0.0%	0.5%
Non-Dual	0.3%	20	0.0%	1.0%

Behavioral health treatment patterns	West Virginia	Rank	Min	Max
Percent of individuals with any MH/SUD diagnosis that received specialty MH/SUD care [3]				
Commercial insurance	22.9%	42	16.2%	43.0%
Medicare FFS	6.9%	48	5.4%	29.5%
Dual	10.7%	46	4.4%	40.5%
Non-Dual	5.6%	51	5.6%	23.9%
Medicaid	40.8%	40	21.0%	65.1%
Dual	19.0%	49	17.3%	59.5%
Non-Dual	43.7%	38	22.0%	67.6%
Aggregate [4]	26.8%	41	21.7%	43.1%
Average number of sessions per year for those receiving outpatient BH therapy				
Commercial insurance	8.3	43	6.0	17.4
Medicare FFS	8.2	39	3.8	17.3
Dual	9.5	33	4.1	18.7
Non-Dual	7.2	45	3.6	16.4
Medicaid	10.9	26	5.8	21.9
Dual	9.7	31	5.5	26.4
Non-Dual	11.0	28	5.5	21.0
Aggregate [4]	9.2	39	6.2	15.5
Percent of emergency department visits with a diagnosis for any MH/SUD condition in the first or second position				
Commercial insurance	7.4%	35	3.9%	9.7%
Medicare FFS	7.1%	25	5.1%	11.3%
Dual	12.3%	12	8.1%	22.6%
Non-Dual	4.5%	31	3.4%	5.6%
Medicaid	12.3%	18	6.9%	29.1%
Dual	8.4%	5	6.1%	42.3%
Non-Dual	13.2%	21	7.0%	30.8%
Percent of MH/SUD emergency department visits or hospitalizations with timely follow-up after discharge [5]				
Commercial insurance	28.2%	42	16.6%	51.1%
Medicare FFS	11.2%	50	10.3%	30.5%
Medicaid	40.4%	26	14.1%	65.5%
Aggregate [4]	30.1%	39	22.7%	48.6%

FIGURE A-49: BEHAVIORAL HEALTH ACCESS MEASURES FOR WEST VIRGINIA

Availability of behavioral health providers	West Virginia	Rank	Min	Max
Percent of population living in a county where:				
Whole county is shortage area	87.8%	39	0.0%	100.0%
None of county is shortage area	3.0%	26	0.0%	51.1%
Percent of psychiatrist need met[6]	13.0%	45	8.5%	72.7%
Ratio of population to MH providers	615.9	49	141.8	797.3
Percent of MH/SUD care provided out-of-network (for commercial health plans with OON coverage)[7]				
Overall	5.1%	6	2%	50%
Inpatient and residential care	7.7%	6	0%	59%
Intensive outpatient and partial hospitalization programs	23.8%	16	1%	84%
Outpatient therapy and other services	1.5%	4	1%	58%
Therapy Access Ratio[8]				
Commercial insurance	30.4%	44	21.9%	97.8%
Medicare FFS	18.5%	49	11.5%	100.0%
Medicaid	72.2%	30	6.1%	100.0%

Affordability of behavioral health services	West Virginia	Rank	Min	Max
Average out of pocket costs for an individual 60-minute psychotherapy visit[9]				
No insurance - self pay	$193	36	$94	$287
Commercial insurance - out-of-network	$94	47	$24	$98
Commercial insurance - in-network	$44	49	$1	$46
Medicare FFS	$30	48	$26	$37
Percent of population by insurance type				
Commercially insured	45.8%		38.4%	68.4%
Medicare	18.9%		8.4%	18.9%
Medicare Advantage	8.1%		0.2%	9.1%
Medicare FFS	10.8%		5.8%	15.9%
Medicaid[10]	28.1%		9.8%	34.4%
Military	1.0%		0.0%	5.3%
Uninsured	6.2%		2.5%	18.0%
Income				
Median income	$51,122	50	$48,871	$91,072
Percent of individuals below FPL	16.9%	48	7.4%	19.4%

Legend

Gradient Interpretation: Adverse → Favorable; Favorable → Adverse

Notes:
1. Kansas uses 2020 prevalence metrics for commercial insurance due to data quality issues with the 2021 data.
2. Medicare Advantage metrics can be found by Census division in Appendix B.
3. Specialty care is defined as care from a behavioral health specialist in an inpatient, outpatient, or professional setting.
4. Aggregate metrics are calculated using the percent of population by insurance type.
5. Timely follow-up is defined as a follow-up visit within 30 days of discharge.
6. "Percent of Need Met" is computed by dividing the number of psychiatrists available to serve the population of the area, group, or facility by the number of psychiatrists that would be necessary to eliminate the mental health HPSA (based on a ratio of 30,000 to 1 (20,000 to 1 where high needs are indicated)).
7. Measured by volume of allowed dollars.
8. Calculated as the average number of therapy visits received by individuals diagnosed with behavioral health conditions in a given MSA, compared against the top decile of MSAs with the highest behavioral health provider supply density. Expressed as a percentage, this ratio illustrates how close an MSA, and by extension a state, is to achieving the reference rate.
9. Defined by HCPCS 90837.
10. Dual-eligible members are reported in the Medicaid category. The Medicare category reflect Medicare-only members.
11. Data for the District of Columbia is not available for all metrics. D.C. is included in rankings only for metrics for which data are available.

FIGURE A-50: BEHAVIORAL HEALTH ACCESS MEASURES FOR WISCONSIN

Prevalence of behavioral health conditions	Wisconsin	Rank	Min	Max
Survey and vital statistics measures				
Adults with frequent mental distress	13.2%	19	9.7%	18.7%
Poor mental health days per month	4.4	26	3.2	5.7
Drug overdose deaths per 100,000	21.8	25	8.5	56.8
Suicides per 100,000	14.7	24	6.2	27.4
Individuals with any diagnosed MH/SUD condition				
Commercial insurance [1]	25.2%	36	10.8%	32.8%
Medicare FFS [2]	35.1%	27	22.4%	42.5%
Dual	61.8%	46	28.9%	65.9%
Non-Dual	29.9%	14	21.6%	38.1%
Medicaid	28.5%	37	13.2%	38.3%
Dual	38.3%	36	19.4%	56.6%
Non-Dual	28.5%	34	12.3%	41.6%
Percent of individuals with diagnosed suicidal ideation or intentional self-harm				
Commercial insurance [1]	0.4%	39	0.1%	0.6%
Medicare FFS	0.0%	32	0.0%	0.2%
Dual	0.2%	32	0.0%	1.0%
Non-Dual	0.0%	27	0.0%	0.1%
Medicaid	0.6%	44	0.0%	0.9%
Dual	0.1%	44	0.0%	0.5%
Non-Dual	0.7%	44	0.0%	1.0%

Behavioral health treatment patterns	Wisconsin	Rank	Min	Max
Percent of individuals with any MH/SUD diagnosis that received specialty MH/SUD care [3]				
Commercial insurance	36.9%	7	16.2%	43.0%
Medicare FFS	13.6%	21	5.4%	29.5%
Dual	18.9%	30	4.4%	40.5%
Non-Dual	11.5%	21	5.6%	23.9%
Medicaid	47.0%	26	21.0%	65.1%
Dual	43.8%	15	17.3%	59.5%
Non-Dual	47.7%	30	22.0%	67.6%
Aggregate [4]	36.8%	11	21.7%	43.1%
Average number of sessions per year for those receiving outpatient BH therapy				
Commercial insurance	9.7	31	6.0	17.4
Medicare FFS	9.0	35	3.8	17.3
Dual	9.4	34	4.1	18.7
Non-Dual	8.7	30	3.6	16.4
Medicaid	9.2	37	5.8	21.9
Dual	10.4	24	5.5	26.4
Non-Dual	9.0	39	5.5	21.0
Aggregate [4]	9.5	34	6.2	15.5
Percent of emergency department visits with a diagnosis for any MH/SUD condition in the first or second position				
Commercial insurance	7.3%	30	3.9%	9.7%
Medicare FFS	7.5%	30	5.1%	11.3%
Dual	14.2%	23	8.1%	22.6%
Non-Dual	4.0%	18	3.4%	5.6%
Medicaid	14.7%	29	6.9%	29.1%
Dual	13.0%	28	6.1%	42.3%
Non-Dual	15.0%	31	7.0%	30.8%
Percent of MH/SUD emergency department visits or hospitalizations with timely follow-up after discharge [5]				
Commercial insurance	36.6%	16	16.6%	51.1%
Medicare FFS	17.3%	32	10.3%	30.5%
Medicaid	43.7%	18	14.1%	65.5%
Aggregate [4]	36.3%	16	22.7%	48.6%

FIGURE A-50: BEHAVIORAL HEALTH ACCESS MEASURES FOR WISCONSIN

Availability of behavioral health providers	Wisconsin	Rank	Min	Max
Percent of population living in a county where:				
Whole county is shortage area	49.0%	19	0.0%	100.0%
None of county is shortage area	17.1%	9	0.0%	51.1%
Percent of psychiatrist need met[6]	38.5%	11	8.5%	72.7%
Ratio of population to MH providers	423.0	35	141.8	797.3
Percent of MH/SUD care provided out-of-network (for commercial health plans with OON coverage)[7]				
Overall	8.9%	14	2%	50%
Inpatient and residential care	11.3%	14	0%	59%
Intensive outpatient and partial hospitalization programs	14.4%	9	1%	84%
Outpatient therapy and other services	6.7%	18	1%	58%
Therapy Access Ratio[8]				
Commercial insurance	59.0%	26	21.9%	97.8%
Medicare FFS	44.2%	26	11.5%	100.0%
Medicaid	60.2%	37	6.1%	100.0%

Affordability of behavioral health services	Wisconsin	Rank	Min	Max
Average out of pocket costs for an individual 60-minute psychotherapy visit[9]				
No insurance - self pay	$218	47	$94	$287
Commercial insurance - out-of-network	$73	33	$24	$98
Commercial insurance - in-network	$27	32	$1	$46
Medicare FFS	$29	40	$26	$37
Percent of population by insurance type				
Commercially insured	59.8%		38.4%	68.4%
Medicare	16.0%		8.4%	18.9%
Medicare Advantage	7.9%		0.2%	9.1%
Medicare FFS	8.1%		5.8%	15.9%
Medicaid[10]	18.1%		9.8%	34.4%
Military	0.8%		0.0%	5.3%
Uninsured	5.4%		2.5%	18.0%
Income				
Median income	$67,150	24	$48,871	$91,072
Percent of individuals below FPL	10.7%	15	7.4%	19.4%

Legend

Gradient Interpretation		
	Adverse	Favorable
	Favorable	Adverse

Notes:
1. Kansas uses 2020 prevalence metrics for commercial insurance due to data quality issues with the 2021 data.
2. Medicare Advantage metrics can be found by Census division in Appendix B.
3. Specialty care is defined as care from a behavioral health specialist in an inpatient, outpatient, or professional setting.
4. Aggregate metrics are calculated using the percent of population by insurance type.
5. Timely follow-up is defined as a follow-up visit within 30 days of discharge.
6. "Percent of Need Met" is computed by dividing the number of psychiatrists available to serve the population of the area, group, or facility by the number of psychiatrists that would be necessary to eliminate the mental health HPSA (based on a ratio of 30,000 to 1 (20,000 to 1 where high needs are indicated)).
7. Measured by volume of allowed dollars.
8. Calculated as the average number of therapy visits received by individuals diagnosed with behavioral health conditions in a given MSA, compared against the top decile of MSAs with the highest behavioral health provider supply density. Expressed as a percentage, this ratio illustrates how close an MSA, and by extension a state, is to achieving the reference rate.
9. Defined by HCPCS 90837.
10. Dual-eligible members are reported in the Medicaid category. The Medicare category reflect Medicare-only members.
11. Data for the District of Columbia is not available for all metrics. D.C. is included in rankings only for metrics for which data are available.

FIGURE A-51: BEHAVIORAL HEALTH ACCESS MEASURES FOR WYOMING

Prevalence of behavioral health conditions	Wyoming	Rank	Min	Max
Survey and vital statistics measures				
Adults with frequent mental distress	12.6%	8	9.7%	18.7%
Poor mental health days per month	4.1	14	3.2	5.7
Drug overdose deaths per 100,000	14.0	7	8.5	56.8
Suicides per 100,000	27.4	51	6.2	27.4
Individuals with any diagnosed MH/SUD condition				
Commercial insurance [1]	21.8%	20	10.8%	32.8%
Medicare FFS [2]	26.6%	4	22.4%	42.5%
Dual	46.8%	11	28.9%	65.9%
Non-Dual	24.6%	4	21.6%	38.1%
Medicaid	25.0%	24	13.2%	38.3%
Dual	42.1%	44	19.4%	56.6%
Non-Dual	27.9%	31	12.3%	41.6%
Percent of individuals with diagnosed suicidal ideation or intentional self-harm				
Commercial insurance [1]	0.4%	42	0.1%	0.6%
Medicare FFS	0.0%	1	0.0%	0.2%
Dual	0.0%	1	0.0%	1.0%
Non-Dual	0.0%	1	0.0%	0.1%
Medicaid	0.1%	7	0.0%	0.9%
Dual	0.0%	1	0.0%	0.5%
Non-Dual	0.2%	7	0.0%	1.0%

Behavioral health treatment patterns	Wyoming	Rank	Min	Max
Percent of individuals with any MH/SUD diagnosis that received specialty MH/SUD care [3]				
Commercial insurance	30.2%	21	16.2%	43.0%
Medicare FFS	6.8%	49	5.4%	29.5%
Dual	11.1%	45	4.4%	40.5%
Non-Dual	6.0%	48	5.6%	23.9%
Medicaid	47.2%	24	21.0%	65.1%
Dual	25.0%	46	17.3%	59.5%
Non-Dual	51.3%	15	22.0%	67.6%
Aggregate [4]	28.1%	35	21.7%	43.1%
Average number of sessions per year for those receiving outpatient BH therapy				
Commercial insurance	11.8	15	6.0	17.4
Medicare FFS	11.8	9	3.8	17.3
Dual	13.4	10	4.1	18.7
Non-Dual	10.5	15	3.6	16.4
Medicaid	8.7	39	5.8	21.9
Dual	11.6	16	5.5	26.4
Non-Dual	8.4	42	5.5	21.0
Aggregate [4]	11.4	17	6.2	15.5
Percent of emergency department visits with a diagnosis for any MH/SUD condition in the first or second position				
Commercial insurance	6.3%	11	3.9%	9.7%
Medicare FFS	5.7%	6	5.1%	11.3%
Dual	11.1%	4	8.1%	22.6%
Non-Dual	4.0%	15	3.4%	5.6%
Medicaid	12.5%	21	6.9%	29.1%
Dual	8.9%	8	6.1%	42.3%
Non-Dual	13.9%	25	7.0%	30.8%
Percent of MH/SUD emergency department visits or hospitalizations with timely follow-up after discharge [5]				
Commercial insurance	41.4%	6	16.6%	51.1%
Medicare FFS	15.3%	40	10.3%	30.5%
Medicaid	36.5%	36	14.1%	65.5%
Aggregate [4]	35.9%	17	22.7%	48.6%

FIGURE A-51: BEHAVIORAL HEALTH ACCESS MEASURES FOR WYOMING

Availability of behavioral health providers	Wyoming	Rank	Min	Max
Percent of population living in a county where:				
Whole county is shortage area	92.0%	43	0.0%	100.0%
None of county is shortage area	6.5%	22	0.0%	51.1%
Percent of psychiatrist need met[6]	41.2%	8	8.5%	72.7%
Ratio of population to MH providers	269.3	14	141.8	797.3
Percent of MH/SUD care provided out-of-network (for commercial health plans with OON coverage)[7]				
Overall	10.3%	15	2%	50%
Inpatient and residential care	11.1%	13	0%	59%
Intensive outpatient and partial hospitalization programs	43.5%	34	1%	84%
Outpatient therapy and other services	8.8%	24	1%	58%
Therapy Access Ratio[8]				
Commercial insurance	64.0%	21	21.9%	97.8%
Medicare FFS	50.1%	21	11.5%	100.0%
Medicaid	49.7%	42	6.1%	100.0%

Affordability of behavioral health services	Wyoming	Rank	Min	Max
Average out of pocket costs for an individual 60-minute psychotherapy visit[9]				
No insurance - self pay	$169	24	$94	$287
Commercial insurance - out-of-network	$66	27	$24	$98
Commercial insurance - in-network	$36	47	$1	$46
Medicare FFS	$27	12	$26	$37
Percent of population by insurance type				
Commercially insured	58.0%		38.4%	68.4%
Medicare	16.9%		8.4%	18.9%
Medicare Advantage	1.0%		0.2%	9.1%
Medicare FFS	15.9%		5.8%	15.9%
Medicaid[10]	11.5%		9.8%	34.4%
Military	2.1%		0.0%	5.3%
Uninsured	11.5%		2.5%	18.0%
Income				
Median income	$66,508	28	$48,871	$91,072
Percent of individuals below FPL	10.7%	15	7.4%	19.4%

Legend

Gradient Interpretation: Adverse → Favorable; Favorable → Adverse

Notes:
1. Kansas uses 2020 prevalence metrics for commercial insurance due to data quality issues with the 2021 data.
2. Medicare Advantage metrics can be found by Census division in Appendix B.
3. Specialty care is defined as care from a behavioral health specialist in an inpatient, outpatient, or professional setting.
4. Aggregate metrics are calculated using the percent of population by insurance type.
5. Timely follow-up is defined as a follow-up visit within 30 days of discharge.
6. "Percent of Need Met" is computed by dividing the number of psychiatrists available to serve the population of the area, group, or facility by the number of psychiatrists that would be necessary to eliminate the mental health HPSA (based on a ratio of 30,000 to 1 (20,000 to 1 where high needs are indicated)).
7. Measured by volume of allowed dollars.
8. Calculated as the average number of therapy visits received by individuals diagnosed with behavioral health conditions in a given MSA, compared against the top decile of MSAs with the highest behavioral health provider supply density. Expressed as a percentage, this ratio illustrates how close an MSA, and by extension a state, is to achieving the reference rate.
9. Defined by HCPCS 90837.
10. Dual-eligible members are reported in the Medicaid category. The Medicare category reflect Medicare-only members.
11. Data for the District of Columbia is not available for all metrics. D.C. is included in rankings only for metrics for which data are available.

Appendix B: Summary of behavioral health access measures by Census division for Medicare Advantage

For ease of reference, we have summarized the Medicare Advantage results for metrics described throughout this report for each Census division in the figures that follow. Sources or definitions for each metric are described below. Further technical details are provided in the Methodology section of this report.

Measure	Description	Source and year
Prevalence of behavioral health conditions		
Individuals with any diagnosed MH/SUD condition.	Percent of individuals that had claims with diagnoses for any behavioral health condition.	CHSD claims dataset, 2021.
Percent of individuals with diagnosed suicidal ideation or intentional self-harm.	Percent of individuals that had claims with diagnoses for suicidal ideation or intentional self-harm.	CHSD claims dataset, 2021.
Behavioral health treatment patterns		
Percent of individuals with any MH/SUD diagnosis that received specialty MH/SUD care.	Percent of individuals with diagnoses for any behavioral health condition that used any services provided by facilities or clinicians specializing in behavioral health.	CHSD claims dataset, 2021.
Average number of sessions per year for those receiving outpatient BH therapy.	Average number of outpatient psychotherapy visits received per year among individuals that received any outpatient psychotherapy.	CHSD claims dataset, 2021.
Percent of emergency department visits with a diagnosis for any MH/SUD condition in the first or second position.	Percent of emergency department visits that had a diagnosis for any behavioral health condition in the first or second position on the claim record.	CHSD claims dataset, 2021.
Percent of MH/SUD emergency department visits or hospitalizations with timely follow-up after discharge.	Percent of hospitalizations or emergency department visits with a principal diagnosis for any behavioral health condition that were followed by outpatient behavioral health care within 30 days of discharge.	CHSD, RIF, and T-MSIS claims datasets, 2021.
Availability of behavioral health providers		
Therapy Access Ratio.	A novel metric describing the proportion of visits received by those with behavioral health diagnoses compared to the number of visits received by those living in areas with the highest provider supply.	CMS NPI Registry, CHSD claims dataset, 2021.
Affordability of behavioral health services		
Average out of pocket costs for an individual 60-minute psychotherapy visit.	Average cost for which patients are responsible under the terms of their insurance coverage (or average undiscounted billed charge for self-pay patients) for a 60-minute psychotherapy visit.	CHSD claims dataset, 2021.

FIGURE B-1: BEHAVIORAL HEALTH ACCESS MEASURES FOR MEDICARE ADVANTAGE IN THE EAST NORTH CENTRAL DIVISION

States in the East North Central division
Illinois
Indiana
Michigan
Ohio
Wisconsin

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Prevalence of behavioral health conditions	East North Central	Rank[6]	Min	East North Central	Max
Individuals with any diagnosed MH/SUD condition	33.0%	4	25.9%		36.9%
Percent of individuals with diagnosed suicidal ideation or intentional self-harm	0.2%	5	0.1%		0.4%
Behavioral health treatment patterns	**East North Central**	**Rank**	**Min**	**East North Central**	**Max**
Percent of individuals with any MH/SUD diagnosis that received specialty MH/SUD care[1]	12.8%	4	8.0%		23.8%
Average number of sessions per year for those receiving outpatient BH therapy	8.2	4	4.7		11.0
Percent of emergency department visits with a diagnosis for any MH/SUD condition in the first or second position	4.7%	2	4.5%		7.2%
Percent of MH/SUD emergency department visits or hospitalizations with timely follow-up after discharge[2]	15.2%	4	8.4%		29.5%
Availability of behavioral health providers	**East North Central**	**Rank**	**Min**	**East North Central**	**Max**
Therapy Access Ratio[3]	45.9%	4	18.5%		93.2%
Affordability of behavioral health services	**East North Central**	**Rank**	**Min**	**East North Central**	**Max**
Average out of pocket costs for an individual 60-minute psychotherapy visit[4]	$12	5	$6		$30

Legend

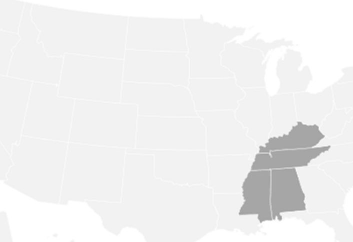
Gradient Interpretation

	Min side	Max side
Gradient 1	Adverse	Favorable
Gradient 2	Favorable	Adverse

Notes:
1. Specialty care is defined as care from a behavioral health specialist in an inpatient, outpatient, or professional setting.
2. Timely follow-up is defined as a follow-up visit within 30 days of discharge.
3. Calculated as the average number of therapy visits received by individuals diagnosed with behavioral health conditions in a given MSA, compared against the top decile of MSAs with the highest behavioral health provider supply density. Expressed as a percentage, this ratio reveals how close an MSA, and by extension a state, is to achieving the reference rate.
4. Defined by HCPCS 90837.
5. Data for the District of Columbia is not available for all metrics. D.C. is included in rankings only for metrics for which data are available.
6. The Medicare Advantage data has been segmented into 9 total divisions.
7. Metrics are displayed and ranked at the division level; they have not been normalized by geographic distribution.

FIGURE B-2: BEHAVIORAL HEALTH ACCESS MEASURES FOR MEDICARE ADVANTAGE IN THE EAST SOUTH CENTRAL DIVISION

States in the East South Central division
Alabama
Kentucky
Mississippi
Tennessee



Prevalence of behavioral health conditions	East South Central	Rank[6]	Min	East South Central	Max
Individuals with any diagnosed MH/SUD condition	34.5%	6	25.9%		36.9%
Percent of individuals with diagnosed suicidal ideation or intentional self-harm	0.1%	1	0.1%		0.4%
Behavioral health treatment patterns	**East South Central**	**Rank**	**Min**	**East South Central**	**Max**
Percent of individuals with any MH/SUD diagnosis that received specialty MH/SUD care[1]	9.6%	8	8.0%		23.8%
Average number of sessions per year for those receiving outpatient BH therapy	4.7	9	4.7		11.0
Percent of emergency department visits with a diagnosis for any MH/SUD condition in the first or second position	6.6%	8	4.5%		7.2%
Percent of MH/SUD emergency department visits or hospitalizations with timely follow-up after discharge[2]	8.5%	8	8.4%		29.5%
Availability of behavioral health providers	**East South Central**	**Rank**	**Min**	**East South Central**	**Max**
Therapy Access Ratio[3]	18.5%	9	18.5%		93.2%
Affordability of behavioral health services	**East South Central**	**Rank**	**Min**	**East South Central**	**Max**
Average out of pocket costs for an individual 60-minute psychotherapy visit[4]	$6	1	$6		$30
Legend					
Gradient Interpretation			Adverse		Favorable
			Favorable		Adverse

Notes:
1. Specialty care is defined as care from a behavioral health specialist in an inpatient, outpatient, or professional setting.
2. Timely follow-up is defined as a follow-up visit within 30 days of discharge.
3. Calculated as the average number of therapy visits received by individuals diagnosed with behavioral health conditions in a given MSA, compared against the top decile of MSAs with the highest behavioral health provider supply density. Expressed as a percentage, this ratio reveals how close an MSA, and by extension a state, is to achieving the reference rate.
4. Defined by HCPCS 90837.
5. Data for the District of Columbia is not available for all metrics. D.C. is included in rankings only for metrics for which data are available.
6. The Medicare Advantage data has been segmented into 9 total divisions.
7. Metrics are displayed and ranked at the division level; they have not been normalized by geographic distribution.

FIGURE B-3: BEHAVIORAL HEALTH ACCESS MEASURES FOR MEDICARE ADVANTAGE IN THE MIDDLE ATLANTIC DIVISION

States in the Middle Atlantic division
New Jersey
New York
Pennsylvania

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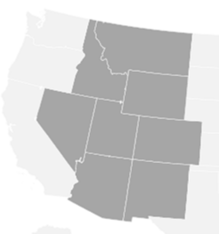
Prevalence of behavioral health conditions	Middle Atlantic	Rank[6]	Min	Middle Atlantic	Max
Individuals with any diagnosed MH/SUD condition	29.8%	3	25.9%		36.9%
Percent of individuals with diagnosed suicidal ideation or intentional self-harm	0.3%	7	0.1%		0.4%
Behavioral health treatment patterns	**Middle Atlantic**	**Rank**	**Min**	**Middle Atlantic**	**Max**
Percent of individuals with any MH/SUD diagnosis that received specialty MH/SUD care[1]	16.2%	2	8.0%		23.8%
Average number of sessions per year for those receiving outpatient BH therapy	10.7	2	4.7		11.0
Percent of emergency department visits with a diagnosis for any MH/SUD condition in the first or second position	5.5%	6	4.5%		7.2%
Percent of MH/SUD emergency department visits or hospitalizations with timely follow-up after discharge[2]	23.2%	2	8.4%		29.5%
Availability of behavioral health providers	**Middle Atlantic**	**Rank**	**Min**	**Middle Atlantic**	**Max**
Therapy Access Ratio[3]	76.7%	2	18.5%		93.2%
Affordability of behavioral health services	**Middle Atlantic**	**Rank**	**Min**	**Middle Atlantic**	**Max**
Average out of pocket costs for an individual 60-minute psychotherapy visit[4]	$16	8	$6		$30
Legend					
Gradient Interpretation			Adverse		Favorable
			Favorable		Adverse

Notes:
1. Specialty care is defined as care from a behavioral health specialist in an inpatient, outpatient, or professional setting.
2. Timely follow-up is defined as a follow-up visit within 30 days of discharge.
3. Calculated as the average number of therapy visits received by individuals diagnosed with behavioral health conditions in a given MSA, compared against the top decile of MSAs with the highest behavioral health provider supply density. Expressed as a percentage, this ratio reveals how close an MSA, and by extension a state, is to achieving the reference rate.
4. Defined by HCPCS 90837.
5. Data for the District of Columbia is not available for all metrics. D.C. is included in rankings only for metrics for which data are available.
6. The Medicare Advantage data has been segmented into 9 total divisions.
7. Metrics are displayed and ranked at the division level; they have not been normalized by geographic distribution.

FIGURE B-4: BEHAVIORAL HEALTH ACCESS MEASURES FOR MEDICARE ADVANTAGE IN THE MOUNTAIN DIVISION

States in the Mountain division
Arizona
Colorado
Idaho
Montana
Nevada
New Mexico
Utah
Wyoming



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Prevalence of behavioral health conditions	Mountain	Rank[6]	Min	Mountain	Max
Individuals with any diagnosed MH/SUD condition	36.2%	8	25.9%		36.9%
Percent of individuals with diagnosed suicidal ideation or intentional self-harm	0.4%	9	0.1%		0.4%
Behavioral health treatment patterns	**Mountain**	**Rank**	**Min**	**Mountain**	**Max**
Percent of individuals with any MH/SUD diagnosis that received specialty MH/SUD care[1]	11.2%	6	8.0%		23.8%
Average number of sessions per year for those receiving outpatient BH therapy	6.9	5	4.7		11.0
Percent of emergency department visits with a diagnosis for any MH/SUD condition in the first or second position	5.0%	5	4.5%		7.2%
Percent of MH/SUD emergency department visits or hospitalizations with timely follow-up after discharge[2]	20.0%	3	8.4%		29.5%
Availability of behavioral health providers	**Mountain**	**Rank**	**Min**	**Mountain**	**Max**
Therapy Access Ratio[3]	45.1%	5	18.5%		93.2%
Affordability of behavioral health services	**Mountain**	**Rank**	**Min**	**Mountain**	**Max**
Average out of pocket costs for an individual 60-minute psychotherapy visit[4]	$30	9	$6		$30

Legend

Gradient Interpretation

Adverse		Favorable
Favorable		Adverse

Notes:
1. Specialty care is defined as care from a behavioral health specialist in an inpatient, outpatient, or professional setting.
2. Timely follow-up is defined as a follow-up visit within 30 days of discharge.
3. Calculated as the average number of therapy visits received by individuals diagnosed with behavioral health conditions in a given MSA, compared against the top decile of MSAs with the highest behavioral health provider supply density. Expressed as a percentage, this ratio reveals how close an MSA, and by extension a state, is to achieving the reference rate.
4. Defined by HCPCS 90837.
5. Data for the District of Columbia is not available for all metrics. D.C. is included in rankings only for metrics for which data are available.
6. The Medicare Advantage data has been segmented into 9 total divisions.
7. Metrics are displayed and ranked at the division level; they have not been normalized by geographic distribution.

FIGURE B-5: BEHAVIORAL HEALTH ACCESS MEASURES FOR MEDICARE ADVANTAGE IN THE NEW ENGLAND DIVISION

States in the New England division
Connecticut
Maine
Massachusetts
New Hampshire
Rhode Island
Vermont

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Prevalence of behavioral health conditions	New England	Rank[6]	Min	Max
Individuals with any diagnosed MH/SUD condition	35.1%	7	25.9%	36.9%
Percent of individuals with diagnosed suicidal ideation or intentional self-harm	0.3%	6	0.1%	0.4%
Behavioral health treatment patterns	**New England**	**Rank**	**Min**	**Max**
Percent of individuals with any MH/SUD diagnosis that received specialty MH/SUD care[1]	23.8%	1	8.0%	23.8%
Average number of sessions per year for those receiving outpatient BH therapy	11.0	1	4.7	11.0
Percent of emergency department visits with a diagnosis for any MH/SUD condition in the first or second position	5.7%	7	4.5%	7.2%
Percent of MH/SUD emergency department visits or hospitalizations with timely follow-up after discharge[2]	29.5%	1	8.4%	29.5%
Availability of behavioral health providers	**New England**	**Rank**	**Min**	**Max**
Therapy Access Ratio[3]	93.2%	1	18.5%	93.2%
Affordability of behavioral health services	**New England**	**Rank**	**Min**	**Max**
Average out of pocket costs for an individual 60-minute psychotherapy visit[4]	$11	4	$6	$30

Legend

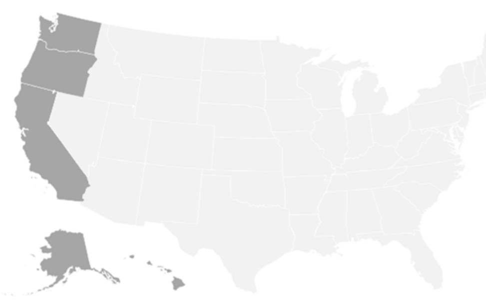
Gradient Interpretation

Min	Max
Adverse	Favorable
Favorable	Adverse

Notes:
1. Specialty care is defined as care from a behavioral health specialist in an inpatient, outpatient, or professional setting.
2. Timely follow-up is defined as a follow-up visit within 30 days of discharge.
3. Calculated as the average number of therapy visits received by individuals diagnosed with behavioral health conditions in a given MSA, compared against the top decile of MSAs with the highest behavioral health provider supply density. Expressed as a percentage, this ratio reveals how close an MSA, and by extension a state, is to achieving the reference rate.
4. Defined by HCPCS 90837.
5. Data for the District of Columbia is not available for all metrics. D.C. is included in rankings only for metrics for which data are available.
6. The Medicare Advantage data has been segmented into 9 total divisions.
7. Metrics are displayed and ranked at the division level; they have not been normalized by geographic distribution.

FIGURE B-6: BEHAVIORAL HEALTH ACCESS MEASURES FOR MEDICARE ADVANTAGE IN THE PACIFIC DIVISION

States in the Pacific division
Alaska
California
Hawaii
Oregon
Washington

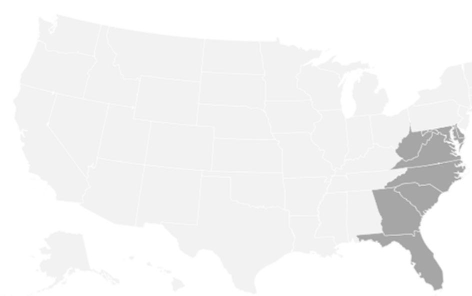


Prevalence of behavioral health conditions	Pacific	Rank[6]	Min	Pacific	Max
Individuals with any diagnosed MH/SUD condition	26.7%	2	25.9%		36.9%
Percent of individuals with diagnosed suicidal ideation or intentional self-harm	0.2%	2	0.1%		0.4%
Behavioral health treatment patterns	**Pacific**	**Rank**	**Min**	**Pacific**	**Max**
Percent of individuals with any MH/SUD diagnosis that received specialty MH/SUD care[1]	14.0%	3	8.0%		23.8%
Average number of sessions per year for those receiving outpatient BH therapy	9.7	3	4.7		11.0
Percent of emergency department visits with a diagnosis for any MH/SUD condition in the first or second position	4.9%	3	4.5%		7.2%
Percent of MH/SUD emergency department visits or hospitalizations with timely follow-up after discharge[2]	13.8%	6	8.4%		29.5%
Availability of behavioral health providers	**Pacific**	**Rank**	**Min**	**Pacific**	**Max**
Therapy Access Ratio[3]	54.6%	3	18.5%		93.2%
Affordability of behavioral health services	**Pacific**	**Rank**	**Min**	**Pacific**	**Max**
Average out of pocket costs for an individual 60-minute psychotherapy visit[4]	$14	6	$6		$30
Legend					
Gradient Interpretation			Adverse		Favorable
			Favorable		Adverse

Notes:
1. Specialty care is defined as care from a behavioral health specialist in an inpatient, outpatient, or professional setting.
2. Timely follow-up is defined as a follow-up visit within 30 days of discharge.
3. Calculated as the average number of therapy visits received by individuals diagnosed with behavioral health conditions in a given MSA, compared against the top decile of MSAs with the highest behavioral health provider supply density. Expressed as a percentage, this ratio reveals how close an MSA, and by extension a state, is to achieving the reference rate.
4. Defined by HCPCS 90837.
5. Data for the District of Columbia is not available for all metrics. D.C. is included in rankings only for metrics for which data are available.
6. The Medicare Advantage data has been segmented into 9 total divisions.
7. Metrics are displayed and ranked at the division level; they have not been normalized by geographic distribution.

FIGURE B-7: BEHAVIORAL HEALTH ACCESS MEASURES FOR MEDICARE ADVANTAGE IN THE SOUTH ATLANTIC DIVISION

States in the South Atlantic division
Delaware
District of Columbia
Florida
Georgia
Maryland
North Carolina
South Carolina
Virginia
West Virginia



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Prevalence of behavioral health conditions	South Atlantic	Rank[6]	Min	South Atlantic	Max
Individuals with any diagnosed MH/SUD condition	25.9%	1	25.9%		36.9%
Percent of individuals with diagnosed suicidal ideation or intentional self-harm	0.2%	4	0.1%		0.4%
Behavioral health treatment patterns	**South Atlantic**	**Rank**	**Min**	**South Atlantic**	**Max**
Percent of individuals with any MH/SUD diagnosis that received specialty MH/SUD care[1]	12.2%	5	8.0%		23.8%
Average number of sessions per year for those receiving outpatient BH therapy	6.3	6	4.7		11.0
Percent of emergency department visits with a diagnosis for any MH/SUD condition in the first or second position	4.5%	1	4.5%		7.2%
Percent of MH/SUD emergency department visits or hospitalizations with timely follow-up after discharge[2]	14.7%	5	8.4%		29.5%
Availability of behavioral health providers	**South Atlantic**	**Rank**	**Min**	**South Atlantic**	**Max**
Therapy Access Ratio[3]	39.3%	6	18.5%		93.2%
Affordability of behavioral health services	**South Atlantic**	**Rank**	**Min**	**South Atlantic**	**Max**
Average out of pocket costs for an individual 60-minute psychotherapy visit[4]	$15	7	$6		$30

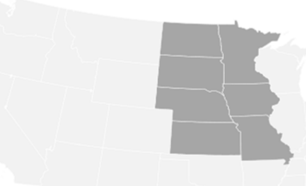
Legend

Gradient Interpretation

Notes:
1. Specialty care is defined as care from a behavioral health specialist in an inpatient, outpatient, or professional setting.
2. Timely follow-up is defined as a follow-up visit within 30 days of discharge.
3. Calculated as the average number of therapy visits received by individuals diagnosed with behavioral health conditions in a given MSA, compared against the top decile of MSAs with the highest behavioral health provider supply density. Expressed as a percentage, this ratio reveals how close an MSA, and by extension a state, is to achieving the reference rate.
4. Defined by HCPCS 90837.
5. Data for the District of Columbia is not available for all metrics. D.C. is included in rankings only for metrics for which data are available.
6. The Medicare Advantage data has been segmented into 9 total divisions.
7. Metrics are displayed and ranked at the division level; they have not been normalized by geographic distribution.

FIGURE B-8: BEHAVIORAL HEALTH ACCESS MEASURES FOR MEDICARE ADVANTAGE IN THE WEST NORTH CENTRAL DIVISION

States in the West North Central division
Iowa
Kansas
Minnesota
Missouri
Nebraska
North Dakota
South Dakota



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Prevalence of behavioral health conditions	West North Central	Rank[6]	Min	West North Central	Max
Individuals with any diagnosed MH/SUD condition	33.3%	5	25.9%		36.9%
Percent of individuals with diagnosed suicidal ideation or intentional self-harm	0.2%	3	0.1%		0.4%
Behavioral health treatment patterns	**West North Central**	**Rank**	**Min**	**West North Central**	**Max**
Percent of individuals with any MH/SUD diagnosis that received specialty MH/SUD care[1]	9.7%	7	8.0%		23.8%
Average number of sessions per year for those receiving outpatient BH therapy	6.2	7	4.7		11.0
Percent of emergency department visits with a diagnosis for any MH/SUD condition in the first or second position	7.2%	9	4.5%		7.2%
Percent of MH/SUD emergency department visits or hospitalizations with timely follow-up after discharge[2]	8.4%	9	8.4%		29.5%
Availability of behavioral health providers	**West North Central**	**Rank**	**Min**	**West North Central**	**Max**
Therapy Access Ratio[3]	26.5%	7	18.5%		93.2%
Affordability of behavioral health services	**West North Central**	**Rank**	**Min**	**West North Central**	**Max**
Average out of pocket costs for an individual 60-minute psychotherapy visit[4]	$10	3	$6		$30

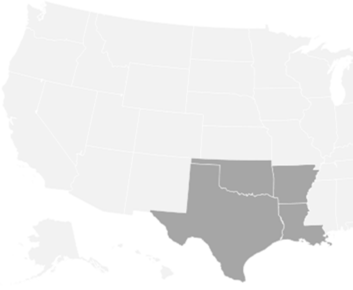
Legend

Gradient Interpretation		
	Adverse	Favorable
	Favorable	Adverse

Notes:
1. Specialty care is defined as care from a behavioral health specialist in an inpatient, outpatient, or professional setting.
2. Timely follow-up is defined as a follow-up visit within 30 days of discharge.
3. Calculated as the average number of therapy visits received by individuals diagnosed with behavioral health conditions in a given MSA, compared against the top decile of MSAs with the highest behavioral health provider supply density. Expressed as a percentage, this ratio reveals how close an MSA, and by extension a state, is to achieving the reference rate.
4. Defined by HCPCS 90837.
5. Data for the District of Columbia is not available for all metrics. D.C. is included in rankings only for metrics for which data are available.
6. The Medicare Advantage data has been segmented into 9 total divisions.
7. Metrics are displayed and ranked at the division level; they have not been normalized by geographic distribution.

FIGURE B-9: BEHAVIORAL HEALTH ACCESS MEASURES FOR MEDICARE ADVANTAGE IN THE WEST SOUTH CENTRAL DIVISION

States in the West South Central division
Arkansas
Louisiana
Oklahoma
Texas



Prevalence of behavioral health conditions	West South Central	Rank[6]	Min	West South Central	Max
Individuals with any diagnosed MH/SUD condition	36.9%	9	25.9%		36.9%
Percent of individuals with diagnosed suicidal ideation or intentional self-harm	0.3%	8	0.1%		0.4%
Behavioral health treatment patterns	**West South Central**	**Rank**	**Min**	**West South Central**	**Max**
Percent of individuals with any MH/SUD diagnosis that received specialty MH/SUD care[1]	8.0%	9	8.0%		23.8%
Average number of sessions per year for those receiving outpatient BH therapy	6.2	8	4.7		11.0
Percent of emergency department visits with a diagnosis for any MH/SUD condition in the first or second position	4.9%	4	4.5%		7.2%
Percent of MH/SUD emergency department visits or hospitalizations with timely follow-up after discharge[2]	8.6%	7	8.4%		29.5%
Availability of behavioral health providers	**West South Central**	**Rank**	**Min**	**West South Central**	**Max**
Therapy Access Ratio[3]	19.6%	8	18.5%		93.2%
Affordability of behavioral health services	**West South Central**	**Rank**	**Min**	**West South Central**	**Max**
Average out of pocket costs for an individual 60-minute psychotherapy visit[4]	$8	2	$6		$30

Legend

Gradient Interpretation

Adverse	Favorable
Favorable	Adverse

Notes:
1. Specialty care is defined as care from a behavioral health specialist in an inpatient, outpatient, or professional setting.
2. Timely follow-up is defined as a follow-up visit within 30 days of discharge.
3. Calculated as the average number of therapy visits received by individuals diagnosed with behavioral health conditions in a given MSA, compared against the top decile of MSAs with the highest behavioral health provider supply density. Expressed as a percentage, this ratio reveals how close an MSA, and by extension a state, is to achieving the reference rate.
4. Defined by HCPCS 90837.
5. Data for the District of Columbia is not available for all metrics. D.C. is included in rankings only for metrics for which data are available.
6. The Medicare Advantage data has been segmented into 9 total divisions.
7. Metrics are displayed and ranked at the division level; they have not been normalized by geographic distribution.

Appendix C: Study sample size by state and healthcare coverage type

FIGURE C-1 – SAMPLE SIZE BY STATE AND HEALTHCARE COVERAGE TYPE

	Commercial		Medicare FFS		Medicaid	
State	**Individuals**	**% of total**	**Individuals**	**% of total**	**Individuals**	**% of total**
Alabama	65,909	0.4%	410,226	1.5%	1,001,951	1.3%
Alaska	10,596	0.1%	84,868	0.3%	209,822	0.3%
Arizona	104,009	0.7%	615,675	2.2%	2,000,147	2.5%
Arkansas	56,555	0.4%	351,148	1.2%	895,760	1.1%
California	757,787	5.1%	2,578,147	9.2%	13,260,785	16.8%
Colorado	98,372	0.7%	401,063	1.4%	1,341,611	1.7%
Connecticut	46,291	0.3%	268,850	1.0%	998,531	1.3%
Delaware	120,413	0.8%	140,093	0.5%	240,257	0.3%
District of Columbia	5,840	0.0%	46,513	0.2%	242,880	0.3%
Florida	262,476	1.8%	1,933,473	6.9%	4,133,557	5.2%
Georgia	341,919	2.3%	742,071	2.6%	2,105,931	2.7%
Hawaii	33,198	0.2%	97,110	0.3%	376,681	0.5%
Idaho	154,133	1.0%	174,727	0.6%	317,753	0.4%
Illinois	412,431	2.8%	1,199,826	4.3%	2,908,988	3.7%
Indiana	123,377	0.8%	629,571	2.2%	1,614,168	2.0%
Iowa	674,558	4.5%	391,262	1.4%	629,449	0.8%
Kansas	262,781	1.8%	341,757	1.2%	365,591	0.5%
Kentucky	76,556	0.5%	428,588	1.5%	1,466,346	1.9%
Louisiana	210,949	1.4%	368,501	1.3%	1,733,337	2.2%
Maine	24,118	0.2%	143,573	0.5%	326,054	0.4%
Maryland	155,617	1.0%	702,254	2.5%	1,485,591	1.9%
Massachusetts	498,479	3.4%	780,142	2.8%	1,778,480	2.3%
Michigan	424,406	2.9%	819,856	2.9%	2,559,021	3.2%
Minnesota	329,800	2.2%	393,089	1.4%	1,107,080	1.4%
Mississippi	69,222	0.5%	356,737	1.3%	665,224	0.8%
Missouri	530,212	3.6%	564,854	2.0%	1,003,964	1.3%
Montana	23,106	0.2%	168,561	0.6%	239,547	0.3%
Nebraska	288,225	1.9%	223,195	0.8%	279,081	0.4%
Nevada	34,392	0.2%	236,738	0.8%	707,929	0.9%
New Hampshire	29,330	0.2%	184,320	0.7%	212,147	0.3%
New Jersey	107,452	0.7%	828,206	2.9%	1,649,134	2.1%
New Mexico	35,404	0.2%	193,524	0.7%	793,615	1.0%
New York	482,196	3.2%	1,545,707	5.5%	6,517,519	8.3%
North Carolina	138,631	0.9%	941,939	3.3%	2,061,056	2.6%
North Dakota	27,521	0.2%	85,587	0.3%	85,185	0.1%
Ohio	1,286,489	8.7%	968,666	3.4%	2,949,300	3.7%
Oklahoma	39,811	0.3%	422,811	1.5%	683,963	0.9%
Oregon	281,988	1.9%	360,379	1.3%	921,915	1.2%
Pennsylvania	1,753,930	11.8%	1,172,975	4.2%	2,937,683	3.7%
Rhode Island	39,598	0.3%	75,416	0.3%	290,268	0.4%
South Carolina	189,263	1.3%	593,232	2.1%	1,324,949	1.7%
South Dakota	193,862	1.3%	110,838	0.4%	112,941	0.1%
Tennessee	873,069	5.9%	615,792	2.2%	1,473,714	1.9%
Texas	820,940	5.5%	1,807,940	6.4%	5,180,390	6.6%
Utah	779,621	5.2%	183,451	0.7%	362,787	0.5%
Vermont	7,464	0.1%	100,572	0.4%	161,012	0.2%
Virginia	256,890	1.7%	891,933	3.2%	1,527,042	1.9%
Washington	780,868	5.3%	690,379	2.5%	1,769,554	2.2%
West Virginia	108,910	0.7%	203,155	0.7%	540,235	0.7%
Wisconsin	423,778	2.9%	502,352	1.8%	1,201,937	1.5%
Wyoming	12,951	0.1%	93,320	0.3%	57,482	0.1%
Total	**14,865,693**	**100.0%**	**28,164,962**	**100.0%**	**78,809,344**	**100.0%**

FIGURE C-2 – SAMPLE SIZE BY CENSUS DIVISION FOR MEDICARE ADVANTAGE

Division	Individuals	% of total
East North Central	646,473	36.5%
East South Central	30,019	1.7%
Middle Atlantic	501,760	28.3%
Mountain	61,554	3.5%
New England	75,694	4.3%
Pacific	170,816	9.6%
South Atlantic	165,824	9.4%
West North Central	24,725	1.4%
West South Central	95,075	5.4%
Total	**1,771,940**	**100.0%**

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