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ISSUE BRIEF

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AVAILABILITY OF CARE FOR OLDER ADULTS IN OUTPATIENT BEHAVIORAL HEALTH FACILITIES

KEY POINTS

- Rates of behavioral health (BH) conditions continue to increase among the growing population of adults aged 65 and older, but older adults remain less likely to receive treatment compared to younger adults.
- In 2023, most facilities that provided outpatient behavioral health (BH) services accepted older adults, but only about one-third of mental health (MH) and substance use treatment facilities offered programs specifically tailored for this population.
- Substance use disorder (SUD) treatment facilities were the least likely to accept Medicare, with less than half doing so, compared to two-thirds of MH facilities and facilities that provided both SUD and MH services.
- Challenges and facilitators to availability of appropriate or tailored care, and older adults' use of such care, exist at the system, clinic, and individual levels. Policy and state-level initiatives can help address affordability challenges and availability of BH care.

BACKGROUND

Mental health (MH) conditions and substance use disorders (SUD) are rising among older adults: over 35% of Medicare beneficiaries aged 65 and older had a diagnosis of or used services related to a behavioral health (BH) condition.[1] Such conditions contribute to emotional distress, reduced health and functioning, increased health care costs, and high suicide rates.[2] The "baby boomer" generation experiences a greater burden of behavioral health (BH) conditions (i.e., MH conditions, SUD, and co-occurring MH conditions and SUD) compared to previous generations due to longer life expectancy and higher rates of continued substance use in older age.[2-6] Older adults (aged 65 and older) experience significant comorbidity between BH conditions, neurocognitive disorders, chronic physical illnesses, and disabilities, which complicates treatment and recovery and increases risks of cognitive decline, dementia, and mortality.[3,4,7,8] Despite these risks, older adults are 40 percent less likely to receive MH or SUD treatment compared to younger adults, including in specialty settings.[3,4]

The Substance Abuse and Mental Health Services Administration (SAMHSA) recommends an integrated, coordinated approach to care for older adults with BH conditions, emphasizing evidence-based programs tailored to this population to address age-specific barriers, improve treatment adherence, and enhance outcomes.[9,10] The proportion of adult-serving facilities offering such tailored programs increased from 2012 to 2019, rising from 21 to 29 percent for MH facilities and from 7 to 25 percent for substance use facilities.[10] However, there is a considerable shortage of BH professionals, particularly those specializing in older adult care, which is projected to worsen as demand increases, and this shortage impacts outpatient BH facilities ability to adequately staff.[3,9]

Medicare serves as the primary payer for health care services for older adults, including for BH counseling, medication management, opioid use disorder (OUD) treatment, and psychiatric hospitalization.[9] Recent policy changes have expanded Medicare coverage for some BH services. Since 2024, the Consolidated Appropriations Act (CAA) of 2023 and the FY 2024 Physician Fee Schedule allow licensed MH counselors and licensed marriage and family therapists to bill Medicare Part B directly for covered services at 75 percent of the psychologist reimbursement rate, which may encourage more providers across various specialties to participate in Medicare.[11] Since 2020, Medicare has also covered treatment provided in opioid treatment programs (OTPs).[12] Beyond changes to Medicare, the Mental Health Parity and Addiction Equity Act of 2008 requires parity in BH coverage for group plans and Medicaid managed care, which cover some older adults. These and other federal reforms have improved access to BH care for older adults, yet barriers to providing and accessing this care persist.

This study examined the availability of care for older adults in outpatient BH facilities across the United States.[a] The quantitative analysis examined the proportion of facilities that offer outpatient BH services that accept older adults, accept Medicare, and/or offer programs tailored for older adults and explored whether certain facility characteristics are associated with these practices. The qualitative analysis identified multi-level factors influencing access to and provision of outpatient BH services for older adults, including state and federal policies and systemic barriers to treatment.

METHODS

We conducted an environmental scan, analyzed national survey data, and led key informant interviews. To provide context to the survey analysis and interviews, we conducted a targeted environmental scan of the literature to identify and summarize recent peer-reviewed and gray literature on the availability and use of outpatient BH services among older adults.

We analyzed publicly available 2023 National Substance Use and Mental Health Services Survey (N-SUMHSS) data to (1) determine the proportion of facilities that offer outpatient BH services that accept older adults, offer tailored or dedicated programs for older adults, and accept Medicare (measures of availability), and (2) examine whether certain facility characteristics are associated with these measures. The N-SUMHSS is an annual survey of MH and substance use treatment facilities registered and listed in SAMHSA's Inventory of Substance Use and Mental Health Treatment Facilities. It is important to note that the survey focuses on what facilities offer, and we could not draw conclusions about what services are being used, how much, and by whom. This analysis included adult-serving facilities providing outpatient BH services, a subset of N-SUMHSS facilities, and was limited to those serving individuals aged 18 and older.

Facilities were stratified into three categories based on their self-reported primary treatment type: (1) MH treatment facilities ("MH facilities"), (2) substance use treatment facilities ("substance use facilities"), and (3) facilities providing both MH and substance use treatment ("mixed facilities"). For each facility type, we examined the facility-level characteristics (for example, ownership status, availability of integrated primary care or peer support services, acceptance of private insurance) associated with our measures of availability. We used logistic regression to model our three measures of availability separately as a function of facility characteristics. The independent variables differed somewhat across the regression models based on their

[a] This issue brief focuses on *availability*, the presence of services, and not *access* to services, the ability to obtain and use those services. [12]

relevance to the facility type, data availability, and extent of missing data. For example, we did not include facility size and whether the facility offered telehealth or telemedicine services in the models, because a substantial portion of facilities in the sample did not provide data for these variables.

We conducted three semi-structured interviews with a total of five federal government agency staff members with expertise in BH-related policy and service delivery. The interviews aimed to capture challenges and successes in providing outpatient BH services for older adults and to contextualize the policy environment. We reviewed notes and cleaned transcripts to identify cross-cutting themes.

INTERVIEW FINDINGS

BH experts discussed multiple drivers of older adults' access to outpatient BH services, which closely aligned with barriers and opportunities identified in the literature. We categorized these drivers into the three levels at which they occur: (1) *system-level factors*, including workforce shortages, transportation barriers, fragmented systems, federal and state policies, and cross-sector collaborations; (2) *clinic-level factors*, such as provider comfort with SUD pharmacotherapy, telehealth readiness, service integration or co-location, and appointment design; and (3) *individual-level factors*, including stigma and the need for strength-based messaging.

System-level Factors

System-level factors encompass statewide and national structural factors and the policy landscape that influence access to BH care.

Ongoing workforce shortages create barriers to accessing outpatient BH services for older adults. A large percentage of older adults live in areas designated as MH provider shortage areas by the Health Resources and Services Administration (HRSA). Few communities have geriatric psychiatrists or other BH providers that specialize in geriatrics, underscoring the need to train more clinicians to address the complex needs of older adults. Outpatient settings can consider creative ways to support the needs of older adults. For example, some experts suggested the need for greater reliance on peer support workers.

Transportation support is critical to help older adults access BH services. Several experts noted that transportation challenges affect all age groups, particularly in rural areas. Various factors could make transportation a greater challenge for older adults, including no longer being able to drive themselves and/or dependence on public transportation, which can pose accessibility challenges.

Across the health care system, MH, substance use, and physical health services are often siloed. The extent of system fragmentation varies by state; for example, lack of data sharing between systems creates barriers for states. Experts noted that parallel aging and BH service systems often fail to coordinate care, with providers struggling to share patient information due to the lack of shared data systems. Care coordination plays an important role in maintaining patients' access to BH services, particularly at transition points such as when individuals become Medicare eligible. Experts suggest expanding grant programs focused on the BH needs of older adults to address challenges with the care delivery network.

Federal policies impact the delivery of BH services for older adults, especially those with Medicare, Medicaid, or dual coverage. Although Medicare coverage of BH treatment has expanded over time, opportunities remain to strengthen Medicare. Experts noted the importance of the CAA of 2023, which expanded Medicare access to counseling services. However, one expert shared that not all BH providers can bill Medicare, such as certified peer support workers. In addition, some psychiatrists and psychologists choose

not to accept Medicare and/or Medicaid due to reimbursement rates perceived as insufficient to compensate for their time. Experts highlighted several federal policies that have positively influenced access to BH services for older adults, including updates to the federal regulation 42 CFR Part 8 final rule governing OTPs that went into effect in 2024.[13] This rule increased access to take-home doses of medication to treat OUD, expanded prescribing authority for non-physician providers (for example, nurse practitioners and physician assistants), and required person-centered care.

Partnerships across sectors serving older adults could also help identify BH conditions in older adults and support linkages to care. For example, experts recommended training Meals on Wheels volunteers and senior center staff to recognize signs and symptoms of BH conditions and refer individuals to appropriate services. Experts also highlighted challenges with the 988 Suicide and Crisis Lifeline for older adults, noting that stigma related to seeking BH care may discourage them from using the service. To address this, they suggested tailoring 988 support for older adults in more states and raising awareness of 988 services among this population.[14] A recent SAMHSA Older Adult Suicide Prevention Policy Academy explored strategies to promote 988 services to caregivers of older adults.

Experts highlighted several state initiatives intended to increase availability of BH services or improve coordination across aging and BH systems. New York and California have dedicated state funding (and, in some cases, local funding) for older adult BH services. New York law also mandates communication and collaboration between the MH and aging systems. Pennsylvania has worked closely with its Area Agencies on Aging (AAAs) to establish a joint referral process between the state's aging and BH systems and to cross-train staff. Oregon has implemented a targeted approach through its regional BH system, assigning an older adult and disability specialist to each region. Illinois has an active MH and aging coalition to address these needs.

Clinic-Level Factors

Clinic-level factors relate to provider behaviors and interactions with older adults, including clinic decisions on insurance acceptance and service offerings.

Providers' prescribing behaviors for SUD medications in older adults may limit use of these treatments. Providers may be reluctant to prescribe medications for SUD treatment for older adults due to concerns about polypharmacy and increased risks of medication-related complications in this population. Experts noted low utilization of medications for OUD and alcohol use disorder (AUD) among older adults and recommended increased provider education on potential undertreatment of these conditions.

Telehealth can reduce barriers to BH care among older adults. Most experts viewed telehealth as a valuable tool to improve access to care and facilitate follow-through on referrals between primary care and BH providers. However, some older adults may lack internet access, particularly in rural or remote areas, or be unfamiliar with technology and video conferencing platforms. Experts suggested that providers identify and adopt user-friendly platforms to better serve this population.

Integrating services within clinics could increase access to BH care for older adults. Although specialty BH treatment settings provide critical services to older adults, they are often not well-equipped to provide holistic support for co-occurring BH, physical, and/or cognitive conditions. Experts recommended co-locating services within specialty BH settings, citing the Certified Community Behavioral Health Clinic[15] model as a promising example, as these clinics are required to provide comprehensive care for all age groups. Experts also suggested co-locating BH providers within primary care settings to reduce the need for travel to another provider, thereby alleviating logistical challenges and stigma related to seeking BH services. Co-location of services may

encourage warm handoffs and data sharing between primary care providers and BH specialists. Improving coordination between primary care and BH providers, even when not co-located, can minimize disruptions in care.

Improving clinical processes and supports can help BH clinics better meet the physical and cognitive needs of older adults. Experts suggested adjusting appointment pacing, extending appointment times, and using appointment reminders to better meet the needs of older adults. They also emphasized the need for counseling services, in which treatment and interventions are tailored to the unique needs of older adults.

Individual-Level Factors

Individual-level factors describe beliefs, knowledge, and interpersonal dynamics that influence the behaviors of older adults or individual BH providers.

Stigma can affect older adults' willingness to seek treatment for MH and SUD conditions. Depression and other MH conditions are often mistakenly viewed as a natural part of aging. Interviewees noted that depression in older adults may manifest through substance misuse or social withdrawal, highlighting the need for more attentive screening. Providers and caregivers may not perceive older adults as at risk for SUD. Across the older adult population, differences in how certain age groups perceive the importance of BH treatment can vary; for example, individuals in their early 60s may be more open to treatment than those aged 75 and older.

Strength-based, person-centered messaging may encourage older adults to engage in BH care. Respondents described resources developed with support from the U.S. Department of Health and Human Services to support communication with and about older adults and BH care, such as the CATCH-ON Anti-Elderspeak Language Guide. These resources promote strategies such as using respectful, person-centered language to reframe discussions about aging and older adults, reduce stigma, and promote dignity.[16,17] One expert pointed to strength-based messaging, which focuses on autonomy and social connections, as a valuable approach to motivate older adults to seek BH treatment.

QUANTITATIVE FINDINGS

We used findings from our analysis of N-SUMHSS data to supplement information gathered through the expert interviews and to quantify the availability of outpatient BH care for older adults, defined as aged 65 and older. As a facility-based survey, N-SUMHSS captures what clinics report offering—rather than individual patient use—and enables assessment of (1) whether facilities accept older adults and Medicare[b] and (2) whether they offer programs tailored to older adults. We also examined facility characteristics aligned with interview themes, including peer support, medication services, treatment for co-occurring conditions, and integration with primary care, using regression to test associations. The results below translate qualitative insights into measurable patterns.

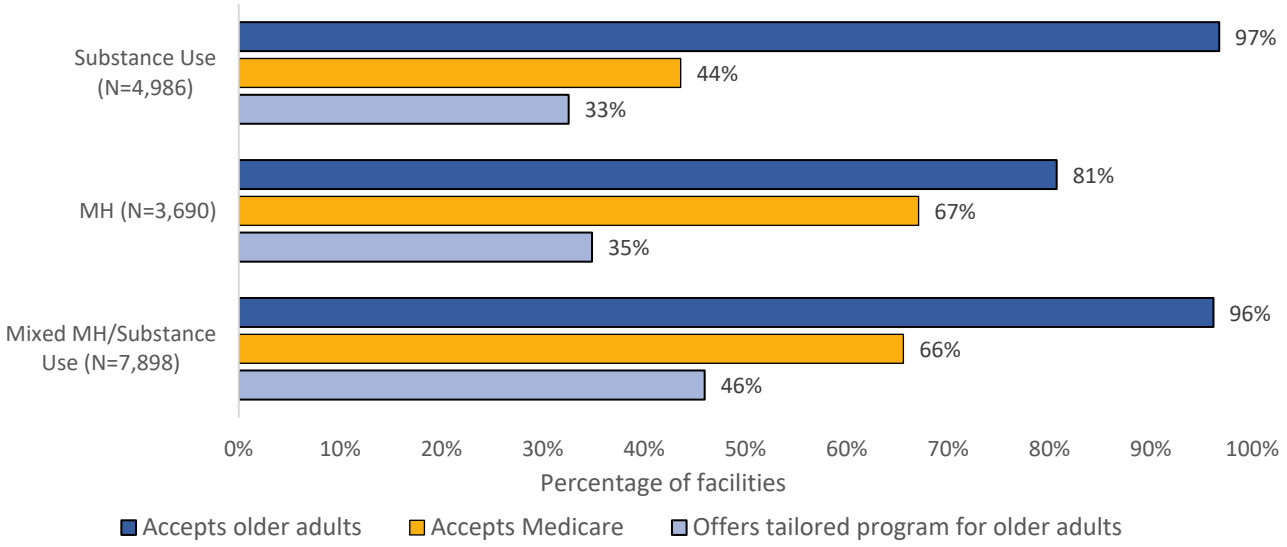
Availability of BH Services for Older Adults

In 2023, most outpatient BH facilities nationwide accepted older adults, but fewer offered tailored programs for this population or accepted Medicare. In our sample, approximately 97 percent of substance use facilities, 81 percent of MH facilities, and 96 percent of mixed facilities accepted older adults (Figure 1). A higher proportion of mixed facilities (46 percent) provided programs tailored to older adults compared to substance

[b] N-SUMHSS question wording does not differentiate between Medicare Parts A and B or D coverage or Medicare Advantage.

use facilities (33 percent) and MH facilities (35 percent). Additionally, about two-thirds of MH and mixed facilities accepted Medicare, compared to only 44 percent of substance use facilities.

Figure 1. Availability of MH/SUD treatment for older adults by facility type

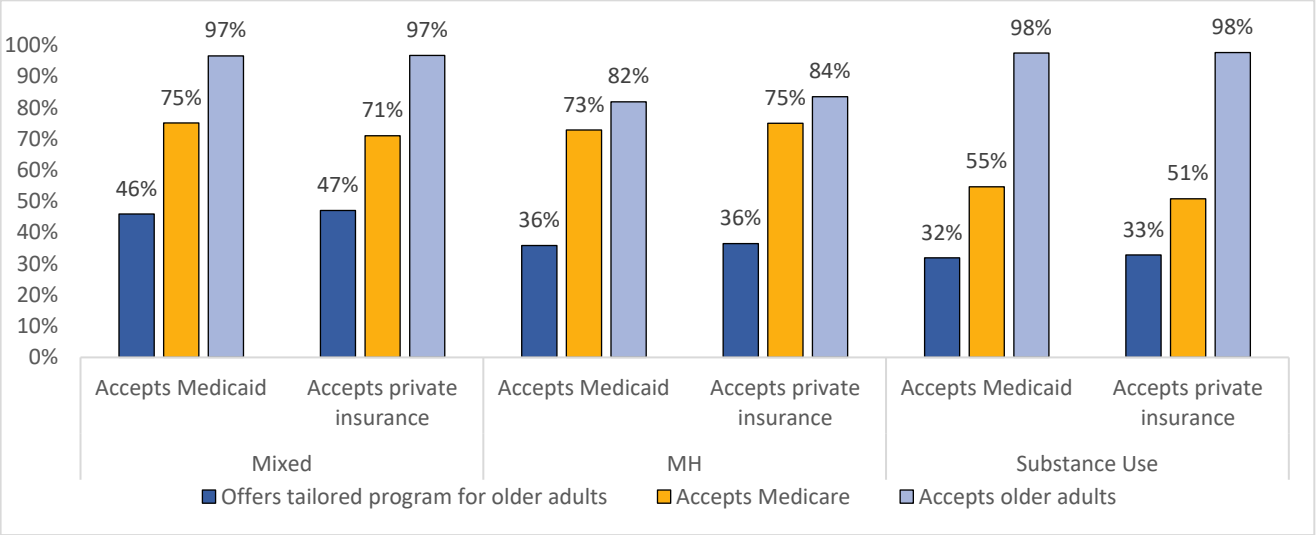


Source: Mathematica's analysis of N-SUMHSS 2023 data.

Note: This figure illustrates the proportion of facilities that offer outpatient BH services whose services are available to older adults according to three measures of availability: facility accepts older adults, facility offers a tailored program for older adults, facility accepts Medicare. These measures are not mutually exclusive, as all measures of availability may be applicable to a facility.

Medicaid and private insurance. The descriptive comparisons of mixed, MH, and substance use facilities showed no uniform pattern of availability – as measured by acceptance of older adults and Medicare and offering tailored programs. Furthermore, these availability measures of acceptance and tailored programs did not vary consistently by whether each type of facility accepted Medicaid or private insurance in the descriptive analysis (Figure 2). For example, among MH facilities, the proportion of facilities offering programs tailored to older adults was similar for those accepting private insurance and those accepting Medicaid (some facilities may accept both). However, across all facility types—mixed, MH, and substance use—those accepting Medicaid were more likely to accept older adults and Medicare compared to non-Medicaid facilities (Appendix Figures A-1 through A-3). MH and mixed facilities accepting Medicaid also had greater odds of offering tailored programs for older adults, though this was not observed in substance use facilities. Mixed and MH facilities accepting private insurance (relative to those that did not accept private insurance) were also more likely to accept older adults, accept Medicare, and offer tailored programs for older adults. For substance use facilities, those accepting private insurance had significantly lower odds of offering tailored programs for older adults.

Figure 2. Facility characteristics, by insurance type

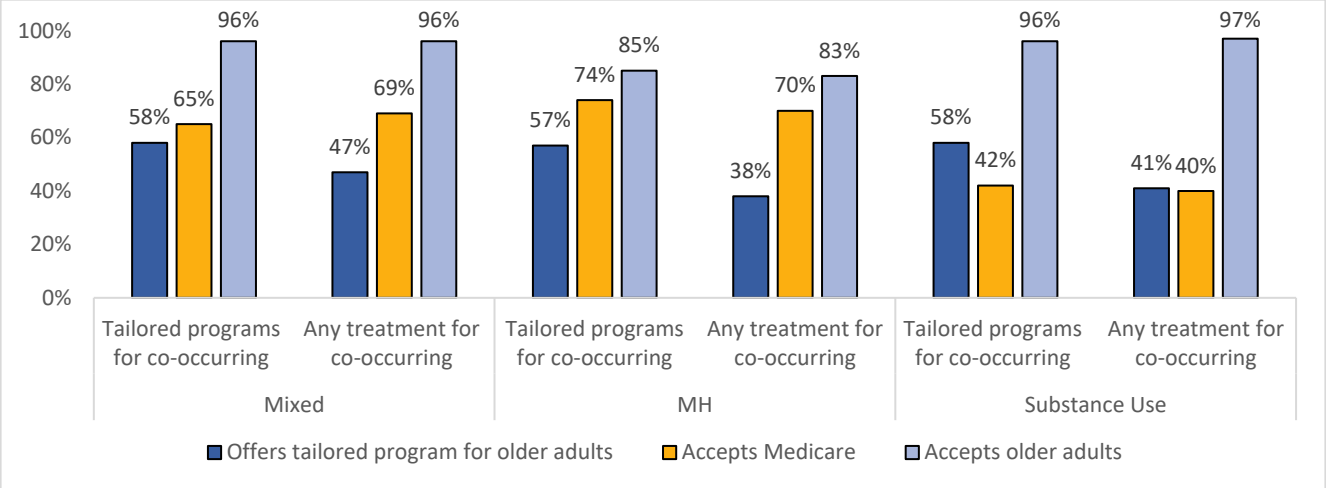


Source: Mathematica's analysis of N-SUMHSS 2023 data.

Note: Each percentage reflects the proportion of facilities with an applicable facility characteristic (that is, insurance type) for the applicable measure of availability.

Treatment for co-occurring MH conditions and SUD. Among facilities offering tailored programs for clients with co-occurring MH conditions and SUD, more than half also provided tailored programs for older adults, including 58 percent of mixed facilities, 57 percent of MH facilities, and 58 percent of substance use facilities (Figure 3). Regression results confirmed this association, showing that facilities offering tailored programs for treating co-occurring MH conditions and SUD were significantly more likely to also provide tailored programs for older adults compared to facilities without such programs (Appendix Figures A-1 through A-3). Most facilities providing tailored programs or treatments for co-occurring conditions accepted older adults, though Medicare acceptance varied (see associated regression results in the Appendix Figures A-1 through A-3).

Figure 3. Facility characteristics, by treatment for co-occurring MH condition and SUD



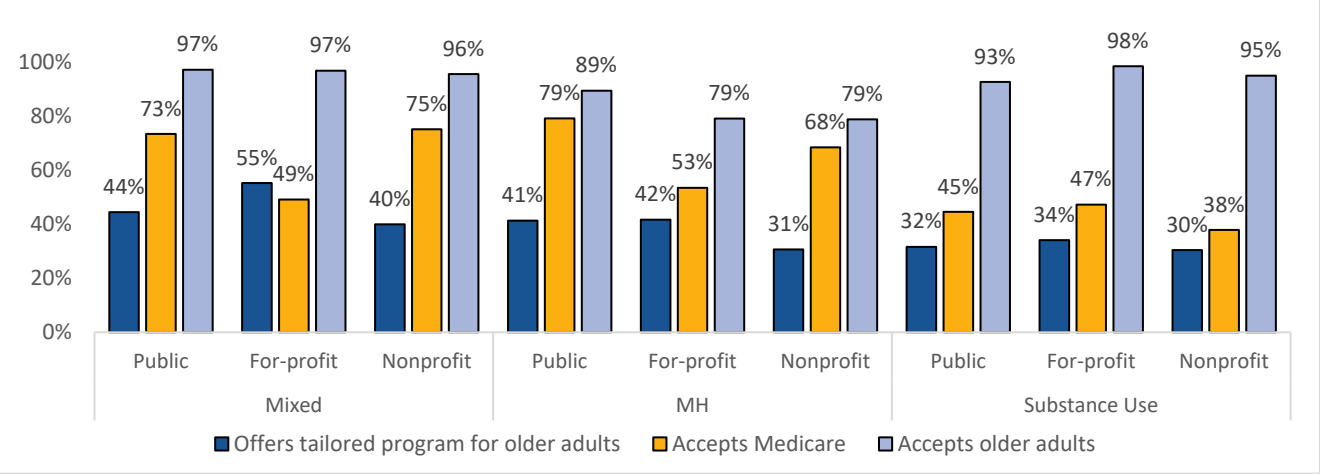
Source: Mathematica's analysis of N-SUMHSS 2023 data.

Note: Each percentage reflects the proportion of facilities with an applicable facility characteristic for the applicable measure of availability.

Ownership. Among private for-profit facilities, 55 percent of mixed facilities, 42 percent of MH facilities, and 34 percent of substance use facilities offered programs tailored for older adults (Figure 4). Less than one-third of private nonprofit MH and substance use facilities offered tailored programs for older adults, compared to 40 percent of mixed facilities. Across facilities, Medicare acceptance varied by ownership type. Less than half of substance use facilities accepted Medicare, regardless of ownership type. However, most facilities accepted older adults.

Consistent with the descriptive findings, private for-profit and nonprofit MH facilities had lower odds of accepting older adults and Medicare relative to public MH facilities (Appendix Figure A-1). However, across all facility types (mixed, MH, and substance use), the odds of having tailored programs for older adults were higher among private for-profit facilities relative to publicly owned facilities (Appendix Figures A-1 through A-3).

Figure 4. Facility characteristics, by ownership type



Source: Mathematica's analysis of N-SUMHSS 2023 data.

Note: Each percentage reflects the proportion of facilities that offer outpatient BH services with an applicable facility characteristic (that is, insurance type) for the applicable measure of availability.

Services. We examined additional facility characteristics aligned with themes identified during BH expert interviews, including peer support services, medication services, and primary care integration. For each facility type, we considered specific services and their relationship with the measures of availability (Appendix Figures A-1 through A-3). Our findings showed that MH facilities offering peer support services were more likely to accept older adults compared to those facilities that did not offer those services. Approximately 67 percent of substance use facilities reported providing medication services for treating BH conditions (e.g., buprenorphine, naltrexone, clonidine). These facilities had slightly higher odds of (1) offering tailored programs for older adults and much higher odds of (2) accepting Medicare and (3) accepting older adults. Mixed facilities integrating primary care had a higher likelihood of (1) offering a tailored program, (2) accepting Medicare, and (3) accepting older adults. Substance use facilities integrating primary care were also more likely to offer tailored programs for older adults; however, no significant associations were observed for MH facilities with integrated primary care.

Discussion

Although BH conditions are common among older adults, this population is less likely to receive treatment compared to younger adults.[21] Outpatient BH facilities play a vital role in supporting older adults' autonomy,

well-being, and healthy aging. This study found that while most facilities providing outpatient BH services accept older adults, fewer provide tailored care or accept Medicare, with these gaps being most pronounced in substance use treatment settings. These gaps create system-, clinic-, and individual-level barriers that limit availability of BH care for older adults. System-level barriers include workforce shortages, transportation challenges, and limited state and local support for aging and BH services that could influence available care. At the clinic level, experts pointed to provider attitudes, telehealth use, care integration, and age-tailored services as potential barriers and opportunities to improve care availability. It is important to note that based on this project's analyses, we cannot draw conclusions to the extent to which such practices as care integration and provider co-location are currently being implemented. Providers and health care systems may already be leveraging the opportunity these efforts afford to better meet older adult BH needs. Additional barriers occur at the individual level, such as stigma surrounding BH conditions and related treatment can negatively impact older adults seeking care.

Expanding tailored programs in outpatient facilities is a critical step to improving access for older adults, especially as the prevalence of BH conditions is expected to rise in this population.[10] Such efforts could be directed towards public BH treatment facilities, which we found to have a lower likelihood of offering tailored programs for older adults compared to private for-profit facilities. At the system level, persistent workforce shortages, particularly among geriatric specialists, limit the availability of care; incorporating peer roles could help expand access to treatment. At the clinic level, adopting age-friendly operations—such as offering appointments at earlier or later times, sending appointment reminders, and integrating user-friendly telehealth platforms—can increase engagement in BH treatment. Additional education for providers, patients, and caregivers can help further reduce stigma and increase engagement; helpful tools for education include the Opioids in Older Adults Compendium and the 4Ms Behavioral Health Framework.

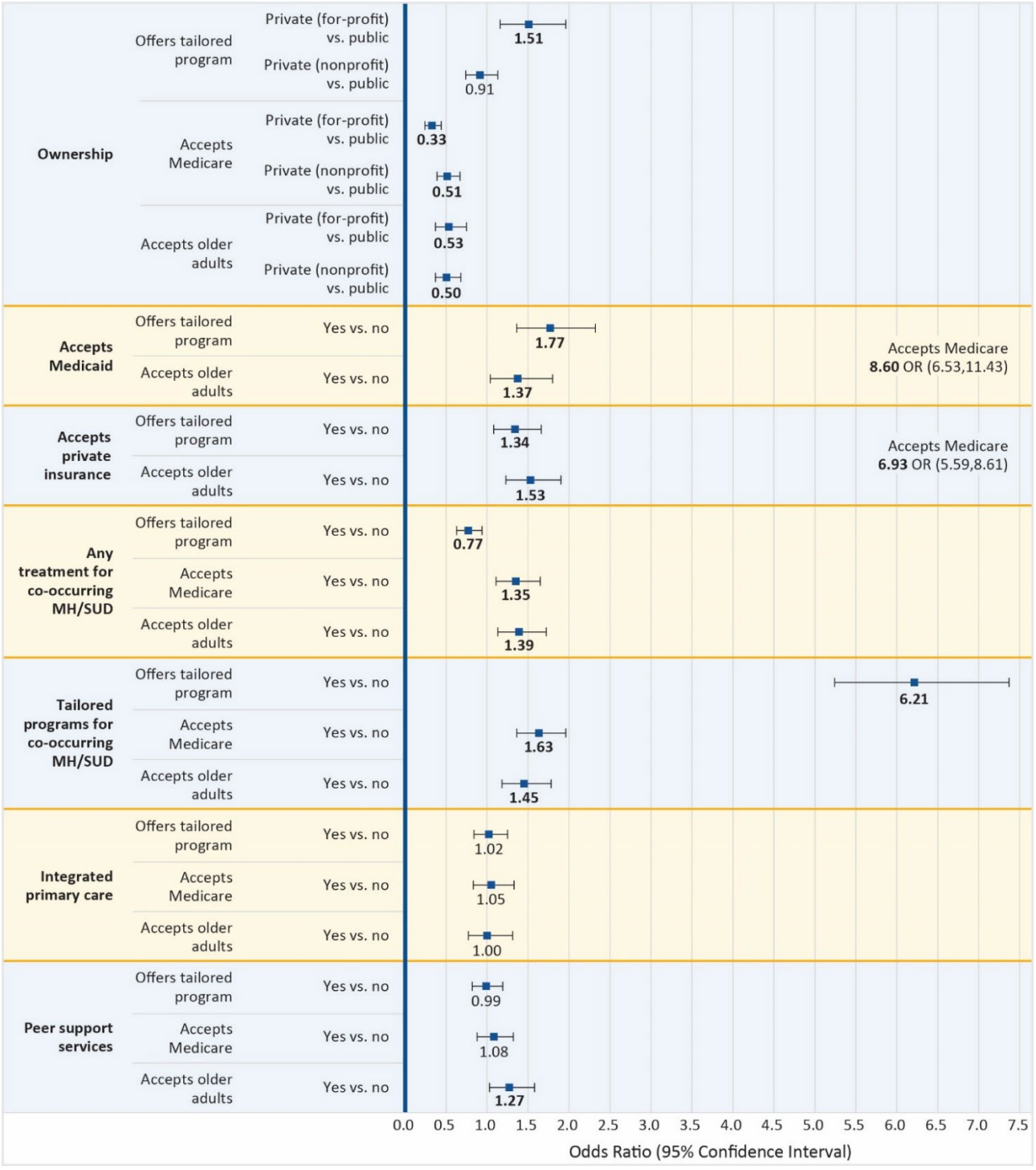
Policy actions can also help address care affordability and appropriateness gaps by increasing Medicare participation in SUD settings and scaling proven state coordination models. Experts identified low Medicare reimbursement rates as a barrier to provider participation, though they highlighted progress in this area – particularly the recent expansions of Medicare coverage for BH services. Raising reimbursement rates could enhance provider participation in Medicare, thereby increasing service availability. Beyond federal efforts, states can build on existing successes by adapting successful models, including those developed by other states. For example, the Oregon Older Adult Behavioral Health Initiative improves BH delivery through coordinated, timely services, while Illinois's Coalition on Mental Health & Aging strengthens care delivery through cross-sector partnerships. Policy actions are most effective when paired with cross-sector initiatives that integrate aging and BH services to reduce barriers and improve care. The Program of All-Inclusive Care for the Elderly (PACE) offers a promising community-based, person-centered model that integrates BH and primary care through community-based, interdisciplinary teams.[3]

Strengthening BH services for this population aligns with the goals of national frameworks for healthy aging.[18] With the anticipated rise in BH conditions among older adults, developing tailored programs for this population can help meet growing demand. Targeted initiatives at the system, clinic, and individual levels are also key to increasing the availability of outpatient MH and substance use treatment for older adults. Future research could include interviews with outpatient BH facility staff to better understand facilities' approaches to implementing or expanding care to better meet the needs of older adults with BH disorders as well as the challenges and successes of those approaches. Additionally, analyzing national survey data and other sources

could help track changes in service availability, explore geographic variations to identify areas of need, and identify strategies to better integrate services for older adults.

APPENDIX A: SUPPLEMENTAL STATISTICS

Figure A-1. MH facility characteristics associated with each measure of availability

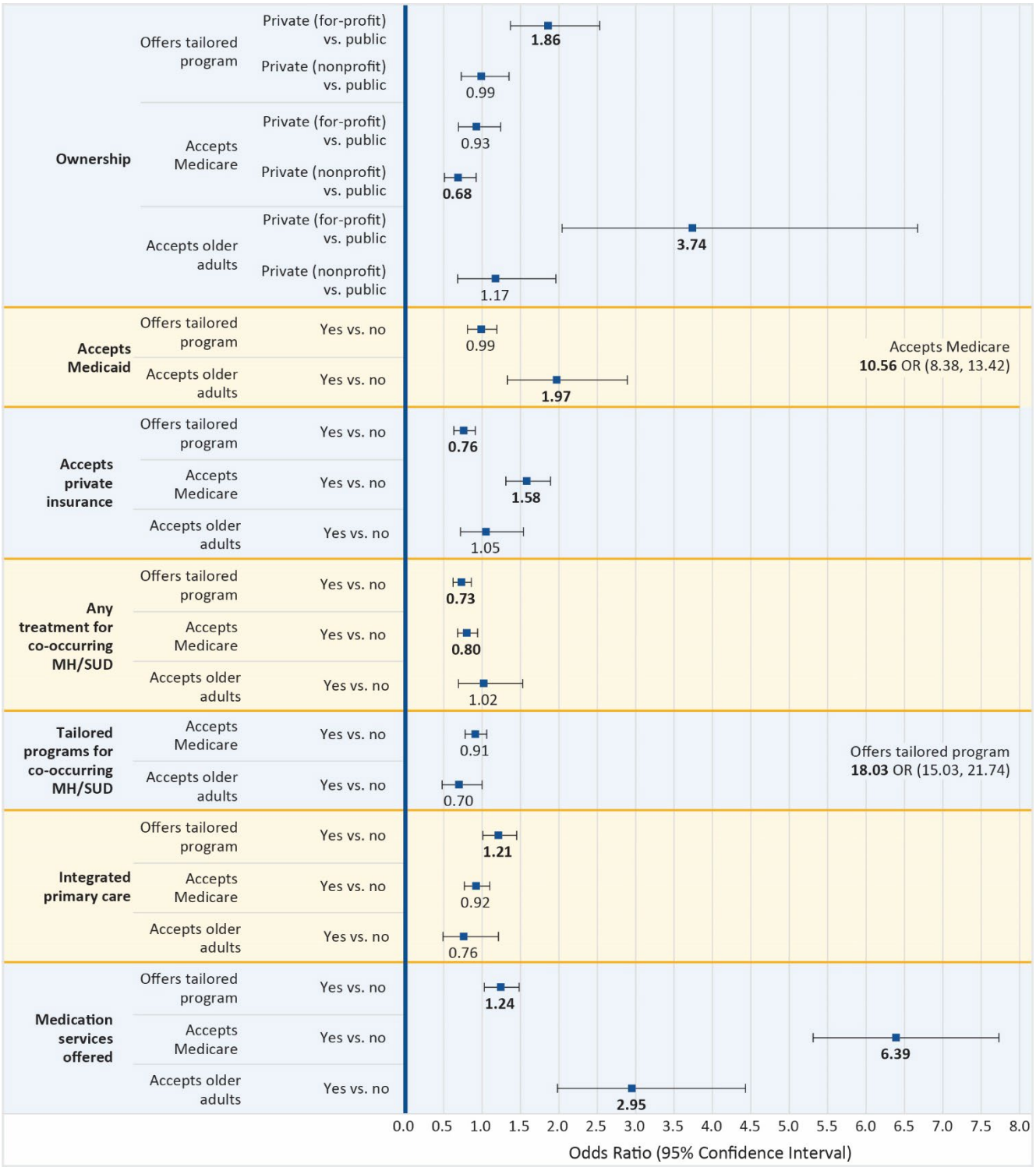


Source: Mathematica's analysis of N-SUMHSS 2023 data.

Note: This figure presents the adjusted odds ratios for three separate logistic regressions, each predicting a different measure of availability: offering tailored programs for older adults, accepting Medicare, and accepting older adults. The figure shows only key findings; bolded values indicate statistical significance (p<.05).

Odds ratios greater than 1.0 indicate that facilities with the characteristic listed had higher odds than those in the reference group to offer the measure of availability. Odds ratios of less than 1.0 indicate that facilities with the characteristic listed had lower odds than those in the reference group to offer the measure of availability.

Figure A-2. Substance use facility characteristics associated with each measure of availability

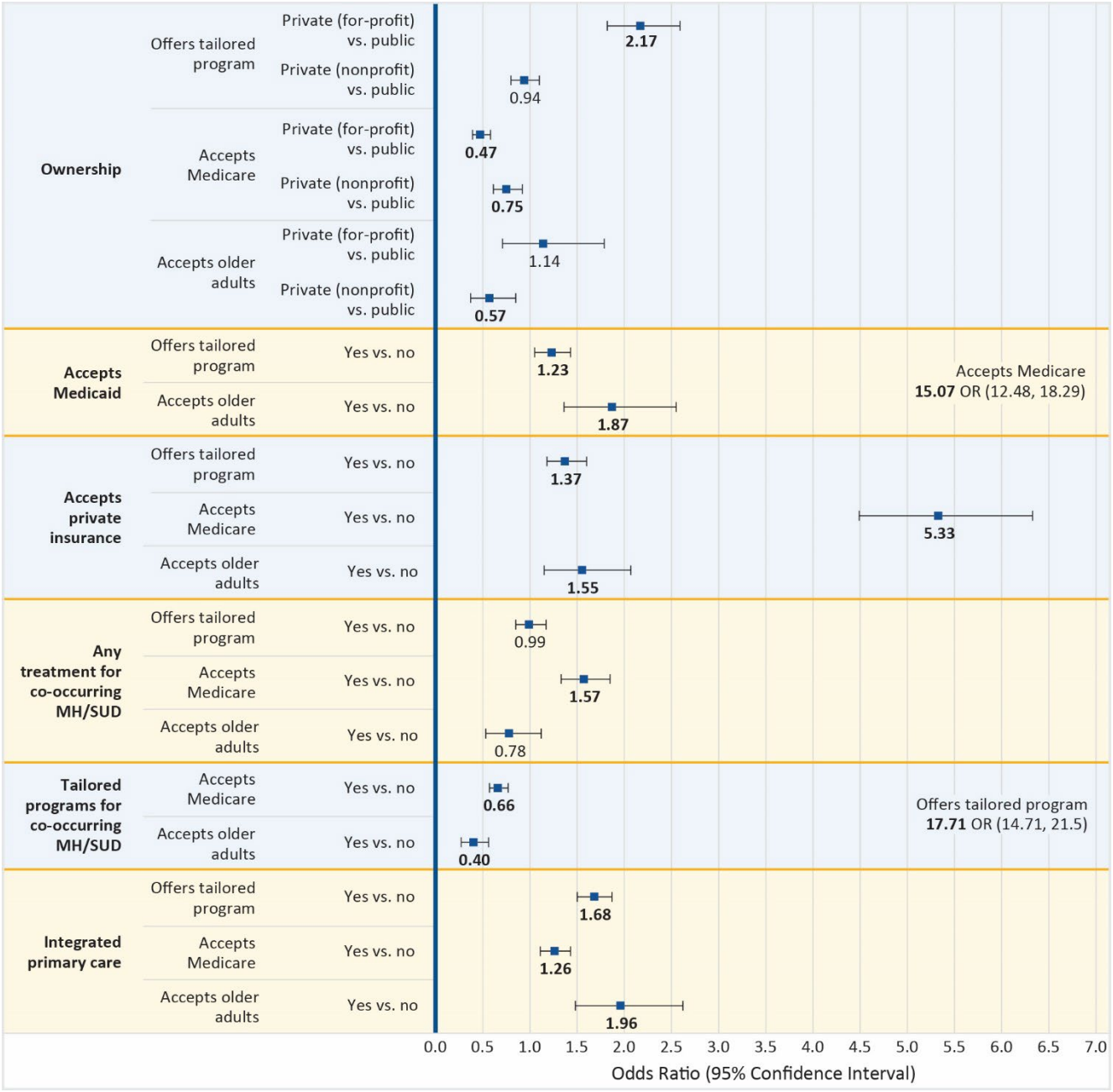


Source: Mathematica's analysis of N-SUMHSS 2023 data.

Note: This figure presents the adjusted odds ratios for three separate logistic regressions, each predicting a different measure of availability: offering tailored programs for older adults, accepting Medicare, and accepting older adults. The figure shows only key findings; bolded values indicate statistical significance (p<.05).

Odds ratios greater than 1.0 indicate that facilities with the characteristic listed had higher odds than those in the reference group to offer the measure of availability. Odds ratios of less than 1.0 indicate that facilities with the characteristic listed had lower odds than those in the reference group to offer the measure of availability.

Figure A-3. Mixed facility characteristics associated with each measure of availability



Source: Mathematica's analysis of N-SUMHSS 2023 data.

Note: This figure presents the adjusted odds ratios for three separate logistic regressions, each predicting a different measure of availability: offering tailored programs for older adults, accepting Medicare, and accepting older adults. The figure shows only key findings; bolded values indicate statistical significance (p<.05).
Odds ratios greater than 1.0 indicate that facilities with the characteristic listed had higher odds than those in the reference group to offer the measure of availability. Odds ratios of less than 1.0 indicate that facilities with the characteristic listed had lower odds than those in the reference group to offer the measure of availability.

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