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Expanding Access to Mental Health Counselors

Evaluation of the TRICARE Demonstration

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Summary

The U.S. Congress, in the National Defense Authorization Act (NDAA) for Fiscal Year 2001 (FY01),[1] specified a series of evaluation objectives in requiring a demonstration project designed to expand access to mental health services by easing restrictions on services provided by licensed or certified mental health counselors (LMHCs). The following list provides a preliminary summary of those objectives and RAND's findings on the evaluation.

Legislative-Directed Objectives of This Study and Findings

- **Describe the extent to which expenditures for LMHCs changed as a result of allowing independent practice.** Allowing for increased access to LMHCs had no measurable impact on expenditures for those who received care from LMHCs.
- **Provide data on utilization and reimbursement for non-physician mental health professionals**. Opening up access to LMHCs may have created a small substitution effect—that is, beneficiaries in the demonstration areas were less likely to see other non-physician mental health care providers, such as psychologists, social workers, and psychiatric nurse practitioners. Expenditures for care for those who sought care from non-physician mental health providers significantly increased in both the two demonstration areas and three non-demonstration catchment areas.
- **Provide data on utilization and reimbursement for physicians who make referrals to and supervise LMHCs.** Removing the referral and supervision requirements significantly decreased the likelihood that beneficiaries in the demonstration areas would seek mental health care from a psychiatrist or non-psychiatric physician. There was also a decreased likelihood that beneficiaries in the demonstration areas would receive a psychotropic medication. Expenditures for mental health (MH) care for those who saw physicians increased in both the demonstration and non-demonstration areas, but only the increase for the non-demonstration, non-psychiatric physician group was significant.
- **Describe the administrative costs incurred as a result of documenting referral and supervision.** While difficult to quantify, the demonstration might have resulted in modest cost savings to LMHCs in terms of reduced time and administrative burden, as revealed from our interviews. However, any savings to TRICARE's managed care

[1] P.L. 106-398, approved October 30, 2000, 114 Stat. 1654.

support contractors (MCSCs)[2] depended on their baseline enforcement procedures regarding supervision and referral (which were minimal in some cases).

- **Describe the ways in which independent practice authority affects the confidentiality of mental health and substance abuse services for TRICARE beneficiaries**. There was no evidence that independent reimbursement of LMHCs had any impact on patient confidentiality, given that the requirements for supervision and referral do not impact or contradict the standards for confidentiality set forth by the Health Insurance Portability and Accountability Act (HIPAA) of 1996.
- **Describe the effect of changing reimbursement policies on the health and treatment of TRICARE beneficiaries**. Using our survey data, we found no effect on perceived access to mental health services, no effect on self-reported adherence to treatment, and no effect on self-reported mental health status. We found that survey respondents in the demonstration areas reported greater satisfaction with mental health services; however, it is not possible to assess whether the demonstration created the greater satisfaction or if it existed prior to the demonstration.
- **Describe the effect of DoD policies on the willingness of LMHCs to participate as health care providers in TRICARE**. Representatives from the American Counseling Association (ACA) and the American Mental Health Counselors Association (AMHCA) indicated that the practice authority for LMHCs was a disincentive or barrier to LMHCs' participation in the TRICARE network prior to the demonstration. LMHCs in the demonstration and non-demonstration areas said that they view the physician referral and supervision requirement as a potential barrier for patients rather than a source of administrative burden per se. In the demonstration areas, the change in practice authority may have been a motivator for network participation. Enrollment of LMHCs as networked providers increased slightly; however, there were no data to compare this increase with the enrollment of LMHCs in the non-demonstration areas.
- **Identify any policy requests or recommendation regarding LMHCs made by TRICARE plans or managed care organizations.** Based on interviews with representatives from TRICARE MCSCs and TRICARE staff, many MCSCs and TRICARE staff members believe that the adoption of formal standardized training and credentialing requirements could help to facilitate independent practice for LMHCs and could address any concerns about quality of care provided by LMHCs.

Study Background

TRICARE, the program through which beneficiaries of the military health system access health care services, provides coverage for most medically necessary mental health care delivered by qualified providers. The NDAA for FY01 required the Department of Defense (DoD) to conduct a demonstration project involving expanded access under TRICARE to a

[2] At the time of this study, TRICARE benefits and coverage policies were implemented through MCSCs (managed care companies under contract with TRICARE to manage and implement TRICARE). They cover 12 geographical regions within the United States.

particular type of mental health service provider—the licensed or certified mental health counselor.

Currently, LMHCs must meet several eligibility and administrative requirements to serve as authorized TRICARE providers. The administrative requirements include documentation of a referral from a physician for each new clinical case and ongoing physician supervision of LMHC services. According to the NDAA, the Secretary of Defense was to conduct a demonstration under which LMHCs who meet eligibility requirements for providers under the TRICARE program may provide services to covered beneficiaries under Title 10 of the U.S. Code without referral by physicians or adherence to existing supervision requirements.

When stipulating the parameters of the demonstration, Congress also required DoD to conduct an evaluation of the demonstration's impact on the utilization, costs, and outcomes of health care services. DoD requested RAND to conduct this evaluation and supply the analyses needed to respond to the evaluation objectives set forth by Congress. This report describes and presents findings from RAND's evaluation.

Under TRICARE, several provider groups are authorized to provide mental health services to beneficiaries, assuming that the individual providers meet eligibility requirements established by TRICARE. The eligible provider groups include physicians, clinical psychologists, clinical social workers, psychiatric nurse specialists, marriage and family therapists, pastoral counselors, and LMHCs. For each provider group, TRICARE stipulates minimum certification or licensure requirements that are relevant to the provider's profession (see *TRICARE Policy Manual 6010.54,* 2002).

As stated above, to be a TRICARE authorized provider, an LMHC must meet several eligibility criteria with respect to training and administrative requirements for his or her practice. The administrative requirements for an LMHC to practice under TRICARE include documentation of a referral from a physician and ongoing supervision of the LMHC's services by a physician. However, services provided by other mental health professionals, including licensed clinical social workers, clinical psychologists, and psychiatric nurse specialists, are currently reimbursed independent of referral or supervision by a physician. TRICARE placed the additional eligibility requirements on LMHCs because of concerns stemming from the lack of nationwide certification standards for this group of mental health professionals.

The professional organizations that represent LMHCs have expressed their concern to the TRICARE Management Activity (TMA; the office within DoD charged with managing TRICARE) and Congress that the eligibility and practice restrictions placed on LMHCs by TRICARE may unduly restrict access to care or may lead potential clients to avoid seeking needed care.

The Demonstration Project

TMA chose to conduct the demonstration project in the Colorado Springs (Ft. Carson and U.S. Air Force Academy) and Omaha (Offutt Air Force Base [AFB]) catchment areas within the TRICARE Central Region. TMA chose these areas because their high volume of LMHCs would ensure ample providers for the demonstration. For purposes of comparison, three non-demonstration catchment areas were chosen: Wright Patterson AFB, Luke AFB, and Ft. Hood. Similar data were collected for beneficiaries in both the demonstration and non-demonstration areas.

Beginning in 2002, Merit-Magellan Behavioral Health, the managed behavioral health care carve-out company for TRIWest Healthcare Alliance,[3] worked collaboratively with TMA to design and implement the demonstration. To advertise the demonstration opportunity, TriWest used a mass mailing to approximately 230 LMHCs who practiced in these areas. LMHCs were informed that by participating in the demonstration, they were eligible to treat TRICARE beneficiaries, over the age of 18 years, without referral or supervision from a physician. To participate, LMHCs were required to sign and return a document titled "Participation Agreement for the TRICARE Expanded Access to Mental Health Counselors Demonstration Project." By signing the participation agreement, counselors agreed to collect a TRICARE Mental Health Counselor Demonstration Project Informed Consent Form (see Appendix A) from each TRICARE patient seen during the demonstration. TRIWest began enrolling LMHCs into the demonstration in late 2002 in preparation for a January 1, 2003, start date. The total number of LMHCs who participated in the demonstration was 123. The relatively low participation rate (55 percent of those who received the mailing) was likely due to the use of only one mass mailing as a means of advertisement.

Evaluation Methods

Our evaluation was guided by a set of general hypotheses based on Avedis Donabedian's model of structure, process, and outcomes of health care (Donabedian, 1980). Accordingly, we expected that the demonstration, which allowed for independent practice by LMHCs, might affect beneficiaries and providers in the following ways: increased access to care delivered by LMHCs (as measured by the percentage of eligible beneficiaries who receive care from LMHCs), higher utilization of mental health services among the eligible beneficiary population in the demonstration areas, decreased total costs of mental health care, and either increased or decreased quality of care.

In the context of this conceptual framework and the evaluation objectives defined by Congress, the purpose of our evaluation analyses was to examine and compare utilization, costs of care, and outcomes for adult beneficiaries receiving mental health services from LMHCs and compare those findings to the findings on beneficiaries seeking services from other mental health providers (including physicians, clinical psychologists, clinical social workers, and others).

To assess the extent to which independent reimbursement of LMHCs affected service utilization, reimbursement costs, and treatment processes, we conducted *secondary analyses of service claims for covered beneficiaries* who received services from mental health providers. These analyses employed a pre-post intervention evaluation methodology that allowed for the identification of any changes over the one-year implementation period among covered beneficiaries in the demonstration catchment areas versus those in the non-demonstration catchment areas.

To assess the impact on treatment and clinical outcomes, we collected and analyzed *primary survey data from a sample of beneficiaries* who received mental health services in the demonstration areas as well as the non-demonstration control areas. These analyses were limited by the requested cross-sectional design; thus, they allow for comparisons between re-

[3] TriWest Healthcare Alliance is a management service organization and DoD MCSC. It is one of several private organizations that administer the TRICARE program in various regions of the United States and abroad (see Triwest.com). It is the MCSC responsible for the TRICARE network in the demonstration areas.

spondents in the demonstration areas and respondents in the non-demonstration catchment areas one year post-implementation, but they do not allow for a pre-post evaluation.

We also used *semi-structured qualitative interviewing* techniques to gather relevant information from mental health care providers and MCSCs before and after the implementation of the expanded access demonstration. We used these techniques to determine the administrative costs associated with the documentation of referral and supervision and to assess the impact of independent reimbursement (provided by the demonstration) on a provider's willingness to participate in TRICARE.

We aimed to use both qualitative and quantitative data for this evaluation for several reasons. The type and source of data were typically driven by the nature of the evaluation question and our knowledge of the available and accessible data for responding. We provide additional details on our methodology in Appendix B.

Challenges Associated with the Evaluation

In late 2002, as DoD moved forward with efforts to implement this demonstration and we developed our evaluation strategy, the United States began major deployments in preparation for Operation Iraqi Freedom. At the same time, military personnel were still deployed in Afghanistan for Operation Enduring Freedom. Major combat operations in Iraq began in spring 2003, just as the expanded access demonstration was getting under way. Both the demonstration catchment areas as well as the non-demonstration areas include military installations with deployable forces, both active duty as well as reserve components. While detailed data about the number of personnel deployed from these areas were not available to us, forces were deployed from both the non-demonstration and the demonstration areas during the course of this study.

In an attempt to examine the potential impact of the Iraq war on mental health service needs and utilization, we included items on the beneficiaries' survey that were aimed at eliciting information relevant to this issue. We then aimed to use those data in our multivariable models to examine differences in self-reported mental health care need, barriers to access, and service utilization between respondents in the demonstration and non-demonstration areas. Because the survey data could not be linked to the administrative claims data, and because there were no comparable administrative data available to us to indicate whether a particular beneficiary had a deployed family member or close friend, we could not examine or control for the impact of the war in the administrative analyses of utilization and costs. Therefore, we offer caution here and again with describing the results that any increases in utilization and costs observed between the pre- and post period in either the demonstration areas or non-demonstration areas could be a consequence of the war in Iraq and not just the demonstration.

Study Results

The Beneficiary Population

Overall, the survey respondent sample was evenly distributed across age groups (14 percent to 23 percent per age group) and was predominantly female (82 percent). Nearly a third had a college education (27 percent), 81 percent were white, and 10 percent were African-American. The majority of the survey respondents were U.S. born (89 percent) and had

children (80 percent). Of those with children, 24 percent reported that their children had also received mental health counseling in the past six months. Only 12 percent lived alone, and about half (44.9 percent) were currently working. A fifth of the survey respondents (20 percent) reported that they were not currently working due to health problems. Several demographic differences were noted between the demonstration and non-demonstration respondent populations: Respondents in the demonstration areas were younger, more likely to be college educated, less likely to be African-American and more likely to be white, less likely to live alone, and more likely to be currently working compared with beneficiaries in the non-demonstration areas. It should be noted that these differences exist among beneficiaries who use mental health (MH) services as well as those who do not, and likely reflect the differences associated with these catchment areas. For example, the student population at the U.S. Air Force Academy would likely influence the age distribution in the demonstration areas that includes that catchment area. Several differences were also noted in use of mental health services. Few beneficiaries in the study areas reported awareness of the demonstration.

Beneficiary Outcomes

Little effect of the demonstration was observed on beneficiary outcomes. With two exceptions, no differences by demonstration area were found in measures of access to mental health services, adherence to treatment, or mental health status: Beneficiaries living in the demonstration areas (regardless of MH provider type) had a 36 percent greater chance of reporting emotional problems that affected their functioning, but a 32 percent lower likelihood of reporting that they had received counseling from a mental health provider in the past six months.

A number of differences between the demonstration and non-demonstration areas were found on Health Plan Employer Data and Information Set (HEDIS) indicators[4] of mental health services. Being in the demonstration areas was associated with greater odds of favorably rating counseling and treatment, a greater chance of reporting an ability to "usually or always" get urgent treatment as soon as needed, greater odds of being able to "usually or always" get an appointment as soon as desired, a greater chance of reporting the ability to get help by telephone, and a lower risk of never having to wait 15 minutes or more to see a clinician.

Other factors associated with access to mental health care include age group, perceived barriers to care, a perceived on-the-job stigma from receiving care, and whether a close relative or acquaintance of the beneficiary was deployed to the war in Iraq. Beneficiaries under the age of 25 and those who perceived that seeking care would cause them to be stigmatized at the workplace were less likely to report seeking mental health services. Those who perceived that a stigma from seeking care was a barrier to care were more likely to be taking a prescription medication for a mental health problem. Deployment of a friend or relative was associated with a higher likelihood of receiving counseling from a mental health provider and a lower likelihood of receiving prescription medications for a mental health problem.

Patient confidentiality did not appear to be affected in any way by the demonstration, based on the findings from the beneficiary surveys and provider interviews.

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[4] This set of indicators is used to rate the quality of services provided by health plans and providers.

Impact on Providers

Interviews with LMHCs were conducted prior to and following the demonstration to assess their attitudes toward the administrative burden of the referral and supervision requirements and their perceptions of the impact of those requirements on beneficiary access to services. Prior to the demonstration, LMHCs tended to regard the referral requirements as a discriminatory policy that reduced access to their services, rather than as a source of administrative burden or increased practice costs. After the demonstration, participating counselors noted that the demonstration had reduced the time needed to obtain referrals. The theme that emerged from the interviews regarding supervision was that baseline supervision practices under TRICARE are highly varied, that some counselors are deeply committed to obtaining supervision regardless of TRICARE's requirements, and that compliance with the supervision requirement was more of a formality than a valuable exercise. Follow-up interviews with providers revealed that removal of the supervision requirement during the demonstration was not perceived as having a major effect on their practice.

Changes in perceptions of professional roles and activities were also assessed. Following the demonstration, LMHCs indicated no demonstration-related changes in their professional roles and activities, apart from reducing the administrative time they spend seeking physician referrals. The primary effect of the demonstration, as perceived by LMHCs, was facilitated access to treatment for TRICARE beneficiaries. The perceptions of other types of MH providers regarding supervision and the scope of LMHC functions were mixed.

Demonstration enrollment records showed that the number of LMHCs who participated in the demonstration increased during the first few months of the demonstration but leveled out during the middle of the demonstration period (likely due to the fact that TMA relied on just the single mailing to advertise the demonstration opportunity). During the demonstration period, the number of LMHCs who enrolled in the TRICARE network increased steadily and modestly in both demonstration areas. Unfortunately, no data were available on the number of enrolled LMHCs in the non-demonstration areas. Thus, it was not possible to assess the role of the demonstration on TRICARE network enrollment.

Impact on TRICARE

The study assessed changes in utilization of mental health services over the demonstration period and endeavored to quantify administrative costs associated with those changes. While controlling for differences in the demonstration and non-demonstration populations, beneficiaries in the demonstration areas were significantly less likely in the post-demonstration period to see a mental health provider other than an LMHC or a psychiatrist, were less likely to see a non-psychiatric physician (such as a primary care physician) for mental health care, and were more likely to have an inpatient psychiatric hospitalization. In addition, we found that those who saw LMHCs in the demonstration areas were significantly less likely to see a psychiatrist or to receive a prescription for a psychotropic medication than those seeing LMHCs in the non-demonstration areas. Based on the administrative nature of the data used to identify these changes, which generally lack clinical information about symptom severity, it was not possible to determine whether the lesser likelihood of seeing a psychiatrist or receiving a psychotropic medication had any clinical significance for this population. That is, it is not possible to determine whether a beneficiary's clinical condition warranted his or her receiving medication and/or psychiatric treatment; however, as a result of the demonstration, there was a lesser likelihood of beneficiaries receiving such treatment.

Changes in patient costs associated with the changes in service utilization were minimal. Attempts to quantify administrative costs associated with referral and supervision and the impact of changes in these policies raised the question of the source of such costs and who, in fact, bears the costs. Costs associated with paperwork would be expected to fall on LMHCs, whereas costs associated with supervision would be expected to fall on the supervising physician; however, neither can be billed to TRICARE. Yet another potential administrative cost associated with supervision and referral is the cost generated from greater demand for and utilization of higher-cost mental health providers, which may result from disincentives to seeking care from LMHCs. To assess the burden of administrative costs to TRICARE, the researchers interviewed representatives from the managed care support contractors (MCSCs) that administered benefits for the demonstration and non-demonstration areas. The consistent theme that emerged from these interviews was that the advantage of the demonstration was not in reducing administrative costs to MCSCs but in increasing access to therapy services for TRICARE beneficiaries. The likelihood that barriers to seeking services from LMHCs would lead beneficiaries to seek care from other, potentially more costly, providers was cited.

Regarding the issue of quality of care, the MCSCs were asked to assess the potential effect on quality of allowing LMHCs greater autonomy. While respondents were divided on whether quality of care might be affected, they agreed that improving credentialing standards for LMHCs, such as through the use of a standardized curriculum, would be a more effective way to promote quality of care and safeguard beneficiaries who seek mental health care.

Conclusions

In summary, our evaluation of the DoD Mental Health Counselor Demonstration for expanded access to mental health counselors under TRICARE found that the demonstration had minimal impact with respect to the variety of outcomes studied here. There were no key effects on expenditures, reimbursement, administrative costs, or patient confidentiality. While we did see increases in utilization and costs for mental health care over the demonstration period, these increases could not be attributed to allowing independent practice authority. Using the administrative data, we found evidence suggesting that the demonstration did affect the type of providers from whom beneficiaries sought mental health care and the likelihood of beneficiaries receiving a psychotropic medication. After controlling for differences in the characteristics of those who see LMHCs, our results revealed a significant decrease in the likelihood of beneficiaries seeing a psychiatrist and a decrease in the likelihood of their receiving a psychotropic drug in the demonstration areas. However, based on administrative data alone, it is not possible to determine whether these changes had a clinically significant impact on beneficiaries.

Where we did observe changes in ratings of satisfaction related to the demonstration, the results were mostly positive. According to self-reported survey data from beneficiaries, those living in the demonstration areas had higher ratings of mental health services.

The effects on administrative costs associated with the requirements for LMHCs were also unclear. From our interviews with LMHCs and other MH providers, it is apparent that supervision and referral were not that onerous to begin with and that any administrative costs associated with the requirements were in fact minimal at the outset. Taken as a whole,

our findings suggest that the impact on beneficiaries, providers, and the TRICARE program from expanding access to LMHCs for providers and beneficiaries was minimal.

Interviews with representatives from two of the national counseling associations we surveyed revealed that removal of the referral and supervision requirements for LMHCs remains a top legislative agenda item. Although the ACA and AMHCA have been able to garner the support of some beneficiary advocacy groups, neither the Senate nor House Armed Services Committee staff members whom we interviewed for this study indicated that any other official requests for policy changes had been submitted by beneficiary groups during the most recent session of Congress.

Table S.1 summarizes the key findings and implications for each of the nine legislative objectives for this evaluation that were mandated by Congress. The findings from this demonstration are important in that they show that merely lifting administrative requirements for the provision of mental health care, by itself, is unlikely to result in expanded access and utilization, especially when beneficiaries already have access to other types of mental health providers who do not have the same administrative requirements as the LMHCs but can provide many similar services. Therefore, if the motivation of this demonstration was to reduce the stigma associated with seeking mental health care and to expand access to mental health care services for the military beneficiary population, our findings suggest that efforts in that direction need to go beyond merely lifting the administrative requirements on LMHCs.

Table S.1
Summary of Evaluation Findings and Implications for Each Legislative Objective

Legislation Objective	Key Findings	Implications
1. Describe the extent to which expenditures for LMHCs changed as a result of allowing independent practice	Controlling for beneficiary characteristics, there was no significant change in expenditures for inpatient and outpatient care among the eligible population or among those seeing LMHCs.[a]	Allowing for increased access to LMHCs had no measurable impact on expenditures for mental health services for those who received care from LMHCs.
2. Provide data on utilization and reimbursement for non-physician MH professionals	Among those MH users in the other mental health (OMH) provider group, the mean number of visits increased in both the demonstration and non-demonstration areas.[a] For those in the OMH group, total expenditures for MH care increased in both the demonstration and non-demonstration areas. Comparing the changes pre- and post-demonstration and demonstration versus non-demonstration, we found a decrease in the likelihood of beneficiaries seeing an OMH provider in the demonstration areas.	Opening up access to LMHCs may have created a substitution effect—that is, beneficiaries were less likely to see other non-physician mental health providers, such as psychologists, social workers, and psychiatric nurse practitioners.
3. Provide data on utilization and reimbursement for physicians who make referrals to and supervise LMHCs	Among those MH users in the group of users who saw a psychiatrist, there were no significant changes in the mean number of outpatient MH visits in the demonstration areas or the non-demonstration areas.[a] For those MH users in the non-psychiatrist physician group, there was a statistically significant increase in the mean number of outpatient visits in the non-demonstration areas but not the demonstration areas.[a] Mean expenditures for MH care among MH users in the psychiatrist and other physician groups increased from pre-demonstration to post-demonstration in both the demonstration and non-demonstration areas, but only the increase in the non-psychiatrist "other" physician group in the non-demonstration physician area was statistically significant. Comparing the changes pre- versus post-demonstration and demonstration versus non-demonstration, we found a significant decrease in the likelihood of beneficiaries seeing a physician (psychiatrist or other physician) for MH care in the demonstration areas.	Removing the referral and supervision requirements significantly decreased the likelihood that beneficiaries would get MH care from a physician (psychiatrist or other physician) and, as such, decreased the likelihood that they would also get a psychotropic medication to treat their mental illness.
4. Describe administrative costs incurred as a result of documenting referral and supervision	According to the LMHCs we interviewed, eliminating the physician referral requirement saves time previously spent in telephone consultations to obtain supervision, confirm referrals, and authorize therapy.	The demonstration probably resulted in modest cost savings to LMHCs in terms of time and administrative burden. Any savings to MCSCs depended on their baseline enforcement procedures regarding supervision and referral (which was minimal in some cases).

Table S.1—Continued

Legislation Objective	Key Findings	Implications
5. Compare effect for items outlined in objectives one through four, over one year (pre-post) in the demonstration areas as compared with non-demonstration areas [b]	All findings listed above are based on analyses that compared data gathered from one year prior to the demonstration with data gathered one year following the demonstration in both the demonstration and non-demonstration areas.	Not applicable
6. Describe the ways in which independent practice affects the confidentiality of MH and substance abuse services for TRICARE beneficiaries	There was no evidence that eliminating the referral and supervision requirements would change the standards for confidentiality.	Independent reimbursement of LMHCs would have no impact on confidentiality.
7. Describe the effect of changing reimbursement policies on the health and treatment of TRICARE beneficiaries	There was no effect on perceived access to MH services. There was no effect on self-reported adherence to MH treatment. There was no effect on self-reported MH status. There was a potential positive effect on HEDIS ratings of mental health services; however, positive ratings may have also been evident prior to the demonstration.	Increased access to LMHCs had no adverse effect on TRICARE beneficiaries and may be associated with greater satisfaction with MH services.
8. Describe the effect of DoD policies on the willingness of LMHCs to participate as health care providers in TRICARE	Lack of independent practice authority for LMHCs was viewed as a disincentive or barrier to participation prior to the demonstration. Demonstration participation increased initially and leveled off around the middle of the demonstration period. Enrollment of LMHCs as TRICARE network providers increased during the demonstration period, but this is not likely the result of the changing practice authority because this was a temporary demonstration.	The findings suggest that the demonstration may have been a motivator to network participation (although we have no data on network enrollment for the non-demonstration catchment areas during the same time period to use for comparison).
9. Identify any policy requests or recommendations regarding LMHCs made by TRICARE plans or managed care organizations	Removal of the referral and supervision requirements for LMHCs remains a top legislative priority for the ACA and AMHCA. According to MCSC representatives, quality concerns could be addressed by development of appropriate and standardized credentialing mechanisms.	Adoption of formal credentialing standards could help to facilitate independent practice for counselors in states with rigorous licensing, while helping to promote the implementation of similar standards elsewhere.

[a]We created hierarchical groups of users by provider type to compare differences in the changes in users' utilization patterns (see Chapter Five).

[b]Item 5 was included in the legislation as a means of describing the methods to be used for responding to objectives 1 through 4. Although it is not included as an objective in the bulleted list at the top of this summary, we include it here for consistency with the legislation.