Are Physical and Behavioral Health Services More Available at Nonprofit or For-Profit Treatment Facilities?

Victoria Lynch, Maya Payton, and Lisa Clemans-Cope

December 2024

Summary

The services provided by behavioral health treatment facilities are essential in addressing the ongoing behavioral health crisis in the United States. These facilities offer various levels of care, including inpatient, residential, partial hospitalization, intensive outpatient, and other outpatient services for individuals with substance use disorders (SUDs) or mental health conditions. Co-occurring physical health conditions are common among individuals with a behavioral health condition, and these individuals experience higher morbidity and mortality, underlining the importance of comprehensive health services availability at behavioral health facilities. Understanding how behavioral health facilities differ in providing physical and behavioral health services by ownership type could be key to improving care delivery because evidence shows for-profits tend to offer lower quality, less accessible, and a more restricted range of services compared with nonprofits. Differences in services offered may influence outcomes, which is especially likely for individuals with co-occurring behavioral and physical conditions, given the broader range of health services they need. However, little is known about how services differ across nonprofit and for-profit behavioral health facilities and whether facilities structured to serve underserved populations are more likely to offer needed services for people with co-occurring physical and behavioral health conditions.

This descriptive study of behavioral health facilities in Michigan, New Mexico, Virginia, and all other states combined examines differences in services offered by for-profits and the large subset of nonprofits that explicitly focus on the underserved because they offer low-cost care. These states were selected for their geographic diversity, public policy emphasis on behavioral health, and because they are part of a larger ongoing study evaluating behavioral health services across different health care settings. Focusing on these states within the broader context of all other states provides specific examples for understanding how service variations between for-profits and nonprofits may affect outcomes in diverse health care landscapes. The data comes from the 2022 National Substance Use and Mental Health Services Survey.[1]

Our key findings are the following:

- ***Nonprofits offering low-cost care represent the majority of behavioral health facilities*:** In 2022, nonprofits offering low-cost care (hereafter referred to as nonprofits) accounted for the majority of behavioral health facilities in Michigan, New Mexico, and Virginia, comprising between 50.7 and 75.6 percent of the total facilities. The remaining behavioral health facilities were primarily for-profit organizations.
- ***For-profit facilities primarily treat SUDs:*** For-profit behavioral health facilities were significantly more likely to primarily treat SUDs and not treat a mix of SUDs and mental health or primarily treat mental health. In New Mexico, 91.9 percent of for-profit facilities primarily treat SUDs, compared with 72.7 percent in Virginia, 74.1 percent in Michigan, and 76.4 percent in all other states. Nonprofits, in contrast, were generally more likely to treat a mix of SUDs and mental health or to primarily treat mental health.
- ***Nonprofits offering low-cost care are generally more likely than for-profits to:***
  - » **offer services in various languages:** Nonprofits were more likely to offer services in various languages. For example, 64 percent of these nonprofit facilities in New Mexico provided services in non-English languages, compared with just 38 percent of for-profit facilities.
  - » **provide metabolic monitoring and integrated primary care**: Nonprofits are more likely to offer integrated primary care services for addressing the general health care needs of individuals with behavioral health conditions, including care for the prevention and treatment of chronic illnesses like hypertension, diabetes, obesity, and cardiovascular disease. In Michigan, New Mexico, and Virginia, approximately 40 percent of nonprofit behavioral health facilities offered integrated behavioral health services, compared with roughly 20 percent or less of for-profit facilities. Nonprofits were about three times more likely to offer metabolic syndrome monitoring in Michigan and New Mexico, and they had substantially higher rates than for-profits in Virginia and all other states combined.
  - » **provide tobacco cessation support**: Approximately 70 percent of nonprofits provided tobacco use screening and smoking cessation counseling. This is notably higher than in for-profit facilities, where only 55 percent offered these services. Nonprofit facilities also had higher rates of offering nicotine replacement therapy, particularly in Virginia, where 40.8 percent of nonprofits offered it, compared with 18.5 percent among for-profit facilities. In

Michigan, 67.4 percent of nonprofits offered cessation services compared with 48.1 percent among for-profits.

» **offer comprehensive mental health assessments and suicide prevention services:** Among facilities that primarily treat SUDs or a mix of SUDs and mental health, nonprofits were more likely to offer comprehensive mental health assessments and suicide prevention services. In Michigan, 62.4 percent of these nonprofits offered mental health assessments, compared with 43.8 percent of for-profits, and 56.2 percent of these nonprofits offered suicide prevention services, compared with 32.0 percent of for-profits. This trend was consistent across New Mexico, Virginia, and other states.

Background

Studying the services offered by behavioral health treatment facilities is essential for identifying and addressing gaps in care, particularly for underserved populations, including individuals with co-occurring physical and behavioral health conditions, as the number and characteristics of these facilities evolve. Behavioral health treatment facilities in the US provide critical services from inpatient and residential care to partial hospitalization, intensive outpatient, and other outpatient services for people with SUDs and mental health conditions. About half of people in the US treated for SUDs receive care in a SUD treatment facility (Lipari and Park-Lee 2019). For people with mental health conditions, care from facilities that offer inpatient and residential care has dramatically dropped over the last decades, but care from facilities that offer outpatient care has increased and is in high demand (Olfson et al. 2019; Sun et al. 2023; APA 2020).

The ownership structure of behavioral health facilities has shifted in recent years, including with increases in private equity ownership, a type of for-profit ownership that involves specialized investment funds and limited partnerships sharing ownership and taking an active role in the structuring and management of the behavioral health facility (Zhu et al. 2024). This rise in for-profit private equity ownership is likely driven by legislation expanding coverage of behavioral health services, consolidation of providers, increased demand for behavioral health services (Zhu et al. 2024), and expanded insurance coverage.[2] There is also evidence that the ownership structure of behavioral health facilities has shifted to include more nonprofits offering low-cost care. The number and reach of Federally Qualified Health Centers (FQHCs) and other nonprofit community health care centers offering free or low-cost care, including for behavioral health conditions, have steadily increased over the past decade. For example, the number of FQHC sites grew from 6,949 in 2010 to 14,987 in 2022, nearly doubling the reach of these centers.[3]

Substantial variation exists in behavioral health facilities' characteristics and services offered and is particularly relevant for underserved populations who often face greater challenges in accessing care—especially individuals with a behavioral health condition and another co-occurring condition (Saunders and Euhus 2024; Lynch, Payton, and Clemans-Cope 2024; Thomas et al. 2023; Anderson et al. 2021). Co-occurring physical health conditions are common among individuals with behavioral health conditions, with, for example, 40 percent of Virginia Medicaid enrollees with an SUD having a co-

occurring physical health condition (Cunningham et al. 2021). Individuals with co-occurring behavioral and physical health conditions are at risk of inadequate care and have higher rates of mortality, with evidence suggesting that physical health conditions often drive mortality (Wittenberg et al. 2021; Pizzol et al. 2023). For example, people with psychiatric disorders have a greater risk of premature mortality, largely stemming from cardiovascular disease (Penninx and Lange 2018). Moreover, studies indicate that for-profit health care facilities may offer a more costly or narrow range of services, potentially making it harder for patients with co-occurring conditions to receive needed health care (Cabin et al. 2014; Dalton and Bradford 2019; Carlson, Gallo, and Bradley 2004; Marsteller, Bovbjerg, and Nichols 1998). However, a mix of nonprofit and for-profit facilities might provide a more diverse range of services for a community, as the variation in types of services each ownership type offers can complement each other and give patients more treatment options.

In the limited body of literature comparing the services offered by for-profit and nonprofit behavioral health facilities, more recent studies find that nonprofit facilities are more likely to offer comprehensive care, including suicide prevention programs, the behavioral health crisis care services best practices in the Substance Abuse and Mental Health Services Administration's (SAMHSA) guidelines, and psychiatric walk-in or crisis services (Nahra, Alexander, and Pollack 2009; Wheeler and Nahra 2000; Hung et al. 2021; Burns et al. 2023; Kalb et al. 2022; Rodgers and Barnett 2000; Bachhuber, Southern, and Cunningham 2014). However, apart from the Bachhuber, Southern, and Cunningham (2014) study focused on opioid treatment programs, we found no recent studies that focus on how well for-profit and nonprofit behavioral health facilities meet the needs of patients with co-occurring behavioral and physical health conditions, and none that specifically focus on nonprofits offering low-cost care for underserved populations.

Individuals with co-occurring behavioral and physical health conditions experience significantly higher morbidity and mortality (Watkins et al. 2016; Iturralde et al. 2021), making integrated and co-located physical and behavioral health services particularly important. Fragmented health care, where these services are siloed, often leads to poor health outcomes, including preventable hospitalizations and increased mortality (Knickman, Krishnan, and Pincus 2016; Kern et al. 2018). Research suggests that chronic physical conditions, such as tobacco use disorder, heart disease, diabetes, and metabolic syndrome, are common among individuals with behavioral health conditions, and inadequate management of these physical health issues contributes to their high mortality rates (Damian and Gallo 2018; Damazo 2021). Addressing these conditions requires a holistic approach that ensures behavioral health treatment facilities also provide essential physical health services, such as screening and treatment for tobacco use disorder, metabolic monitoring, and communicable disease screening.

This study seeks to address these research gaps by identifying the distribution of for-profit and nonprofit behavioral health facilities, focusing on nonprofits offering low-cost care, and comparing the services they offer that are important for patients with co-occurring behavioral health and physical health conditions. Given high levels of tobacco and nicotine use disorder, metabolic syndrome, communicable diseases, and other physical health issues experienced by people with behavioral health conditions (Das-Munshi et al. 2020; Sud et al. 2021; Butler, Rehm, and Fischer 2017; O'Grady et al.

2024), this study examines the extent to which nonprofits and for-profit behavioral health facilities offer services such as testing for communicable diseases, screening and treatment for tobacco use disorder, integrated primary care, and metabolic syndrome monitoring. We also examine variations in the type of behavioral health services offered, the setting in which services are offered, and the languages in which services are offered.

First, we provide a detailed description of the data and methodology used for the analysis. Next, we present findings on the differences in service offerings across nonprofit and for-profit facilities. Finally, we discuss the implications of these findings for policy and practice, particularly in improving access to whole-person care for individuals with co-occurring physical and behavioral health conditions.

Data and Methods

This study uses data from the 2022 National Substance Use and Mental Health Services Survey (N-SUMHSS), conducted annually by SAMHSA. This survey provides data on the characteristics of SUD and mental health treatment facilities nationwide.[4]

BOX 1

Types of Behavioral Health Facilities Included in the 2022 N-SUMHSS

- Federally Qualified Health Centers, Community Mental Health Centers, and Certified Community Behavioral Health Clinics
- Other outpatient facilities
- Psychiatric hospitals
- Inpatient substance use and psychiatric units in a general hospital
- State hospitals
- Veterans Affairs medical centers or other health care facilities
- Partial hospitalization or day treatment facilities
- Residential treatment centers
- Multisetting mental health facilities (e.g., nonhospital residential plus other outpatient)

Source: National Substance Use and Mental Health Services Survey (N-SUMHSS) 2022 codebook.
Notes: The above list does not include all behavioral health facility types listed in the 2022 N-SUMHSS. There is also an "other" category that includes other facilities not defined above.

The N-SUMHSS, a point-prevalence survey, provides a snapshot of the services offered by these facilities on March 31, 2022, and may not reflect the facility activities and characteristics over the year. A total of 14,854 eligible facilities that primarily treat SUDs or treat a mix of SUDs and mental health and 9,586 eligible facilities that primarily treat mental health or are the same subset that treat a mix of

SUDs and mental health responded to the survey, yielding an overall response rate of 88 percent. The N-SUMHSS excludes jails and prisons, Department of Defense treatment facilities, and individual and small-group providers in practices not licensed or certified SUD or mental health treatment centers. We focus on mean estimates, assuming the survey respondents represent the larger population of treatment facilities, and no adjustments were made for nonresponse.

The analysis centers on behavioral health treatment facilities in three Medicaid expansion states, Michigan, New Mexico, and Virginia, because Medicaid expansion has played a significant role in improving access to behavioral health services for low-income, underserved individuals. These states were selected not only for their geographic and demographic diversity but also for their innovative efforts to expand and improve access to behavioral health care through Medicaid, which has helped increase health care coverage for low-income individuals and provided critical funding for facilities offering mental health and substance use disorder services. Project collaborators from Georgetown's Center on Health Insurance Reforms are conducting qualitative research in Michigan, New Mexico, and Virginia to evaluate federal and state efforts to expand the behavioral health system capacity in underserved areas. Issues explored will include efforts to boost capacity at existing facilities, barriers to creating new sites of care, and the impact of the Certified Community Behavioral Health Clinic (CCBHC) demonstration project on system capacity.[5] In this brief, we also examined results for all other states and the District of Columbia combined (hereafter referred to as all other states). We calculated state-level proportion estimates by dividing counts of facilities that indicated 'yes' to a binary questionnaire item by the total number of facilities in a state or the 'all other states' category. Analyses were performed in Stata 18.

Key Variables

We examined several key variables to describe the characteristics of services offered by for-profit and nonprofit behavioral health facilities in the US.

- Services offered were examined separately by type of ownership, with a focus on for-profit facilities compared with nonprofit facilities. For-profit facilities were defined as those reported to be "private for-profit organizations," including those that reported government funding. Nonprofits offering low-cost care were defined as federal, state, tribal, or local government-operated facilities, FQHCs, CCBHCs, CMHCs, and other nonprofits that offered a sliding fee scale, treatment at no or minimal charge, or free treatment to all clients, or received government funding.[6] Other nonprofits were defined as all other nonprofits.
- Facility characteristics were examined by computing the share of nonprofit facilities that are FQHCs, CCBHs, or CMHCs because these entities explicitly focus on the underserved, and CMHCs and FQHCs have comprehensive service requirements.[7] We also examined the share of for-profit and nonprofit facilities that offered outpatient, residential, and inpatient services.
- We separately computed the proportion of facilities that reported offering the following services (survey terminology in quotes):

- **testing for communicable infections:** The N-SUMHSS asks whether facilities offer onsite testing for hepatitis B virus ("HBV"), hepatitis C virus ("HCV"), "HIV," and sexually transmitted disease ("STD") testing, also commonly referred to as sexually transmitted infections.
- **screening:** The N-SUMHSS asks whether facilities offer onsite screening for "tobacco use" and tuberculosis ("TB") screening.
- **physical health care treatment:** The N-SUMHSS asks whether facilities offer onsite "integrated primary care services" and "metabolic syndrome monitoring or testing." The N-SUMHSS also asks about "nicotine replacement" pharmacotherapy, "nonnicotine smoking/tobacco cessation medication," and "smoking/vaping/tobacco cessation counseling."
- **mental health care at facilities that primarily treat SUDs or treat a mix of SUDs and mental health:** The N-SUMHSS asks this subset of behavioral health facilities that do not focus primarily on mental health treatment whether they offer "comprehensive mental health assessment or diagnosis (for example, psychological or psychiatric evaluation and testing)" and "suicide prevention services."
- **SUD treatment at facilities that primarily treat mental health or treat a mix of SUDs and mental health:** The N-SUMHSS asks this subset of behavioral health facilities that do not focus primarily on SUD treatment whether they offer "substance use treatment."

Results

Characteristics of Behavioral Health Facilities by Ownership Type, Care Setting, Treatment Focus, and Language Services

Most behavioral health treatment facilities were nonprofits offering low-cost care, ranging from a low of 50.7 percent in Virginia to roughly 75 percent in Michigan and New Mexico and averaging 61.2 percent in all the other states combined (table 1). Most other behavioral health treatment facilities were for-profits, with a high of 45.1 percent in Virginia, 23.1 percent in Michigan, 22.0 percent in New Mexico, and 33.4 percent in all other states.

Although Michigan and New Mexico had similar shares of nonprofits, New Mexico had a substantially higher share of all behavioral health facilities that are FQHCs, CCBHs, or CMHCs. In New Mexico, 35.7 percent of behavioral health facilities were FQHCs, compared with only 9.9 percent in Michigan, 1.6 percent in Virginia, and 8.4 percent in all other states (appendix table 1).[8] New Mexico had no CCBHCs, while they represented 3.8 percent of behavioral health facilities in Michigan, 1.4 percent in Virginia, and 2.3 percent in all other states. In New Mexico, 21.4 percent of behavioral health facilities were categorized as CMHCs, compared with 11.3 percent in Michigan, 12.6 percent in Virginia, and 8.5 percent in all other states.

TABLE 1

Number and Percentage Distribution of Respondent Behavioral Health Facilities by Type of Ownership and State, 2022

State (response rate)	Facility type	Number	Percentage distribution
Michigan (85.0%)	For-profits	135	23.1%
	Nonprofits without low-cost care	28	4.8%
	Nonprofits with low-cost care	422	72.1%
	All facilities	585	
New Mexico (74.3%)	For-profits	37	22.0%
	Nonprofits without low-cost care	4	2.4%
	Nonprofits with low-cost care	127	75.6%
	All facilities	168	
Virginia (80.6%)	For-profits	194	45.1%
	Nonprofits without low-cost care	18	4.2%
	Nonprofits with low-cost care	218	50.7%
	All facilities	430	
All other states (79.2%)	For-profits	6,614	33.4%
	Nonprofits without low-cost care	1,083	5.5%
	Nonprofits with low-cost care	12,135	61.2%
	All facilities	19,832	

Source: Estimates are from the 2022 National Substance Use and Mental Health Services Survey (N-SUMHSS).
Notes: n = sample size. Nonprofits offering low-cost care were defined as Federally Qualified Health Centers, Certified Community Behavioral Health Clinics, Community Mental Health Centers, and other nonprofits that offered a sliding fee scale, treatment at no or minimal charge, or free treatment to all clients, or received government funding. 'All other states' include DC, the 47 other US states, and no territories. Percentages are a snapshot of respondent facilities operating on March 31, 2022 (survey response rate 79.2 percent nationally). Percentages have not been reweighted to represent the number or characteristics of facilities in the state/US N-SUMHSS universe.

A large majority of behavioral health treatment facilities offered outpatient treatment, and for-profits were more likely to offer outpatient care (appendix table 2). Most behavioral health facilities did not offer residential or inpatient care, with the average offering residential care ranging from 10.4 percent of for-profit facilities in Michigan to 23.8 percent of nonprofit facilities in all other states combined, and the average offering inpatient care ranging from 2.7 percent of for-profits behavioral health facilities in New Mexico to 11.9 percent of nonprofits in all other states combined. Nonprofit facilities were generally more likely to offer care in these settings (except inpatient care in all other states combined, where we observed no difference).

For-profit behavioral health facilities were significantly more likely to focus on SUD treatment and not treat a mix of SUD and mental health or primarily treat mental health. In Michigan, 74.1 percent of for-profits primarily treated SUDs compared with 91.9 percent in New Mexico, 72.7 percent in Virginia, and 76.4 percent in all other states (table 2).

TABLE 2

Treatment Focus of Behavioral Health Facilities by Type of Facility and State, 2022

State (response rate)	Facility type	Total respondent facilities	Treatment Focus: Both SUD and mental health	Treatment Focus: SUD only	Treatment Focus: Mental health only	Chi-square significance
		N	N (%)	N (%)	N (%)	*
Michigan (85.0%)	For-profits	135	28 (20.7)	100 (74.1)	7 (5.2)	*
	Nonprofits with low-cost care	422	76 (18.0)	182 (43.1)	164 (38.9)	
New Mexico (74.3%)	For-profits	37	3 (8.1)	34 (91.9)	0 (0.0)	*
	Nonprofits with low-cost care	127	40 (31.5)	63 (49.6)	24 (18.9)	
Virginia (80.6%)	For-profits	194	19 (9.8)	141 (72.7)	34 (17.5)	*
	Nonprofits with low-cost care	218	81 (37.2)	61 (28.0)	76 (34.9)	
All other states (79.2%)	For-profits	6,614	644 (9.7)	5,054 (76.4)	916 (13.8)	*
	Nonprofits with low-cost care	12,135	2,255 (18.6)	5,370 (44.3)	4,510 (37.2)	

Source: Estimates are from the 2022 National Substance Use and Mental Health Services Survey (N-SUMHSS).

Notes: n = sample size. Nonprofits offering low-cost care were defined as Federally Qualified Health Centers, Certified Community Behavioral Health Clinics, Community Mental Health Centers, and other nonprofits that offered a sliding fee scale, treatment at no or minimal charge, or free treatment to all clients, or received government funding. 'All other states' include DC, the 47 other US states, and no territories. Percentages are a snapshot of respondent facilities operating on March 31, 2022 (survey response rate 79.2 percent nationally). Percentages have not been reweighted to represent the number or characteristics of facilities in the state/US N-SUMHSS universe. * indicates that the null hypothesis of no difference between the proportion of for-profits and nonprofits with low-cost care offering the service can be rejected at the 0.01 alpha level.

Nonprofits were substantially less likely to primarily treat SUDs and more likely to treat a mix of SUDs and mental health or primarily treat mental health compared with for-profits in Michigan, New Mexico, Virginia, and all other states. For example, in Michigan, 18.0 percent of nonprofits treated a mix of SUDs and mental health, compared with 31.5 percent in New Mexico, 37.2 percent in Virginia, and 18.6 percent in all other states, while for-profits were less likely to treat a mix of SUDs and mental health, with only 20.7 percent in Michigan, 8.1 percent in New Mexico, 9.8 percent in Virginia, and 9.7 percent in all other states treating a mix.

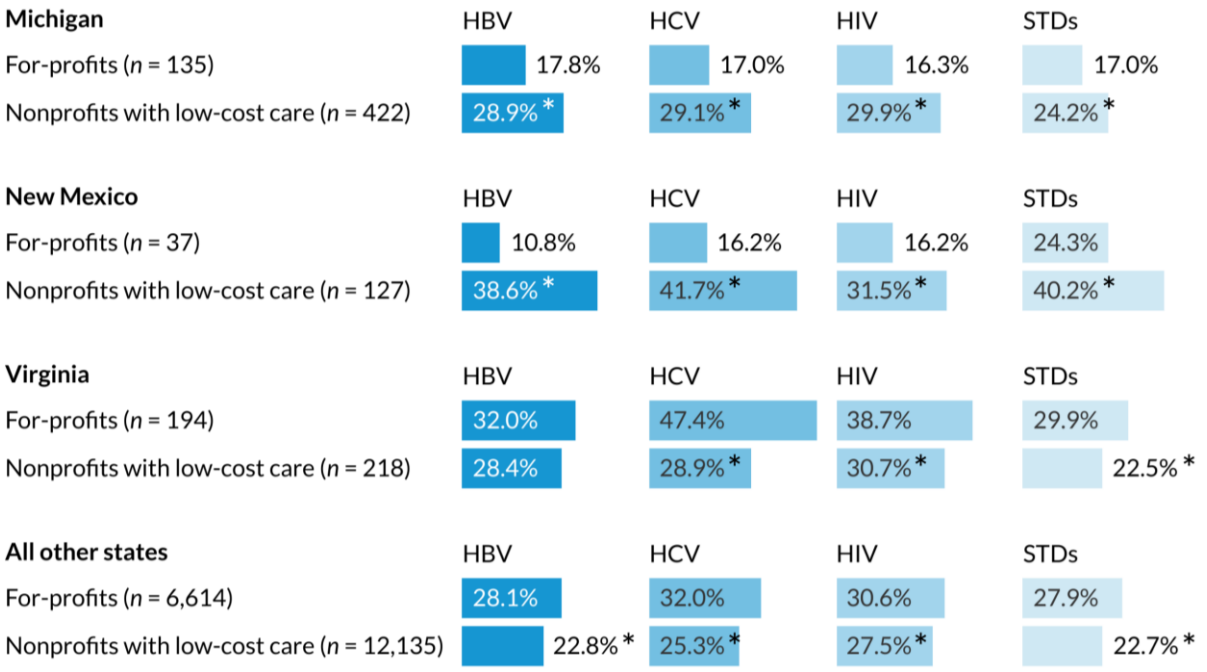
The availability of language treatment options at behavioral health treatment facilities varied by state and type of ownership (appendix table 3). Nonprofits were substantially more likely to have staff counselors who could provide treatment in sign language, ranging from about half of facilities in New Mexico to about three out of four facilities in Michigan. Nonprofits were also more likely to have Spanish-speaking counselors in Michigan, Virginia, and all other states combined, but for-profits in New Mexico were more likely to have Spanish-speaking counselors. Nonprofits were more likely to staff counselors who spoke American Indian or Alaska Native languages in New Mexico and all other states combined.

Facilities Offering Communicable Infection Testing

In 2022 overall, fewer than 30 percent of behavioral health facilities offered onsite testing for each of the following: HBV, HCV, HIV, or STDs (figure 1 and appendix table 4). The facility averages for HBV testing ranged from a low of 10.8 percent among for-profits in New Mexico to a high of 38.6 percent among nonprofits in New Mexico. For HCV testing, facility averages ranged from a low of 17.9 percent among for-profits in Michigan to 47.4 percent among for-profits in Virginia. For HIV, averages ranged from a low of 16.2 percent among for-profits in New Mexico to 38.7 percent among for-profits in Virginia. For STDs, averages ranged from 17.0 percent among for-profits in Michigan to 40.2 percent among nonprofits in New Mexico. Results by ownership status were mixed. Nonprofits in Michigan and New Mexico were more likely to offer HBV, HCV, HIV, and STD testing compared with for-profits in those states, but in Virginia and all other states combined, for-profits were more likely to offer these tests compared with nonprofits, or no difference was discerned between the two types of facility ownership (i.e., HBV testing in Virginia) (figure 1 and appendix table 4).

FIGURE 1

Share of Behavioral Health Facilities Offering Onsite HBV, HCV, HIV, and STD Testing by Type of Facility and State, 2022



URBAN INSTITUTE

Source: Estimates are from the 2022 National Substance Use and Mental Health Services Survey (N-SUMHSS).
Notes: HBV = hepatitis B virus; HCV = hepatitis C virus; HIV = human immunodeficiency virus; STD = sexually transmitted disease; n = sample size. Nonprofits offering low-cost care were defined as Federally Qualified Health Centers, Certified Community Behavioral Health Clinics, Community Mental Health Centers, and other nonprofits that offered a sliding fee scale, treatment at no or minimal charge, or free treatment to all clients, or received government funding. 'All other states' include DC, the 47 other US states, and no territories. Percentages are a snapshot of respondent facilities operating on March 31, 2022 (survey response rate 79.2 percent nationally). Percentages have not been reweighted to represent the number or characteristics of facilities in the state/US N-SUMHSS universe. * indicates that the null hypothesis of no difference between the proportion of for-profits and nonprofits with low-cost care offering the service can be rejected at the 0.01 alpha level.

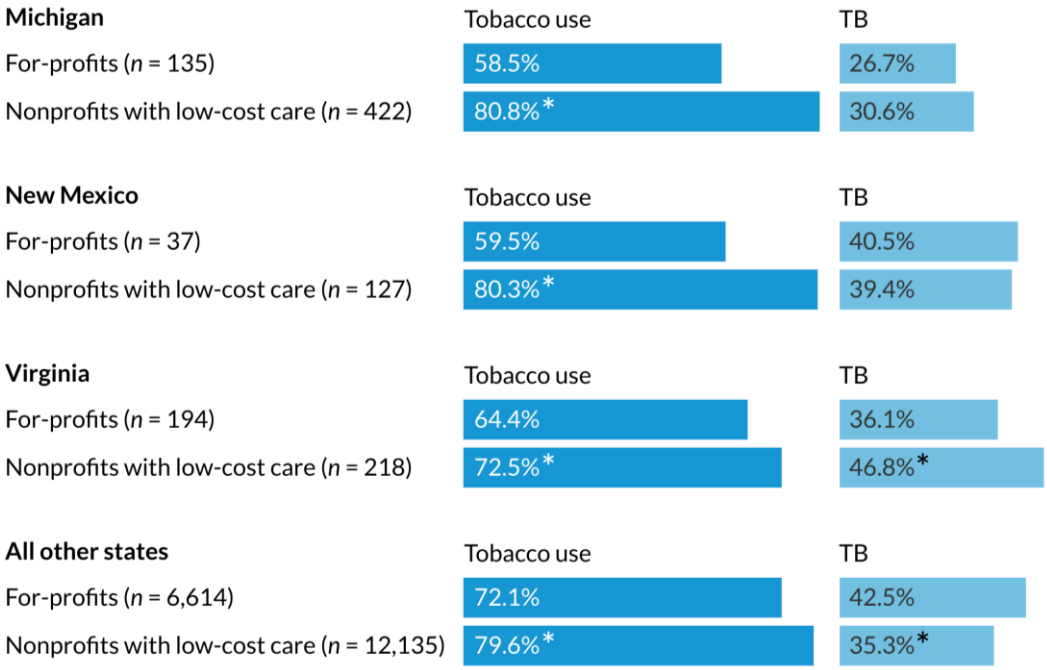
Facilities Offering Integrated Primary Care and Metabolic Syndrome Monitoring and Testing

Fewer than one in three behavioral health facilities reported offered integrated primary care services or monitoring or testing for metabolic syndrome (figure 2 and appendix table 5). In New Mexico, integrated primary care services were available at only 16.2 percent of for-profits but 42.5 percent of nonprofits, with a similar pattern in Michigan and Virginia. Overall, nonprofits were more likely to offer integrated primary care services in the focus states, with rates twice as high or more than for-profits. In all other states, integrated primary care services were available at 23.9 percent of for-profits and 30.6 percent of nonprofits.

Nonprofits were consistently more likely to offer metabolic syndrome monitoring and testing, e.g., assessments for heart disease and diabetes, compared with for-profit behavioral health facilities. In Michigan, only 9.6 percent of for-profit facilities offered metabolic syndrome monitoring and testing, while 32.9 percent of nonprofits provided this service. The service was more widely available in Virginia, but nonprofits still outpaced for-profits, offering testing at 50.0 percent of facilities, compared with 29.9 percent of for-profits. Overall, nonprofits were about three times more likely to offer this service than for-profits in Michigan and New Mexico.

FIGURE 2

Share of Behavioral Health Facilities Offering Integrated Primary Care Services and Metabolic Syndrome Monitoring or Testing by Type of Facility and State, 2022



URBAN INSTITUTE

Source: Estimates are from the 2022 National Substance Use and Mental Health Services Survey (N-SUMHSS).
Notes: n = sample size. Integrated primary care is defined as services for addressing the general health care needs of individuals with behavioral health conditions, including care for the prevention and treatment of chronic illnesses like hypertension, diabetes, obesity, and cardiovascular disease. Nonprofits offering low-cost care were defined as Federally Qualified Health Centers, Certified Community Behavioral Health Clinics, Community Mental Health Centers, and other nonprofits that offered a sliding fee scale, treatment at no or minimal charge, or free treatment to all clients, or received government funding. 'All other states' include DC, the 47 other US states, and no territories. Percentages are a snapshot of respondent facilities operating on March 31, 2022 (survey response rate 79.2 percent nationally). Percentages have not been reweighted to represent the number or characteristics of facilities in the state/US N-SUMHSS universe. * indicates that the null hypothesis of no difference between the proportion of for-profits and nonprofits with low-cost care offering the service can be rejected at the 0.01 alpha level.
[a] E.g., weight, abdominal girth, blood pressure, glucose, hemoglobin A1c, cholesterol, triglycerides.

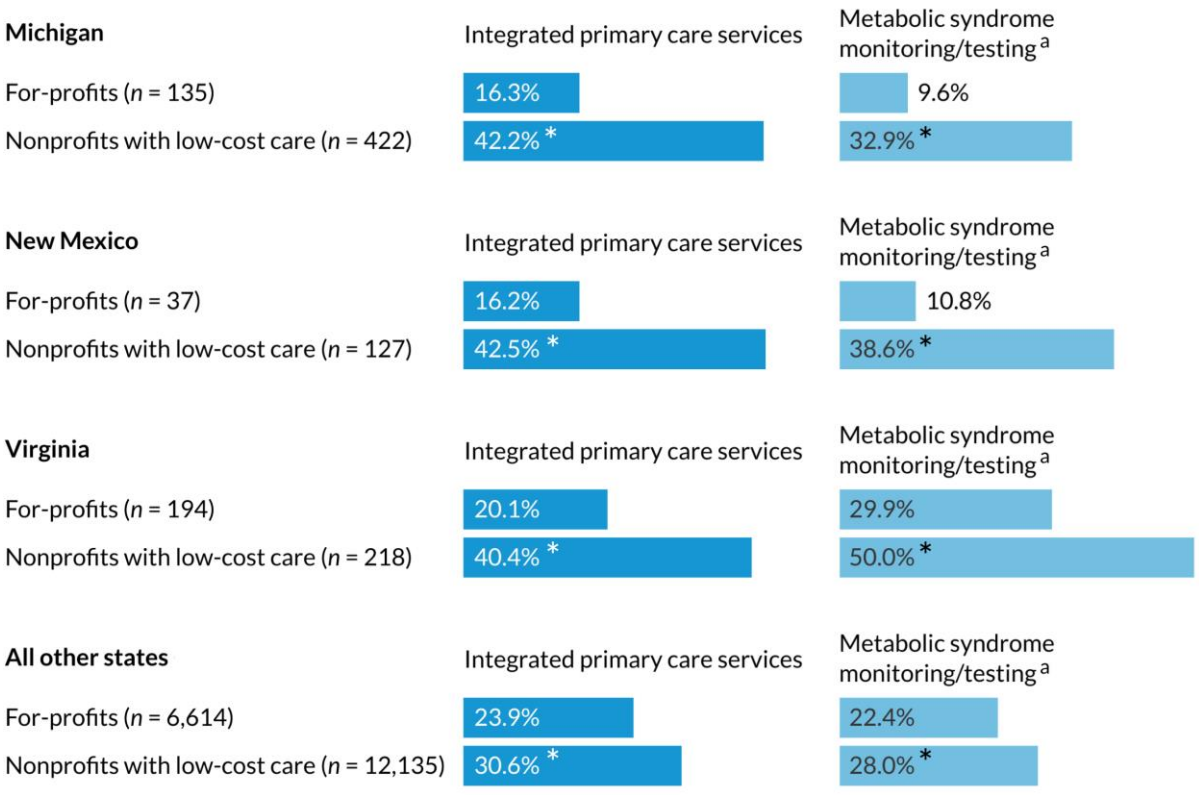
Facilities Offering Tobacco Use Screening and Tuberculosis Screening

About 70 percent of behavioral health facilities offered tobacco use screening in 2022, and nonprofits were more likely to offer this service than for-profits (figure 3 and appendix table 6). The facility averages for tobacco use screening ranged from a low of 58.5 percent among for-profits in Michigan to a high of about 80 percent among nonprofits in Michigan, New Mexico, and all other states combined category.

Overall, about 37 percent of behavioral health facilities offered TB screening in 2022, ranging from 26.7 percent among for-profits in Michigan to 56.8 percent among nonprofits in Virginia. Results by ownership status were mixed. Our analysis detected no difference in Michigan and New Mexico and found Virginia nonprofits were more likely to offer TB screening than for-profits, while in all other states combined, for-profits were more likely to offer TB screening than nonprofits.

FIGURE 3

Share of Behavioral Health Facilities that Offer Tobacco Use and TB Screening by Type of Facility and State, 2022



URBAN INSTITUTE

Source: Estimates are from the 2022 National Substance Use and Mental Health Services Survey (N-SUMHSS).
Notes: TB = tuberculosis; n = sample size. Nonprofits offering low-cost care were defined as Federally Qualified Health Centers, Certified Community Behavioral Health Clinics, Community Mental Health Centers, and other nonprofits that offered a sliding fee scale, treatment at no or minimal charge, or free treatment to all clients, or received government funding. 'All other states'

include DC, the 47 other US states, and no territories. Percentages are a snapshot of respondent facilities operating on March 31, 2022 (survey response rate 79.2 percent nationally). Percentages have not been reweighted to represent the number or characteristics of facilities in the state/US N-SUMHSS universe. * indicates that the null hypothesis of no difference between the proportion of for-profits and nonprofits with low-cost care offering the service can be rejected at the 0.01 alpha level.

Facilities Offering Treatment for Nicotine and Tobacco Dependence

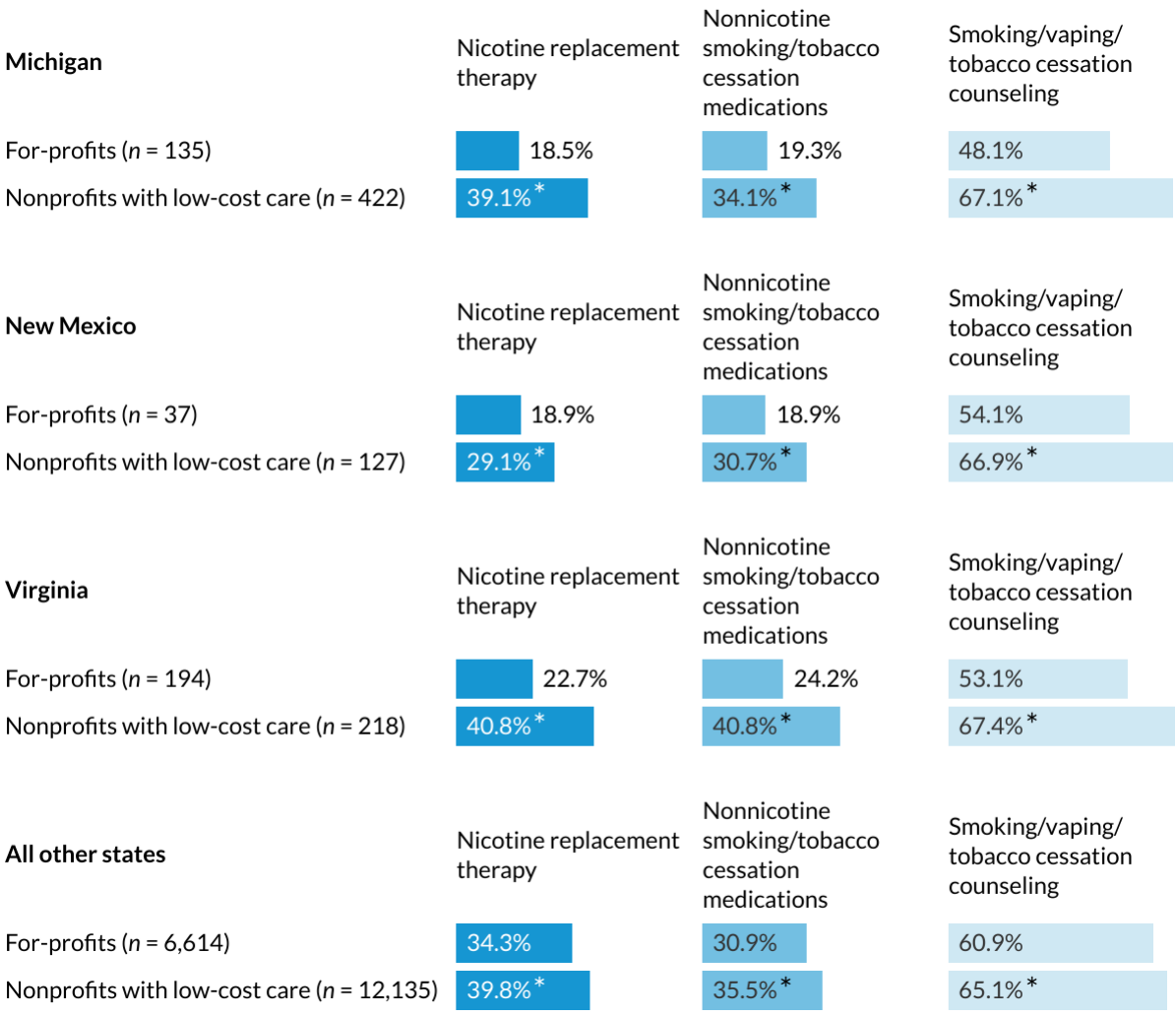
Overall, fewer than one in three behavioral health facilities offered nicotine replacement therapy and nonnicotine tobacco cessation medication, and about 60 percent offered cessation counseling for smoking, tobacco, or nicotine dependence (figure 4 and appendix table 7). The facility averages for offering nicotine replacement therapy ranged from a low of 18.5 percent among for-profits in Michigan to a high of 40.8 percent among nonprofits in Virginia. Nonprofits were more likely to offer nicotine replacement therapy and were roughly twice as likely to offer this service than for-profits in Michigan.

The facility averages for offering nonnicotine tobacco cessation medication ranged from a low of 18.9 percent among for-profits in New Mexico to a high of 40.8 percent among nonprofits in Virginia. Nonprofits were more likely to offer this service than for-profits in the focal states and all other states combined.

The facility averages for offering cessation counseling ranged from a low of 48.1 percent among for-profits in Michigan to a high of 67.4 percent among nonprofits in Virginia. Nonprofits were more likely to offer this service than for-profits in the focal states and all other states combined.

FIGURE 4

Share of Behavioral Health Facilities Offering Nicotine Replacement Therapy, Nonnicotine Tobacco Cessation Medications, and Cessation Counseling by Type of Facility and State, 2022



URBAN INSTITUTE

Source: Estimates are from the 2022 National Substance Use and Mental Health Services Survey (N-SUMHSS).
Notes: n = sample size. Nonprofits offering low-cost care were defined as Federally Qualified Health Centers, Certified Community Behavioral Health Clinics, Community Mental Health Centers, and other nonprofits that offered a sliding fee scale, treatment at no or minimal charge, or free treatment to all clients, or received government funding. 'All other states' include DC, the 47 other US states, and no territories. Percentages are a snapshot of respondent facilities operating on March 31, 2022 (survey response rate 79.2 percent nationally). Percentages have not been reweighted to represent the number or characteristics of facilities in the state/US N-SUMHSS universe. * indicates that the null hypothesis of no difference between the proportion of for-profits and nonprofits with low-cost care offering the service can be rejected at the 0.01 alpha level.

Facilities Offering Mental Health Assessments and Suicide Prevention Services

Among behavioral health facilities that report primarily treating SUDs or treating a mix of SUDs and mental health, nonprofits were more likely to offer comprehensive mental health assessments and

suicide prevention services across Michigan, New Mexico, Virginia, and all other states combined (appendix table 8). For example, in Michigan, 62.4 percent of these nonprofits that did not primarily treat mental health nevertheless offered comprehensive mental health assessments, compared with 43.8 percent of for-profits. Similarly, 56.2 percent of these nonprofits offered suicide prevention services, compared with only 32.0 percent of for-profits. This trend was also evident in Virginia, where 78.2 percent of these nonprofits that do not primarily treat mental health nevertheless offered comprehensive mental health assessments, compared with 48.1 percent of for-profits, and 73.9 percent of these nonprofits provided suicide prevention services, compared with 32.5 percent of for-profits. In contrast, among facilities that primarily treat mental health, for-profits were more likely to offer SUD treatment compared with nonprofits. For example, in Michigan, 91.4 percent of these for-profits that do not primarily treat SUDs nevertheless provided SUD treatment, whereas only 69.2 percent of these nonprofits offered these services. This pattern was similarly reflected in New Mexico, Virginia, and the other states combined.

Discussion

This study investigated whether facilities structured to serve underserved populations are more likely to offer needed services for people with co-occurring physical and behavioral health conditions. The findings demonstrate that nonprofits were generally more likely than for-profit behavioral health facilities to offer these services and point to the importance of monitoring local area availability of holistic care for people with behavioral health conditions who also need treatment for physical health conditions. As previous literature has shown, individuals with co-occurring conditions, such as SUD and chronic diseases like diabetes, face higher risks for poor outcomes because of gaps in care at behavioral health facilities, often resulting in fragmented care and leading to worsened health and increased hospitalization rates (National Council for Mental Wellbeing 2022).

Despite generally being more likely to offer services that are important for people with co-occurring behavioral and physical health conditions, our study suggests that patients with these co-occurring conditions are nevertheless likely to experience gaps in care at nonprofit facilities because many of these facilities do not offer one or more critical physical health services we examined, including testing for communicable infections (HBV, HCV, HIV, or sexually transmitted infection testing), TB screening, metabolic syndrome monitoring and testing, nicotine replacement therapy, or nonnicotine tobacco cessation medication. Patients are less likely to experience gaps in tobacco use screening and tobacco cessation counseling because most facilities in this study offered these services, and nonprofits were more likely than for-profits to offer these services.

The services examined in this study, such as integrated primary care, communicable disease testing, metabolic syndrome monitoring, and tobacco cessation, are critical because they help address patients' complex, co-occurring physical and behavioral health needs at behavioral health facilities. Many individuals with mental health or substance use disorders also have chronic physical health conditions like diabetes, cardiovascular disease, or infectious diseases, which can exacerbate their overall health risks. Health care services for these conditions, when offered together, create a more holistic approach

that improves patient outcomes by helping prevent physical disease progression, reducing hospitalizations, and supporting long-term recovery. Expanding these services across nonprofit and for-profit facilities is essential to ensure that vulnerable populations receive comprehensive care tailored to their needs.

Our findings are generally consistent with other studies, which have highlighted the narrower range of services offered by for-profit facilities in other types of health care, such as hospitals, opioid treatment programs, and hospices (Horwitz and Nichols 2022; Bachhuber, Southern, and Cunningham 2014; Carlson, Gallo, and Bradley 2004). Although for-profits may meet the immediate needs of individuals without co-occurring conditions, their limited scope of services may present challenges for holistic care for patients with co-occurring conditions if there are no local area facilities that offer these services and have openings. There is a growing recognition that nonprofits may be better positioned to deliver whole-person care by offering a broader range of physical and behavioral health services.[9]

These findings point to the importance of policymakers strategically promoting the availability of holistic services at behavioral health facilities (Schuster et al. 2021; Herschell et al. 2023; Korthuis et al. 2017). Given the high levels of co-occurring physical and other health conditions among people with a behavioral health condition, reimbursement levels and other policy levers must be adjusted to promote the availability of services at for-profit and nonprofit facilities, such as the increase in the availability of behavioral health services after the introduction of Virginia's Addiction and Recovery Treatment Services program and its higher reimbursement levels (Barnes et al. 2020; Cunningham et al. 2021).

The findings of more limited physical health services at for-profits, coupled with evidence that private equity firms now account for as much as a quarter of practices providing behavioral health services in some states (Zhu et al. 2024), highlights the need for stakeholders to monitor and support the availability of holistic care at behavioral health facilities. On the one hand, private equity and other for-profits could expand access to behavioral health care by leveraging operational and administrative efficiencies and market power to negotiate better reimbursements (Zhu et al. 2024). However, on the other hand, evidence suggests that, like other for-profits, they tend to provide more limited and lower quality services, with little indication that they improve care quality or patient outcomes (Cai and Song 2023).

Historically, state policymakers have had leverage to affect care offered at behavioral health facilities, including discretion in overseeing conversions between nonprofit and for-profit health care facility ownership and monitoring local market conditions through community benefits assessments and other data collection to promote a mix of health care service providers that meet the needs of local communities (Marsteller et al. 1998). Facilities may convert to and from nonprofit status based on incentives related to local market forces and other factors, and nonprofits have been challenged for not offering enough community benefits to justify their tax-exempt status (Bai, Zare, and Hyman 2022; Wolfson 1996).

Given the critical role that FQHCs, CCBHCs, and CMHCs play in providing behavioral and physical health care to underserved populations, ensuring these facilities have the necessary resources and

support is essential for broadening the availability of care for individuals with physical and behavioral health conditions (Waidmann et al. 2023). Effective policies at the state and federal levels can be leveraged to bolster their ability to deliver comprehensive services to underserved populations. To support FQHCs, CCBHCs, and CMHCs, state and federal governments can focus on several key areas. First, ensuring adequate funding and sustainable reimbursement rates is crucial, including potentially increasing federal funding for programs like the FQHC Prospective Payment System and SAMHSA CCBHC Expansion Grants, while states can supplement with general funds (National Council for Mental Wellbeing 2023).[10] State and federal governments can also potentially expand alternative payment models in state Medicaid programs to incentivize quality care for these health centers (Markowski et al. 2024; Hostetter and Klein 2022).

Policies that promote care coordination and integration may help promote the availability of holistic services at both for-profit and nonprofit behavioral health facilities (National Council for Mental Wellbeing 2023). Reducing the administrative burden by streamlining federal and state reporting requirements and promoting flexible service delivery methods such as telehealth could also help incentivize for-profit and nonprofit behavioral health facilities to offer more services that meet the needs of patients with co-occurring physical and behavioral health conditions and other complex needs.

Lastly, incorporating patient and community perspectives and focusing on reducing health disparities can help promote the availability of services for patients with co-occurring physical and behavioral health conditions and other underserved populations (Bui et al. 2022).

Conclusion

This study highlights significant differences in physical and behavioral health services offered by for-profit and nonprofit behavioral health facilities. Nonprofits were generally substantially more likely to offer important physical health services, including integrated primary care and metabolic syndrome monitoring—services essential for addressing the needs of individuals with co-occurring behavioral and physical health conditions. However, despite their broader service offerings, gaps remain, particularly in the availability of critical physical health services such as metabolic syndrome monitoring and testing for hepatitis and HIV. For-profit facilities, on the other hand, focused more on providing SUD treatment and offered a narrower range of services, which is unlikely to adequately meet the needs of patients with co-occurring conditions. These findings emphasize the need for policies that promote the expansion of holistic care and ensure that nonprofit and for-profit facilities can meet the complex health needs of individuals with co-occurring behavioral and physical health conditions.

Notes

[1] "Take Part in the 2022 National Substance Use and Mental Health Services Survey," SAMHSA, accessed August 8, 2024.

[2] "The Mental Health Parity and Addiction Equity Act (MHPAEA)," CMS.gov, accessed November 5, 2024, https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea_factsheet,

[3] "Community Health Center Chartbook 2024: Analysis of 2022 UDS Data," NACHC, March 1, 2024. https://www.nachc.org/resource/community-health-center-chartbook/.

[4] "Take Part in the 2022 National Substance Use and Mental Health Services Survey" SAMHSA, accessed November 5, 2024.

[5] "Improving Access to Mental Health and Substance Use Disorder Services," Georgetown University, accessed November 8, 2024, https://behavioralhealth.chir.georgetown.edu/.

[6] FQHCs, CCBHCs, and CMHCs offer sliding scale fees, free treatment, or services funded by government programs, making them accessible to clients with low incomes or specific needs, but they differ in scope and specialization, see "Comparison of Health Centers and Certified Community Behavioral Health Clinics," NACHC, June 14, 2023, https://www.nachc.org/resource/comparison-of-health-centers-and-certified-community-behavioral-health-clinics/ (Wishon and Brown 2021; Jiao et al. 2022; Kelleher and Gardner 2016). FQHCs focus primarily on primary care services for medically underserved populations, while CCBHCs specialize in comprehensive mental health and substance use disorder services, offering nine core services such as crisis management and psychiatric rehabilitation. CMHCs, by contrast, offer a broad range of mental health services, including assertive community treatment, residential support, and school-based services. FQHCs receive federal funding under Section 330, CCBHCs have multiple funding mechanisms, including Medicaid and SAMHSA grants, and CMHCs rely on a mix of state and federal Medicaid funding sources.

[7] Centers for Medicare and Medicaid Services (CMS), "Medicare Learning Network Booklet: Federally Qualified Health Center," September 2019; and Substance Abuse and Mental Health Services Administration (SAMHSA), "Criteria for the Demonstration Program to Improve Community Mental Health Centers and to Establish Certified Community Behavioral Health Clinics," 2022.

[8] Appendix tables are available in online at https://www.urban.org/research/publication/are-physical-and-behavioral-health-services-more-available-nonprofit-or-profit.

[9] Helene M. Langevin, "New Coalition is Another Stepping Stone toward Whole Person Health," NCCIH, June 10, 2024, https://www.nccih.nih.gov/about/offices/od/director/past-messages/new-coalition-is-another-stepping-stone-toward-whole-person-health.

[10] "Organization & Funding of Community Mental Health Services: NRI's 2020-2021 State Profiles," NRI, September 2021; and "Comparison of Health Centers and Certified Community Behavioral Health Clinics," NACHC.

References

Anderson, Kelly E., G. Caleb Alexander, Lauren Niles, Sarah H. Scholle, Brendan Saloner, and Sydney M. Dy. 2021. "Quality of Preventive and Chronic Illness Care for Insured Adults With Opioid Use Disorder." *JAMA Network Open* 4 (4): e214925. https://doi.org/10.1001/jamanetworkopen.2021.4925.

APA (The American Psychiatric Association). 2020. *Psychiatric Bed Crisis Report.* Washington, DC: APA.

Bachhuber, Marcus A., William N. Southern, and Chinazo O. Cunningham. 2014. "Profiting and Providing Less Care: Comprehensive Services at for-Profit, Nonprofit, and Public Opioid Treatment Programs in the United States." *Medical Care* 52 (5): 428–34. https://doi.org/10.1097/MLR.0000000000000121.

Bai, Ge, Hossein Zare, and David A. Hyman. 2022. "Evaluation of Unreimbursed Medicaid Costs among Nonprofit and For-Profit US Hospitals." *JAMA Network Open* 5 (2): e2148232. https://doi.org/10.1001/jamanetworkopen.2021.48232.

Barnes, Andrew J., Peter J. Cunningham, Lauryn Saxe-Walker, Erin Britton, Yaou Sheng, Melanie Boynton, Ke'Shawn Harper, et al. 2020. "Hospital Use Declines after Implementation of Virginia Medicaid's Addiction and Recovery Treatment Services." *Health Affairs* 39 (2): 238–46. https://doi.org/10.1377/hlthaff.2019.00525.

Bui, Juliet, Annette Waters, Robin Ghertner, Eva Allen, Lisa Clemans-Cope, and Kimá Joy Taylor. 2022. "Addressing Substance Use and Social Needs of People of Color with Substance Use Disorders." Washington, DC: ASPE.

Burns, Ashlyn, Nir Menachemi, Valerie A. Yeager, Joshua R. Vest, and Olena Mazurenko. 2023. "Adoption of Best Practices in Behavioral Health Crisis Care by Mental Health Treatment Facilities." *Psychiatric Services* 74 (9). https://doi.org/10.1176/appi.ps.20220427.

Butler, Ainslie J., Jürgen Rehm, and Benedikt Fischer. 2017. "Health Outcomes Associated with Crack-Cocaine Use: Systematic Review and Meta-Analyses." *Drug and Alcohol Dependence* 180:401–16. https://doi.org/10.1016/j.drugalcdep.2017.08.036.

Cabin, William, David U. Himmelstein, Michael L. Siman, and Steffie Woolhandler. 2014. "For-Profit Medicare Home Health Agencies' Costs Appear Higher and Quality Appears Lower Compared to Nonprofit Agencies." *Health Affairs* 33 (8): 1460–5. https://doi.org/10.1377/hlthaff.2014.0307.

Cai, Christopher, and Zirui Song. 2023. "A Policy Framework for the Growing Influence of Private Equity in Health Care Delivery." *JAMA* 329 (18): 1545–6. https://doi.org/10.1001/jama.2023.2801.

Carlson, Melissa D. A., William T. Gallo, and Elizabeth H. Bradley. 2004. "Ownership Status and Patterns of Care in Hospice: Results from the National Home and Hospice Care Survey." *Medical Care* 42 (5): 432–8. https://doi.org/10.1097/01.mlr.0000124246.86156.54.

Cunningham, Peter, Megan Mueller, Erin Britton, Huyen Pham, Lauren Guerra, Heather Saunders, Xue Zhao, Andrew Barnes, and Vimbainashe Dihwa. 2021. "Addiction and Recovery Treatment Services: Access, Utilization, and Quality of Care 2016-2019." Richmond, VA: Virginia Commonwealth University School of Medicine, Department of Health Behavior and Policy.

Dalton, Christina Marsh, and W. David Bradford. 2019. "Better Together: Coexistence of for-Profit and Nonprofit Firms with an Application to the U.S. Hospice Industry." *Journal of Health Economics* 63: 1–18. https://doi.org/10.1016/j.jhealeco.2018.10.001.

Damazo, Stacey A. 2021. "Integration of Behavioral Health in Diabetes Care and Management in a Federally Qualified Health Center: A Needs Assessment." Portland, OR: OHSU.

Damian, April Joy, and Joseph J. Gallo. 2018. "Models of Care for Populations with Chronic Conditions and Mental/Behavioral Health Comorbidity." *International Review of Psychiatry* 30 (6): 157–69. https://doi.org/10.1080/09540261.2019.1568233.

Das-Munshi, Jayati, Maya Semrau, Corrado Barbui, Neerja Chowdhary, Petra C. Gronholm, Kavitha Kolappa, Dzmitry Krupchanka, Tarun Dua, and Graham Thornicroft. 2020. "Gaps and Challenges: WHO Treatment Recommendations for Tobacco Cessation and Management of Substance Use Disorders in People with Severe Mental Illness." *BMC Psychiatry* 20:237. https://doi.org/10.1186/s12888-020-02623-y.

Herschell, Amy D., James M. Schuster, Donna J. Keyser, Deborah S. Wasilchak, Geoffrey B. Neimark, Sherry L. Shaffer, and Matthew O. Hurford. 2023. "Human Services and Behavioral Health Integration: A Model for Whole-Person Medicaid Managed Care." *Psychiatric Services* 74 (9): https://doi.org/10.1176/appi.ps.20220478.

Horwitz, Jill R., and Austin Nichols. 2022. "Hospital Service Offerings Still Differ Substantially by Ownership Type: Study Examines Service Offerings by Hospital Ownership Type." *Health Affairs* 41 (3): 331–40. https://doi.org/10.1377/hlthaff.2021.01115.

Hostetter, Martha, and Sarah Klein. 2022. "The Perils and Payoffs of Alternative Payment Models for Community Health Centers." New York: The Commonwealth Fund.

Hung, Peiyin, Yi-Wen Shih, Monique J. Brown, and Elizabeth Crouch. 2021. "Suicide Prevention Programs Across U.S. Outpatient Mental Health Care Settings: Differences by Facility Ownership." *Psychiatric Services* 72 (9): 998–1005. https://doi.org/10.1176/appi.ps.202000203.

Iturralde, Esti, Natalie Slama, Andrea H. Kline-Simon, Kelly C. Young-Wolff, Don Mordecai, and Stacy A. Sterling. 2021. "Premature Mortality Associated with Severe Mental Illness or Substance Use Disorder in an Integrated Health Care System." *General Hospital Psychiatry* 68: 1–6. https://doi.org/10.1016/j.genhosppsych.2020.11.002.

Jiao, Shiyin, R. Tamara Konetzka, Harold A. Pollack, and Elbert S. Huang. 2022. "Estimating the Impact of Medicaid Expansion and Federal Funding Cuts on FQHC Staffing and Patient Capacity." *The Milbank Quarterly* 100 (2): 504–24. https://doi.org/10.1111/1468-0009.12560.

Kalb, Luther G., Calliope Holingue, Emma K. Stapp, Kathryn Van Eck, and Johannes Thrul. 2022. "Trends and Geographic Availability of Emergency Psychiatric Walk-In and Crisis Services in the United States." *Psychiatric Services* 73 (1): 26–31. https://doi.org/10.1176/appi.ps.202000612.

Kelleher, Kelly J., and William Gardner. 2016. "Are FQHCs the Solution to Care Access for Underserved Children?" *Pediatrics* 138 (4): e20162479. https://doi.org/10.1542/peds.2016-2479.

Kern, L., Joanna K. Seirup, M. Rajan, R. Jawahar, and Susan S. Stuard. 2018. "Fragmented Ambulatory Care and Subsequent Healthcare Utilization among Medicare Beneficiaries." *The American Journal of Managed Care* 24 (9): e278-e284.

Knickman, James, Ranga Krishnan, and Harold Pincus. 2016. "Improving Access to Effective Care for People With Mental Health and Substance Use Disorders." *JAMA* 316 (16): 1647. https://doi.org/10.1001/jama.2016.13639.

Korthuis, P. Todd, Dennis McCarty, Melissa Weimer, Christina Bougatsos, Ian Blazina, Bernadette Zakher, Sara Grusing, Beth Devine, and Roger Chou. 2017. "Primary Care–Based Models for the Treatment of Opioid Use Disorder: A Scoping Review." *Annals of Internal Medicine* 166 (4): 268. https://doi.org/10.7326/M16-2149.

Lipari, Rachel N., and Eunice Park-Lee. 2019. *Key Substance Use and Mental Health Indicators in the United States: Results from the 2018 National Survey on Drug Use and Health*. Rockville, MD: SAMHSA.

Lynch, Victoria, Maya Payton, and Lisa Clemans-Cope. 2024. "State Variation in Substance Use Disorder and Mental Health Treatment." Washington, DC: Urban Institute.

Markowski, Justin, Jacob Wallace, Mark Schlesinger, and Chima D. Ndumele. 2024. "Alternative Payment Models and Performance in Federally Qualified Health Centers." *JAMA Internal Medicine* 184 (9): 1065–73. https://doi.org/10.1001/jamainternmed.2024.2754.

Marsteller, Jill A., Randall R. Bovbjerg, and Len M. Nichols. 1998. "Nonprofit Conversion: Theory, Evidence, and State Policy Options." *Health Services Research* 33 (5 Pt 2): 1495–1535.

Nahra, Tammie A., Jeffrey Alexander, and Harold Pollack. 2009. "Influence of Ownership on Access in Outpatient Substance Abuse Treatment." *Journal of Substance Abuse Treatment* 36 (4): 355–65. https://doi.org/10.1016/j.jsat.2008.06.009.

National Council for Mental Wellbeing. 2022. *The Comprehensive Healthcare Integration (CHI) Framework.* Washington, DC: National Council for Mental Wellbeing.

———. 2023. *CCBHCs: A Vision for the Future of Community Behavioral Health Care.* Washington, DC: National Council for Mental Wellbeing.

O'Grady, Thomas, Nina Inman, Alitasha Younger, Bishan Huang, Taylor Olivia Bouton, Heeun Kim, and Emily DeLorenzo. 2024. "The Characteristics and HIV-Related Outcomes of People Living with Co-Occurring HIV and Mental Health Conditions in the United States: A Systematic Review of Literature from 2016 to 2021." *AIDS and Behavior* 28 (1): 201–24. https://doi.org/10.1007/s10461-023-04150-9.

Olfson, Mark, Shuai Wang, Melanie Wall, Steven C. Marcus, and Carlos Blanco. 2019. "Trends in Serious Psychological Distress and Outpatient Mental Health Care of US Adults." *JAMA Psychiatry* 76 (2): 152–61. https://doi.org/10.1001/jamapsychiatry.2018.3550.

Penninx, Brenda W. J. H., and Sjors M. M. Lange. 2018. "Metabolic Syndrome in Psychiatric Patients: Overview, Mechanisms, and Implications." *Dialogues in Clinical Neuroscience* 20 (1): 63. https://doi.org/10.31887/DCNS.2018.20.1/bpenninx.

Pizzol, Damiano, Mike Trott, Laurie Butler, Yvonne Barnett, Tamsin Ford, Sharon As Neufeld, Anya Ragnhildstveit, et al. 2023. "Relationship between Severe Mental Illness and Physical Multimorbidity: A Meta-Analysis and Call for Action." *BMJ Mental Health* 26 (1): e300870. https://doi.org/10.1136/bmjment-2023-300870.

Rodgers, John H., and Paul G. Barnett. 2000. "Two Separate Tracks? A National Multivariate Analysis of Differences Between Public and Private Substance Abuse Treatment Programs." *The American Journal of Drug and Alcohol Abuse* 26 (3): 429–42. https://doi.org/10.1081/ADA-100100254.

Saunders, Heather, and Rhiannon Euhus. 2024. "A Look at Substance Use and Mental Health Treatment Facilities across the U.S." San Fransisco: KFF.

Schuster, James, Shari Hutchison, Irina Karpov, and Amy Herschell. 2021. "Dissemination of a Behavioral Health Home Model with Improved Physical Health and Wellness across Behavioral Health Settings." *Health Services Research* 56 (S2): 37. https://doi.org/10.1111/1475-6773.13770.

Sud, Dolly, Eileen Laughton, Robyn McAskill, Eleanor Bradley, and Ian Maidment. 2021. "The Role of Pharmacy in the Management of Cardiometabolic Risk, Metabolic Syndrome and Related Diseases in Severe Mental Illness: A Mixed-Methods Systematic Literature Review." *Systematic Reviews* 10: 92. https://doi.org/10.1186/s13643-021-01586-9.

Sun, Ching-Fang, Christoph U. Correll, Robert L. Trestman, Yezhe Lin, Hui Xie, Maria Stack Hankey, Raymond Paglinawan Uymatiao, et al. 2023. "Low Availability, Long Wait Times, and High Geographic Disparity of Psychiatric Outpatient Care in the US." *General Hospital Psychiatry* 84: 12–17. https://doi.org/10.1016/j.genhosppsych.2023.05.012.

Thomas, Cindy Parks, Maureen T. Stewart, Emily Ledingham, Rachel Sayko Adams, Lee Panas, and Sharon Reif. 2023. "Quality of Opioid Use Disorder Treatment for Persons With and Without Disabling Conditions." *JAMA Network Open* 6 (3): e232052. https://doi.org/10.1001/jamanetworkopen.2023.2052.

Waidmann, Timothy A., Eva H. Allen, Carla Willis, Vincent Pancini, and Juliana Mayer. 2023. *Critical Role of New York's Community Health Centers in Advancing Equity in Medicaid*. Washington, DC: Urban Institute.

Watkins, Katherine E., Susan M. Paddock, Teresa J. Hudson, Songthip Ounpraseuth, Amy M. Schrader, Kimberly A. Hepner, and Greer Sullivan. 2016. "Association Between Quality Measures and Mortality in Individuals With Co-Occurring Mental Health and Substance Use Disorders." *Journal of Substance Abuse Treatment* 69:1–8. https://doi.org/10.1016/j.jsat.2016.06.001.

Wheeler, John R.C., and Tammie A. Nahra. 2000. "Private and Public Ownership in Outpatient Substance Abuse Treatment: Do We Have a Two-Tiered System?" *Administration and Policy in Mental Health* 27 (4): 197–209. https://doi.org/10.1023/A:1021357318246.

Wishon, Allison, and Jonathan D. Brown. 2021. "Variation in Services Offered by Certified Community Behavioral Health Clinics and Community Mental Health Centers." Princeton, NJ: Mathematica.

Wittenberg, Eve, Carolina Barbosa, Riley Hein, Emma Hudson, Benjamin Thornburg, and Jeremy W. Bray. 2021. "Health-Related Quality of Life of Alcohol Use Disorder with Co-Occurring Conditions in the US Population." *Drug and Alcohol Dependence* 221:108558. https://doi.org/10.1016/j.drugalcdep.2021.108558.

Wolfson, J. 1996. "Overcoming Challenges to Tax-Exempt Status." *Healthcare Financial Management: Journal of the Healthcare Financial Management Association* 50 (4): 58–63, 65.

Zhu, Jane M., Emmanuel Greenberg, Marissa King, and Susan Busch. 2024. "Geographic Penetration of Private Equity Ownership in Outpatient and Residential Behavioral Health." *JAMA Psychiatry*, May. https://doi.org/10.1001/jamapsychiatry.2024.0825.

About the Authors

Victoria Lynch is a senior research associate in the Health Policy Center at the Urban Institute. Lynch's areas of expertise include health surveys, enrollment, claims and encounter data, Medicaid and the Children's Health Insurance Program (CHIP), health care use and expenditure, substance use disorder, and mental health. Lynch has numerous publications from research examining survey methods, participation in Medicaid/CHIP, prevalence, and characteristics of people with behavioral health disorders, gaps in recommended health services, and other health services topics. Lynch has a BS in politics from Princeton University and an MS in survey methodology from the University of Maryland/University of Michigan/Westat.

Maya Payton is a research analyst in the Health Policy Center, where her work focuses on topics of health equity, treatments for substance use disorders, and Medicaid. She graduated from the University of Chicago with a BA in statistics.

Lisa Clemans-Cope is a senior fellow in the Health Policy Center. Her areas of expertise include substance use disorder and opioid use disorder and treatment; health use and spending; access to and use of health care, private insurance, and Medicaid and the Children's Health Insurance Program; people dually eligible for Medicare and Medicaid; health reform legislation and regulation; and health-related survey and administrative data. Clemans-Cope has published her research in the *New England Journal of Medicine*, *Health Affairs*, *Pediatrics*, and *Inquiry*. Clemans-Cope has a BA in economics from Princeton University and a PhD in health economics from the Johns Hopkins Bloomberg School of Public Health.

Acknowledgments

This brief was funded by the National Institute for Health Care Reform (NIHCR). We are grateful to them and to all our funders, who make it possible for Urban to advance its mission.

The views expressed are those of the authors and should not be attributed to the Urban Institute, its trustees, or its funders. Funders do not determine research findings or the insights and recommendations of Urban experts. Further information on the Urban Institute's funding principles is available at urban.org/fundingprinciples.

The authors are grateful for Eva Allen's expertise in reviewing this brief.

500 L'Enfant Plaza SW
Washington, DC 20024
www.urban.org

ABOUT THE URBAN INSTITUTE

The Urban Institute is a nonprofit research organization that provides data and evidence to help advance upward mobility and equity. We are a trusted source for changemakers who seek to strengthen decisionmaking, create inclusive economic growth, and improve the well-being of families and communities. For more than 50 years, Urban has delivered facts that inspire solutions—and this remains our charge today.