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BOWEN CENTER
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INDIANA UNIVERSITY
SCHOOL OF MEDICINE

Bowen Center for Health Workforce Research and Policy | www.bowenportal.org | @IUBowenCtr | 317.278.4818

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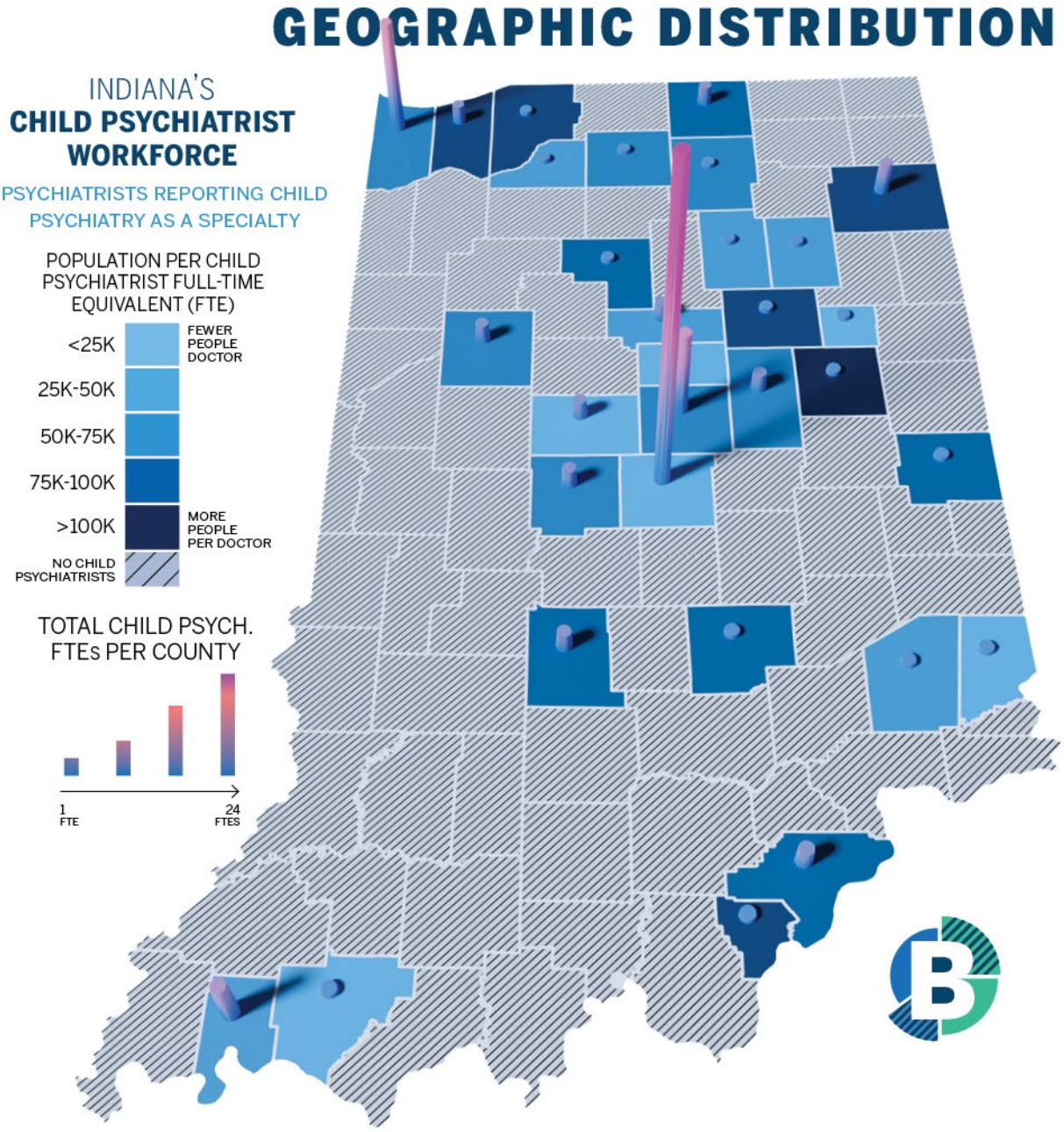
# INTRODUCTION

## A NATIONAL CRISIS IN YOUTH MENTAL HEALTH

Child and adolescent mental health in the United States has reached a critical tipping point. An estimated 7.7 million children ages 0-17 have a mental health disorder such as depression, anxiety, or attention-deficit/hyperactivity disorder. Despite growing national recognition of the issue, less than half of the millions of children and adolescents with mental health concerns received the treatment they need. Untreated mental illness in children and adolescents can have lifelong negative consequences and is compounded by issues with care. With only 14 child and adolescent psychiatrists available per 100,000 children in the United States, it is clear that novel workforce solutions are necessary.

### A CLOSER LOOK AT INDIANA

While national statistics are worrying, Indiana communities and youth are much worse off. Nearly one in four Hoosier families report difficulty accessing mental health treatment for their children, with few (11%) successfully receiving care. This lack of access is further strained by a shortage of mental health providers across the state. Of Indiana's 92 counties, 31 (33.7%) have no actively practicing psychiatrists. The landscape of child and adolescent psychiatrists in Indiana is even more sparse. Supporting youth mental health through unique workforce models is essential to securing Indiana's future.




## NOVEL SOLUTION: CHILD PSYCHIATRY ACCESS PROGRAMS

The integration of mental and behavioral health into primary care settings is a recognized solution to increasing access to care. Given the access challenges children face and the fact that more than 80% of Hoosier children had a primary care visit in the last year, expanding mental and behavioral health services offered by pediatric providers is a top strategy to increase access. Child Psychiatry Access Programs

(CPAPs) are a solution for the integration of these services into pediatric appointments. The CPAP model, as defined by the National Network of Child Psychiatry Access Programs (NNCPAP), promotes integrated care through four components: tele-consultation, direct consultation, referral, and education/training to support primary care practitioners.

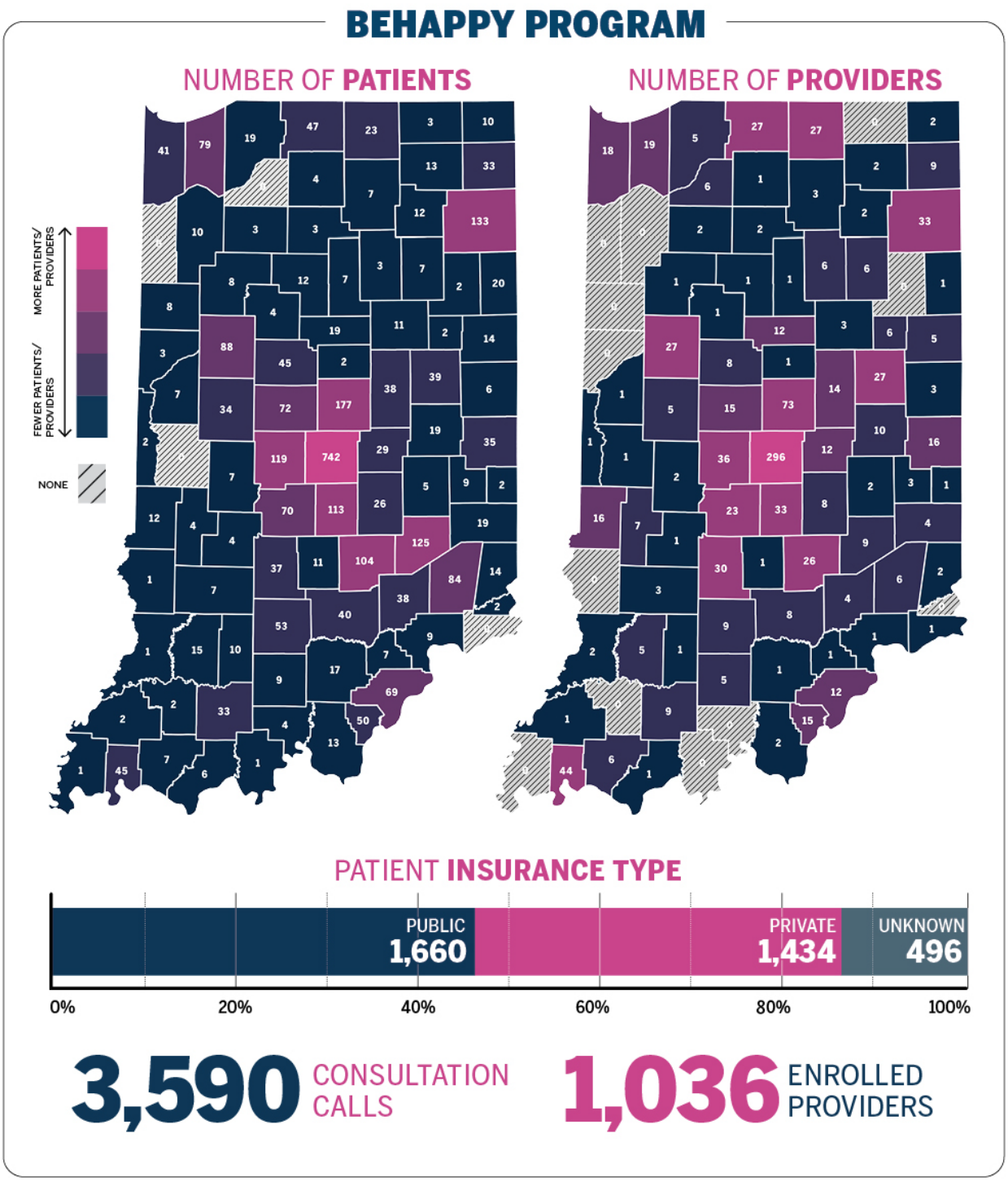
## INDIANA BEHAVIORAL HEALTH ACCESS PROGRAM FOR YOUTH ("BE HAPPY")

Indiana's CPAP is the "Indiana Behavioral Health Access Program for Youth" ("Be Happy"). Be Happy has board-certified child and adolescent psychiatrists who consult with community-based providers to help with assessment, diagnostic clarification, medication management, treatment planning, and other pediatric mental health questions. Additionally, Be Happy staff assist with community referrals. They also offer provider education and training opportunities. These services are provided at no cost to providers or patients.

From 2019 to 2025, Be Happy has consulted on cases for over 3,500 patients, representing Hoosiers in 88 of Indiana's 92 counties, and approximately half of these were on public insurance programs (see the figure on the next page). Although Be Happy provides services at no cost to providers or patients, funding through a sustainable mechanism is essential to the continued operation of this vital program for Indiana's youth. Be Happy is currently funded through the Health Resources and Services Administration (HRSA) through September 2026.

To better understand the program's impact, a survey of Primary Care Providers enrolled in Be Happy provided the following reflections on how the program has influenced their clinical practice and level of mental health care provided.

- *"I can screen, diagnose, and treat common mental health disorders on my own. I'm also able to recognize more complex mental health concerns and facilitate referrals to my mental health colleagues. The Be Happy Program has truly revolutionized my approach to and comfort with addressing mental health problems in my patients."*
- *"This is the most helpful, impactful, and practical program I've encountered since residency. I've been able to make a real difference in my patients' lives thanks to Be Happy."*
- *"While it's hard to find therapists or counselors for my patients, it's not impossible—our local schools have good resources. But it's nearly impossible to find a psychiatrist; there aren't any in our entire city. Knowing I can reach out to speak with a child psychiatrist for help with complicated cases is amazing."*
- *"This program gives me greater confidence in diagnosing, initiating treatment, and following up with patients who have behavioral health conditions."*




## SUSTAINING THE SOLUTION

The financial sustainability of CPAP models is important to ensure the continuity of these key services. There are a variety of mechanisms for funding CPAPs. These range

from grant-funded models to state-appropriated models and other strategies, such as insurer-supported models. Given the dynamic nature of healthcare delivery and associated funding, understanding the various funding mechanisms for CPAPs is critical. This report presents an overview of various existing and/or potential funding models for CPAPs for the purpose of informing future planning.

# EXPLORING CHILD PSYCHIATRY ACCESS PROGRAM FUNDING MODELS

## THE APPROACH

The Bowen Center for Health Workforce Research and Policy partnered with Be Happy to prepare case studies of various funding model approaches for CPAPs. There were multiple steps in the process to identify case studies of funding strategies. State CPAPs were identified using the NNCPAP website. Be Happy prioritized specific state CPAPs for review, which included examining programmatic information and state policies related to funding. Key informant interviews were held with CPAP program leadership and selected state Medicaid offices to capture additional insights into funding models, including design, implementation, benefits, and challenges. Key informant tools were based on a review of programmatic information, policy related to CPAPs, and relevant reports and literature. Additional funding strategies and potential innovative models were identified or developed as part of the review and research process. A review of federal guidelines regarding reimbursement for interprofessional consultations was also performed to understand intersections.

*The following organizations participated in interviews and provided insights related to CPAP funding models:*

| Program Name | Model Represented | Models Discussed |
|---|---|---|
| Illinois DocAssist | Grant-funded | Grant-funded, Insurer-supported, Direct reimbursement, State-appropriated |
| Kentucky Medicaid | N/A | Grant-funded, Direct reimbursement |
| Massachusetts Child Psychiatry Access Program (MCPAP) | State-appropriated, Insurer-supported | Grant-funded, Insurer-supported, Direct-reimbursement, State-appropriated, Health system-integrated |
| Missouri Child Psychiatry Access Project (MO-CPAP) | Grant-funded | Grant-funded, Direct-reimbursement, State-appropriated, Health system-integrated |

| | | |
|---|---|---|
| National Network of Child Psychiatry Access Programs (NNCPAP) | N/A | Grant-funded, Direct reimbursement, State-appropriated |
| Pennsylvania Medicaid | Insurer-supported | Direct-reimbursement, Health system-integrated |
| Texas Child Psychiatry Access Network (CPAN) | State-appropriated | Grant-funded, State-appropriated, Health system-integrated |
| Wisconsin Child Psychiatry Consultation Program (WI-CPCP) | State-appropriated | Grant-funded, Direct-reimbursement, State-appropriated, Health system-integrated |

Five funding models were identified and are featured as case studies:

1. **Grant-funded model**
2. **Insurer-supported model**
3. **Direct reimbursement model**
4. **State-appropriated model**
5. **Health system-integrated model**

To aid in comparability, each model is evaluated based on its potential impact, sustainability, and feasibility. The considerations for each of these categorizations were developed based on insights from key informant interviews.


Each of these funding models was identified as having varying strengths, limitations, and implementation considerations. This report summarizes the opportunities and obstacles associated with each funding approach, offering information on the potential "*Pathways to Sustainability*" for Be Happy and other CPAPs.

# FINDINGS

## GRANT-FUNDED MODEL

### MODEL DESCRIPTION

The **grant-funded model** includes any funding provided to CPAPs from government or non-governmental sources. This is the current funding model for Be Happy. It is also the funding model for the majority of CPAPs across the United States.

**Government funding** is a top source of grant funding for CPAPs. The Health Resources and Services Administration (HRSA), a federal agency, administers a "Pediatric Mental Health Care Access Program" grant, which supports CPAPs in 46 states, including Indiana. This program has distributed $189 million since 2018. This funding has been used to create new CPAPs, expand existing CPAPs, and support third-party technical assistance for CPAPs. In the 2023 grant cycle, HRSA funding applicants were required to be "states, political subdivisions of states, territories, Indian Tribes and/or Tribal organizations." This required CPAPs to have a collaborative partnership with a state agency.

**Non-governmental** sources are another source of grant funding for CPAPs. Several CPAPs have been kick-started through private investments to support initial pilots, including Be Happy in Indiana. In some cases, these programs subsequently received government funding for operations following the pilot phase.

### KEY INFORMANT INSIGHTS

Seven of the interviewees provided insights on grant funding as a strategy for CPAPs (see the above list). Three specifically discussed grant funding that they received to support their program operations. Illinois and Missouri described the HRSA grant funding that currently supports their programs and shared insights on how these grant funds are passed through to them from a state agency. Wisconsin shared insights on how private sector (non-governmental) investments helped them to pilot the access program and substantiate a successful state appropriation request (additional information presented in the State Appropriated Programs model section). Impact, sustainability, and feasibility considerations for the grant-funded model sourced from key informant interviews are summarized below.

## MODEL CONSIDERATIONS

**Impact: High ↑**

Grant funding has contributed significantly to the creation and expansion of CPAPs, particularly during early development and program scaling. It has enabled the launch of new CPAPs, supported expansion into underserved areas, and facilitated innovation. This is the most common funding strategy for CPAPs and has enabled access to mental health services for thousands of children across America.

**Sustainability: Low ↓**

The availability of grant funding is subject to prioritization within the budgets of the sponsoring organizations, regardless of whether they are government or non-government sources. Recent shifts indicate there may be reductions in both the number of awards and award amounts for relevant HRSA grant opportunities. Additionally, grant funding can be challenging to obtain because of the competitive and administratively time-consuming nature of the application process. Grants are generally time-limited in nature, requiring funded programs to submit renewal requests at specific intervals. The temporary and competitive nature of grant funding may threaten long-term operations, program stability, and service continuity.

**Feasibility: Moderate ↔**

Grant funding has historically been the leading model for CPAPs. This is largely due to federal investment in these programs. However, changes in budgetary prioritization may impact the landscape of federal grant funding. Sole dependency on federal grants may not be a viable option for CPAPs in the future. Private sector (non-government) grant funding may help CPAPs diversify funding sources and bridge funding gaps while supporting efforts to pursue more sustainable funding strategies.

## MODEL TAKEAWAY

A grant-funded model is most feasible when used as a **complementary** rather than **primary** funding mechanism and should be integrated into a broader, more stable financial strategy to support CPAP operational needs.

**Snapshot of Benefits vs. Challenges**

| Benefits | Challenges |
|---|---|
| ■ May provide critical funding during program development<br>■ Instrumental in the expansion of CPAPs nationally<br>■ Has demonstrated an impact on access<br>■ May serve as a stopgap option to bridge funding shortages | ■ Provides time-limited financial support<br>■ Highly competitive environment<br>■ Limited availability of grant funding<br>■ Administrative burden can strain the program<br>■ Subject to budget prioritization |

## APPLICATIONS FOR INDIANA

The grant-funded model has been instrumental in the development of the Be Happy program in Indiana. Be Happy received an initial investment through the Indiana University Health Foundation. Additional grant funding from the Elevance Foundation and the state of Indiana has also been used previously. The current model uses a HRSA grant passed through the Indiana Department of Mental Health and Addiction (DMHA) to educate providers across the state and expand access to specialized care for children and adolescent Hoosiers in need.

While Be Happy has experienced success with this model, current funding is set to expire in 2026. Be Happy should carefully consider the limitations of grant funding when planning for long-term operations and leverage it as a supplementary source of funding.

- **Diversify funding sources.** The most important action that can be taken at this time is the pursuit of additional funding sources to diversify Be Happy's funding portfolio. To secure continuity, it is critical to ensure that the program is not fully reliant upon federal grant funding. Private sector (non-government) grant funding should be explored, including philanthropic organizations that prioritize children's mental health. The other funding models described in this report should also be explored as strategies.
- **Develop and implement a comprehensive sustainability plan to support long-term planning.** Grant-making organizations may need to be more competitive in awards if funding were to be reduced. Sustainability plans may increase the

competitiveness of a grant application as they show a commitment to long-term service delivery, impact, and responsible usage of funds. They may also be useful for long-term organizational planning. This plan should outline specifics for diversifying the program's funding sources, including identifying specific organizations, individuals, or grant opportunities to be pursued, strategies for cultivating old and developing new relationships, and potential corporate partnerships.

- **Collect data on outcomes to show the impact and reach of the program to various stakeholders.** Data has been used to support several grant funding applications from access programs as well as to enhance support and buy-in from stakeholders across the state, which may result in connections with funding opportunities. The most impactful data elements include:
    1. The cost per child if the access program provided care to every pediatric Hoosier. When interviewed, Massachusetts' CPAP reported an estimated cost of operating at $2.33 per child in their state. Indiana has approximately 1,587,254 children under the age of 18. Dividing the cost for statewide Be Happy operations by this figure will provide an estimate for Indiana.
    2. A comparison of Medicaid claims with consultation and those without consultation to show improvements in outcomes.
    3. Call volume over time: if this shows a decrease because pediatric primary care providers feel more confident seeing their patients, this could be beneficial.

# INSURER-SUPPORTED MODEL

## MODEL DESCRIPTION

The **insurer-supported model** includes any funding provided to CPAPs by insurers, including both Medicaid Managed Care Entities (MCEs) and commercial insurance companies. Several CPAPs are currently funded, either in whole or in part, through this model. The Pennsylvania Medicaid Office and the Massachusetts CPAP confirmed that insurers support CPAP operations through a per member per month (PMPM) payment structure.

In the **MCE-Supported Model,** Medicaid MCEs contribute to CPAP funding through contract-required PMPM payments. In Pennsylvania, the Office of Medicaid recommended a state CPAP after identifying a need for mental health consultation support for primary care providers. Pennsylvania MCEs are required, through contract with the State Office of Medicaid, to contribute a portion of their revenue to support the Pennsylvania Telephonic Psychiatric Consultation Service Program (TiPS). Each MCE pays a cost-share amount to support TiPS programming across three regions of the state (Southeast, Northeast and Lehigh/Capital, and Southwest/Northwest). Regional vendors for telephonic consultations were procured by MCEs, required to be enrolled in and accept Pennsylvania Medicaid, and capable of providing telemedicine services. The specific amount an MCE pays is based on the PMPM calculation using the number of pediatric members they cover. TiPS consultation services are limited to children who are Pennsylvania Medicaid members. There is interest in expanding the program to children with commercial insurance; however, the Office of Medicaid has no authority over commercial insurers, and other options are being explored.

In the **Commercial Insurance Supported Model**, CPAPs receive financial support from commercial insurance companies. In Massachusetts, CPAP funding comes from two sources: insurer-supported and legislative earmark (described below). The state legislature established the Massachusetts CPAP (MCPAP) as a budget earmark in 2004. Later, in 2016, the state introduced a commercial insurer-funded model to diversify funding. Commercial insurers contribute to CPAP operations through a PMPM amount based on the share of the state's pediatric population covered. This funding strategy was modeled after a successful universal vaccine program that allowed the state to split the cost of vaccines among insurers. The Massachusetts CPAP refers to this strategy as only requiring insurers to pay "pennies per member" to support 60% of CPAP operations. However, this model only supports patients with commercial insurance, so the legislature continues to provide funding to cover the 40% of CPAP operations associated with public insurance patients. This strategy demonstrates how commercial insurers can contribute to CPAPs through cost-sharing, especially when supported by state-level policy and oversight.

## KEY INFORMANT INSIGHTS

Four of the interviewees provided insights on the insurer-supported model as a strategy for CPAPs (see above list), including NNCPAP, Pennsylvania, Massachusetts, and Missouri. Insights from Pennsylvania and Massachusetts are highlighted above.

NNCPAP described the successes and limitations of this strategy. For models implemented through state policy levers, NNCPAP emphasized that advocacy efforts would be necessary for every budgetary cycle. Prior to the onset of the COVID-19 pandemic, Missouri CPAP reported exploring an MCE-supported model, but progress stalled, and they hope to reenergize the work in the future. Impact, sustainability, and feasibility considerations for this model sourced from key informant interviews are summarized below.

## MODEL CONSIDERATIONS

**Impact: High ↑**
Insurer priorities typically include reducing high-cost medical care visits and improving health outcomes for their patient population. CPAPs directly contribute to this goal by providing specialized mental health education to pediatric primary care providers, ultimately reducing youth admissions to emergency departments and psychiatric hospitals. This model has the potential to align CPAP goals of identifying stable long-term operational support with insurer priorities while also benefiting communities and youth. Once under contract, insurers may advertise the CPAP to their providers, which increases the visibility and integration of CPAPs into the mental health care delivery system. This model would also improve CPAP access to claims data. CPAPs will be able to evaluate this data to show decreased costs and improved outcomes.

**Sustainability: High ↑**
An insurer-supported model would provide a stable source of funding for CPAPs. While there may be some fluctuations in enrollees, this model ties funding directly to the population served. It is also important to note that contracts are renegotiated regularly. In model language that has been recommended in Indiana, an association is created for the primary purpose of fair and equitable administrative oversight and coordination of the fund. Insurers would be represented in this association, ensuring sustained engagement from insurers for continued collaboration.

**Feasibility: Low ↓**
While these models can be highly effective, they require significant coordination. First, CPAPs must develop relationships with insurers in their states, which may be difficult. CPAPs should leverage relationships with other relevant stakeholders to support these efforts. Second, this model would require data demonstrating program effectiveness and outcomes to obtain buy-in. Finally, this model would require legislative or executive branch action for contractual modifications. MCOs and commercial insurers have contracts with state executive branch agencies such as Offices of Medicaid or

Insurance. Contractual modifications requiring insurers to provide telephonic consultation services are necessary. It may be difficult to determine the specific proportional payment arrangement; however, the creation of an association or advisory board could significantly reduce the complexities associated with this. These modifications should also outline the specific proportional payment arrangement, which may be complex given insurer competition. It is important to ensure the contractual language is not too directive. This ensures insurer autonomy and avoids the time-consuming directed payment approval process through the Centers for Medicaid and Medicare Services (CMS). The success of these models depends on sustained stakeholder engagement and clear contractual frameworks. Model language is available from the KV Foundation, which may address many of these considerations.

## MODEL TAKEAWAY

While insurer-supported models offer the potential for **far-reaching impact** and **long-term sustainability**, **feasibility is low** due to the significant coordination and relationship-building required to implement. Given these considerations, CPAPs with an interest in transitioning to this model should begin planning and implementing in advance to ensure no gaps in operational funding.

**Snapshot of Benefits vs. Challenges**

| Benefits | Challenges |
|---|---|
| ■ Stable and predictable funding streams<br>■ Cost benefit to insurers due to reduced use of high-cost mental health services<br>■ Claim data may be used to evaluate program outcomes<br>■ Deeper integration into the mental health system through collaboration with insurers | ■ Requires legislative or executive branch action<br>■ Negotiation of proportional contributions can be difficult and complex<br>■ Administrative implementation requires significant strategy to avoid CMS complications<br>■ Fluctuations in enrollment may impact funding |

## APPLICATIONS FOR INDIANA

Be Happy should understand the policy considerations of implementing an insurer-supported model. Indiana Medicaid is administered through a managed care model, with six major MCEs providing services in the state. Twelve commercial insurance

companies operate in the state and are considered Affordable Care Act compliant. There are several organizations that provide both commercial and public insurance in Indiana. The structure necessary for implementing this model exists, and there has been previous interest in the approach. The 2024 Indiana Behavioral Health Commission (INBHC) Final Report explicitly recommended the Indiana General Assembly require insurers to support Be Happy using this model.

The best approach to ensure full operational support for Be Happy would be a combination of the commercial insurer-supported model and the MCE-supported model. Commercial and public insurers would cover their respective portions of the pediatric population, ensuring full access to Be Happy services for Indiana youth regardless of insurance status.

There are key considerations for this model:

- **Develop a plan for stakeholder engagement**. Many stakeholders will need to be engaged when implementing this model. These individuals would include leaders for all relevant insurers, the Indiana Department of Insurance, the Indiana Office of Medicaid Policy and Planning (OMPP), legislators, and others. In Pennsylvania, implementation was led by the Office of Medicaid, which may indicate a good starting point. Be Happy should leverage existing relationships to connect with relevant leaders, including those with the DMHA and Indiana University Government Relations.
- **Collect data on outcomes to show the relevance for insurers.** As discussed in previous models, data demonstrating program outcomes will increase stakeholder trust in the program. Data depicting Be Happy's impact on healthcare outcomes and cost will be the most relevant for insurers. Obtaining Indiana claims data and assessing the differences between calls with consultations and those without consultations may be helpful. There may also be opportunities to leverage national sources of evaluation data.

# DIRECT REIMBURSEMENT MODEL

## MODEL DESCRIPTION

The **direct reimbursement model** involves billing insurance for CPAP services using interprofessional consultation codes. Early in 2023, the Centers for Medicare and Medicaid Services (CMS) issued guidance that coverage of interprofessional consultation services was now permissible. Prior to this guidance, the lack of direct contact between the patient and the consulting practitioner prohibited reimbursement for these services. CMS highlights this policy change as a beneficial update for CPAPs.

CMS defines interprofessional consultation as when a "treating practitioner requests opinion/advice from a consulting practitioner to assist with the patient's care without patient face-to-face contact with the consulting practitioner." CMS has instructed providers to document interprofessional consultation through Current Procedural Terminology (CPT) codes 99446-99449 and 99451-99452. An estimated 30 states cover interprofessional consultation as a distinct service. The average reimbursement rate across states for these codes ranges from $14.92 for 5-10 minutes up to $52.17 for more than 31 minutes.

## KEY INFORMANT INSIGHTS

While seven interviewees provided insights on the direct reimbursement model as a funding strategy (see above list), none of the CPAPs interviewed reported using this approach. Three of the CPAPs (Illinois, Missouri, Wisconsin) and NNCPAP cited legal concerns related to establishing a direct patient-provider relationship as a key barrier. Another commonly cited barrier was the low reimbursement rate. NNCPAP, Illinois, Missouri, Wisconsin, Massachusetts, and Pennsylvania Medicaid all agreed that low reimbursement rates combined with average call volume limits the financial viability of this model.

To better understand state-level utilization of relevant CPT codes, interviews were conducted with representatives from the Kentucky Department of Medicaid Services and Pennsylvania Medicaid. Although these codes are covered by Medicaid in both states, utilization remains low. A summary of key informant perspectives on the impact, sustainability, and feasibility of the direct reimbursement model is included below.

## MODEL CONSIDERATIONS

**Impact: Moderate ↔**

A direct reimbursement model would create a revenue stream directly proportionate to call volume. By reimbursing for services, CPAPs could become more integrated into the existing health care billing infrastructure and gain access to valuable claims data. This data would support program evaluation and help quantify outcomes. Additionally, the model would align CPAPs with CMS priorities that emphasize team-based, integrated care. However, because patients may receive a bill for a copay, this model could reduce patient satisfaction with CPAPs.

**Sustainability: Low ↓**

Sustainability of this model is closely tied to evolving state and federal Medicaid reimbursement policies. Based on the typical CPAP call volume, current reimbursement rates may be insufficient to fully cover program operating costs. Additionally, implementing this model requires significant upfront investment to build and sustain administrative capacity. This would include obtaining billing software, training staff in claims processing, and integrating into electronic health record systems. These administrative demands would not be one-time and instead would need to be sustained over time to ensure effective claims management.

**Feasibility: Low ↓**

As of 2025, 35 states reimburse for these CPT codes, while Indiana is among the 15 that do not. In states where these codes are not covered by Medicaid, this model would not be feasible without state-level policy changes. To implement this model, such states would need to amend their Medicaid State Plan to include interprofessional consultation services. A state plan amendment (SPA) may increase a state's Medicaid budget, require substantial administrative effort from a state's Medicaid agency, and require approval from CMS.

It is important to note that all CPAPs interviewed for this project reported that they do not currently use these codes, even in states where they are covered by Medicaid. Many CPAPs suggested implementing this model would require significant changes to their existing program structure. Another commonly cited concern was the increased medical-legal risk associated with accessing a patient's electronic health record.

Finally, KY and PA Medicaid leaders emphasized that these codes are generally underutilized. Both states attributed this to limited awareness of the codes,

uncertainty around usage requirements, and concerns about the broader implications for health systems.

## MODEL TAKEAWAY

While the direct reimbursement model offers a mechanism for consistent financial support, its effectiveness as a sole source of funding is severely limited. For most CPAPs, direct reimbursement through interprofessional consultation codes is **not a recommended model** based on the current structure.

**Snapshot of Benefits vs. Challenges**

| Benefits | Challenges |
|---|---|
| ■ Provides a consistent revenue stream due to regular claims submission<br>■ Integration into existing funding structures by utilizing CPT codes<br>■ Alignment with CMS priorities around team-based care<br>■ Claim data may be used for program evaluation | ■ Low Medicaid reimbursement rates<br>■ Increased risk of legal liability for providers<br>■ Underutilization and lack of awareness of CPT codes<br>■ Requires complex and repeated administrative tasks<br>■ May impact patient satisfaction due to patient co-pays |

## APPLICATIONS FOR INDIANA

In Indiana, interprofessional consultation CPT codes (99446–99449 and 99451–99452) are currently not reimbursed under Medicaid and are excluded from coverage through the Indiana Health Coverage Programs.

When considering the direct reimbursement model, Be Happy should evaluate whether average reimbursement rates, when paired with projected call volume, would be sufficient to sustain operations. Additionally, Be Happy leaders should carefully weigh potential benefits against challenges, including patient dissatisfaction and legal implications related to patient records.

If Indiana were interested in this model, the first and most critical step would be building the political will necessary to support a SPA. Given the current Medicaid policy environment in Indiana, this would likely be a long-term endeavor requiring sustained stakeholder engagement and advocacy over several years.

- **Engage key stakeholders and build strategic relationships.** Begin by identifying key stakeholders and cultivating new relationships. This may include the Indiana OMPP, Indiana DMHA, state legislators, and/or representatives from the Governor's Office. Additionally, it will be important to obtain buy-in from large health systems, professional associations, and other stakeholders. Be Happy may be able to leverage their existing connections and those of Indiana University Government Relations.
- **Align with broader state health priorities.** Explore opportunities to align the request for a SPA with other health initiatives in Indiana. Because SPAs often require significant administrative effort, combining multiple health initiatives into a single amendment may enhance its strategic value, attract other stakeholders, and improve the likelihood of obtaining state buy-in.
- **Demonstrate program value through data.** Collect and disseminate outcomes data that highlight Be Happy's impact on access to care, quality of services, and cost-effectiveness. Transparent reporting will help build trust, reinforce program credibility, and strengthen support among policymakers.

# STATE-APPROPRIATED MODEL

## MODEL DESCRIPTION

The **State-appropriated model** includes funding for CPAPs allocated from state legislatures, executive office budgets, or an earmark included within a broader state appropriation. Several CPAPs were identified as currently using this model. This includes Texas, where program funding was included in the Governor's budget; Wisconsin, which is fully funded through a line item appropriation; and Massachusetts, which receives an earmark within the Department of Health budget. All three of these CPAPs operate statewide through regional vendors/hubs.

In Texas, CPAP funding follows the **Executive Office Model,** meaning it comes through the Governor's budget. A major health system/university led a five-year-long process of building relationships and political will to accomplish this. They formed a workgroup that included system psychiatric leaders, and over time, it grew to include representatives from other universities, hospitals, state agencies, and advocacy groups. As a result of ongoing engagement with legislators, the workgroup received a bill request. This led to the creation of the Texas Child Mental Health Care Consortium (TCMHCC). The TCMHCC seeks to address mental health challenges through five initiatives, one of which is the Child Psychiatry Access Network (CPAN). From 2022-2025, Texas's CPAP has received $78.8 million in state funding.

### TCMHCC HAS FIVE INITIATIVES:

- **The Child Psychiatry Access Network** (CPAN) provides telehealth-based consultation and training to primary care providers.
- **The Texas Child Health Access Through Telemedicine** (TCHATT) program provides in-school behavioral telehealth care to at-risk children and adolescents.
- **The research initiative** has created two state-wide networks to study and improve the delivery of child and adolescent mental health services in Texas.
- **The Community Psychiatry Workforce Expansion** (CPWE) funds full-time academic psychiatrists as academic medical directors and new psychiatric resident rotation positions at facilities operated by community mental health providers.
- **The Child and Adolescent Psychiatry (CAP) Fellowships** program expands both the number of child and adolescent psychiatry fellowship positions in Texas and the number of these training programs at Texas HRIs.

In Wisconsin, CPAP funding follows a **line-item model**, meaning the program receives money directly through a specific line in the state's budget bill. According to interviews with CPAP leaders, the program began as a pilot. Wisconsin CPAP leaders reported that, after the pilot showed compelling results, two state legislators took notice and led the effort to make the program permanent by establishing it in state statute. The Department of Health was tasked with selecting vendors and launching the full program. Over time, funding for CPAP operations grew through

gradual increases in the initial support but was also instrumental in justifying and securing funding increases. In 2024-2025, Wisconsin's CPAP received $4.0 million in appropriation.

In Massachusetts, CPAP funding comes from two sources: **insurer-funded and legislative earmark**. The state legislature established the Massachusetts CPAP (MCPAP) as a budget earmark in 2004. Later, in 2016, the state introduced a commercial insurer-funded model (described above) to diversify funding. However, this model only supports patients with commercial insurance, so the legislature continues to provide funding to cover the 40% of CPAP operations associated with public insurance patients. For Fiscal Year 2024, Massachusetts CPAP reports receiving $3.785 million in appropriation.

## KEY INFORMANT INSIGHTS

Five of the interviewees provided insights on state-appropriated programs as a strategy for CPAPs (see above list). The three programs described above reported receiving direct state appropriations to support their CPAP operations. Both Texas and NNCPAP emphasized the importance of stakeholder engagement in building the political will necessary to secure appropriation. Massachusetts highlighted the value of establishing an advisory board to set the CPAP budget. This advisory board would facilitate budgeting with the legislature to reduce the burden on CPAP leadership. Impact, sustainability, and feasibility considerations for the state-appropriated model sourced from key informant interviews are summarized below.

## MODEL CONSIDERATIONS

**Impact: Moderate ↔**
State appropriations have played a crucial role in ensuring the long-term stability and growth of several CPAPs. This state-appropriated model can enhance the program's visibility among the public and key stakeholders, such as philanthropic organizations and hospital systems that may advocate for the program and assist with recruitment. When a CPAP is established in state statute, it gains legitimacy as a state priority. Furthermore, state funding may foster greater collaboration and alignment with other state agencies. However, programs that receive state appropriations are typically required to adhere to state policies and procedures, which may restrict flexibility in the program's operations.

**Sustainability: Low ↓**
The availability of state-appropriated funding is subject to the prioritization of legislative or executive branch leaders. The sustainability of this model is closely tied to the ability to maintain legislative support, which may shift with administration

changes and budget constraints. Access programs may reduce the impact of political volatility by prioritizing engagement with various legislators and collecting and disseminating positive outcomes data.

**Feasibility: Moderate ↔**
Implementation of this model requires sustained legislative advocacy, coalition-building, and navigation of the political system. University-based CPAPs may face unique challenges, such as restrictions on lobbying, which make collaboration with university government relations offices essential. Another challenge is securing funding when the university already receives state support. Understanding the specific political landscape and appropriate timing will be key success factors. Presenting strong outcomes data to legislators can help build support, especially when focused on those with interest in youth, mental health, or healthcare access. While it may take several legislative sessions to secure funding and build toward full operational support, it is possible to build bipartisan support and secure state appropriations.

## MODEL TAKEAWAY

While the implementation of the state-appropriated model requires sustained advocacy and political navigation, this model can **significantly enhance CPAP operations** and expand access. CPAPs pursuing this model should prioritize **early coalition building** and collecting **program outcomes data**. With a strategic approach, this model can become an impactful and durable funding mechanism.

**Snapshot of Benefits vs. Challenges**

| Benefits | Challenges |
|---|---|
| ■ Encourages collaboration and alignment with other state agencies<br>■ Establishes CPAP legitimacy as a state priority and increases visibility<br>■ States can tailor CPAPs to meet their constituent needs | ■ Subject to budget prioritization<br>■ University-based CPAPs may face lobbying restrictions<br>■ Difficult to secure CPAP funding if program is housed within a state-funded institution<br>■ State requirements for usage of funds |

## APPLICATIONS FOR INDIANA

Securing a state appropriation will require sustained advocacy efforts. If interested in pursuing this approach, Be Happy leaders should consider the following strategic steps and prioritize them accordingly.

- **Develop a strategic plan.** The plan should outline the necessary steps to build stakeholder and legislative buy-in for a state appropriation.
    1. *Identify legislative champions*. Finding legislators to sponsor legislation for a state appropriation is a key first step. It may help to identify policymakers who have previously supported youth, mental health, or behavioral health infrastructure. Developing deep relationships with well-positioned individuals will be a key factor contributing to success or failure.
    2. *Conduct a fiscal analysis*. Program leaders should determine the funding needed to support Be Happy's state-wide operations. Currently, Be Happy operates with a grant of about $500,000 a year.
    3. *Draft/revise statutory language*. The Indiana Behavioral Health Commission has drafted statutory language establishing Be Happy in statute and funding the program through an insurer-supported model. Revisions to this statutory language may be necessary depending on the funding model selected. Additional revisions may be needed to include the development of a CPAP advisory board. Several CPAPs using this model recommended this to reduce the burden of legislative advocacy on CPAP leadership.
    4. *Leverage IU Government Relations*. As the office overseeing advocacy, discussions with elected officials, or political activity, Government Relations may be able to assist with some aspects of developing this strategic plan.
- **Conduct a legislative landscape assessment.** Be Happy should assess the current legislative environment to identify opportunities and barriers to pursuing this model.
    1. Understand when key events happen in the budgetary process, including agency budget requests, the release of the Governor's budget, and budget hearings. These dates will guide legislative engagement throughout the session.
    2. Identify key legislative committees that may review this bill (i.e., Health and Provider Services, Appropriations, etc.). Knowing the chairs of these committees and members who may support or oppose the effort will help prioritize individuals for relationship building and education.
    3. Assess the political climate. Review recent trends in mental health legislation in Indiana to understand current state priorities. This review can also be used to identify pieces of legislation that did not pass. Follow-up discussions with those bill authors might reveal opportunities to avoid the challenges they experienced. Insights from this review and follow-up conversations may help Be Happy align with the goals of legislators and tailor the legislative request to be effective.
- **Explore strategic collaboration with stakeholders who have similar legislative requests.** Aligning with broader mental health or youth services initiatives can strengthen the overall case for investment. For example, in Texas, the CPAP

program collaborated with an initiative that had strong legislative backing and was able to benefit from this. Joint advocacy efforts demonstrate unified support, increase visibility, and appeal to legislators who favor integrated or comprehensive solutions.

# HEALTH SYSTEM-INTEGRATED MODEL

## MODEL DESCRIPTION

The **health system-integrated model** embeds CPAPs within a nonprofit health system, hospital, or hospital association. While no CPAPs have reported operating under this model, several have explored it and view it as a promising and innovative funding approach.

In this model, the CPAP functions as part of a health system's infrastructure, providing telephonic consultations to outpatient pediatric primary care providers. The health system funds the program using internal resources, which may qualify as a community benefit and support its 501(c)(3) tax-exempt status. This approach leverages the resources of a health system, including its existing billing and administrative infrastructure. Additionally, this model may align well with the direct reimbursement model described above. Because the CPAP is integrated into the health system and has access to patient records and health system infrastructure, billing for interprofessional consultation codes for reimbursement is easier. Additionally, providers seeking consultations within the health system may bill for their time.

A variation of this model involves embedding the CPAP within a hospital association rather than a single health system. Hospital associations represent and serve different types of hospitals and health systems that choose to become members. The American Hospital Association recognizes a hospital association in every state in the U.S. Hospital associations are typically funded through membership dues that allow them to participate in advocacy, education, or strategic initiatives to support health. Funding for this model would be pooled from hospital association members. Any contributing members gain access to CPAP services for their patients and providers. The hospital association would manage the administration of the CPAP and coordinate finances and operations. This model may better support access to services statewide when compared to the health system-integrated model.

## KEY INFORMANT INSIGHTS

Four interviewees shared their insights on using the health system-integrated model to fund CPAPs (see above list). Both Wisconsin and Massachusetts CPAPs viewed the model as viable and impactful, particularly if implemented on a statewide scale. The Missouri CPAP had previously explored this model with the state hospital association, but efforts were paused due to the COVID-19 pandemic. Leaders expressed an interest in reviving the work due to the model's promising nature. Pennsylvania Medicaid emphasized that the billing infrastructure of a large health system could facilitate reimbursement through interprofessional consultation codes. See below for further

insights on the health system-integrated model's impact, sustainability, and feasibility based on these interviews.

## MODEL CONSIDERATIONS

**Impact: Moderate ↔**
A health system-integrated model offers several advantages for CPAPs, including increased visibility and integration into existing care systems. A CPAP using this model can access patient medical records, which may enhance the depth of information available for quality consultations. This model also aligns with nonprofit hospitals' missions to address community health needs. When implemented through a hospital association, this model can engage providers from multiple member hospitals, broaden the program's service delivery statewide, and reduce perceptions of system exclusivity.

However, there are limitations. Services may be restricted to patients seen by providers within the system, potentially limiting reach. Even if access is extended beyond the system, external providers might be hesitant to participate due to the system's affiliation. Neutral branding and inclusive messaging can help address this concern. The Wisconsin CPAP noted that in-house psychiatrists may worry that CPAPs could interfere with their service delivery. Clear communication from senior system leadership can help clarify roles and promote use.

**Sustainability: High ↑**
This model offers a potentially stable source of funding, as health systems can allocate community benefit dollars to fully support CPAP operations. While still subject to changes in leadership or shifting financial priorities, health system funding may be an innovative, alternative option. Integration into a health system also facilitates reimbursement through interprofessional consultation codes. Health systems typically have the infrastructure to manage billing, communicate clearly with patients to reduce confusion about copays, and provide legal and administrative support.

**Feasibility: Moderate ↔**
The feasibility of this model largely depends on the willingness of health systems to participate. Securing buy-in from health systems or hospital associations may be challenging, depending on budget constraints and organizational priorities. While no CPAPs have yet implemented this model, several have generated interest among health systems, which may suggest this is an innovative and alternative option. To secure organizational buy-in, CPAPs should highlight how their goals align with the hospital's mission and community health priorities. It may also help to emphasize the potential for external operational support generated through reimbursement. Successful implementation of this model would require sustained buy-in from organizational leadership.

## MODEL TAKEAWAY

While implementation of the health system-integrated model depends on securing sustained leadership buy-in, this approach offers a **highly feasible and sustainable** path for CPAP funding. CPAPs interested in pursuing this model should begin relationship building and emphasize alignment with system missions. This model can serve as a **stable and impactful** funding mechanism, especially when scaled through hospital associations or systems with statewide reach.

**Snapshot of Benefits vs. Challenges**

| Benefits | Challenges |
|---|---|
| ■ Opportunity to integrate with Electronic Medical Records (EMR) and care coordination systems<br>■ Access to existing infrastructure and administrative support<br>■ Potential for broader provider engagement and recruitment in association model<br>■ Stable funding source with potential for diversification through reimbursement<br>■ Opportunity for hospital systems to support community<br>■ Increased program visibility due to integration into existing care system | ■ Services only available to patients within the health system<br>■ Potential conflicts with in-system psychiatric services<br>■ Potential recruitment difficulties with providers hesitant to associate with one specific system<br>■ Subject to budget prioritization |

## APPLICATIONS FOR INDIANA

Indiana is well-positioned to explore a health system-integrated model because of the presence of several large health systems. A health system with a large geographic footprint may be able to champion this work and expand services to urban, suburban, and rural areas. By partnering with a large health system, Be Happy could expand its services across the state and take advantage of the provider network, resources, and infrastructure of a large system.

Looking at a hospital association model, the Indiana Hospital Association (IHA) represents more than 170 hospitals across the state and has a significant reach in

rural, urban, and suburban areas. An affiliation with the Indiana Hospital Association would also help ensure access for many of the children and youth in Indiana.

There are key considerations for this model:

- **Identify strategic partners**. IU Health, one of several large health systems, and IHA both represent potential candidates for housing or leading a collaboration to support the Be Happy program. Be Happy should leverage existing relationships to connect with leaders from IU Health and/or IHA. These meetings should be used to introduce these leaders to the Be Happy program and how it aligns with the priorities of the chosen partner. As mentioned previously, data on program effectiveness and outcomes will assist in this strategic relationship development.
- **Clarify scope and access for non-system providers.** While IU Health's network covers much of the state and IHA has many participating hospitals, Be Happy must determine whether and how services would be extended to providers outside of either system. This may represent a major change for Be Happy operations. If the program becomes exclusive to a system, there should be a clear communication strategy and referrals for non-affiliated providers.
- **Address institutional constraints.** Be Happy would need to work closely with IU Health/IHA leadership to align goals, clarify roles, and ensure that the program's mission and operations remain consistent with its broader vision of statewide access. A pilot program may help clarify the process before full integration.

## CONCLUSION

As CPAPs continue to expand their role in supporting pediatric mental health care, identifying a sustainable and effective funding model remains a critical priority. Each potential funding mechanism presents distinct advantages and limitations. Understanding the feasibility, sustainability, and potential impact of these models is essential for CPAPs seeking to align their financial strategies to support long-term service delivery.

- **Grant-funded models** are most feasible when used as a complementary rather than a primary funding mechanism and should be integrated into a broader, more stable financial strategy to support CPAP operational needs.
- **Insurer-supported models** offer the potential for far-reaching impact and long-term sustainability, but feasibility is low due to the significant coordination and relationship-building required to implement them. Given these considerations, CPAPs with an interest in transitioning to this model should begin planning and implementing in advance to ensure there are no gaps in operational funding.
- **Direct reimbursement models** offer a mechanism for consistent financial support, but their effectiveness as a sole source of funding is severely limited. For most CPAPs, direct reimbursement through interprofessional consultation codes is not a recommended model based on the current structure.
- **State-appropriated models** require sustained advocacy and political navigation and can significantly enhance CPAP operations while expanding access. CPAPs pursuing this model should prioritize early coalition building and collecting program outcomes data. With a strategic approach, this model can become an impactful and durable funding mechanism.
- **Health system-integrated models** would depend on securing sustained leadership buy-in but offer a highly feasible and sustainable path for CPAP funding. CPAPs interested in pursuing this model should begin relationship building and emphasize alignment with system missions. This model can serve as a stable and impactful funding mechanism, especially when scaled through hospital associations or systems with statewide reach.

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Please address any correspondence regarding this document to the Bowen Center via email at bowenctr@iu.edu or by phone at 317.278.4818.

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## AUTHORED BY

- **Mykayla Moore,** MPH
- **Madison Bott,** MPA
- **Hannah Maxey,** PhD, MPH

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