National Council for Mental Wellbeing – H.R.1 Member Baseline Survey Findings (December 2025)

The National Council for Mental Wellbeing surveyed members in December 2025 to understand their challenges prior to H.R.1 implementation. Survey responses from National Council members highlight access, workforce and administrative challenges that, without effective implementation strategies, could undermine the goals of H.R.1.

In many instances, the survey results reveal a system operating near or at capacity, which would struggle to absorb additional strain. As the data indicates, some clinics are already facing significant workforce challenges and staffing reductions, administrative burden and extensive waitlists. These conditions represent challenges facing many organizations now, before the most impactful provisions of H.R.1 are implemented.

Survey Respondent Profiles

The National Council's survey received responses from 97 members, encompassing 40 states, Puerto Rico and the District of Columbia. Respondents included leaders and staff from Certified Community Behavioral Health Clinics, Community Mental Health Centers, Opioid Treatment Programs, government agencies and other organizations.

Key Findings

Uncompensated care

Approximately 22% of organizations surveyed reported that, on average, between 10% and 19% of services provided each year consist of uncompensated care. An additional 22% of respondents indicated that, on average, over 20% of annual services provided were uncompensated. If coverage loss projections prove accurate, the amount of uncompensated care provided may rise for many organizations serving Medicaid clients, many of which must provide care regardless of ability to pay.

Limited capacity and access to care

More than 50% of organizations surveyed report ongoing waitlists and many people who are turned away each year due to insufficient capacity, creating access gaps for many individuals seeking care. These access gaps may lead to lower productivity and difficulty

meeting new community engagement requirements for people who are able to work but need timely treatment to stabilize and remain employed.

Workforce shortages and staffing reductions

Approximately 36% of respondents reported having to reduce staff over the past year. In many cases, staff reductions included both administrative and clinical staff. Reasons cited include reimbursement rates, rising costs and recruitment challenges. Some report operating at or near minimum staffing levels, limiting their ability to expand services. Each of these existing issues has the potential to be exacerbated by H.R.1 requirements.

Increasing clinical complexity and crisis utilization

On average, 43% of respondents reported referring patients to higher levels of care each year. Many respondents report high patient acuity, with substantial portions of patients requiring higher levels of care or emergency services. This indicates that delays in access and reduced outpatient capacity can drive people into more costly crisis settings, increasing pressure on hospitals, law enforcement and emergency systems. H.R.1's Medicaid provisions could further create challenges due to restricted access and clinic staffing levels.

Administrative burden and inefficiency

Approximately 33% of respondents report spending at least 100 hours per month on Medicaid eligibility and coverage paperwork, with some respondents reporting over 1,000 hours of monthly total staff time devoted to these tasks. Excessive administrative requirements reduce efficiency, limit the return on federal and state investments, and especially strain the resource capacity of smaller and more rural providers.

Conclusion

Survey findings suggest that effective H.R.1 implementation will require:

- Maintaining broad, timely access to mental health and substance use care.
- Minimizing administrative complexity.
- Ensuring providers have the workforce and resources needed to keep people healthy and productive.
- Reducing compliance burden for people that meet criteria for exemptions to community engagement requirements and other new requirements.

Without these considerations, additional requirements risk reducing access to care and placing further strain on local communities.

The National Council will continue surveying members, with assessments following the distribution of Rural Health Transformation Program funds, as well as the implementation of community engagement requirements, more frequent eligibility redeterminations, and several other Medicaid provisions in 2027. This will enable us to understand and demonstrate how these changes impact members, the services they provide and the system of care more broadly.