Department of Health and Human Services

Office of Inspector General

A Lack of Behavioral Health Providers in Medicare and Medicaid Impedes Enrollees' Access to Care

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March 2024, OEI-02-22-00050

March 2024 | OEI-02-22-00050

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Why OIG Did This Review

- Almost half of all Americans will experience a behavioral health condition—which includes mental health disorders and substance use disorders—in their lifetime.[1]
- Without enough behavioral health providers willing to participate in Medicare and Medicaid, enrollees may experience difficulty accessing providers or delays in care and may even forgo treatment altogether.
- OIG is conducting this review, in part, because of congressional interest in ensuring that enrollees have access to behavioral health services in traditional Medicare, Medicare Advantage, and Medicaid managed care (hereafter referred to as "Medicaid").[2]

What OIG Found

Overall, there were few behavioral health providers in the selected counties who actively served Medicare and Medicaid enrollees.

These providers represented about one-third of the total behavioral health workforce in the counties.

Despite unprecedented demand for behavioral health services, treatment rates in all three programs remained relatively low.

Most enrollees saw their behavioral health providers in person; however, many enrollees traveled long distances to see them.

What OIG Recommends

OIG recommends that CMS:

1. Take steps to encourage more behavioral health providers to serve Medicare and Medicaid enrollees.
2. Explore options to expand Medicare and Medicaid coverage to additional behavioral health providers.
3. Use network adequacy standards to drive an increase in behavioral health providers in Medicare Advantage and Medicaid.
4. Increase monitoring of Medicare and Medicaid enrollees' use of behavioral health services and identify vulnerabilities.

CMS concurred with or concurred with the intent of all four recommendations.

Primer: Behavioral Health in Medicare and Medicaid

Need for Behavioral Health Services

Having timely access to behavioral health services—which includes services for both mental health disorders and substance use disorders—is critical for the well-being of Medicare and Medicaid enrollees. However, the United States does not have enough behavioral health providers to meet the current demand for services. More than 160 million people live in Federally designated mental health professional shortage areas,[3] and in 2021, fewer than half of those with a mental illness were able to access timely care.[4] Since the onset of the COVID-19 pandemic, the need for behavioral health services has increased dramatically and has remained elevated almost 4 years later. At the height of the pandemic, 40 percent of adults reported symptoms of anxiety or depression—compared with 11 percent prior to the pandemic.[5]

In addition, many types of behavioral health providers have reported concerns about being able to meet the increased need for behavioral health services. For example, 65 percent of surveyed psychologists said they had no capacity for new patients, and 68 percent said their wait lists were longer than they were prior to the pandemic.[6] Many other behavioral health providers may be accepting new patients but do not participate in programs such as traditional Medicare, Medicare Advantage, or Medicaid. For example, a recent study found that almost two-thirds of Medicare Advantage plans had fewer than a quarter of the counties' available psychiatrists in a plan's network.[7] Additionally, less than 55 percent of the Nation's psychiatrists accept traditional Medicare, compared to more than 85 percent for other types of physicians.[8]

Medicare and Behavioral Health

In 2023, about half of Medicare enrollees (51 percent) enrolled in a Medicare Advantage plan. The remainder (49 percent) enrolled in traditional Medicare (also known as Medicare fee-for-service).[9] At a minimum, Medicare Advantage plans must cover the same services as traditional Medicare; however, plans can impose additional restrictions on coverage, such as requiring prior authorization for certain services or requiring enrollees to pay more for services provided by out-of-network providers.[10]

Medicare spends more than $27 billion annually on behavioral health services.[11] Although one in four Medicare enrollees are living with a mental illness, less than half of them receive treatment.[12] Medicare covers outpatient and inpatient services for mental health and substance use disorders. Outpatient services include individual and group psychotherapy, psychiatric evaluation, and medications.[13]

Medicaid and Behavioral Health

Medicaid is the single largest payer of behavioral health services in the United States, spending more than $52 billion annually on behavioral health services.[14] Medicaid plays a critical role in providing behavioral health care. Almost one in three adult enrollees (29 percent) have a mental illness, and about one in five (21 percent) have a substance use disorder.[15]

Most States provide the majority—if not all—of their behavioral health services through Medicaid managed care plans.[16] Medicaid managed care plans typically cover a wide range of behavioral health

services, including most outpatient services for the treatment of mental health and substance use disorders. State Medicaid programs may also offer additional behavioral health services that are not typically covered by Medicare, such as case management and peer support for substance use disorder treatment.[17]

Network Adequacy Standards

Network adequacy standards are quantitative metrics to ensure that there are adequate numbers of providers to serve enrollees, such as minimum provider-to-enrollee ratios for plans, time and distance standards, and wait-time standards.

Medicare and Medicaid do not have uniform standards to ensure that an adequate number of behavioral health providers meet the needs of enrollees. In Medicare Advantage, the network adequacy standards vary by specialty and location. For example, in a large metropolitan county, 90 percent of Medicare Advantage enrollees must have a psychiatrist within 20 minutes or 10 miles of their home.[18] Prior to 2024, these standards applied only to psychiatrists and did not apply to other types of behavioral health providers; however, as of January 1, 2024, the standards were expanded to include clinical psychologists and clinical social workers.[19] In traditional Medicare, because an enrollee can see any provider participating in Medicare, there are no similar quantitative standards to measure whether there are an adequate number of providers to meet the needs of enrollees.[20] In Medicaid, States must set a quantitative standard for behavioral health providers—such as a time and distance standard—to measure the adequacy of their managed care networks; however, these standards vary across States, and States may define behavioral health providers differently. Additionally, these standards are typically calculated based on data from plan provider directories; however, a number of researchers have found that these directories contain inaccurate or out of date information.[21]

Behavioral Health Providers

Providers who specialize in behavioral health are essential to meeting the behavioral health needs of Medicare and Medicaid enrollees. Enrollees with serious mental illnesses or substance use disorders often require a team of several different types of providers. This includes prescribing providers—such as psychiatrists and advanced practice nurses—as well as others, such as counselors, therapists, and social workers.

Focus of This Review

This review focuses on providers with a specialization and training in behavioral health in 20 selected counties. We selected a diverse group of 10 urban and 10 rural counties from 10 States that are geographically dispersed throughout the country. (See Appendix A.) We determined the ratio of providers to enrollees in each of the three programs as a key measure of provider availability. We based these ratios on providers who actively served enrollees in the selected counties. More specifically, we considered a provider to actively serve Medicare or Medicaid enrollees if the provider had at least one outpatient behavioral health service with an enrollee at a location in the enrollee's county of residence in 2021.

We also determined the extent to which enrollees in each of the three programs received behavioral health services and saw their behavioral health providers in person or via telehealth. Unless otherwise specified, all calculations presented in this report are an average among the 20 selected counties.

Scope and Limitations

This review focuses on a critical measure of provider availability: the number of providers who actively served enrollees in each of the three programs. Other reviews in this series will look at other aspects of provider availability, including the availability of appointments and the accuracy of provider network directories. All of these approaches help to better understand the availability of behavioral health providers to enrollees.

In this review, we primarily focus on providers with at least one behavioral health service in the selected counties as a measure of provider availability. We present this measure as a ratio of active providers in each county to the number of enrollees in each county, which allows us to compare these ratios across the counties and across the three programs.

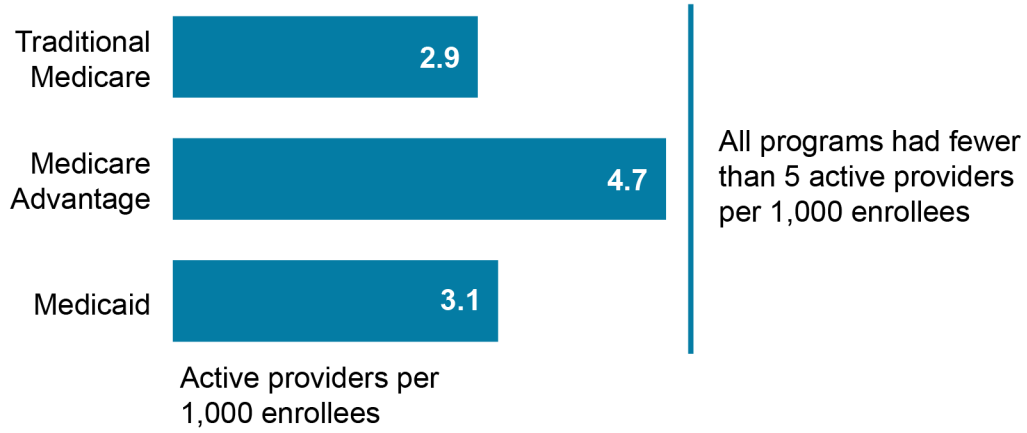
We limited this analysis to providers who provided at least one service in each of the selected counties because these providers are the ones who are reasonably available to the enrollees in that county. We did not include providers who provided all of their services outside of the selected counties, as providers who work and serve enrollees throughout the United States cannot be reasonably compared to the enrollee population in each county. In other parts of this report, we include information on the use of behavioral health services from all providers, regardless of where they provide their services. This analysis is based on Medicare claims and Medicare Advantage and Medicaid encounter data for outpatient behavioral health services provided in 2021. We took numerous steps to verify and supplement the data to enable us to report and compare the data across programs. See the Methodology section for additional information.

FINDINGS

Overall, there were few behavioral health providers in the counties who actively served Medicare and Medicaid enrollees in 2021

Few behavioral health providers in the selected counties actively served Medicare and Medicaid enrollees.[22] On average, in the selected counties, there were fewer than 5 active behavioral health providers per 1,000 enrollees in each program.[23] (See Exhibit 1.) We considered a provider to actively serve Medicare or Medicaid enrollees if the provider had at least one outpatient service with an enrollee at a location in the enrollee's county in 2021. Having providers who are easily accessible can improve mental health outcomes and reduce adverse outcomes such as suicide.[24] However, as noted earlier, the need for behavioral health services increased dramatically during the emergence of COVID-19, and many enrollees experience difficulties accessing timely care.

Exhibit 1: On average, there were fewer than 5 active behavioral health providers per 1,000 enrollees in the selected counties in 2021



Source: OIG analysis of Medicare and Medicaid data in 20 selected counties, 2023.

Prior OIG work has found that similar ratios of active providers to enrollees resulted in challenges for enrollees, who were often unable to receive timely access to care. For example, OIG's evaluation of New Mexico's Medicaid program found that there was an average of 4 behavioral health providers per 1,000 enrollees, and almost three-quarters of the State's key behavioral health providers reported that they did not have enough behavioral health providers in their counties to meet the needs of enrollees.[25] These providers also reported difficulties finding and retaining staff, a lack of timely

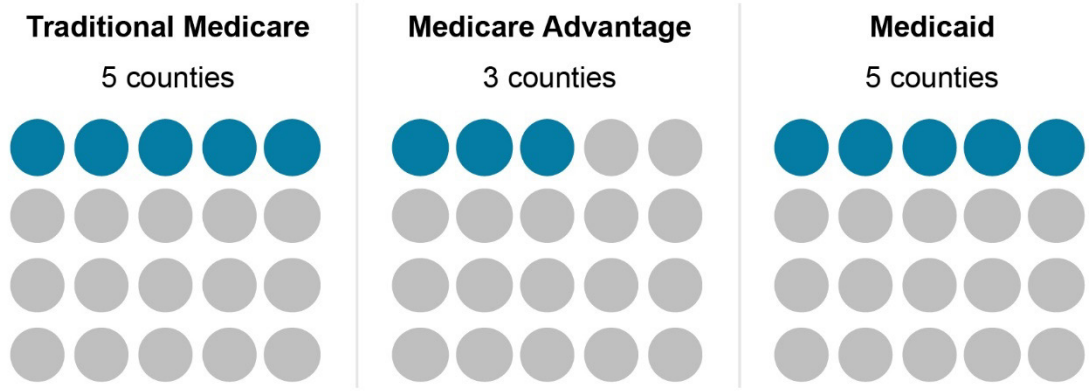
access to care, and difficulty arranging or making referrals for key behavioral health services, largely because of the lack of available providers.

When enrollees are not able to find available providers, they may face higher health care costs, delays in receiving care, and difficulty finding a provider close to home.[26] Such challenges could cause enrollees to forego treatment altogether.

Some counties and managed care plans had very few behavioral health providers—or none at all—who actively served enrollees

Some counties had no providers or very few providers who actively served enrollees. Notably, in traditional Medicare and in Medicaid, a quarter of the counties had fewer than 1 active provider per 1,000 enrollees, and in Medicare Advantage, 3 counties had fewer than 1 active provider per 1,000 enrollees. Enrollees in these counties may have to seek providers located in other counties and may need to travel significant distances to see a behavioral health provider. See Exhibit 2 and Appendix B for additional information on the number of active behavioral health providers by county.

Exhibit 2: Some counties had fewer than 1 active behavioral health provider per 1,000 enrollees



Source: OIG analysis of Medicare and Medicaid data in 20 selected counties, 2023.

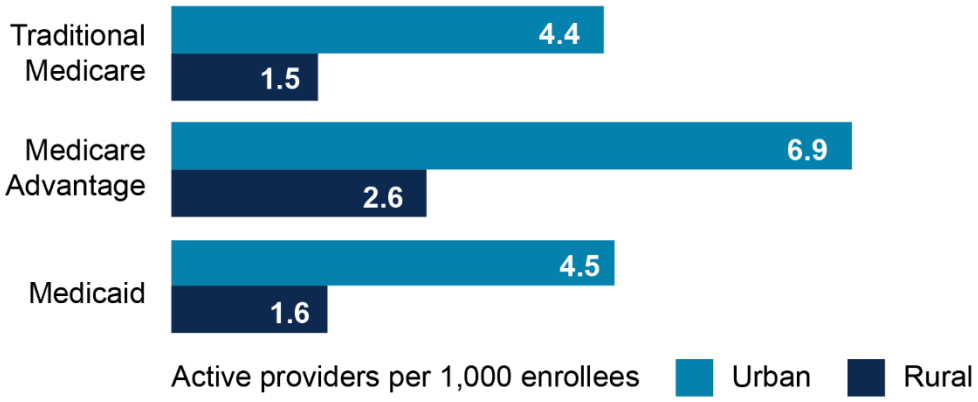
Within Medicare Advantage and Medicaid, there were also a number of managed care plans offered in the selected counties that had no active providers serving enrollees in that county. In Medicare Advantage, there were 35 plans with no active providers serving enrollees in the county in which they lived. Similarly, in Medicaid, two managed care plans had no active providers in the county.[27]

Rural counties had fewer active providers than urban counties

On average, rural counties had fewer than half the number of active providers per 1,000 enrollees, compared to the number of active providers in urban counties. As shown in Exhibit 3 (on the next page), traditional Medicare had the largest difference. There were almost three times as many urban providers as rural providers, with an

average of 4.4 providers per 1,000 enrollees in urban counties compared to an average of 1.5 providers in rural counties.

Exhibit 3: On average, rural counties had fewer than half the number of active providers compared to urban counties



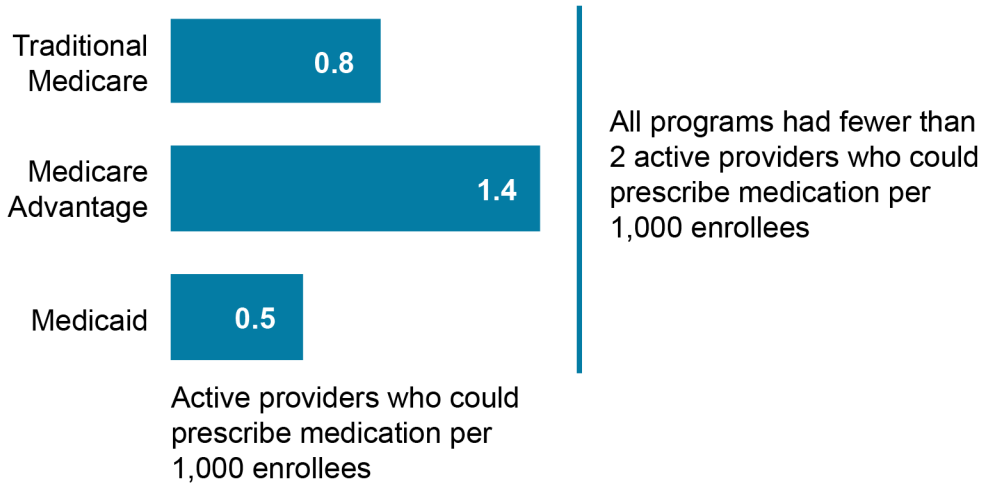
Source: OIG analysis of Medicare and Medicaid data in 20 selected counties, 2023.

There were even fewer providers in the counties who could prescribe medication to Medicare and Medicaid enrollees

Very few providers who could prescribe medication actively served Medicare and Medicaid enrollees. Behavioral health providers who can prescribe medications—such as psychiatrists or psychiatric advanced practice nurses—are critical to behavioral health care.[28] Growing research suggests that medication is most effective when used in combination with therapy and when prescribed and monitored by providers with expertise in behavioral health.[29]

On average, in the selected counties, there were fewer than 2 active providers who could prescribe medication per 1,000 enrollees in each program. (See Exhibit 4 on the next page.) In addition, there were three counties with no active providers who could prescribe in Medicaid, two counties with no active providers who could prescribe in traditional Medicare, and one county with no active providers who could prescribe in Medicare Advantage. Similarly, there were 61 Medicare Advantage plans and 20 Medicaid managed care plans offered in the selected counties that had no active prescribers in that county.

Exhibit 4: On average, there were fewer than 2 active providers who could prescribe medication per 1,000 enrollees in the counties



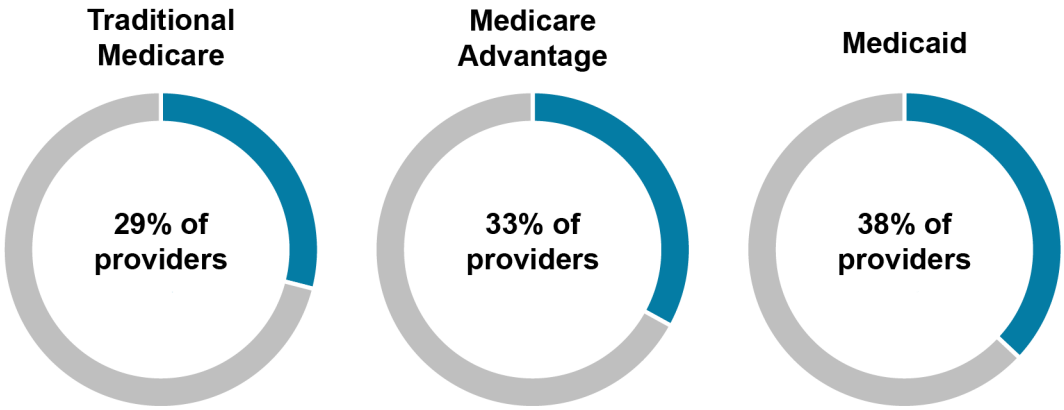
Source: OIG analysis of Medicare and Medicaid data in 20 selected counties, 2023.

Active providers in Medicare and Medicaid represented about one-third of the total behavioral health workforce

Providers who actively served Medicare and Medicaid enrollees represented only about one-third of all providers in the selected counties in 2021.[30] (See Exhibit 5 on the next page.)

A large barrier to accessing behavioral health care is that there are not enough behavioral health providers in many parts of the country to meet the need for behavioral health services. This problem is even more significant for Medicare and Medicaid enrollees when providers do not serve enrollees in these programs. If a smaller proportion of a county's workforce serves Medicaid or Medicare enrollees—or if providers opt to work only with specific managed care plans—enrollees' access to critical services can be impeded.

Exhibit 5: On average, only about one-third of providers in the counties served Medicare and Medicaid enrollees



Note: Providers can serve enrollees in more than one program.

Source: OIG analysis of Medicare and Medicaid data in 20 selected counties compared to data from the Behavioral Health Workforce Tracker, 2023.

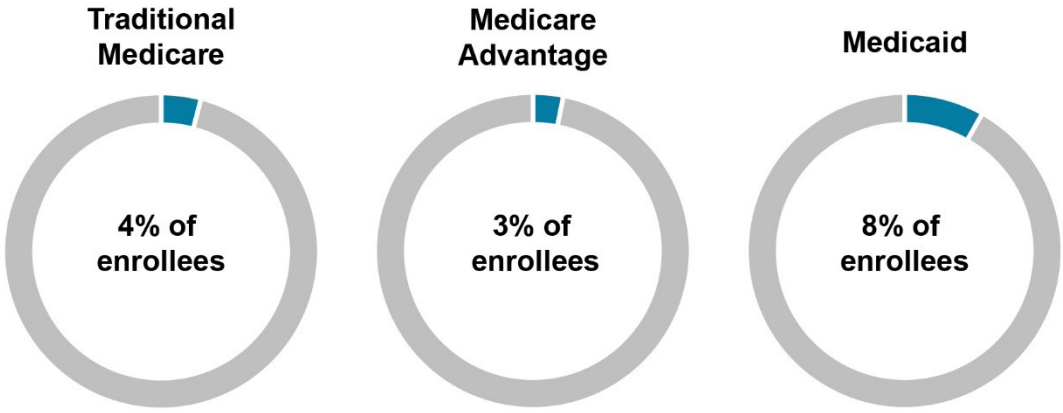
A number of reasons could explain why certain providers did not serve Medicare and Medicaid enrollees.[31] Research suggests that reasons can include burdensome administrative requirements for providers and low payment rates.[32] Further, in Medicare and Medicaid, either CMS or State Medicaid agencies will determine what types of providers and services are eligible for reimbursement, which can affect whether providers are able to serve enrollees. Licensure and other supervision requirements can also impact whether providers are able to serve enrollees.[33]

Few Medicare and Medicaid enrollees received services from a behavioral health provider

As noted earlier, the COVID-19 pandemic greatly exacerbated mental health and substance use issues; however, despite these increases in need, the treatment rates in Medicare and Medicaid were low in the selected counties. On average, only 8 percent of Medicaid enrollees and less than 5 percent of Medicare and Medicare Advantage enrollees received services from a behavioral health provider in 2021.[34] (See Exhibit 6 on the next page.)

Although a relatively small percentage of enrollees received care from a behavioral health provider, the need is likely much greater. In the United States, about one in five adults has a mental illness but less than half of those receive services.[35]

Exhibit 6: On average, less than 10 percent of enrollees received treatment from a behavioral health provider



Source: OIG analysis of Medicare and Medicaid data in 20 selected counties, 2023.

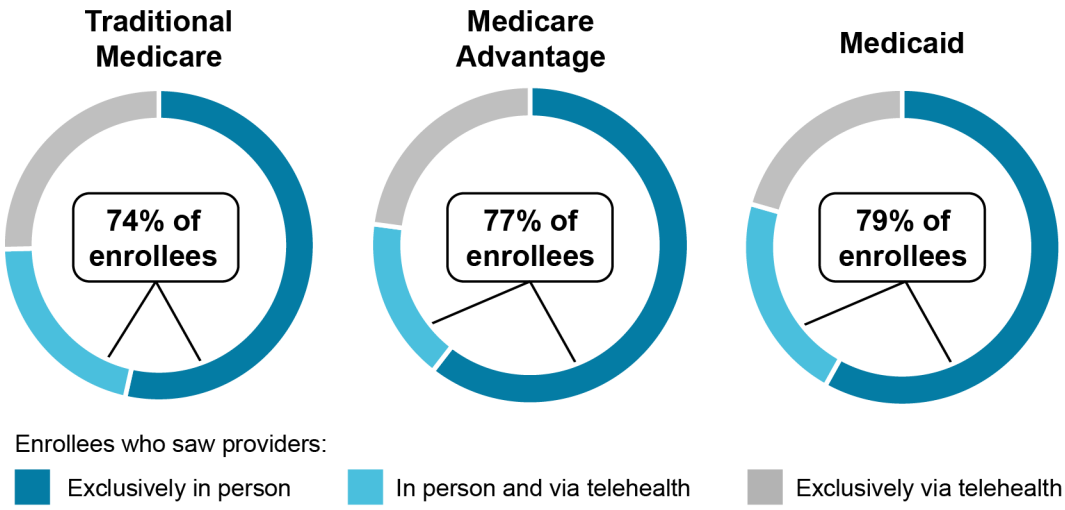
Most commonly, enrollees saw only one provider rather than several different behavioral health providers during the year.[36] Enrollees also typically saw the same provider multiple times over the year. Enrollees in traditional Medicare typically saw their behavioral health provider eight times a year; enrollees in Medicare Advantage saw their provider five times a year; and enrollees in Medicaid saw their provider six times a year.

Further, Medicare and Medicaid enrollees saw a variety of behavioral health providers. In traditional Medicare and Medicare Advantage, enrollees most commonly saw social workers and psychologists.[37] In Medicaid, enrollees most often saw counselors and social workers.[38] However, Medicaid enrollees also saw other types of providers such as peer support specialists, who are individuals who use their own experience recovering from mental illness or substance use disorders to support enrollees. Although Medicare recently expanded its coverage to certain types of behavioral health counselors, Medicaid continues to allow a broader range of types of providers to bill for services.[39]

Most enrollees saw their behavioral health providers in person; however, many enrollees traveled long distances to see them

Roughly three-quarters of enrollees who received behavioral health care in 2021 saw at least one of their providers in person. This includes enrollees who exclusively saw their providers in person and enrollees who saw their providers both in person and via telehealth. (See Exhibit 7 on the next page and Appendix C. See Exhibit 9 on page 8 for an alternative view of the data.)

Exhibit 7: On average, about three-quarters of enrollees saw their behavioral health providers in person

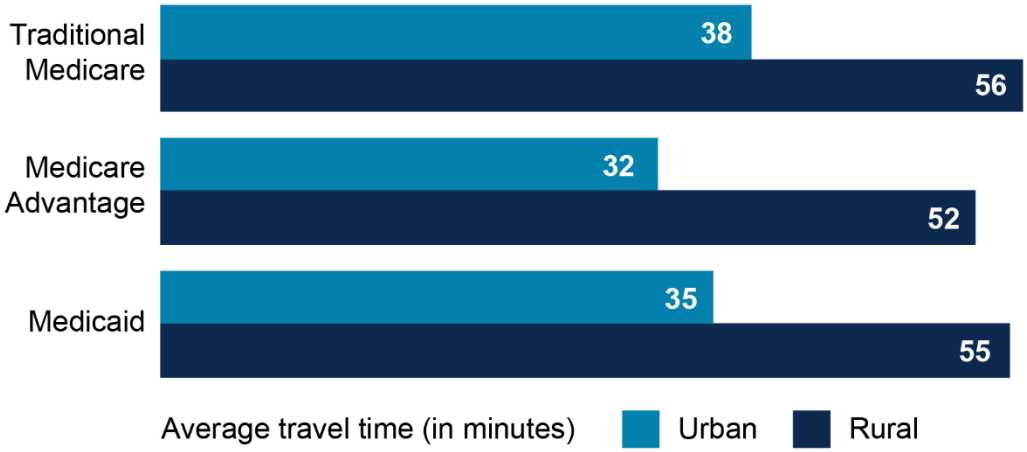


Source: OIG analysis of Medicare and Medicaid data in 20 selected counties, 2023.

Long travel times to see providers can cause significant burdens for enrollees and may decrease the likelihood that they will see their provider regularly and attend scheduled appointments. Although enrollees typically traveled about 45 minutes to see their providers for an in-person visit, many traveled much further. About one in four enrollees in all three programs traveled more than 1 hour to see their behavioral health providers, with about 1 in 10 traveling more than 1.5 hours.[40]

Rural enrollees traveled longer to see their providers than urban enrollees. In all three programs, rural enrollees traveled about 20 minutes longer to see a provider than urban enrollees. (See Exhibit 8 and Appendix D.)

Exhibit 8: Many enrollees had long travel times to see a provider in person

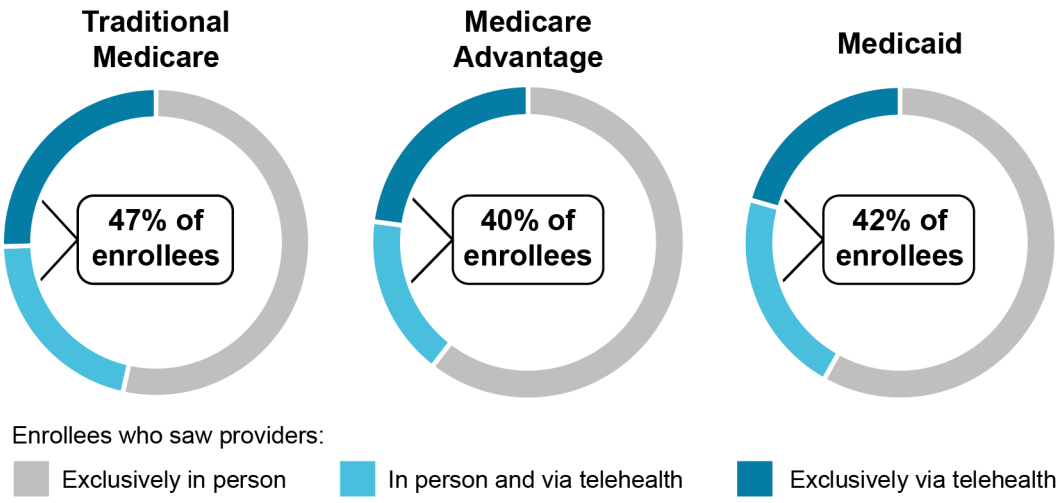


Source: OIG analysis of Medicare and Medicaid data in 20 selected counties, 2023.

Telehealth expanded access to behavioral health, and many enrollees combined telehealth with in-person care

In all three programs, between 40 and 47 percent of enrollees who received behavioral health care opted to see at least one provider via telehealth. In each of the three programs, about half of these enrollees saw their behavioral health providers exclusively via telehealth. The other half saw their providers through a combination of telehealth and in-person visits. (See Exhibit 9.)

Exhibit 9: Many enrollees saw a behavioral health provider either exclusively via telehealth or via telehealth and in-person visits



Source: OIG analysis of Medicare and Medicaid data in 20 selected counties, 2023.

Enrollees in urban areas used telehealth more than enrollees in rural areas

Enrollees in urban areas were more likely than those in rural areas to use telehealth services. A previous OIG report found similar results examining all telehealth services in Medicare during the first year of the COVID-19 pandemic.[41] This may indicate that there are some additional barriers to using telehealth in rural areas, such as lack of access to broadband connectivity and equipment. (See Exhibit 10 on the next page.)

Exhibit 10: In all three programs, on average, a greater percentage of enrollees in urban counties used telehealth compared to enrollees in rural counties

	Percentage of enrollees in rural counties who used telehealth	Percentage of enrollees in urban counties who used telehealth
Traditional Medicare	42%	51%
Medicare Advantage	36%	43%
Medicaid	38%	45%

Source: OIG analysis of Medicare and Medicaid data in 20 selected counties, 2023.

RECOMMENDATIONS

The United States is facing an unprecedented mental health crisis, as people of all ages are experiencing a need for services related to mental health and substance use disorders. One out of five adults report having a mental illness, and many experience difficulty getting access to behavioral health care. Even before the COVID-19 pandemic, access to high-quality behavioral health care was often hard to find, but the increased need for services in the wake of the pandemic has challenged behavioral health providers and enrollees around the country.

This report finds that few behavioral health providers in the selected counties actively served Medicare and Medicaid enrollees. On average, there were fewer than 5 active behavioral health providers per 1,000 enrollees in each of the three programs, with some counties and managed care plans having no providers at all. Additionally, active behavioral health providers represented only about one-third of all providers in the workforce in the selected counties.

Although the pandemic greatly exacerbated mental health and substance use conditions, the treatment rates across all three programs remained relatively low. On average, only 8 percent of Medicaid enrollees and less than 5 percent of Medicare and Medicare Advantage enrollees received services from a behavioral health provider. Most enrollees received behavioral health care in person; however, many enrollees traveled long distances to see these providers. We also found that telehealth expanded access to behavioral health care, and many enrollees combined telehealth with in-person care.

CMS has taken a number of steps to meet the unprecedented demand for behavioral health services and address the provider shortages that often hinder enrollees' ability to seek treatment. For example, CMS published a toolkit to help State Medicaid agencies and managed care plans meet network adequacy requirements for behavioral health care providers.[42] Additionally, recent legislation allowed Medicare coverage of services provided by marriage and family therapists and mental health counselors.[43] Further, as of January 1, 2024, CMS established network adequacy standards for clinical psychologists and clinical social workers in Medicare Advantage.[44] CMS also published a final rule that sets the maximum appointment wait time for routine behavioral health care at 30 business days in Medicare Advantage and has proposed a rule that sets the standard at 10 business days in Medicaid managed care.[45]

Additionally, CMS developed a Behavioral Health Strategy, which sets forth a number of goals, including increasing the number and availability of behavioral health providers, removing barriers to care, and using data to evaluate behavioral health programs and policies.[46] CMS is working with other agencies within the Department

of Health and Human Services and across the Government to implement these strategies. In furtherance of these goals, we recommend that CMS:

Take steps to encourage more behavioral health providers to serve Medicare and Medicaid enrollees

A significant number of providers in the existing behavioral health workforce did not provide services to Medicare and Medicaid enrollees. CMS should take additional steps to encourage more behavioral health providers to serve Medicare and Medicaid enrollees. Such steps could include strategies for reducing administrative burden for providers and reviewing and ensuring the appropriateness of payment rates for behavioral health services.

Administrative burdens affecting behavioral health providers can include a wide range of administrative activities, such as burdensome prior authorization requirements, a lengthy credentialling process, or a slow reimbursement process. A number of States and managed care organizations have already taken steps to reduce these burdens, perhaps most notably by revising the prior authorization process.[47] OIG has also made recommendations in past reports to improve the prior authorization process.[48]

CMS should take additional steps to improve the prior authorization process for behavioral health services. For example, CMS could develop additional guidance to States and Medicare Advantage plans to help ensure the appropriateness of prior authorization denials for behavioral health services. CMS could also consider collecting data on prior authorization requests, denials, and appeals of behavioral health services to inform such guidance.

To encourage additional behavioral health providers to actively serve enrollees, CMS should also take steps to more accurately value and pay for behavioral health services. CMS could take steps—seeking statutory authority, if needed—to increase payments to behavioral health providers, particularly those in rural and underserved communities. For example, CMS could take steps to expand the Health Professional Shortage Area (HPSA) bonus program to provide additional payments to behavioral health providers, such as psychologists, social workers, and mental health counselors.[49] CMS could also institute new requirements to increase the transparency of payment rates, with the goal of better understanding how payment affects access to care. When possible, CMS or States should attempt to address significant disparities in payment rates in order to increase the number of providers actively serving enrollees.

Explore options to expand Medicare and Medicaid coverage to additional behavioral health providers

Extending the types of providers who can bill for behavioral health services in Medicare and Medicaid could expand access to these services. In Medicare, recent

legislation has allowed new types of behavioral health providers, including mental health counselors and marriage and family therapists, to provide behavioral health services.[50] When appropriate, CMS should take additional steps—seeking statutory authority, if needed—to allow additional behavioral health providers to bill for behavioral health services.

Such steps could include allowing providers—such as occupational therapists, paraprofessionals, and peer support workers—to receive payments for behavioral health services provided to Medicare and Medicaid enrollees. A number of State Medicaid programs have already taken steps to implement such changes. CMS should encourage additional States to take these steps, as appropriate. CMS should also explore options to take these steps in Medicare.

CMS should also encourage additional providers to serve Medicare and Medicaid enrollees by expanding coverage of key behavioral health services in traditional Medicare, Medicare Advantage, and Medicaid managed care. When appropriate, CMS should take steps—and seek statutory authority, if needed—to expand coverage to additional school-based and community-based behavioral health services, including peer supports, mobile crisis intervention services, and integrated behavioral health services. Such expansions could significantly increase the number of behavioral health providers actively serving enrollees.

Use network adequacy standards to drive an increase in behavioral health providers in Medicare Advantage and Medicaid

One method CMS has to increase the number of providers in managed care plans is to strengthen its network adequacy standards. CMS should strengthen its existing network adequacy standards for behavioral health providers in Medicare Advantage and Medicaid managed care. This could help to ensure that there is an adequate number of network providers and an appropriate geographic distribution of providers to deliver the behavioral health services that meet the needs of enrollees.

CMS has introduced proposed regulations designed to change network adequacy requirements in Medicaid managed care. If implemented, these regulations would establish maximum wait times of 10 business days for routine behavioral health appointments and would require the use of independent secret shopper surveys to determine compliance. These changes would represent a notable shift from prior network adequacy approaches. CMS should consider aligning network adequacy standards in Medicare Advantage and Medicaid managed care and establishing consistent enforcement measures across programs.[51] CMS should also consider requirements to publicize the extent to which each plan is meeting the network adequacy standards.

Increase monitoring of Medicare and Medicaid enrollees' use of behavioral health services and identify vulnerabilities

Analyzing utilization data provides critical insight into understanding enrollees' access to care. When analyzed in conjunction with measures of enrollee needs, which should drive demand for services, it can illuminate real-world access issues in a way that few other metrics can.

The percentage of enrollees who initiate treatment and receive ongoing treatment can be a powerful indication of vulnerabilities in the availability of care. For example, if enrollees from certain plans are using behavioral health services at a low rate—relative to enrollees in other plans—it may be an indication that there are not enough available providers, and further investigation is warranted. Similarly, if certain plans provide few services delivered by a particular provider type—such as psychiatrists or addiction specialists—it may be an indication that there are not enough available providers with this specialty.

CMS should—either independently or in conjunction with States and managed care plans—monitor the percentage of enrollees who receive behavioral health services from behavioral health providers, such as substance use counselors or prescribing providers. This analysis could be used to identify potential barriers to accessing certain behavioral health services.

AGENCY COMMENTS AND OIG RESPONSE

CMS concurred with or concurred with the intent of all four recommendations. While OIG recognizes the many steps CMS has already taken, OIG encourages CMS to continue to pursue actions to meet the unprecedented demand for behavioral health services and address provider shortages.

CMS concurred with the intent of the first recommendation and noted that it will continue to take steps within its authority to encourage more behavioral health providers to serve Medicaid and Medicare enrollees. CMS noted a number of steps it has already taken, including finalizing regulations that authorize marriage and family therapists and mental health counselors to enroll as Medicare providers and bill directly for their mental health services. In Medicare Advantage, CMS finalized policies to add licensed clinical social workers and clinical psychologists as specialty types for network adequacy standards. CMS has also proposed outpatient behavioral health facilities as an additional facility-specialty type to be included in network adequacy standards. Further, CMS increased payment for psychotherapy, crisis services, and certain timed behavioral health services in order to better reflect costs involved in furnishing these services. OIG values these important steps and encourages CMS to implement additional strategies, such as seeking opportunities to reduce administrative burden for providers and reviewing and ensuring the appropriateness of payment rates for behavioral health services.

CMS concurred with the second recommendation to explore options to expand Medicare and Medicaid coverage to additional behavioral health providers. CMS stated that it is actively collaborating with the Substance Abuse and Mental Health Services Administration to expand coverage and access to providers. CMS also noted that although recently finalized regulations allow marriage and family therapists and mental health counselors to enroll as Medicare providers, legislation may be required to further expand Medicare payment to additional types of behavioral health practitioners. OIG appreciates CMS's efforts and continues to recommend that CMS seek statutory authority to expand coverage to additional behavioral health providers, as appropriate.

CMS concurred with the intent of the third recommendation and noted that it will continue to take steps within its authority to use network adequacy standards to drive an increase in behavioral health providers in Medicare Advantage and Medicaid managed care. CMS noted that it has already taken several actions, including finalizing policies for 2024 for Medicare Advantage to include licensed clinical social workers and clinical psychologists in its network adequacy standards. CMS also proposed appointment wait times and other provisions for Medicaid managed care in a proposed rule. OIG recognizes the steps CMS is taking and also encourages CMS to align network adequacy standards in Medicare Advantage and Medicaid managed

care and—to the extent possible—establish consistent enforcement measures across programs.

CMS concurred with the fourth recommendation to increase monitoring of Medicare and Medicaid enrollees' use of behavioral health services and identify vulnerabilities. For Medicare, CMS stated that it will consider the best approach to explore the evaluation of available data and determine appropriate next steps. For Medicaid, CMS noted that it is working with Transformed Medicaid Statistical Information System (T-MSIS) claims and enrollment data to develop resources providing information on access to treatment. These resources will make the data more accessible, similar to the annual Report to Congress on enrollees with substance use disorders. CMS also stated that it incorporated new audit procedures into its Medicaid managed care plans audits to help ensure that managed care plans are paying claims correctly and that services are necessary and being delivered appropriately.

For the full text of CMS's comments, see Appendix E.

METHODOLOGY

This review assesses the extent to which behavioral health providers actively served enrollees in traditional Medicare, Medicare Advantage, and Medicaid in 2021. We focused this review on 20 counties in 10 States, and we reviewed Medicare claims and Medicare Advantage and Medicaid encounter data for all Medicare and Medicaid enrollees in these counties. We included all outpatient behavioral health services provided in 2021 by providers who specialize in behavioral health. This included psychiatrists and other physicians specializing in behavioral health, psychologists, advanced practice nurses and physician assistants specializing in behavioral health, social workers, and mental health counselors.

Selecting counties and States

To select the 20 counties and 10 States, we considered several factors. Because managed care is the primary delivery system for behavioral health services in Medicaid, we excluded States that provided behavioral health services on a fee-for-service basis and States that had distinct plans for specific populations, such as enrollees with serious mental illness. We also excluded States with poor quality data in T-MSIS.[52] To select counties, we considered the number of enrollees in traditional Medicare and Medicare Advantage to ensure that there was a sufficient number of enrollees in each program.[53] Finally, we considered geographic diversity and population size when selecting the States and counties. In total, we selected one urban and one rural county from each of the 10 selected States.[54]

Identifying behavioral health services

We identified all outpatient behavioral health services provided to enrollees in the selected counties in each of the three programs.[55] We based this analysis on all Medicare fee-for-service claims data and Medicare Advantage encounter data from CMS's National Claims History file and Medicaid encounter data from T-MSIS. We analyzed the claims and encounter data for behavioral health services provided to enrollees in 2021.

Calculating ratios of active behavioral health providers to enrollees

We determined the ratio of providers to enrollees in each of the three programs as a key measure of provider availability. We based these ratios on providers who actively served enrollees. We considered a provider to actively serve Medicare or Medicaid enrollees if the provider had at least one outpatient service with an enrollee at a location in the enrollee's county in 2021.

To calculate this ratio, we first determined the total number of enrollees in each county for each program. To do this, we used Medicare and Medicaid enrollment data and based this analysis on the enrollee's address in the enrollment data. [56]

Next, we determined the number of active behavioral health providers in each program in each county. To do this, we took several steps. First, for each program, we identified the providers who specialize in behavioral health. We based this on providers' taxonomy information in the National Plan and Provider Enumeration System (NPPES) and information about their specialties in the Provider Enrollment, Chain, and Ownership System (PECOS). We also considered providers' specialties in CMS's contractor file, if available. For providers with missing information or conflicting information in NPPES or PECOS, we relied on additional data sources—including the providers' claims history, licensure data, and the providers' practice or clinic—to identify the correct specialty for each provider. For example, if a provider had a specialty of "psychiatry" in PECOS and a taxonomy of "nurse practitioner" in NPPES, we would rely on additional licensure information to determine whether the provider was a psychiatric nurse practitioner or a psychiatrist.

We considered the following providers to specialize in behavioral health: (1) psychiatrists, (2) other behavioral health physicians (such as addiction medicine specialists), (3) nonprescribing psychologists, (4) prescribing psychologists, (5) behavioral health-related advanced practice nurses and physician assistants, (6) social workers, and (7) counselors. For Medicaid, we also included other types of behavioral health providers allowed by the State Medicaid agencies, such as peer support counselors or behavior analysts.

Next, for each program, we determined the number of providers who specialized in behavioral health who actively served enrollees at a location in the enrollee's county. We based the location on the providers' addresses. For traditional Medicare, we primarily used the provider identification number to determine the provider address and supplemented it with data from PECOS and NPPES. For Medicare Advantage, we used the practice location address from the Medicare Advantage encounter data. For Medicaid, we used the address data in T-MSIS and addresses in the Medicaid managed care organization network lists when the data in T-MSIS were insufficient.[57]

For each program, we determined the ratio of the total number of active behavioral health providers in the county to the total number of enrollees in the county and the overall average for the 20 counties.[58] We did a similar analysis for the urban counties and the rural counties for each program. In Medicare Advantage and Medicaid, we also determined the ratio for each plan and assessed the number of plans in each program that had few active behavioral health providers or no providers at all.[59]

We followed the same methodology to calculate the overall average ratio for each program of behavioral health providers who could prescribe medication to enrollees.

Calculating proportion of behavioral health providers who served Medicare and Medicaid enrollees

For this analysis, we compared the number of behavioral health providers who actively served enrollees to the total behavioral health workforce in the county. We relied on the Fitzhugh Mullan Institute for Health Workforce Equity Behavioral Health Workforce Tracker to determine the total number of providers who worked in each county.[60] This tracker classifies behavioral health providers based on State licensure data and prescribing data.[61]

We compared the number of psychiatrists, social workers, and psychologists who actively served Medicare and Medicaid enrollees to the number of psychiatrists, social workers, and psychologists in the tracker who worked in the selected counties. We focused this analysis on these key types of behavioral health providers because we could reliably compare our analysis of these behavioral health providers to the tracker.

Calculating the use of behavioral health services and the use of in-person visits and telehealth

We determined the extent to which enrollees received behavioral health services in each program. To do this, we determined the proportion of enrollees who received a behavioral health service from a provider who specialized in behavioral health, regardless of the provider's location or whether the service was provided in person or via telehealth. Similar to the analyses of ratios, we calculated the average proportion for the 20 counties.

We also calculated the proportion of enrollees who saw their behavioral health providers exclusively via telehealth, exclusively in person, or through a combination of telehealth and in-person visits. We identified claims and encounter data billed with a telehealth modifier (i.e., 95, GT, GQ, or G0) or a telehealth place of service code (i.e., 02), indicating that a service was delivered via telehealth.

Next, for in-person visits, we calculated the approximate travel time between enrollees and their behavioral health providers.[62] Using ArcGIS, we calculated the approximate travel time and distance for each unique combination of enrollee and provider addresses.[63]

Data limitations

This analysis is based on Medicare claims data and Medicare Advantage and Medicaid encounter data. We took numerous steps to verify and supplement the data to enable us to report and compare the data across programs. However, in some cases, the data had limitations. Some claims had missing or incomplete provider information that made it difficult to identify an individual provider. Examples include

missing rendering and billing provider information, claims whose only provider was an organization, and providers with missing or invalid address information.

Standards

We conducted this study in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

APPENDIX A

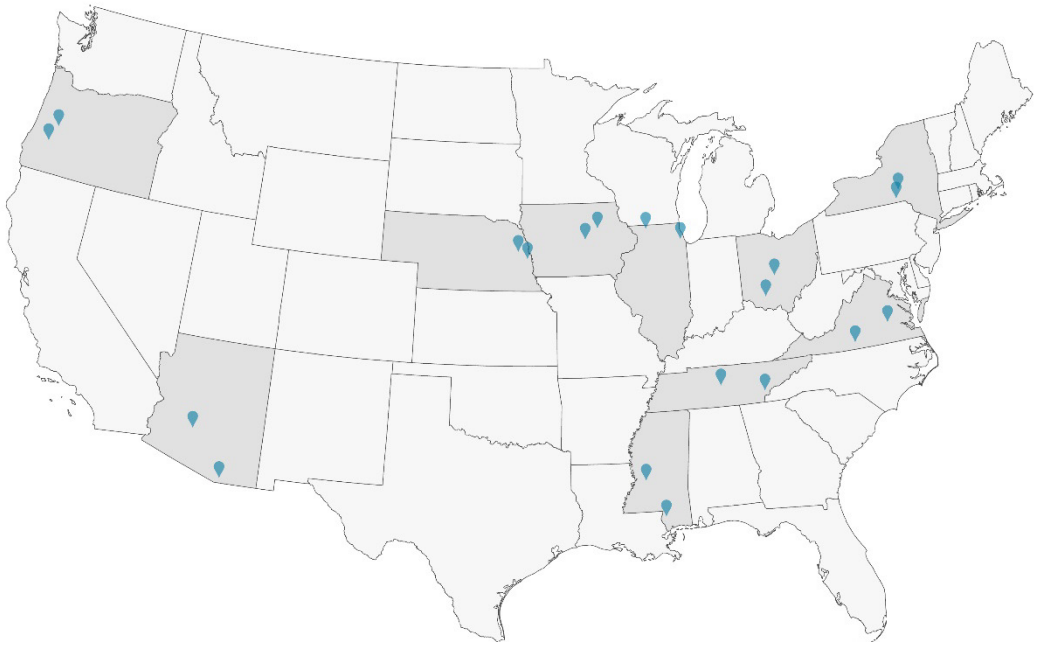
Selected counties and States

Exhibit A-1: List of 20 selected counties and 10 selected States

State	Urban County	Rural County
Arizona	Maricopa County	Santa Cruz County
Illinois	Cook County	Stephenson County
Iowa	Black Hawk County	Marshall County
Mississippi	Hinds County	Pearl River County
Nebraska	Douglas County	Dodge County
New York	Broome County	Chenango County
Ohio	Franklin County	Highland County
Oregon	Lane County	Douglas County
Tennessee	Rutherford County,	Monroe County
Virginia	Chesterfield County	Pittsylvania County

Source: Classification of Counties based on the National Center for Health Statistics Urban-Rural Classification Scheme for Counties, 2013 codes.

Exhibit A-2: Map of 20 selected counties and 10 selected States



APPENDIX B

Behavioral health providers who actively served enrollees in 20 selected counties

Exhibit B-1: Ratio of behavioral health providers who actively served enrollees per 1,000 enrollees, by county

	County	State	Traditional Medicare	Medicare Advantage	Medicaid
Overall	**Average**		**2.9**	**4.7**	**3.1**
Urban	Maricopa	AZ	2.9	4.3	1.5
	Cook	IL	4.9	7.8	1.1
	Black Hawk	IA	3.0	7.9	4.6
	Hinds	MS	2.6	4.1	2.4
	Douglas	NE	6.3	11.5	8.3
	Broome	NY	5.2	7.5	3.0
	Franklin	OH	6.2	7.2	6.7
	Lane	OR	7.0	8.1	10.2
	Rutherford	TN	1.7	4.0	1.1
	Chesterfield	VA	3.8	6.8	6.0
	Average		**4.4**	**6.9**	**4.5**
Rural	Santa Cruz	AZ	0.0	0.2	0.1
	Stephenson	IL	2.6	2.8	0.4
	Marshall	IA	1.8	4.1	2.0
	Pearl River	MS	1.1	1.9	1.5
	Dodge	NE	0.7	4.7	3.5
	Chenango	NY	4.8	5.7	0.9
	Highland	OH	0.4	0.8	2.7
	Douglas	OR	2.3	4.2	4.6
	Monroe	TN	0.9	1.2	0.2
	Pittsylvania	VA	0.1	0.0	0.4
	Average		**1.5**	**2.6**	**1.6**

Source: OIG analysis of Medicare and Medicaid data in 20 selected counties, 2023.

Exhibit B-2: Ratio of behavioral health providers who could prescribe medications per 1,000 enrollees, by county

	County	State	Traditional Medicare	Medicare Advantage	Medicaid
Overall	**Average**		**0.8**	**1.4**	**0.5**
Urban	Maricopa	AZ	1.4	1.9	0.8
	Cook	IL	1.0	1.9	0.4
	Black Hawk	IA	0.6	2.8	1.0
	Hinds	MS	1.5	1.7	0.7
	Douglas	NE	2.4	3.7	1.3
	Broome	NY	0.4	1.5	0.3
	Franklin	OH	1.5	1.7	0.9
	Lane	OR	1.8	1.4	0.9
	Rutherford	TN	0.7	1.5	0.3
	Chesterfield	VA	0.6	1.6	0.6
	Average		**1.2**	**2.0**	**0.7**
Rural	Santa Cruz	AZ	0.0	0.2	0.1
	Stephenson	IL	0.7	0.7	0.4
	Marshall	IA	0.9	1.8	0.6
	Pearl River	MS	0.3	0.7	0.5
	Dodge	NE	0.0	2.6	0.0
	Chenango	NY	0.4	0.6	0.0
	Highland	OH	0.4	0.3	0.1
	Douglas	OR	0.5	1.0	0.6
	Monroe	TN	0.2	0.4	0.0
	Pittsylvania	VA	0.1	0.0	0.1
	Average		**0.3**	**0.8**	**0.2**

Source: OIG analysis of Medicare and Medicaid data in 20 selected counties, 2023.

APPENDIX C

Use of behavioral health services in person and via telehealth

Exhibit C-1: Percentage of enrollees receiving behavioral health care who saw providers exclusively in person

	County	State	Traditional Medicare	Medicare Advantage	Medicaid
Overall	**Average**		**53%**	**60%**	**58%**
Urban	Maricopa	AZ	52%	63%	46%
	Cook	IL	42%	51%	70%
	Black Hawk	IA	53%	61%	59%
	Hinds	MS	75%	69%	76%
	Douglas	NE	55%	62%	51%
	Broome	NY	31%	45%	38%
	Franklin	OH	45%	53%	49%
	Lane	OR	31%	47%	39%
	Rutherford	TN	58%	66%	72%
	Chesterfield	VA	50%	57%	47%
	Average		**49%**	**57%**	**55%**
Rural	Santa Cruz	AZ	63%	54%	43%
	Stephenson	IL	59%	61%	71%
	Marshall	IA	44%	55%	54%
	Pearl River	MS	68%	70%	85%
	Dodge	NE	55%	64%	56%
	Chenango	NY	23%	42%	47%
	Highland	OH	60%	63%	60%
	Douglas	OR	66%	70%	43%
	Monroe	TN	69%	80%	88%
	Pittsylvania	VA	69%	77%	69%
	Average		**58%**	**64%**	**62%**

Source: OIG analysis of Medicare and Medicaid data in 20 selected counties, 2023.

Exhibit C-2: Percentage of enrollees receiving behavioral health care who saw providers exclusively via telehealth

	County	State	Traditional Medicare	Medicare Advantage	Medicaid
Overall	**Average**		**25%**	**23%**	**21%**
Urban	Maricopa	AZ	30%	24%	37%
	Cook	IL	36%	28%	19%
	Black Hawk	IA	19%	17%	17%
	Hinds	MS	14%	18%	11%
	Douglas	NE	23%	19%	17%
	Broome	NY	32%	32%	36%
	Franklin	OH	30%	26%	21%
	Lane	OR	48%	33%	26%
	Rutherford	TN	25%	19%	11%
	Chesterfield	VA	30%	29%	28%
	Average		**29%**	**25%**	**22%**
Rural	Santa Cruz	AZ	29%	32%	48%
	Stephenson	IL	19%	26%	21%
	Marshall	IA	23%	22%	29%
	Pearl River	MS	14%	14%	2%
	Dodge	NE	27%	14%	11%
	Chenango	NY	39%	39%	38%
	Highland	OH	22%	28%	10%
	Douglas	OR	15%	13%	21%
	Monroe	TN	18%	12%	2%
	Pittsylvania	VA	16%	12%	7%
	Average		**22%**	**21%**	**19%**

Source: OIG analysis of Medicare and Medicaid data in 20 selected counties, 2023.

Exhibit C-3: Percentage of enrollees receiving behavioral health care who saw providers both in person and via telehealth

	County	State	Traditional Medicare	Medicare Advantage	Medicaid
Overall	**Average**		**21%**	**17%**	**21%**
Urban	Maricopa	AZ	18%	13%	17%
	Cook	IL	22%	20%	11%
	Black Hawk	IA	28%	22%	24%
	Hinds	MS	12%	13%	13%
	Douglas	NE	22%	19%	32%
	Broome	NY	36%	23%	26%
	Franklin	OH	24%	21%	30%
	Lane	OR	21%	20%	35%
	Rutherford	TN	17%	15%	17%
	Chesterfield	VA	20%	14%	24%
	Average		**22%**	**18%**	**23%**
Rural	Santa Cruz	AZ	8%	15%	9%
	Stephenson	IL	22%	13%	8%
	Marshall	IA	34%	23%	17%
	Pearl River	MS	19%	16%	13%
	Dodge	NE	18%	21%	33%
	Chenango	NY	38%	19%	16%
	Highland	OH	17%	9%	30%
	Douglas	OR	19%	17%	37%
	Monroe	TN	13%	9%	9%
	Pittsylvania	VA	15%	11%	24%
	Average		**20%**	**15%**	**20%**

Source: OIG analysis of Medicare and Medicaid data in 20 selected counties, 2023.

Note: The data in tables C-1, C-2, and C-3 may not sum to 100% due to rounding.

APPENDIX D

Distance and travel time for in-person behavioral health services

Exhibit D-1: Average travel distance (in miles) and time (in minutes) for enrollees to receive in-person behavioral health, by county

	County	State	Traditional Medicare	Medicare Advantage	Medicaid
Overall	**Average**		**38 miles/47 minutes**	**33 miles/42 minutes**	**36 miles/45 minutes**
Urban	Maricopa	AZ	18 miles/27 minutes	17 miles/27 minutes	22 miles/30 minutes
	Cook	IL	18 miles/32 minutes	15 miles/30 minutes	22 miles/38 minutes
	Black Hawk	IA	67 miles/74 minutes	20 miles/30 minutes	18 miles/26 minutes
	Hinds	MS	25 miles/34 minutes	33 miles/41 minutes	**
	Douglas	NE	16 miles/23 minutes	10 miles/18 minutes	**
	Broome	NY	42 miles/51 minutes	23 miles/32 minutes	28 miles/37 minutes
	Franklin	OH	21 miles/29 minutes	20 miles/28 minutes	22 miles/31 minutes
	Lane	OR	16 miles/25 minutes	13 miles/22 minutes	19 miles/28 minutes
	Rutherford	TN	40 miles/50 minutes	40 miles/48 minutes	53 miles/60 minutes
	Chesterfield	VA	21 miles/32 minutes	33 miles/43 minutes	21 miles/29 minutes
	Average		**29 miles/38 minutes**	**23 miles/32 minutes**	**26 miles/35 minutes**
Rural	Santa Cruz	AZ	82 miles/90 minutes	65 miles/73 minutes	88 miles/88 minutes
	Stephenson	IL	24 miles/31 minutes	34 miles/44 minutes	54 miles/68 minutes
	Marshall	IA	29 miles/37 minutes	24 miles/32 minutes	37 miles/45 minutes
	Pearl River	MS	44 miles/51 minutes	45 miles/52 minutes	**
	Dodge	NE	33 miles/42 minutes	26 miles/34 minutes	**
	Chenango	NY	29 miles/38 minutes	30 miles/40 minutes	23 miles/32 minutes
	Highland	OH	58 miles/72 minutes	60 miles/74 minutes	43 miles/54 minutes
	Douglas	OR	33 miles/40 minutes	34 miles/40 minutes	18 miles/24 minutes
	Monroe	TN	65 miles/72 minutes	46 miles/57 minutes	60 miles/72 minutes
	Pittsylvania	VA	71 miles/86 minutes	62 miles/77 minutes	46 miles/59 minutes
	Average		**47 miles/56 minutes**	**43 miles/52 minutes**	**46 miles/55 minutes**

Source: OIG analysis of Medicare and Medicaid data in 20 selected counties, 2023.

**Due to limitations in the Medicaid data, we were not able to analyze travel distance and time for counties in Mississippi and Nebraska. See the Methodology section for additional information.

Exhibit D-2: 90th percentile for travel distance (in miles) and time (in minutes) for enrollees to receive in-person behavioral health, by county

	County	State	Traditional Medicare	Medicare Advantage	Medicaid
Overall	**Average**		**87 miles/96 minutes**	**75 miles/89 minutes**	**82 miles/93 minutes**
Urban	Maricopa	AZ	33 miles/49 minutes	31 miles/47 minutes	41 miles/51 minutes
	Cook	IL	33 miles/58 minutes	30 miles/53 minutes	42 miles/68 minutes
	Black Hawk	IA	142 miles/141 minutes	83 miles/94 minutes	60 miles/70 minutes
	Hinds	MS	58 miles/60 minutes	124 miles/119 minutes	**
	Douglas	NE	16 miles/28 minutes	15 miles/27 minutes	**
	Broome	NY	137 miles/151 minutes	54 miles/65 minutes	136 miles/144 minutes
	Franklin	OH	63 miles/68 minutes	36 miles/48 minutes	67 miles/74 minutes
	Lane	OR	46 miles/60 minutes	27 miles/40 minutes	63 miles/72 minutes
	Rutherford	TN	130 miles/128 minutes	135 miles/145 minutes	117 miles/119 minutes
	Chesterfield	VA	50 miles/65 minutes	109 miles/128 minutes	50 miles/59 minutes
	Average		**71 miles/81 minutes**	**64 miles/77 minutes**	**72 miles/82 minutes**
Rural	Santa Cruz	AZ	174 miles/157 minutes	91 miles/111 minutes	167 miles/149 minutes
	Stephenson	IL	84 miles/97 minutes	110 miles/129 minutes	114 miles/136 minutes
	Marshall	IA	59 miles/70 minutes	54 miles/68 minutes	87 miles/96 minutes
	Pearl River	MS	83 miles/92 minutes	70 miles/82 minutes	**
	Dodge	NE	57 miles/68 minutes	51 miles/62 minutes	**
	Chenango	NY	67 miles/87 minutes	51 miles/67 minutes	53 miles/75 minutes
	Highland	OH	84 miles/99 minutes	95 miles/108 minutes	76 miles/88 minutes
	Douglas	OR	100 miles/104 minutes	101 miles/105 minutes	35 miles/43 minutes
	Monroe	TN	151 miles/150 minutes	92 miles/104 minutes	83 miles/104 minutes
	Pittsylvania	VA	181 miles/195 minutes	146 miles/187 minutes	122 miles/135 minutes
	Average		**104 miles/112 minutes**	**86 miles/102 minutes**	**92 miles/103 minutes**

Source: OIG analysis of Medicare and Medicaid data in 20 selected counties, 2023.

**Due to limitations in the Medicaid data, we were not able to analyze travel distance and time for counties in Mississippi and Nebraska. See the Methodology section for additional information.

APPENDIX E

Agency Comments

Following this page are the official comments from CMS.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: February 5, 2024

TO: Juliet T. Hodgkins
Principal Deputy Inspector General

FROM: Chiquita Brooks-LaSure
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: *A Lack of Behavioral Health Providers in Medicare and Medicaid Impedes Enrollees' Access to Care*, OEI-02-22-00050

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of Inspector General's (OIG) draft report regarding access to behavioral health providers in Medicare and Medicaid. CMS is committed to ensuring that high-quality behavioral health services and supports are accessible to CMS beneficiaries and consumers. To accomplish these goals, CMS has begun implementation of the CMS Behavioral Health Strategy, which advances priorities in the Department of Health and Human Services (HHS) Roadmap for Behavioral Health Integration, the HHS Overdose Prevention Strategy, and the HHS Pain Management Task Force Report.[1]

CMS's Behavioral Health Strategy focuses on three key areas: substance use disorders (SUD) prevention, treatment and recovery services, ensuring effective pain treatment and management, and improving mental health care and services. These areas are aligned with CMS's overall focus on four health outcomes-based domains: coverage and access to care, quality of care, equity and engagement, and data and analytics. CMS's vision is for all beneficiaries and consumers to receive access to person-centered, timely, and affordable care.[2] Outlined in CMS's strategic plan are 12 cross-cutting initiatives, including a behavioral health initiative that aims to increase and enhance access to equitable and high-quality behavioral health services and improve outcomes for people with behavioral health care needs.[3] CMS's investment in behavioral health spans across Medicare, Medicare Advantage (MA), and Medicaid and Children's Health Insurance Program (CHIP) services.

CMS has taken many actions to ensure behavioral health care access for Medicare enrollees by providing coverage and payment for covered mental health services furnished by psychiatrists or

[1] https://www.cms.gov/cms-behavioral-health-strategy#:~:text=The%20CMS%20Behavioral%20Health%20Strategy,mental%20health%20care%20and%20services.
[2] https://www.cms.gov/cms-behavioral-health-strategy#:~:text=The%20CMS%20Behavioral%20Health%20Strategy,mental%20health%20care%20and%20services.
[3] https://www.cms.gov/files/document/cms-cross-cutting-initiatives-infographic.pdf

other doctors, clinical psychologists, clinical social workers, clinical nurse specialists, nurse practitioners, physician assistants, and other mental health professionals. In the 2023 Medicare Physician Fee Schedule (PFS) final rule, CMS expanded access to mental health and SUD services by allowing licensed professional counselors, licensed marriage and family therapists (MFTs), and other practitioners who previously did not have direct billing rights to provide their mental health services under the general supervision of the billing and supervising physician or non-physician practitioner, rather than under their direct supervision.[4]

In the 2024 Medicare PFS final rule, CMS implemented Section 4121 of the Consolidated Appropriations Act , 2023 (CAA, 2023), which provides for Medicare Part B coverage and payment under the PFS for the services of MFTs and mental health counselors (MHCs) when billed by these professionals. Additionally, CMS finalized its proposal to allow addiction counselors or drug and alcohol counselors who meet the applicable requirements to be an MHC to enroll in Medicare as MHCs. MFTs and MHCs were able to begin submitting Medicare enrollment applications after the 2024 Medicare PFS final rule was issued on November 2, 2023, and they are able to bill Medicare for services as of January 1, 2024, consistent with the statute.

In the 2024 Medicare PFS final rule, CMS also implemented Section 4123 of the CAA, 2023, which requires the Secretary to establish new Healthcare Common Procedure Coding System (HCPCS) codes under the PFS for psychotherapy for crisis services that are furnished in an applicable site of service (any place of service at which the non-facility rate for psychotherapy for crisis services applies, other than the office setting, including the home or a mobile unit) furnished on or after January 1, 2024. Section 4123 of the CAA, 2023 specifies that the payment amount for psychotherapy for crisis services shall be equal to 150% of the fee schedule amount for non-facility sites of service for each year for the services identified (as of January 1, 2022) by HCPCS codes 90839 (*Psychotherapy for crisis; first 60 minutes*) and 90840 (*Psychotherapy for crisis; each additional 30 minutes — List separately in addition to code for primary service*), and any succeeding codes. Additionally, CMS finalized its proposal to allow the Health Behavior Assessment and Intervention (HBAI) services, to be billed by clinical social workers, MFTs, and MHCs, in addition to clinical psychologists. HBAI services address the psychological, behavioral, emotional, cognitive, and social factors included in the treatment of physical health problems. Allowing a wider range of practitioner types to furnish these services will allow for better integration of physical and behavioral health care, particularly given that there are so many behavioral health ramifications of physical health illness. Lastly, CMS finalized an increase in the valuation for timed behavioral health services under the PFS. Specifically, CMS finalized an upward adjustment to the work RVUs for psychotherapy services, which is being implemented over a four-year transition.

To move toward parity between behavioral health and physical health services and advance whole-person care in the MA program, CMS has finalized policies to require that care coordination programs established by MA organizations (MAOs) include behavioral health services. CMS also finalized policies for 2024 to strengthen network adequacy requirements, such as adding licensed clinical social workers and clinical psychologists as specialty types for which CMS sets Medicare Advantage plan network adequacy standards, reaffirming MAOs' responsibilities for behavioral health services and codifying wait-time standards, among other policies.[5] To help ensure that people with a Medicare Advantage plan have access to behavioral

[4] https://www.federalregister.gov/documents/2022/11/18/2022-23873/medicare-and-medicaid-programs-cy-2023-payment-policies-under-the-physician-fee-schedule-and-other
[5] https://www.cms.gov/files/document/cms-behavioral-health-strategy.pdf

health providers, including these newly enrolled providers, for CY2025, CMS proposed to add a range of behavioral health providers under one category called "Outpatient Behavioral Health" as a facility-specialty type under Medicare Advantage plan network adequacy standards. Specialists under this category will include MFTs and MHCs, Opioid Treatment Program providers, Community Mental Health Centers, addiction medicine physicians, and other providers who furnish addiction medicine and behavioral health counseling or therapy services in Medicare today.[6]

For children and adolescents enrolled in Medicaid and CHIP, CMS has engaged in a multifaceted approach to strengthen access to mental health and SUD treatment, including several ongoing initiatives to improve access through schools. These activities have most recently included issuing updated guidance on "Delivering Service in School-Based Settings: A Comprehensive Guide to Medicaid Services and Administrative Claiming"[7] and establishing a technical assistance center to assist states in providing these benefits.[8] The updated guidance offers new flexibilities and consolidates existing guidance, making it easier for all schools, no matter their size or the resources available to them, to receive payment for delivering Medicaid-covered services, including behavioral health services.

CMS is actively collaborating with the Substance Abuse and Mental Health Services Administration (SAMHSA) to expand the Certified Community Behavioral Health Clinic (CCBHC) demonstration across more states, with up to ten additional states added every two years as authorized in the Bipartisan Safer Communities Act (BSCA). In the CCBHC demonstration, participating state Medicaid programs receive enhanced federal match for services provided at community-based clinics that meet specific federal criteria including offering comprehensive mental health and SUD services and evidence-based programs, improving care coordination, and reporting quality measures. There are currently nine states in this demonstration. As part of the expansion under BSCA, planning grants were awarded to 15 states in March 2023 to help these states prepare to apply to be one of the up to 10 additional states selected to participate in the CCBHC demonstration in 2024. This cycle of planning grants and up to ten additional states will be repeated every two years. As a part of this effort, CMS is developing and updating guidance on prospective payment system options including performance measures and policies for the quality bonus component of these reimbursement methodologies. In addition, CMS is proposing a new payment policy to encourage states to improve support for crisis response services by CCBHCs, including mobile units and facility-based walk-in/urgent care services at CCBHCs.[9]

As authorized in the American Rescue Plan (ARP), CMS provided $15 million in planning grants to 20 states to support implementation of community-based mobile crisis intervention services that meet criteria to qualify for enhanced Medicaid match.[10] CMS is working with a number of states to implement state plan amendments (SPAs) to qualify for the temporary enhanced federal Medicaid match for services provided by qualifying community-based mobile crisis intervention teams. SPAs implementing mobile crisis benefits that qualify for the enhanced

[6] https://www.federalregister.gov/documents/2023/11/15/2023-24118/medicare-program-contract-year-2025-policy-and-technical-changes-to-the-medicare-advantage-program
[7] Delivering Service in School-Based Settings: A Comprehensive Guide to Medicaid Services and Administrative Claiming
[8] Please see technical assistance center materials
[9] Certified Community Behavioral Health Clinic (CCBHC) Prospective Payment
[10] State Planning Grants for Qualifying Community-Based Mobile Crisis Intervention Services

match have been approved in 14 states and DC so far. However, these are not the only states that provide Medicaid coverage for mobile crisis services: an estimated 33 states provide this coverage, although not all have completed steps to qualify for the enhanced federal Medicaid match under the ARP.[11]

CMS recently issued guidance to states clarifying that Medicaid and CHIP can pay for interprofessional consultations, even when the beneficiary is not present, as long as the consultation is for the direct benefit of the beneficiary.[12] Previous policy prohibited direct coverage and payment of interprofessional consultation as a distinct service in the absence of the consulting provider seeing the patient. This new policy allows consulting providers to bill and be paid directly, rather having to create a separate arrangement with the treating provider. By clarifying and simplifying billing procedures, this new guidance supports improved integration of mental health and SUD treatment in additional settings, including primary care and emergency departments, and school-based health centers, as well as the potential to mitigate workforce shortages by better leveraging the existing supply of mental health and SUD specialists.[13]

CMS would like to note that states have broad flexibility to utilize a provider network with a range of different qualifications that can best meet the disparate needs of Medicaid beneficiaries. Licensed professionals, such as psychiatrists and other physicians, psychologists, social workers, and nurses can complement peer support specialists with lived experience, case managers, and community health workers to provide direct services and/or linkages to needed health care and community resources. Therefore, CMS has issued guidance related to mental health and SUD that encourages states to recognize an array of providers who together can maximize beneficiary access to services across a robust continuum of care.[14]

On January 18, 2024, a CMS final rule appeared in the Federal Register that is expected to reduce response times for standard (i.e. non-urgent) prior authorization requests in Medicaid Fee for Service (FFS) and managed care and is also expected to improve the prior authorization process by requiring Medicaid FFS programs and managed care plans to implement and maintain a Prior Authorization application programming interface.[15] Implementation of this final rule should bring noticeable improvements to prior authorization processes for impacted payers, including Medicare Advantage Organizations, fee-for-service programs and managed care plans, CHIP and managed care entities, and issuers of Qualified Health Plans offered on the Federally Facilitated Exchanges across delivery systems and is expected to encourage more providers to serve Medicaid beneficiaries, reduce provider burden, and facilitate faster access to care.

Additionally, on April 12, 2023, CMS finalized a rule that revises Medicare Advantage regulations and clarifies rules related to acceptable coverage criteria for basic benefits by requiring that MA plans must comply with national coverage determinations, local coverage determinations, and general coverage and benefit conditions included in Traditional Medicare regulations. The final rule also streamlines prior authorization requirements, including adding continuity of care requirements and reducing disruptions for beneficiaries. CMS is also requiring all Medicare Advantage plans to establish a Utilization Management (UM) Committee to review

[11] Behavioral Health Crisis Response: Findings from a Survey of State Medicaid Programs
[12] https://www.medicaid.gov/sites/default/files/2023-12/sho23001.pdf
[13] Coverage and Payment Guidance
[14] https://www.medicaid.gov/sites/default/files/2022-08/bhccib08182022.pdf
[15] https://www.federalregister.gov/public-inspection/2024-00895/medicare-and-medicaid-programs-patient-protection-and-affordable-care-act-advancing-interoperability.

policies annually and ensure consistency with Traditional Medicare's national and local coverage decisions and guidelines.

CMS recognizes that prior authorization policies and procedures may have a disproportionate impact on underserved populations and may delay or deny access to certain services. For CY2025, CMS proposed to require Medicare Advantage organizations analyze their utilization management (UM) policies and procedures from a health equity perspective. [16]

Furthermore, on January 18, 2024, CMS announced a new model to test approaches for addressing the behavioral and physical health, as well as health-related social needs, of people with Medicaid and Medicare. The Innovation in Behavioral Health (IBH) Model's[17] goal is to improve the overall quality of care and outcomes for adults with mental health conditions and/or substance use disorder by connecting them with the physical, behavioral, and social supports needed to manage their care. The model will also promote health information technology (health IT) capacity building through infrastructure payments and other activities. The IBH Model will be tested by the Center for Medicare and Medicaid Innovation (CMS Innovation Center). Under IBH, community-based behavioral health practices will form interprofessional care teams consisting of behavioral and physical health providers, as well as community-based supports. The model will launch in Fall 2024 and is anticipated to operate for eight years in up to eight states. CMS will release a Notice of Funding Opportunity for the model in Spring 2024.

As noted in this response, CMS has taken a number of steps, and will continue to pursue efforts, to meet the unprecedented demand for behavioral health services and address the provider shortages that often hinder enrollees' ability to seek treatment.

OIG's recommendations and CMS's responses are below.

OIG Recommendation

CMS should take steps to encourage more behavioral health providers to serve Medicare and Medicaid enrollees.

CMS Response

CMS concurs with the intent of the recommendation and will continue to take steps within our authority to encourage more behavioral health providers to serve Medicare and Medicaid enrollees. As noted below, CMS has taken numerous steps within our authority to address this issue.

CMS initially finalized for 2023 regulations to professionals without direct billing rights such as MFTs certain types of therapists and MHCs to provide mental health services as auxiliary personnel incident to, and under the general supervision, rather than direct supervision, of the supervising/billing physician or nonphysician practitioner.

To implement the CAA, 2023, CMS has finalized regulations that authorize MFTs and MHCs (including addiction counselors or alcohol and drug counselors who meet all the requirements to be an MHC) to enroll in the Medicare program and bill directly for their mental health services

[16] https://www.federalregister.gov/documents/2023/04/12/2023-07115/medicare-program-contract-year-2024-policy-and-technical-changes-to-the-medicare-advantage-program

[17] Please see the model's webpage: https://www.cms.gov/priorities/innovation/innovation-models/innovation-behavioral-health-ibh-model

rather than providing their services incident to the professional services of other Medicare-enrolled clinicians. Accordingly, more than 400,000 MFTs and MHCs are now able to independently treat people with Medicare and be paid directly. As of January 18, 2024, 1,732 Marriage and Family Therapists and 11,206 Mental Health Counselors have enrolled, and additional provider enrollment applications continue to come in.

For people with Medicare Advantage, we are also focused on ensuring adequate access to these newly enrolled behavioral health practitioners. CMS finalized MA policies for 2024 that added Licensed Clinical Social Workers and Clinical Psychologists as specialty types for which CMS sets network adequacy and evaluation standards to include specific standards for. CMS also has recently proposed Outpatient Behavioral Health Facilities, which can include marriage and family therapists, mental health counselors, Opioid Treatment Program providers, and other practitioners providing therapy and SUD treatment, as a facility-specialty type to be included under Medicare Advantage plan network adequacy standards.

For the Medicare FFS program, CMS is implementing changes to more accurately value and pay for behavioral health services. As noted above, CMS has increased payment for psychotherapy for crisis services 150% of the non-facility PFS rate when this crisis care is provided outside of health care settings. This change is required under section 4123 of the CAA, 2023, and will better reflect better reflect the costs that behavioral health practitioners incur to provide these services. CMS has also increased payment for certain timed behavioral health services, including psychotherapy, and increased the payment rate for SUD treatment furnished in the office setting in order to better reflect the costs involved in furnishing these services.

In Medicaid, CMS issued guidance to states in 2023 clarifying that Medicaid and CHIP can directly pay practitioners who did not see the patient at issue for interprofessional consultations, even when the beneficiary is not present, as long as the consultation is for the direct benefit of the beneficiary. Previous policy prohibited coverage and payment of interprofessional consultation as a distinct service. This new policy allows consulting providers to bill and be paid directly, rather than having to create a separate arrangement with the treating provider to share payment. By clarifying and simplifying billing procedures, this new guidance supports improved integration of mental health and SUD treatment in additional settings, including primary care, emergency departments, and school-based health centers, as well as the potential to mitigate workforce shortages by better leveraging the existing supply of mental health and SUD specialists.[18]

OIG Recommendation

CMS should explore options to expand Medicare and Medicaid coverage to additional behavioral health providers.

CMS Response

CMS concurs with this recommendation and will continue engaging in a multi-faceted approach to strengthen access to mental health and SUD treatment through Medicare, Medicaid, and CHIP. CMS is actively collaborating with SAMHSA to expand coverage and access to providers and has recently issued guidance to states regarding coverage and reimbursement for interprofessional consultations.[19] Furthermore, while CMS has recently finalized regulations to

[18] Coverage and Payment Guidance

[19] https://www.medicaid.gov/sites/default/files/2023-12/sho23001.pdf

allow MFTs and MHCs to enroll as Medicare providers, legislation may be required to further expand Medicare payment to additional types of behavioral health practitioners such as paraprofessionals and peer support workers. CMS will take OIG's report and this recommendation into consideration as we continue to make positive changes to ensure access to behavioral health for all beneficiaries.

OIG Recommendation

CMS should use network adequacy standards to drive an increase in behavioral health providers in Medicare Advantage and Medicaid.

CMS Response

CMS concurs with the intent of the recommendation, and we will continue to take steps within our authority to address this issue.

CMS notes that we have taken several actions to strengthen network adequacy standards in MA and Medicaid and continues to pursue additional efforts. As stated above, CMS finalized MA policies for 2024 that strengthened the existing network adequacy and evaluation requirements by adding Licensed Clinical Social Workers and Clinical Psychologists as specialty types, which reaffirms MAOs' responsibilities for behavioral health services, and by codifying wait-time standards, among other policies. CMS has also proposed to strengthen Medicaid managed care network adequacy requirements (i.e., appointment wait time standards) and other provisions to improve access to care in a proposed rule (CMS-2439-P). CMS hopes to finalize this rule in Spring 2024.

Additionally, for 2025, CMS proposed to add a range of behavioral health providers under one category called "Outpatient Behavioral Health" as a facility-specialty type under Medicare Advantage plan network adequacy standards. Specialists under this category will include MFTs and MHCs, Opioid Treatment Program providers, Community Mental Health Centers, addiction medicine physicians, and other providers who furnish addiction medicine and behavioral health counseling or therapy services in Medicare today.

OIG Recommendation

CMS should increase monitoring of Medicare and Medicaid enrollees' use of behavioral health services and identify vulnerabilities.

CMS Response

CMS concurs with the recommendation. CMS will consider the best approach to explore the evaluation of available Medicare data regarding enrollee use of behavioral health services and determine appropriate next steps. Additional resources and funding may be required in order to complete the request.

For Medicaid, CMS annually publishes a Report to Congress (RTC) on the number of Medicaid beneficiaries with SUDs, the services they received, the settings where they receive these services, the delivery systems that provide these services, and the progression of care based on analysis of claims data from the Transformed Medicaid Statistical Information System (T-MSIS).[20] These reports provide an important resource for assessing access to treatment services and supports as well as highlighting opportunities for improving care for beneficiaries with

[20] Transformed Medicaid Statistical Information System (T-MSIS) Analytic Files (TAF) Report

SUDs.

CMS is working with Medicaid T-MSIS claims and enrollment data to develop resources providing information on access to treatment among individuals with mental health conditions. These resources will make these data more accessible and include information on mental health topics like those included in the SUD Databook described in the previous section.

CMS has also incorporated audit procedures into its Medicaid managed care plans audits to ensure beneficiaries are receiving the value of care that is being paid for by Medicaid. Specifically, CMS will be conducting claims review of high-risk areas including behavioral health. The claims review of behavioral health services will help ensure managed care plans are paying claims correctly, services are necessary, and are being delivered.

CMS thanks OIG for their efforts on this issue and looks forward to working with OIG on this and other issues in the future.

ACKNOWLEDGMENTS AND CONTACT

Acknowledgments

Meridith Seife served as the team leader for this study along with key contributors, Hannah Morgan and Michael Reilly. Other Office of Evaluation and Inspections staff who contributed to this study include Rosemary Rawlins Bartholomew, Benjamin Engler, Robert Gibbons, Lyndsay Hopper, Eunji Kim, Ivy Ngo, Elena Pereira, Chelsea Samuel, and Yasasvi Talagadadeevi.

We would also like to acknowledge the contributions of other Office of Inspector General staff, including Emily Boltwood Miller, Jessica Swanstrom, and Nora Witek.

This report was prepared under the direction of Jodi Nudelman, Regional Inspector General for Evaluation and Inspections in the New York Regional Office, and Nancy Harrison and Meridith Seife, Deputy Regional Inspectors General. Additional support was provided from Blaine Collins, Regional Inspector General in the San Francisco Regional Office.

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ENDNOTES

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[2] Because most States provide the majority—if not all—of their Medicaid covered behavioral health services through Medicaid managed care plans, this review focuses exclusively on behavioral health services provided through Medicaid managed care. Sections 1915(a), 1915(b), 1932(a), and 1115(a) of the Social Security Act authorize States to operate managed care delivery systems in which a State and a managed care organization enter a comprehensive risk contract to cover certain services. See 42 CFR §438.2. Accessed at https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-A/section-438.2 on Oct. 30, 2023.

[3] Health Resources & Services Administration, "Health Workforce Shortage Areas." Accessed at https://data.hrsa.gov/topics/health-workforce/shortage-areas on Aug. 10, 2023.

[4] Substance Abuse and Mental Health Services Administration, *Key Substance Use and Mental Health Indicators in the United States: Results from the 2021 National Survey on Drug Use and Health*, December 2022. Accessed at https://www.samhsa.gov/data/sites/default/files/reports/rpt39443/2021NSDUHFFRRev010323.pdf on Apr. 4, 2023.

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[6] American Psychological Association, "Worsening mental health crisis pressures psychologist workforce." Accessed at https://www.apa.org/pubs/reports/practitioner/covid-19-2021 on Aug. 10, 2023.

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[8] The Commonwealth Fund, "Medicare's Mental Health Coverage: What's Included, What's Changed, and What Gaps Remain." Accessed at https://www.commonwealthfund.org/publications/explainer/2023/mar/medicare-mental-health-coverage-included-changed-gaps-remain on Apr. 4, 2023.

[9] Kaiser Family Foundation, "Medicare Advantage in 2023: Enrollment Update and Key Trends." Accessed at https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2023-enrollment-update-and-key-trends/ on Dec. 11, 2023.

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[12] The Commonwealth Fund, "Medicare's Mental Health Coverage: What's Included, What's Changed, and What Gaps Remain." Accessed at https://www.commonwealthfund.org/publications/explainer/2023/mar/medicare-mental-health-coverage-included-changed-gaps-remain on Apr. 4, 2023.

[13] Medicare also covers inpatient mental health services in a general hospital or in a psychiatric hospital. See CMS, *Medicare & Your Mental Health Benefits*, August 2023. Accessed at https://www.medicare.gov/Pubs/pdf/10184-Medicare-and-Your-Mental-Health-Benefits.pdf on Sep. 1, 2023.

[14] Substance Abuse and Mental Health Services Administration, *Behavioral Health Spending & Use Accounts 2006-2015*. Accessed at https://store.samhsa.gov/sites/default/files/d7/priv/bhsua-2006-2015-508.pdf on Apr. 4, 2023.

[15] Kaiser Family Foundation, "Demographics and Health Insurance Coverage of Nonelderly Adults With Mental Illness and Substance Use Disorders in 2020." Accessed at https://www.kff.org/medicaid/issue-brief/demographics-and-health-insurance-coverage-of-nonelderly-adults-with-mental-illness-and-substance-use-disorders-in-2020/# on May 22, 2023.

[16] Kaiser Family Foundation, "State Policies Expanding Access to Behavioral Health Care in Medicaid." Accessed at https://www.kff.org/medicaid/issue-brief/state-policies-expanding-access-to-behavioral-health-care-in-medicaid/ on Apr. 4, 2023.

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[18] 42 CFR §422.116. Accessed at https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-422/subpart-C/section-422.116 on Sept. 12, 2023.

[19] CMS, "2024 Medicare Advantage and Part D Final Rule (CMS-4201-F)." Accessed at https://www.cms.gov/newsroom/fact-sheets/2024-medicare-advantage-and-part-d-final-rule-cms-4201-f on Oct. 31, 2023. See also 42 CFR §422.116. Accessed at https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-422/subpart-C/section-422.116 on Oct. 31, 2023.

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[21] Senate Committee on Finance, *Major Study Findings: Medicare Advantage Plan Directories Haunted by Ghost Networks*, May 3, 2023. Accessed at https://www.finance.senate.gov/imo/media/doc/050323%20Ghost%20Network%20Hearing%20-%20Secret%20Shopper%20Study%20Report.pdf on June 6, 2023. See also Zhu, J. M., Charlesworth, C. J., Polsky, D., and McConnell, K. J., "Phantom Networks: Discrepancies Between Reported and Realized Mental Health Care Access in Oregon Medicaid." *Health Affairs*, Vol. 41, No. 7, July 2022. Accessed at https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2022.00052 on June 7, 2023. See also Kaiser Family Foundation, "Network Adequacy Standards and Enforcement." Accessed at https://www.kff.org/health-reform/issue-brief/network-adequacy-standards-and-enforcement on Oct. 27, 2023.

[22] In this report, Medicaid managed care is referred to as Medicaid.

[23] Note that even though a provider is actively serving in a particular program, those providers do not necessarily work exclusively for a single program. For example, a provider may serve enrollees in traditional Medicare in addition to enrollees in several Medicare Advantage plans. Active providers may also be serving enrollees with private insurance.

[24] Tadmon, D., and Bearman, P. S. "Differential spatial-social accessibility to mental health care and suicide." *PNAS*, Vol. 120, No. 19, 2023. Accessed at https://www.pnas.org/doi/epdf/10.1073/pnas.2301304120 on June 21, 2023.

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[26] Government Accountability Office, *Mental Health Care: Access Challenges for Covered Consumers and Relevant Federal Efforts*, March 2022. Accessed at https://www.gao.gov/assets/gao-22-104597.pdf on Aug. 16, 2023.

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[28] In Illinois and Iowa, psychologists may also apply for prescriptive authority. Louisiana, New Mexico, and Idaho also allow psychologists to prescribe medication.

[29] Smith, B. L., "Inappropriate Prescribing." *Monitor on Psychology,* Vol. 43, No. 6, June 2012. Accessed at https://www.apa.org/monitor/2012/06/prescribing on Mar. 20, 2023. See also Wiechers, I. R., Leslie, D. L., and Rosenheck, R. A., "Prescribing of Psychotropic Medications to Patients Without a Psychiatric Diagnosis." *Psychiatric Services*, Vol. 64, No. 12, December 2013. Accessed at https://ps.psychiatryonline.org/doi/full/10.1176/appi.ps.201200557 on Mar. 20, 2023.

[30] This analysis is based on a comparison of the number of providers who actively served Medicare and Medicaid enrollees to the number of providers in the Behavioral Health Workforce Tracker in each of the selected counties. We focused this analysis on a subset of behavioral health providers: psychiatrists, psychologists, and social workers. For more information on the Behavioral Health Workforce Tracker see Fitzhugh Mullan Institute for Health Workforce Equity, "2017-2021 Behavioral Health Workforce Tracker." Accessed at https://www.gwhwi.org/behavioralhealth-workforce-tracker-v20.html on Apr. 7, 2023.

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[35] Substance Abuse and Mental Health Services Administration, "Key Substance Use and Mental Health Indicators in the United States: Results from the 2021 National Survey on Drug Use and Health." Accessed at https://www.samhsa.gov/data/sites/default/files/reports/rpt39443/2021NSDUHFFRRev010323.pdf on Apr. 4, 2023.

[36] On average, 83 percent of traditional Medicare and Medicare Advantage enrollees and 76 percent of Medicaid enrollees saw only one provider during the year. Only 3 percent of enrollees in traditional Medicare, 4 percent of enrollees in Medicare Advantage, and 7 percent of enrollees in Medicaid saw three or more providers during the year.

[37] In traditional Medicare, 40 percent of enrollees saw a social worker and 31 percent saw a psychologist, and in Medicare Advantage, 36 percent of enrollees saw a social worker and 27 percent saw a psychologist. Note that enrollees can see more than one type of behavioral health provider, and these are not exclusive categories.

[38] In Medicaid, 36 percent of enrollees saw a counselor and 34 percent saw a social worker.

[39] The Consolidated Appropriations Act, 2023, Pub. L. No. 117-328, Division FF, Title IV, Subtitle C, Sec. 4121 established Medicare coverage of behavioral health services provided by marriage and family therapists and certain types of mental health

counselors under Medicare Part B beginning on Jan. 1, 2024. Accessed at https://www.govinfo.gov/content/pkg/PLAW-117publ328/pdf/PLAW-117publ328.pdf on June 9, 2023.

[40] In traditional Medicare, 27 percent of enrollees traveled more than 60 minutes for an in-person visit with a provider, and 13 percent of enrollees traveled more than 90 minutes. In Medicare Advantage, 23 percent of enrollees traveled more than 60 minutes, and 11 percent traveled more than 90 minutes. In Medicaid, 27 percent of enrollees traveled more than 60 minutes, and 14 percent traveled more than 90 minutes.

[41] *Certain Medicare Beneficiaries, Such as Urban and Hispanic Beneficiaries, Were More Likely Than Others To Use Telehealth During the First Year of the COVID-19 Pandemic* (OEI-02-20-00522) Sept. 2, 2022.

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[47] Kaiser Family Foundation, "A Look at Strategies to Address Behavioral Health Workforce Shortages: Findings from a Survey of State Medicaid Programs." Accessed at https://www.kff.org/medicaid/issue-brief/a-look-at-strategies-to-address-behavioral-health-workforce-shortages-findings-from-a-survey-of-state-medicaid-programs/ on May 30, 2023.

[48] *High Rates of Prior Authorization Denials by Some Plans and Limited State Oversight Raise Concerns About Access to Care in Medicaid Managed Care* (OEI-09-19-00350) July 17, 2023.. *Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care* (OEI-09-18-00260) Apr. 27, 2022.

[49] The HPSA physician bonus program provides additional payments to physicians, including psychiatrists, in federally designated HPSAs. See 42 CFR §414.67. Accessed at https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-414/subpart-B/section-414.67 on Nov. 16, 2023.

[50] The Consolidated Appropriations Act, 2023, Pub. L. No. 117-328, Division FF, Title IV, Subtitle C, Sec. 4121. Accessed at https://www.govinfo.gov/content/pkg/PLAW-117publ328/pdf/PLAW-117publ328.pdf on Nov. 16, 2023.

[51] Qualified health plans on the Federally-facilitated Exchange are also required to meet appointment wait time standards. For behavioral health providers, the standard is 10 business days. See 45 CFR §156.230(a)(2). Accessed at https://www.ecfr.gov/current/title-45/part-156/subpart-C#p-156.230(a)(2) on Nov. 20, 2023. See also CMS, "2023 Final Letter to Issuers in the Federally-facilitated Exchanges," Accessed at https://www.cms.gov/cciio/resources/regulations-and-guidance/downloads/final-2023-letter-to-issuers.pdf on Nov. 20, 2023.

[52] To determine the quality of States' T-MSIS, we relied on CMS's Data Quality Atlas. For more information see CMS, "DQ Atlas." Accessed at https://www.medicaid.gov/dq-atlas/welcome on Oct. 15, 2021.

[53] We considered counties that had between 25 and 75 percent Medicare Advantage penetration.

[54] We used the National Center for Health Statistics (NCHS) Urban-Rural classification scheme to define urban and rural areas. For more information see CDC, "NCHS Urban-Rural Classification Scheme for Counties." Accessed at https://www.cdc.gov/nchs/data_access/urban_rural.htm on Sep. 14, 2021.

[55] To identify behavioral health services, we used the Restructured Berenson-Eggers Type of Service (BETOS) Classification System. This system is a taxonomy that allows researchers to group health care service codes for Medicare Part B services into clinically meaningful categories and subcategories. For more information see CMS, "Restructured BETOS Classification System." Accessed at https://data.cms.gov/provider-summary-by-type-of-service/provider-service-classifications/restructured-betos-classification-system on Aug. 31, 2021.

[56] We included all enrollees who lived in a selected county for at least 180 days and had continuous enrollment in a selected Medicaid or Medicare Advantage plan or were enrolled in traditional Medicare for at least 180 days. For Medicare Advantage, we included all Health Maintenance Organization plans and local and regional Preferred Provider Organization plans that operated in the selected counties. For Medicaid, we included all plans that cover behavioral health services in the selected counties, with the exception of plans that served special populations, such as Medicaid plans that solely served children in foster care or plans that only served dually eligible enrollees. We determined whether enrollees were living in the selected county through their home address.

[57] The CMS Data Quality Atlas indicates that the provider address information on Nebraska Medicaid encounters is insufficient. For Medicaid encounters in Nebraska, we utilized the address information maintained by the Medicaid managed care organizations.

[58] All numbers presented in this report and in the appendices were rounded. The averages for all 20 counties, and the rural and urban averages, were calculated prior to rounding.

[59] We included plans that had at least 250 enrollees in urban counties and 100 enrollees in rural counties. In total, we reviewed 328 Medicare Advantage plans and 75 Medicaid managed care plans.

[60] Fitzhugh Mullan Institute for Health Workforce Equity, "2017-2021 Behavioral Health Workforce Tracker." Accessed at https://www.gwhwi.org/behavioralhealth-workforce-tracker-v20.html on Apr. 7, 2023.

[61] To identify psychologists and licensed clinical social workers, the Fitzhugh Mullen Institute relied on State licensure data obtained from all 50 States for 2021. When licensure data was unavailable or incomplete, NPPES data was used to supplement these data. Psychiatrists were identified by using prescribing data and specialty information from 2021 IQVIA Xponent reports. For more information on data, methods, and limitations see Fitzhugh Mullan Institute for Health Workforce Equity, "Behavioral Health Workforce Tracker v2.0." Accessed at https://www.gwhwi.org/uploads/4/3/3/5/43358451/data_and_methods.pdf on Apr. 7, 2023.

[62] To determine driving distance and travel time, we compared the address of the behavioral health provider and the address of the enrollee on in-person claims and encounters. This analysis only examined the distance between each unique pairing of enrollees and their providers and did not consider how many visits a patient had with a given provider.

[63] In all three programs, we excluded provider or enrollee street addresses that were invalid such as, "Homeless" or "General delivery." In Medicaid, we excluded Mississippi and Nebraska due to a lack of complete and accurate address data.