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DATA BRIEF

October 2025 | OEI-02-23-00540

Many Medicare Advantage and Medicaid Managed Care Plans Have Limited Behavioral Health Provider Networks and Inactive Providers

HHS Office of Inspector General
HIGHLIGHTS

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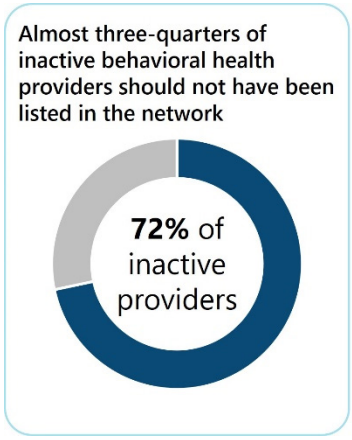
Why OIG Did This Review

- Medicare and Medicaid play significant roles in ensuring access to care for millions of enrollees with behavioral health conditions, which include mental health disorders and substance use disorders.
- Most Medicare and Medicaid enrollees' behavioral health care is covered by managed care plans. As a result, enrollees' access to providers is largely determined by the network of providers contracted by each plan.
- Plans must provide enrollees with a list of all providers in their network, i.e., a network directory. This review assessed the extent to which selected plan networks were limited and whether the providers listed in each directory were actively providing services to the plan's enrollees.

What OIG Found

- Many Medicare Advantage and Medicaid managed care plans had limited networks of behavioral health providers.
- These provider networks were further limited by including inactive providers who did not provide any services to enrollees.
- Most of these inactive providers should not have been listed as network providers by the plan. For example, these providers no longer worked at any of the locations listed by the plan or they indicated they would not see patients enrolled in the plan.
    - These inactive providers are sometimes referred to as "ghost" providers and can make the networks appear larger than they are.



- Providers cited administrative burden and low payment rates as factors affecting their willingness to work with managed care plans.

What OIG Recommends

OIG recommends that CMS:

1. Use data to monitor provider networks and take additional steps to improve the accuracy of network directories in Medicare Advantage.
2. Work with States to improve the accuracy of network directories in Medicaid managed care.
3. Continue exploring how a nationwide directory could reduce inaccuracies and increase administrative efficiencies for providers and patients.

CMS did not explicitly concur or nonconcur with our recommendations; however, it indicated that it has taken a number of steps that are aligned with each of the three recommendations and that additional steps are planned.

Primer: Behavioral Health in Medicare Advantage and Medicaid Managed Care

Almost half of all Americans will experience a behavioral health condition—which includes mental health disorders and substance use disorders—in their lifetime.[1] However, in many parts of the United States, Medicare and Medicaid enrollees struggle to find behavioral health providers who accept their insurance.

Roughly 3 out of every 10 Americans are covered by a Medicare Advantage or Medicaid managed care plan.[2] In 2024, 32.8 million people, or more than half of all Medicare enrollees, were enrolled in a Medicare Advantage plan.[3] In Medicaid, more than 83 million enrollees were enrolled in a managed care plan, with most States providing the majority—if not all—of their behavioral health services through managed care.[4]

Provider Networks in Managed Care

Managed care plans contract with providers who agree to work with the plan and provide services to the plan's enrollees at specified payment rates.[5] Most managed care plans impose restrictions on coverage, such as requiring prior authorization for certain services or covering services only by providers who are in their network.

Plans must provide enrollees with a list of all providers in their network, i.e., a network directory. In general, plans are required to update their network lists quarterly or within 30 days after being notified of a change.[6] Additionally, Medicaid plans are required to publish "accurate, updated, and searchable provider directories."[7]

When a plan's network includes only a small proportion of the behavioral health workforce, the network is considered "limited." The breadth of a plan's network is typically measured by comparing the total workforce of providers in a given area to the number of providers who contract with a plan. When a plan has a limited provider network, enrollees may face challenges finding care.

Network Adequacy

Managed care plans in Medicare and Medicaid are required to have enough providers in their networks to meet enrollees' needs.[8] Network adequacy standards are quantitative metrics designed to ensure that each plan's network has an adequate number of providers to serve enrollees. These standards can include metrics such as minimum provider-to-enrollee ratios or a maximum distance or travel time for enrollees to see a provider in their network. However, compliance with these standards is typically measured on the basis of data about the providers who plans say participate in their networks.

In Medicaid managed care, each State must set quantitative metrics for certain provider types, including behavioral health providers. In Medicare Advantage, CMS established minimum provider ratios and time and distance standards which vary by provider type and county. CMS also finalized two rules that set the maximum appointment wait time for routine behavioral health appointments at 30 business days in Medicare Advantage and 10 business days in Medicaid managed care.[9] The new rule in Medicaid also

requires States to implement secret shopper surveys to determine compliance with appointment wait time standards and to verify the accuracy of provider directory information.[10] These surveys are slated to begin as early as mid-2028.[11]

In addition, the new rule in Medicaid managed care establishes a new oversight mechanism—a "remedy plan"—which is designed to identify and address difficulties in meeting network adequacy standards.[12] If plans fail to meet the established network adequacy standards, CMS or States can take a number of steps to ensure compliance, including establishing corrective action plans, suspending plan enrollment for new enrollees, or terminating the plan's contract. CMS and many State Medicaid agencies also have the ability to issue sanctions or civil monetary penalties for plans that do not meet program requirements; however, these types of actions are relatively rare.[13]

Related OIG Reports on Access to Behavioral Health Care

In a prior report, OIG found few behavioral health providers in the selected counties who actively served enrollees in traditional Medicare, Medicare Advantage, or Medicaid managed care.[14] On average, there were fewer than 5 active behavioral health providers per 1,000 enrollees in each program. Most enrollees saw their behavioral health providers in person; however, many enrollees traveled long distances to see them. The report recommended that CMS:

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

In another report, OIG found that about 45 percent of active providers were not accepting new patients with Medicare or Medicaid.[15] Among the providers who were available to treat a new patient, about 24 percent reported wait times of more than 30 days.

Methodology

This review builds on the prior OIG work and focuses on access to behavioral health care in Medicare Advantage and Medicaid managed care. It determines the proportion of the behavioral health workforce in each county that was included in plans' networks. It also determines the extent to which managed care plans had inactive providers in their networks—meaning providers who did not provide any services to enrollees in that plan during 2023. Lastly, it looks at the reasons why these inactive providers did not provide services to enrollees. While these are important measures of access to care, they are not considered network adequacy standards; this review does not measure compliance with any network adequacy standards.

This review is based on analyses of provider network lists; information about the behavioral health workforce from State licensing boards; Medicare Advantage and Medicaid encounter data; and a survey of

inactive providers. We focused this review on four Medicare Advantage and two Medicaid managed care plans from 10 selected counties, for a total of 60 plans. We selected these plans from a diverse group of five urban and five rural counties from five States that are geographically dispersed throughout the country. In addition, we focused this review on key behavioral health providers (i.e., psychiatrists, psychologists, and clinical social workers).[16] See Detailed Methodology and Appendix A for additional information.

FINDINGS

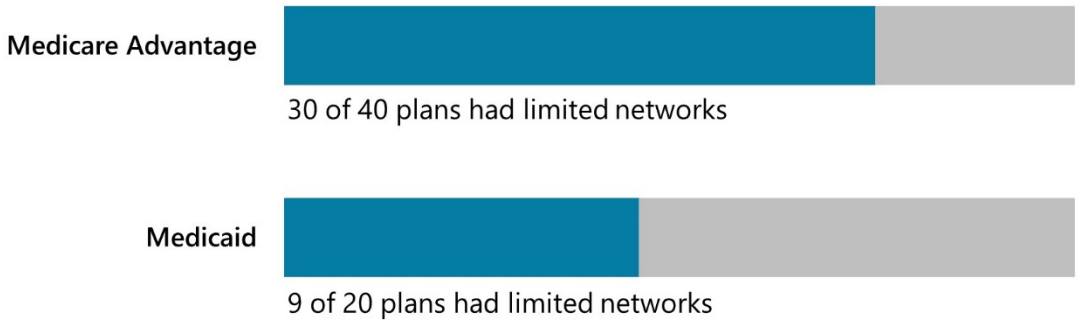
Many managed care plans had limited behavioral health networks, containing few providers to care for enrollees

Limited networks provide Medicare Advantage and Medicaid managed care enrollees with access to fewer behavioral health providers.

The breadth of a network is an important measure of access to providers.[17] Many of the selected managed care plans had provider networks that included only a small percentage of the counties' behavioral health workforce.[18]

When a network has less than 25 percent of the area's workforce, it is considered a limited network.[19] Three-quarters of the Medicare Advantage plans had less than 25 percent of the counties' behavioral health workforce in their networks. In Medicaid, almost half of the plans had less than 25 percent of the counties' workforce in their networks. (See Exhibit 1.) This means that enrollees in these plans may not have had access to 75 percent or more of the behavioral health providers in their counties because these providers were not included in their plans' networks.

Exhibit 1: Many Medicare Advantage and Medicaid plans had limited networks with less than 25 percent of the area's behavioral health workforce



Source: OIG analysis of 40 Medicare Advantage plans and 20 Medicaid managed care plans in 10 counties, 2024.

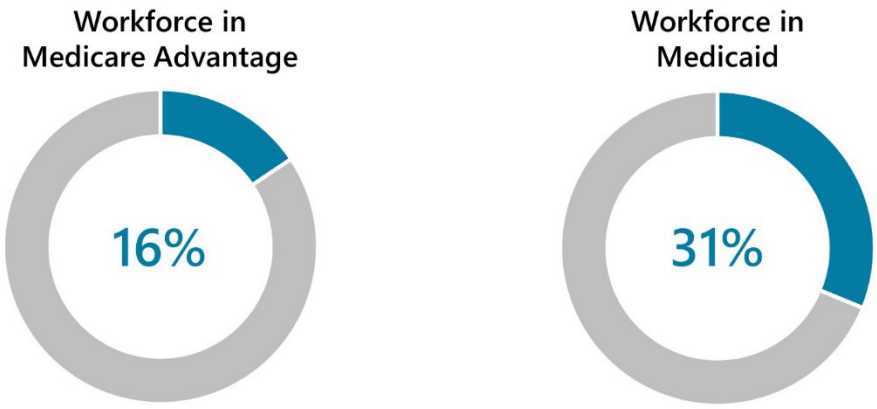
Some managed care plans had even smaller percentages of the workforce in their networks, meaning that they had extremely limited networks. In Medicare Advantage, 15 of the plans had networks that included less than 10 percent of the behavioral health workforce. Seven of these plans had no in-network behavioral health providers in the counties at all. In Medicaid, four plans had networks that included less than 10 percent of the behavioral health workforce, with one plan having no in-network behavioral health providers in the county at all.

In contrast, other plans had much more expansive networks. Five of the 60 plans had more than half of the county's behavioral health workforce in their networks. Some of these plans were in the same counties as plans that had limited networks.

On average, Medicare Advantage plans included a smaller percentage of the behavioral health workforce than Medicaid plans

On average, Medicare Advantage plans included 16 percent of the counties' behavioral health workforce in their networks. In contrast, Medicaid plans included an average of 31 percent of the counties' behavioral health workforce in their networks. (See Exhibit 2.)

Exhibit 2: On average, Medicare Advantage plans included a smaller percentage of the behavioral health workforce than Medicaid plans



Source: OIG analysis of 40 Medicare Advantage plans and 20 Medicaid managed care plans in 10 counties, 2024.

In Medicare Advantage, enrollees may choose to enroll in different types of managed care plans, such as preferred provider organization (PPO) plans or health maintenance organization (HMO) plans.[20] There were no large differences in the percentage of the behavioral health workforce between PPOs and HMOs. (See Appendix B, Exhibit B-2.)

On average, plans included a smaller percentage of psychologists and social workers in their networks than psychiatrists

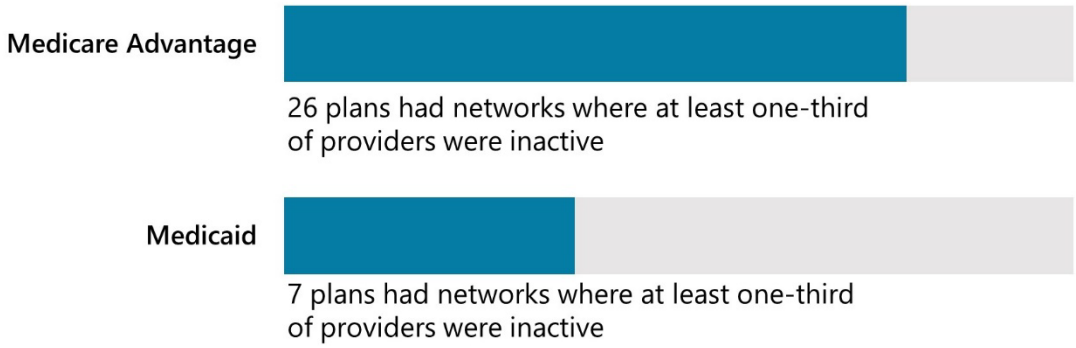
Both Medicare Advantage and Medicaid plan networks included a smaller percentage of psychologists and social workers than psychiatrists. In Medicare Advantage, plans included an average of 13 percent of psychologists and 13 percent of social workers, whereas in Medicaid, plans included an average of 28 percent of psychologists and 30 percent of social workers. In both Medicare Advantage and Medicaid, plans included about half of the psychiatrists in the county, on average. (See Appendix B, Exhibit B-3.)

Many managed care plans had a high percentage of inactive providers in their networks who did not provide services to enrollees

CMS regulations require plans to provide enrollees with a list of all network providers—a provider directory—and information about how to contact them. However, for many plans, a significant percentage of the providers listed in their networks were inactive—meaning they did not provide a single service to the plan's enrollees in 2023.

Notably, in more than half of the Medicare Advantage plans and a third of the Medicaid plans, at least one-third of the providers listed in their networks were inactive. (See Exhibit 3.) A high percentage of inactive providers may indicate that there are significant inaccuracies in the plan's directory.

Exhibit 3: Many plans had networks where at least one-third of providers were inactive



Source: OIG analysis of 33 Medicare Advantage plans and 19 Medicaid managed care plans in 10 counties, 2024. Seven Medicare Advantage plans and one Medicaid managed care plan did not have any network providers in the selected counties and were not included in this analysis.

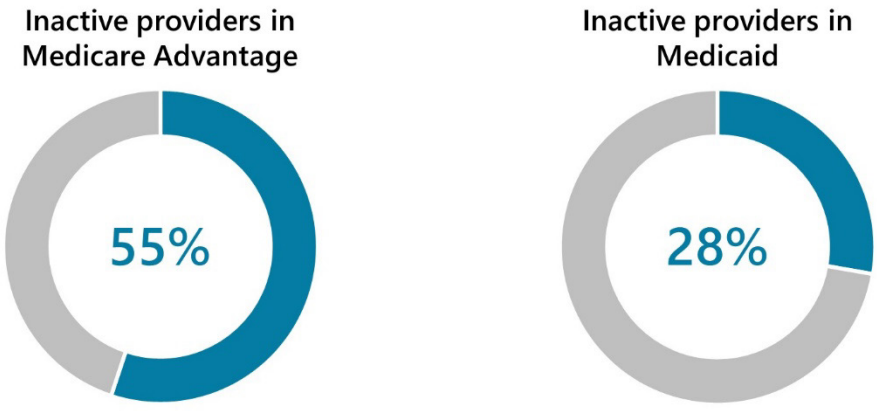
For some plans, the percentage of network providers who were inactive was much higher. In 18 Medicare Advantage plans and 1 Medicaid plan, more than 60 percent of providers listed in their networks did not provide a single service to enrollees. In one Medicare Advantage plan, only 3 out of 356 network providers actually provided a service to an enrollee from that plan; all of the remaining 353 providers listed in the plan's directory were inactive.

In contrast, other plans had a much lower percentage of inactive providers. For example, in one plan, less than 10 percent (24 of 272) of network providers were inactive. This may indicate that some plans were taking actions to ensure the accuracy of the provider information in their directories and that network providers were actually serving enrollees. (See Appendix C, Exhibit C-1.)

On average, Medicare Advantage plans had more inactive providers than Medicaid plans

On average, in Medicare Advantage, 55 percent of behavioral health providers listed in plans' networks did not provide a single service to enrollees in 2023. In Medicaid, an average of 28 percent of providers listed in plans' networks did not provide any services to enrollees.[21] (See Exhibit 4.)

Exhibit 4: On average, more than half of plans' network providers in Medicare Advantage were inactive, and more than a quarter were inactive in Medicaid



Source: OIG analysis of 33 Medicare Advantage plans and 19 Medicaid managed care plans in 10 counties, 2024. Seven Medicare Advantage plans and one Medicaid managed care plan did not have any network providers in the selected counties and were not included in this analysis.

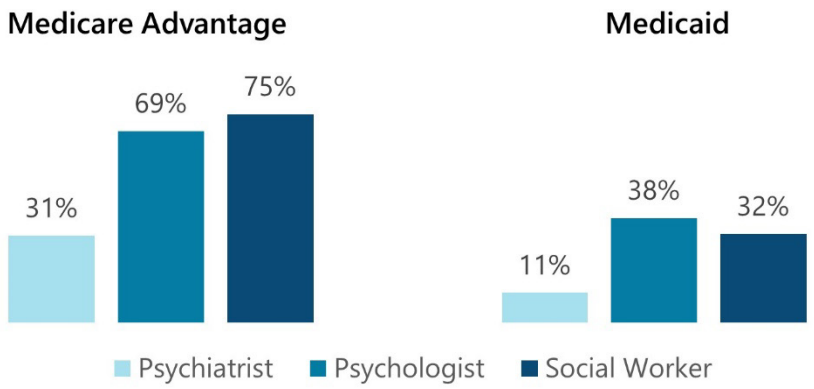
On average, Medicare Advantage plans in rural areas had more inactive providers than plans in urban areas. Plans in rural counties had an average of 63 percent of network providers who did not provide services to any of the plans' enrollees,

compared to an average of 50 percent for plans in urban counties. In Medicaid, there were smaller differences; on average, plans in rural counties had 27 percent of network providers who were inactive, compared to 28 percent for plans in urban counties.

On average, plans had more social workers and psychologists who were inactive than psychiatrists

On average, both Medicare Advantage and Medicaid plans had a higher percentage of social workers and psychologists who were inactive compared to psychiatrists. (See Exhibit 5.)

Exhibit 5: On average, plans had a higher percentage of social workers and psychologists than psychiatrists who were inactive



Source: OIG analysis of 33 Medicare Advantage plans and 19 Medicaid managed care plans in 10 counties, 2024. Seven Medicare Advantage plans and one Medicaid managed care plan did not have any network providers in the selected counties and were not included in this analysis.

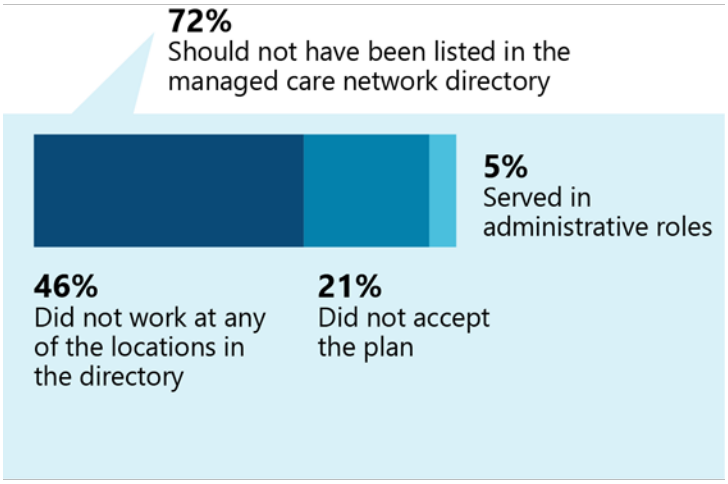
Almost three-quarters of inactive providers should not have been listed as network providers

"Ghost networks" occur when a plan's network contains providers who should not be listed as network providers (such as providers who have retired or changed locations). **Plans with large ghost networks may appear to meet network adequacy standards but may not have enough providers to meet the needs of enrollees.**

To better understand the reasons why providers were not providing services to enrollees and to determine whether they should be listed in plans' networks, we surveyed a random sample of inactive providers in Medicare Advantage and Medicaid plans. On the basis of these providers' responses, we found that 72 percent of the inactive providers should not have been listed as network providers in the plan directories. (See Exhibit 6.) Most often, these providers should not have been listed because they no

longer worked at any of the locations listed by the plan.[22] In other cases, providers should not have been listed in the network because the providers indicated they would not have seen patients enrolled in the plan or never signed up to be a network provider with the plan. A high proportion of providers who should not have been listed as network providers may be an indication of "ghost networks," which can pose a significant barrier to enrollees seeking behavioral health care.

Exhibit 6: Most inactive providers should not have been listed as network providers



Source: OIG analysis of survey of inactive providers in Medicare and Medicaid managed care plans in 10 counties, 2024.

Almost half of all inactive providers did not work at any of the locations listed in the network directory

Notably, 46 percent of inactive providers did not work at any location listed in the network directory. Some of these providers had retired, while others had left to practice elsewhere. In many cases, the provider had stopped working at the clinic years earlier; in one case, the provider had not worked at the clinic for more than 10 years. In another instance, a provider was listed in the directory under 19 different practice locations; however, a receptionist said the provider retired a number of years ago and did not work at any of the listed locations.

About one-fifth of inactive providers did not accept patients with the managed care plan

> **"I do not accept Medicare, nor would I knowingly enroll as a provider in a Medicare program."**
>
> - A social worker in Oregon

Twenty-one percent of inactive providers indicated that they did not accept patients with the managed care plan. Most of these providers indicated that they were not actually network providers, either because they had not renewed their contract with the plan, and therefore should not have been listed, or because they never had a contract with the managed care plan. For example, one provider indicated she was mistakenly listed as a provider in the managed care plan. She explained that she contracted with a commercial plan offered by the parent

organization of the Medicare Advantage plan and believed that is why she was listed as a network provider, even though she would not have accepted patients with a Medicare Advantage plan. Other inactive providers confirmed they had agreed to be network providers, but they were only seeing patients who paid privately or who had other types of insurance.

Some inactive providers did not see patients because they served in administrative roles

Despite being listed in the network directory as behavioral health providers, 5 percent of inactive providers indicated that they did not provide direct care to patients because they served in administrative roles. Some of these providers reported no longer seeing patients because they had shifted to new roles within their organization, such as a clinic director, or a role in which they exclusively conducted research.

Many of the remaining inactive providers cited factors that could impede enrollees' access to care

Of the remaining providers, most cited at least one of the following factors:

- **Inaccurate information in the network directory**
- **No or limited availability to see patients**
- **Ability to see only certain patient populations**

Twenty-eight percent of inactive providers potentially could have served as network providers. However, most of these providers (72 percent) cited at least one of the factors below that could impede enrollees' ability to reach them and access care.[23] These factors could also explain why these providers were inactive and provided no services to enrollees from the plans.

Some providers had **inaccurate information in the network directory**. In some cases, every phone number provided by the plan to enrollees was inaccurate and did not lead to the provider.[24] For example, phone numbers were disconnected or led to unrelated businesses or individuals who had never heard of the provider. These providers may have been network providers; however, an enrollee would not be able to reach these providers and receive services from them using the contact information in the network directory. In addition, other providers confirmed they were network providers, but they also indicated that their information was inaccurate for at least one listing in the directory, most commonly their phone number. While these providers may have been willing to provide services to enrollees, enrollees would have had difficulty actually reaching them and accessing care.

Other providers had **no availability or limited availability**. Many of these providers indicated that they had no capacity to see any new patients who called for an appointment or requested care, due to the provider's current patient load; others had an extremely limited capacity to see additional patients. These providers commonly

explained that they had a limited schedule at the practice or clinic or that they had a limited amount of time to provide direct care to patients, because they had other responsibilities that did not involve patient care.

Finally, some providers indicated that they worked with **specific patient populations** and could not see most enrollees. For example, some providers in Medicare Advantage plan networks explained that they worked in a children's clinic or served a younger patient population and could not see older patients enrolled in a Medicare Advantage plan. One provider noted that she saw only young children for very specific kinds of evaluations and was frustrated when she received calls from patients looking for other services. In other cases, providers noted that they worked only at specific nursing homes or assisted living facilities.

Providers cited administrative burden and low payment rates as factors affecting their willingness to work with managed care plans

About one-fifth of inactive providers expressed concern about **administrative burdens** imposed by managed care plans.[25] Administrative burdens can include complex billing or enrollment procedures or any tasks other than direct clinical services that managed care companies may require, such as completing prior authorizations and appealing denials of care for enrollees.

> **"[Plans] have a tremendous amount of administrative requirements that make keeping up with them nearly impossible . . . . [Clinical staff] feel like they are just 'cogs in the wheel' versus clinicians."**
>
> - A social worker in Arizona

> **"The amount of paperwork, the nature of the paperwork—it seems redundant. It doesn't encourage people to participate in managed care plans."**
>
> - A social worker in Oregon

Some providers referred to the "hoops" and large amounts of documentation needed with an application to enroll as a network provider with a managed care plan. As one provider noted, "It's very hard to get the application going for Medicare [Advantage] . . . . The application, recertifying, even getting started on the application, it's huge, [and] it's time-consuming." Another provider noted the challenges of working with multiple plans, because each plan had different IT systems, passwords, and administrative processes. Others raised similar concerns, finding that physicians had to update directory information for an average of 20 payers per practice and that plans often requested different types of information and used different methods for reporting provider information.[26]

Other providers cited administrative burdens associated with receiving prior authorizations so that enrollees could receive care. As one provider noted, the services she provided typically required prior authorizations; however, each plan had

different requirements for requesting prior authorizations, which could be burdensome to navigate. She noted that for an evaluation appointment, it would typically take an additional hour to complete the prior authorization paperwork. This provider reported that her clinic often provided patients pro bono services because something went wrong during the prior authorization process.

> **"If you won't reimburse at a more appropriate rate, providers won't take insurance and services won't be available to patients who can't pay out of pocket."**
>
> - A social worker in Ohio

Providers also cited **low payment rates** from managed care plans as a concern. About 14 percent of inactive providers expressed concern about low payment rates. For example, one provider noted that it was the mission of her clinic to serve all patients regardless of their ability to pay; however, seeing Medicaid patients at her clinic often resulted in a net loss for the institution, because payment rates did not cover the cost of care. Another provider noted that when he was in private practice he would not accept patients with Medicare or Medicaid managed care plans because the payment rates were too low. He also noted that very few of his colleagues in private practice accepted patients with Medicare plans.

> **"I had friends who've left and now we have less clinicians when there are already few clinicians . . . . I can see how people would burn out, especially not making enough money."**
>
> - A social worker in Oregon

Other providers noted that they believed that the low payment rates were preventing some providers in the community from participating in managed care plans. For example, one provider mentioned having to send patients out of the community to get care because there were no local providers who could see patients after their release from an inpatient psychiatric facility. Another provider mentioned that the existing provider shortage was getting worse because colleagues were no longer practicing behavioral health, partly because of low payment rates from managed care plans.

CONCLUSION AND RECOMMENDATIONS

Although managed care plans are required to contract with enough providers to meet the needs of enrollees, many managed care plans had limited behavioral health networks, with few providers to care for enrollees. These provider networks were further limited by including providers who did not provide any services to enrollees. Many Medicare and Medicaid plans had a high percentage of such inactive providers in their networks, and most of those inactive providers should not have been listed in the plan directories. Most often, the reason they were inactive was that they no longer worked at any of the locations listed by the plan. Other providers reported that their directory information was inaccurate and cited other factors that could impede enrollees' access to care.

These findings show that additional efforts are needed to ensure that there are enough behavioral health providers in the plans' provider networks who are available to meet the current needs of enrollees. They further highlight the importance of ensuring that plans provide enrollees with accurate information about their provider networks and that assessments of network adequacy are based on accurate lists of provider networks.

Congress and CMS have taken a number of steps aimed at improving the accuracy of network directories and access to behavioral health providers. Notably, in 2024, CMS finalized a Medicaid managed care rule that includes numerous provisions designed to improve access to care.[27] The Consolidated Appropriations Act, 2023, included requirements to strengthen provider network directories and improve access to care in Medicaid.[28] In Medicare, the law allowed coverage of services provided by marriage and family therapists and mental health counselors.[29] Additionally, CMS clarified its rules around how other types of behavioral health providers (such as peer support workers) can be paid through Medicare.[30] CMS also added clinical psychologists and clinical social workers as specialty types to which network adequacy standards apply in Medicare Advantage.[31] Additionally, CMS developed a behavioral health strategy which sets forth a number of goals, including increasing the number and availability of behavioral health providers.[32]

To further address the findings of this report, we recommend that CMS:

Use data to monitor provider networks and take additional steps to improve the accuracy of network directories in Medicare Advantage

CMS should promote the use of encounter data to monitor provider networks in Medicare Advantage. This analysis shows that encounter data can be used to identify inactive providers listed in a plan's network directory. A high percentage of inactive providers may indicate that there are significant inaccuracies in the plan's directory. It also raises concerns about "ghost networks" and may pose a significant barrier to enrollees seeking behavioral health care. CMS should provide technical assistance to Medicare Advantage plans to encourage the use of encounter data to determine whether inactive providers are being inappropriately listed as network providers.

In addition to assisting Medicare Advantage plans in the identification of inactive providers, CMS should take steps to correct other types of inaccurate provider information in network directories, such as inaccurate provider phone numbers and addresses. CMS should provide assistance and guidance about how to maintain accurate directories and ensure that enrollees are being provided with accurate information about their network providers.

CMS should also, to the extent possible, include analyses of inactive providers in plan networks as a part of its regular reviews and oversight of Medicare Advantage plans.[33] For example, CMS could use these analyses to identify plans that appear to have significant inaccuracies in the information they provide about their networks. Inaccuracies—such as representing that a retired provider is an active in-network provider—should be corrected before compliance with the network adequacy standards is assessed.

Work with States to improve the accuracy of network directories in Medicaid managed care

CMS should also promote the use of encounter data to monitor provider networks in Medicaid managed care. "Ghost networks" of inactive providers may pose a significant barrier to enrollees in Medicaid. CMS should provide technical assistance to States to ensure that they have the ability to use encounter data to determine whether inactive providers are being inappropriately listed as network providers.

In addition to assisting States in the identification of inactive providers, CMS should work with States to correct other types of inaccurate provider information in network directories, such as inaccurate provider phone numbers and addresses. CMS should provide assistance and guidance to States about how to maintain accurate directories and ensure that enrollees are being provided with accurate information about their

network providers. CMS should continue to support the implementation of annual secret shopper surveys to determine the accuracy of provider directories.

CMS should consider, to the extent possible, including analyses of inactive providers in plan networks as a part of its regular reviews of Medicaid managed care plans.[34] For example, CMS could use these analyses to identify plans that appear to have significant inaccuracies in the information they provide about their networks. Inaccuracies—such as representing that a retired provider is an active in-network provider—should be corrected before compliance with the network adequacy standards is assessed.

Continue exploring how a nationwide directory could reduce inaccuracies and increase administrative efficiencies for providers and patients

CMS has requested information from the public about the feasibility of a National Directory of Healthcare Providers and Services, which would provide a single, centralized system of validated provider data.[35] Such a directory would include contact information and the plans each provider accepts. It could be a standardized source of information about providers' specialties, services, and ability to accept new patients. A nationwide directory could make it easier for enrollees to find accurate, up-to-date information when seeking care. It could reduce the paperwork burden on plans and providers, resulting in cost savings. CMS should continue to explore whether a nationwide directory could improve accuracy and efficiency and reduce provider and patient burden.

AGENCY COMMENTS AND OIG RESPONSE

CMS did not explicitly concur or nonconcur with our recommendations; however, it indicated that it has taken a number of steps that are aligned with each of the three recommendations and that additional steps are planned.

In response to our first recommendation that CMS use data to monitor provider networks and improve the accuracy of network directories in Medicare Advantage, CMS noted that it uses available data when setting network adequacy standards, as well as when reviewing Medicare Advantage networks. CMS indicated that it uses fee-for-service claims utilization data when setting network adequacy standards and when determining where available providers are located. CMS also noted that it monitors network adequacy compliance by reviewing contract-level networks at a point in time on at least a triennial basis. CMS also noted that it is exploring the potential for establishing a national directory of health care providers with the goal of improving the accuracy of directory information.

OIG appreciates the steps that CMS has taken and stresses the importance of taking additional steps to use encounter data to monitor provider networks and to improve the accuracy of network directories in Medicare Advantage. OIG recognizes the distinction that CMS is making between assessing the accuracy of the network directories and assessing network adequacy. OIG continues to stress the importance of ensuring that the providers that plans describe as "in-network" are in fact seeing enrollees and that enrollees are provided with accurate information. As stated in the report, on average, more than half of the plans' network providers were inactive and did not provide a single service to enrollees over the course of a year. Further, most inactive providers should not have been listed in the plan directories, while other inactive providers reported that their information in the network directory was inaccurate. OIG reiterates that inaccurate information about network providers should be corrected before determining compliance with network adequacy standards to ensure that enough behavioral health providers in each plan's network are available to meet the needs of enrollees.

In response to our second recommendation to work with States to improve the accuracy of network directories in Medicaid managed care, CMS noted that it finalized the Medicaid and Children's Health Insurance Program Managed Care Access, Finance, and Quality Final Rule (CMS-2439-F). This rule establishes new standards for appointment wait times, the use of secret shopper surveys, the use of enrollee experience surveys, and requiring States to submit a managed care plan analysis of payments made by plans to providers. CMS believes that these new provisions will address issues with inaccurate provider directories. OIG appreciates the steps that CMS has taken in this area. We will continue to assess the extent to which CMS has

implemented this recommendation once the requirements of the Final Rule go into effect.

In response to our final recommendation to explore how a nationwide directory could reduce inaccuracies and increase administrative efficiencies, CMS stated that it will continue its effort to study the potential for establishing a national directory of health care providers. CMS noted that it has compiled information through a Request for Information and listening sessions from providers and has established an automated, statewide provider directory through the Qualified Health Plan Directory Pilot Portal. This pilot is being launched in collaboration with the Oklahoma Insurance Department. OIG appreciates the steps CMS is undertaking and looks forward to seeing CMS's assessment of the pilot and the next steps to further implement this recommendation.

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

DETAILED METHODOLOGY

This review is based on analyses of provider network lists; Medicare Advantage and Medicaid encounter data; information about the behavioral health workforce from State licensing boards; and a survey of providers. It focuses on four Medicare Advantage and two Medicaid managed care plans from 10 selected counties, for a total of 60 plans. We selected these plans from a diverse group of five urban and five rural counties from five States that are geographically dispersed throughout the country. (See Appendix A.) We focused this review on three key types of behavioral health providers: psychiatrists, psychologists, and clinical social workers. These are the most essential types that were allowed to serve both Medicare Advantage and Medicaid managed care enrollees in 2023.[36]

Selecting managed care plans

We selected plans from a diverse group of five urban and five rural counties from five States.[37] We considered geographic diversity and population size when selecting the counties and States. From each county, we selected four Medicare Advantage plans and two Medicaid managed care plans, for a total of 60 selected plans.[38] We generally selected the plans with the highest enrollment in each county.[39]

We requested the list of in-network providers—the provider directory—for each plan from the Medicare Advantage organizations and from the State Medicaid agencies. We collected this information in November and December 2023.

Identifying plans that had limited networks

We determined the percentage of the behavioral health workforce in each county that was included in each selected plan's network. We defined a limited network as a plan including less than 25 percent of the behavioral health workforce in the county.

To do this analysis, we first obtained a list of all licensed providers and their addresses from the State licensing boards.[40] We used that information to identify the behavioral health providers in each county.

Because many State licensing boards do not maintain National Provider Identification (NPI) numbers for licensees, we used the National Plan and Provider Enumeration System (NPPES) to identify the NPIs for all licensed providers.

Using the NPIs, we compared all licensed providers in the county with the providers listed in each plan's network directory. We then calculated the percentage of the behavioral health workforce in a county that was included in each plan's network. We calculated this percentage for each plan and determined the average for the selected

Medicare Advantage plans and for the selected Medicaid plans. We also calculated the percentage of each type of provider in each plan and determined the average for the selected plans.[41]

Calculating the proportion of network providers who were inactive

We based this analysis on Medicare Advantage encounter data from CMS's Integrated Data Repository and Medicaid encounter data from the Transformed Medicaid Statistical Information System (T-MSIS). For the selected plans, we identified all the Medicare Advantage and Medicaid managed care encounters for licensed psychiatrists, psychologists, and clinical social workers in 2023.

For each plan, we identified the behavioral health providers in the network who did not provide a service to any enrollees in that plan in 2023. We calculated the percentage of providers in each plan who did not have any encounters for any enrollees in that plan. We considered these providers to be inactive. We then determined the average percentage of inactive providers for all selected Medicare Advantage plans and for all selected Medicaid managed care plans.[42]

Surveying inactive providers to understand why they did not provide any services to enrollees

We developed a list, based on our analysis, of inactive providers for each plan who did not provide any services to enrollees in that plan. We then selected a random sample of those providers using the four strata in the table below to ensure that we had providers from Medicare Advantage plans and Medicaid plans and from plans in urban and rural counties. We selected a sample of 331 network providers, who were asked about their experiences with specific managed plans.[43]

Stratum	Population of inactive providers	Selected sample	Survey respondents
Rural Medicare Advantage providers	68	68	50
Urban Medicare Advantage providers	2,502	111	82
Rural Medicaid providers	41	41	35
Urban Medicaid providers	1,252	111	80

We developed a structured survey to find out whether the provider was accurately listed in the plan's network and other factors that may have impeded enrollees' access to care. We also asked providers about factors that might have affected their willingness to work with the managed care plans.

We used the contact information from the network directories that we obtained from the Medicare Advantage organizations and from State Medicaid agencies. For the providers with a valid email address, we administered an online survey. For providers who did not have a valid email address and those who did not respond by email, we conducted a telephone survey. We conducted these online and telephone surveys with providers in June and July 2024.

We received responses from 247 sampled providers or others at the practice who could answer questions on their behalf, such as a clinic director or billing official.[44]

We analyzed the responses from these providers and the reasons why they did not provide services to enrollees. We grouped these providers' responses into categories and determined the percentage of providers who should not have been listed in the network directory.[45]

We generated weighted point estimates for the percentage of inactive providers who should not have been listed in the network directory as well as point estimates for the subclassifications of providers.

Data limitations

This analysis is based on information from State licensing boards; Medicare Advantage and Medicaid encounter data; and information about providers in plans' networks. Although we did not independently verify the accuracy of the data provided by State licensure boards or managed care plans, we took numerous steps to supplement the data to enable us to report and compare the data across sources.[46] Additionally, this report focuses on selected managed care plans in 10 counties and the results may not be generalizable to all plans and all counties.

Standards

We conducted this study in accordance with the *Quality Standards for Inspection and Evaluation* issued in 2020 by the Council of the Inspectors General on Integrity and Efficiency.

APPENDIX A

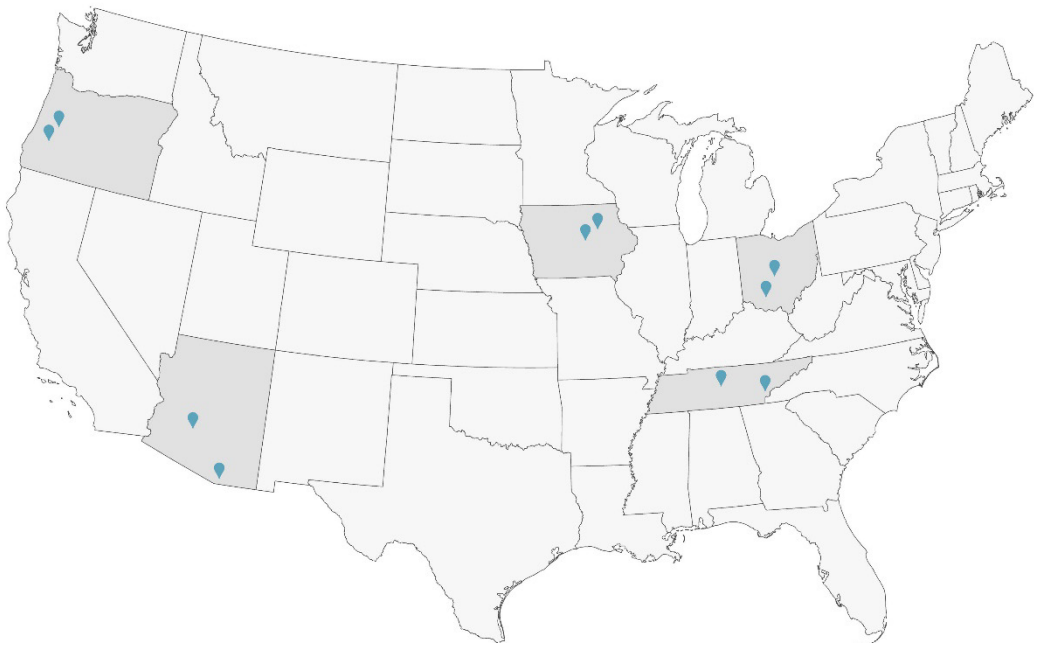
Selected counties and States

Exhibit A-1: List of 10 selected counties and 5 selected States

State	Urban county	Rural county
Arizona	Maricopa County	Santa Cruz County
Iowa	Black Hawk County	Marshall County
Ohio	Franklin County	Highland County
Oregon	Lane County	Douglas County
Tennessee	Rutherford County	Monroe County

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

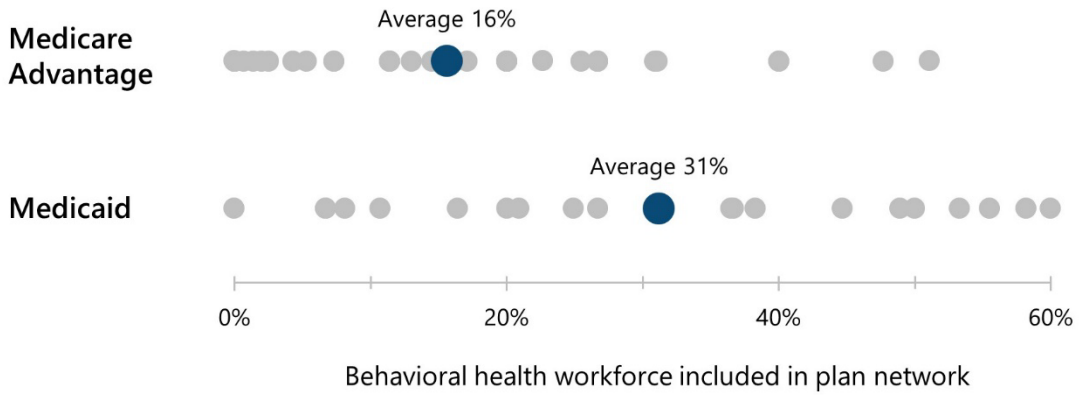
Exhibit A-2: Map of 10 selected counties and 5 selected States



APPENDIX B

Percentage of behavioral health workforce included in managed care plan networks

Exhibit B-1: The percentage of the behavioral health workforce included in a plan's network



Source: OIG analysis of 40 Medicare Advantage plans and 20 Medicaid managed care plans in 10 counties, 2024.

Exhibit B-2: Average percentage of behavioral health workforce included in Medicare Advantage plans' networks, by type of plan

Program	Plan type	Average percentage of behavioral health workforce included in plans' networks	Number of plans
Medicare Advantage	HMO	15%	11
	PPO	19%	19

Source: OIG analysis of Medicare Advantage plans in 10 counties, 2024.
Note: This analysis does not include 10 Medicare Advantage plans that were HMO-POS plans. An HMO-POS plan is a hybrid type of plan that is similar to an HMO but also allows enrollees to see out-of-network providers.

Exhibit B-3: Average percentage of behavioral health workforce included in plans' networks, by type of provider

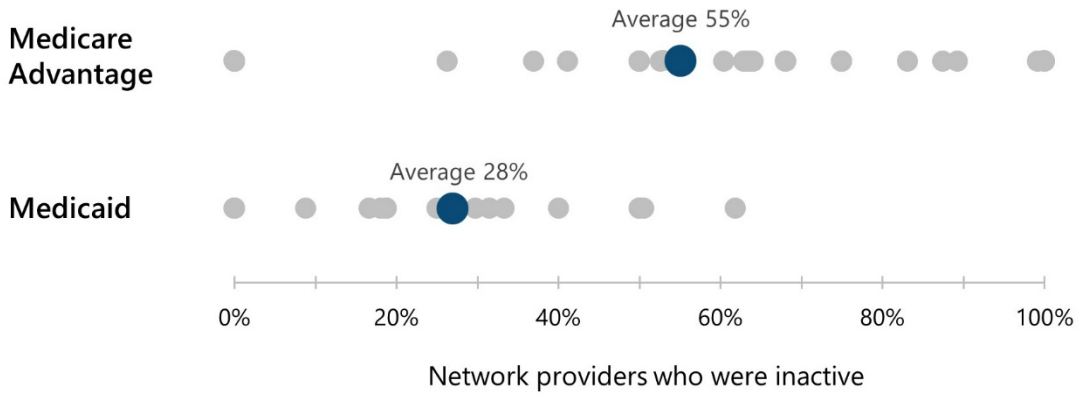
Program	Provider type	Average percentage of behavioral health workforce included in a plan's network
Medicare Advantage	Psychiatrist	46%
	Psychologist	13%
	Social worker	13%
Medicaid	Psychiatrist	49%
	Psychologist	28%
	Social worker	30%

Source: OIG analysis of 40 Medicare Advantage plans and 20 Medicaid managed care plans in 10 counties, 2024.

APPENDIX C

Percentage of network providers who were inactive

Exhibit C-1: The percentage of providers listed in a plan's network who were inactive



Source: OIG analysis of 33 Medicare Advantage plans and 19 Medicaid managed care plans in 10 counties, 2024. This analysis includes only plans that had network providers in the selected counties.

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APPENDIX D

Survey of inactive providers

Exhibit D-1: Results from survey of inactive providers, point estimates, and confidence intervals

	Percent	Confidence interval: lower 95%	Confidence interval: upper 95%
Providers who should not have been listed in the network directory	**72%**	**64%**	**78%**
Were not at directory location	46%	38%	53%
Did not accept patients with the managed care plan	21%	15%	28%
Had administrative role and did not see patients	5%	2%	10%
Providers who were potentially serving as network providers	**28%**	**22%**	**36%**

Source: OIG analysis of inactive providers surveyed from Medicare Advantage and Medicaid managed care plans in 10 counties, 2024.

Exhibit D-2: Inactive providers who were potentially serving as network providers but cited at least one factor that impedes enrollees' access to care

	Percent	Confidence interval: lower 95%	Confidence interval: upper 95%
Cited at least one factor that impedes enrollees' access to care	72%	57%	84%

Source: OIG analysis of inactive providers surveyed from Medicare Advantage and Medicaid managed care plans in 10 counties, 2024.
Note: The 95-percent confidence interval for this estimated percentage exceeds 10-percent absolute precision.

Exhibit D-3: Factors that affected provider willingness to work with managed care plans

	Percent	Confidence interval: lower 95%	Confidence interval: upper 95%
Administrative burden	21%	12%	35%
Payment rates	14%	7%	26%

Source: OIG analysis of inactive providers surveyed from Medicare Advantage and Medicaid managed care plans in 10 counties, 2024.
Note: Providers were asked about a number of factors that may have affected their willingness to work with managed care plans. Survey respondents could indicate more than one answer, and these categories are not mutually exclusive.
Note: The 95-percent confidence interval for these estimated percentages exceeds 10-percent absolute precision.

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: August 22, 2025

TO: Ann Maxwell
Deputy Inspector General for Evaluations and Inspections

FROM: Dr. Mehmet Oz DR
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: *Many Medicare Advantage and Medicaid Managed Care Plans Have Limited Behavioral Health Provider Networks and Inactive Providers*, OEI-02-23-00540

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of Inspector General's (OIG) draft report on access to behavioral health care in Medicare Advantage and Medicaid Managed Care.

CMS remains committed to optimizing the health outcomes and well-being of those who are living with, or at risk of developing, behavioral health conditions. To accomplish these goals, CMS continues to implement the CMS Behavioral Health Strategy and is embarking on a multi-faceted approach to increase access to high-quality behavioral health services and improve outcomes for people covered by Medicare and Medicaid.[1]

In Medicare Advantage, Medicare Advantage organizations (MAOs) must meet current network adequacy requirements as defined under 42 C.F.R. 422.116, including access to behavioral health care providers and facilities. CMS requires that MAOs continuously monitor their contracted networks throughout the contract year to ensure compliance with CMS network adequacy criteria, including minimum number as well as time and distance standards. CMS assesses access to each specialty type using quantitative standards based on the local availability of providers and facilities to ensure that MAOs contract with a sufficient number of providers and facilities without placing an undue travel or distance burden on enrollees seeking covered services. In addition to reviewing networks at the time of application, CMS monitors network compliance by reviewing contract-level networks on at least a triennial basis.[2] CMS also may perform a network review after specific triggering events, such as a significant provider termination.

CMS finalized policies in the CY 2024 Medicare Advantage and Part D Final Rule to strengthen network adequacy requirements, such as adding licensed clinical social workers and clinical psychologists as specialty types for which CMS sets network adequacy standards, reaffirming MAOs' responsibilities for providing access to behavioral health services and codifying wait-time standards,

[1] Please see Centers for Medicare and Medicaid Services, Addressing and Improving Behavioral Health
[2] Please see Medicare Advantage and Section 1876 Cost Plan Network Adequacy Guidance

among other policies[3] To help ensure that Medicare Advantage plan enrollees have access to behavioral health providers, in the CY 2025 Medicare Advantage and Part D Final Rule for CY2025, CMS a new facility-specialty type called "Outpatient Behavioral Health" for CMS network adequacy standards.[4] This facility-specialty type includes marriage and family therapists and mental health counselors, 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.

For Medicaid Managed Care, CMS has engaged in a multifaceted approach to strengthen access to mental health and substance use disorder treatment. On April 22, 2024, CMS finalized the Medicaid and Children's Health Insurance Program Managed Care Access, Finance, and Quality Final Rule (CMS-2439-F).[5] This rule finalizes new standards to help states improve their monitoring of access to care by requiring the establishment of new standards for appointment wait times, use of secret shopper surveys, use of enrollee experience surveys, and requiring states to submit a managed care plan analysis of payments made by plans to providers for specific services, to monitor plans' network adequacy more closely. Specifically, after the first rating period beginning on or after July 9, 2027, the rule establishes maximum appointment wait time standards for outpatient mental health and substance use disorder services at 10 business days. Additionally, for contract rating periods starting on July 9, 2028, the final rule requires states to use an independent entity to conduct annual secret shopper surveys to validate managed care plans' compliance with appointment wait time standards and the accuracy of provider network directories to identify errors and providers that do not offer appointments.

As noted in this response, CMS has taken a number of steps and will continue to pursue efforts to meet the demand for behavioral health services. CMS appreciates OIG's work and findings. OIG's recommendations and CMS' responses are below.

OIG Recommendation

CMS should use data to monitor provider networks and take additional steps to improve the accuracy of network directories in Medicare Advantage

CMS Response

CMS currently does use available data when setting network adequacy standards, as well as when reviewing MAO networks. When setting network adequacy standards, CMS uses fee-for-service (FFS) claims utilization data, not Medicare Advantage encounter data, to determine where available providers are located. The FFS claims utilization data is preferable for purposes of Medicare Advantage network adequacy, because it is a more comprehensive dataset than the encounter data.

However, it is important to note that there is a distinction between monitoring provider networks and ensuring the provider directories are accurate. CMS monitors network adequacy compliance by reviewing

[3] Please see 2024 Medicare Advantage and Part D Final Rule (CMS-4201-F)
[4] Please see Contract Year 2025 Medicare Advantage and Part D Final Rule (CMS-4205-F)
[5] Please see https://www.cms.gov/newsroom/fact-sheets/medicaid-and-childrens-health-insurance-program-managed-care-access-finance-and-quality-final-rule and https://www.federalregister.gov/documents/2024/05/10/2024-08085/medicaid-program-medicaid-and-childrens-health-insurance-program-chip-managed-care-access-finance

contract-level networks at a point in time on at least a triennial basis. CMS may also perform a network review after specific triggering events, such as a significant network termination.

Provider directory data are inherently dynamic and, under CMS regulations, must be updated within 30 days of a plan receiving notice of changes to provider information that require an update.[6] For example, a provider may temporarily stop seeing enrollees in a plan for a month and then resume seeing enrollees in that same plan at a later date.

Finally, CMS is exploring the potential for establishing a national directory of health care providers, with the goal of improving the accuracy of directory information.

OIG Recommendation
CMS should work with States to improve the accuracy of network directories in Medicaid managed care

CMS Response
As explained above, CMS finalized the Medicaid and Children's Health Insurance Program Managed Care Access, Finance, and Quality Final Rule (CMS-2439-F). This rule finalizes new standards to help states improve their monitoring of access to care by requiring the establishment of new standards for appointment wait times, use of secret shopper surveys, use of enrollee experience surveys, and requiring states to submit a managed care plan analysis of payments made by plans to providers for specific services, to monitor plans' network adequacy more closely. Specifically, for contract rating periods starting on July 9, 2028, the final rule requires states to use an independent entity to conduct annual secret shopper surveys to validate managed care plans' compliance with appointment wait time standards and the accuracy of provider network directories to identify errors and providers that do not offer appointments. CMS is confident that these new provisions will address issues with inaccurate provider directories. CMS released guidance further clarifying these requirements on July 16, 2024 and will continue working with our state Medicaid agency partners and others to improve the availability of information regarding providers.[7] Because CMS is already engaged in these efforts, CMS requests that the OIG close this recommendation as implemented.

OIG Recommendation
CMS should continue exploring how a nationwide directory could reduce inaccuracies and increase administrative efficiencies for providers and patients

CMS Response
CMS will continue its effort to study the potential for establishing a national directory of healthcare providers to assist consumers in identifying providers. Over the past several years CMS has compiled information through a Request for Information (RFI) and listening sessions from providers. Most recently, in September 2024, CMS announced a first-of-its-kind Qualified Health Plan (QHP) Directory Pilot ("the pilot") to establish and launch an automated, one-stop shop, statewide, provider directory that will be accessible through the QHP Directory Pilot Portal ("the portal"). The goal of the pilot is to improve data accuracy, lessen the administrative burden on providers and payers, lower administrative costs, support interoperable data exchange, and ultimately improve patient and provider experiences. The pilot is now officially open and being launched in collaboration with the Oklahoma Insurance

[6] Please see 422.2267(e)(11)(iv)
[7] Please see State Health Official (SHO) letter on Consolidated Appropriations Act, 2023 Amendments to Provider Directory Requirements

Department. Upon completion of this pilot, CMS will assess the data to understand results and identify the lessons learned. CMS will rely on end users for feedback on the portal's ease of use, burden reduction, and other value-added benefits.[8] Because CMS is already engaged in this effort, CMS requests that the OIG close this recommendation as implemented.

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

[8] Please see CMS Qualified Health Plan Directory Pilot Fact Sheet.

ENDNOTES

[1] The Commonwealth Fund, *Understanding the U.S. Behavioral Health Workforce Shortage*. Accessed at https://www.commonwealthfund.org/publications/explainer/2023/may/understanding-us-behavioral-health-workforce-shortage on Sept. 6, 2023.

[2] A Medicare Advantage plan is a health care plan offered under a policy or contract by a Medicare Advantage organization. See 42 CFR § 422.2. Accessed at https://www.ecfr.gov/current/title-42/section-422.2 on Feb. 25, 2025. Medicaid managed care organizations have a comprehensive risk contract with the State to cover comprehensive services for enrollees. Other types of managed care plans include prepaid ambulatory health plans (PAHPs), which do not provide or arrange for inpatient hospital or institutional services, and prepaid inpatient health plans (PIHPs), which provide inpatient or institutional services to enrollees. 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 Feb. 25, 2025.

[3] Kaiser Family Foundation, *Medicare Advantage in 2024: Enrollment Update and Key Trends*. Accessed at https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2024-enrollment-update-and-key-trends/ on Oct. 7, 2024.

[4] CMS, *Managed Care Enrollment Summary*. Accessed at https://data.medicaid.gov/dataset/52ed908b-0cb8-5dd2-846d-99d4af12b369 on Mar. 4, 2025.

[5] CMS, *What You Should Know About Provider Networks*. Accessed at https://www.cms.gov/marketplace/outreach-and-education/what-you-should-know-provider-networks.pdf on Apr. 11, 2024.

[6] See CMS, *Medicare Managed Care Manual, Chapter 4 – Benefits and Beneficiary Protections*. Accessed at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c04.pdf on Oct. 2, 2024. See also 42 CFR § 438.10(h). Accessed at https://www.ecfr.gov/current/title-42/part-438#p-438.10(h) on Oct. 7, 2024.

[7] The Consolidated Appropriations Act, 2023, Pub. L. No. 117-328, Division FF, Title V, Subtitle C, Sec. 5123, requires managed care organizations to publish, on a public website, a searchable directory of network providers. This network directory must be updated at least quarterly and include the provider's name, specialty, address, and telephone number. The deadline for meeting these new requirements was July 1, 2025. Accessed at https://www.govinfo.gov/content/pkg/PLAW-117publ328/pdf/PLAW-117publ328.pdf on May 6, 2025.

[8] In Medicare Advantage, CMS requires Medicare Advantage organizations to develop written standards for network adequacy. See 42 CFR § 422.112. Accessed at https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-422/subpart-C/section-422.112 on Feb. 25, 2025. In Medicaid, States that contract with a managed care organization, PIHP, or PAHP to deliver managed care must develop and enforce network adequacy standards. See 42 CFR § 438.68(a). Accessed at https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-B/section-438.68 on Feb. 25, 2025.

[9] A 2023 final rule codified wait time standards for routine behavioral health services in Medicare Advantage. The maximum wait time for these services is 30 business days. 88 Fed. Reg. 22120 (Apr. 12, 2023). Accessed at https://www.federalregister.gov/documents/2023/04/12/2023-07115/medicare-program-contract-year-2024-policy-and-technical-changes-to-the-medicare-advantage-program on July 16, 2024. See also 42 CFR § 422.112. Accessed at https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-422/subpart-C/section-422.112 on July 18, 2024. In Medicaid, States must establish wait time standards of no longer than 10 business days for routine appointments for outpatient mental health and substance use disorder. 89 Fed. Reg. 41002 (May 10, 2024). Accessed at https://www.federalregister.gov/documents/2024/05/10/2024-08085/medicaid-program-medicaid-and-childrens-health-insurance-program-chip-managed-care-access-finance on May 10, 2024. See also 42 CFR § 438.68. Accessed at https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-B/section-438.68 on July 18, 2024.

[10] 89 Fed. Reg. 41002 (May 10, 2024). Accessed at https://www.federalregister.gov/documents/2024/05/10/2024-08085/medicaid-program-medicaid-and-childrens-health-insurance-program-chip-managed-care-access-finance on May 10, 2024.

[11] CMS's new rule requires States to implement secret shopper surveys for contract rating periods starting on or after July 10, 2028, that verify the network provider's active network status, street address, and telephone number, and whether they are accepting new enrollees.

[12] When a State, a managed care organization, or CMS identifies an issue with a managed care plan's access, the State must submit a remedy plan within 90 calendar days. The plan must address the issue within 12 months. See 89 Fed. Reg. 41002 (May 10, 2024). Accessed at https://www.federalregister.gov/documents/2024/05/10/2024-08085/medicaid-program-medicaid-and-childrens-health-insurance-program-chip-managed-care-access-finance on May 10, 2024. See also 42 CFR § 438.207(f). Accessed at https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-D/section-438.207 on Oct. 11, 2024.

[13] In Medicare Advantage, CMS has the authority to impose intermediate sanctions or civil monetary penalties for noncompliance with network adequacy standards, but it has never done so for an existing Medicare Advantage plan. See Medicare Payment Advisory Committee, *Report to the Congress: Medicare and the Health Care Delivery System*, June 2024. Accessed at https://www.medpac.gov/wp-content/uploads/2024/06/Jun24_MedPAC_Report_To_Congress_SEC.pdf on Oct. 8, 2024. In a survey, less than a quarter of State Medicaid agencies reported issuing monetary or nonmonetary penalties (e.g., suspending plan enrollment) for noncompliance with network adequacy standards in the past 3 years. See Kaiser Family Foundation, *Medicaid Managed Care Network Adequacy & Access: Current Standards and Proposed Changes*. Accessed at https://www.kff.org/medicaid/issue-brief/medicaid-managed-care-network-adequacy-access-current-standards-and-proposed-changes/ on Oct. 7, 2024.

[14] *A Lack of Behavioral Health Providers in Medicare and Medicaid Impedes Enrollees' Access to Care* (OEI-02-22-00050), Apr. 3, 2024.

[15] *Availability of Surveyed Behavioral Health Providers to Treat New Patients Enrolled in Medicare and Medicaid* (OEI-09-21-00410), June 26, 2025.

[16] Note that other types of providers, such as therapists or nurse practitioners, may also have provided behavioral health services to enrollees. We focused this review on psychiatrists, psychologists, and social workers because they are essential behavioral health providers who were allowed to serve both Medicare Advantage enrollees and Medicaid managed care enrollees in 2023. Other types of behavioral health providers, such as mental health counselors and marriage and family therapists, became eligible to provide Medicare services beginning in January 2024. See 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 June 9, 2023.

[17] Note that the breadth of a plan network is not a network adequacy standard.

[18] The behavioral health workforce in each county was determined using information from State licensing boards.

[19] In this report, we refer to a "limited network" as a plan network which includes less than 25 percent of the county's behavioral health providers. While there is no Federal standard for a "limited network," researchers often define "limited" as less than 25 percent or 30 percent of the area's providers. One study from Kaiser Family Foundation defined limited networks as having less than 30 percent of the physicians in the county, while Consumer Reports defined limited networks as having 25 percent or less of the physicians in the local area. See Kaiser Family Foundation, *Medicare Advantage: How Robust Are Plans' Physician Networks*? Accessed at https://www.kff.org/medicare/report/medicare-advantage-how-robust-are-plans-physician-networks/ on Apr. 4, 2024. See also Consumer Reports, *What to Know About Narrow Network Health Insurance Plans*. Accessed at https://www.consumerreports.org/health-insurance/what-to-know-about-narrow-network-health-insurance-plans/ on Apr. 4, 2024.

[20] A PPO plan has a provider network but also covers out-of-network providers for a higher cost. An HMO plan typically requires enrollees to see network providers and requires enrollees to receive referrals for specialists from a primary care provider. An HMO-POS plan is a hybrid type of plan that is similar to an HMO but also allows enrollees to see out-of-network providers. Medicaid managed care does not have the same types of plans as Medicare Advantage. Out-of-network coverage or whether referrals are required to see a specialist can vary by State. See CMS, *What You Should Know About Provider Networks*. Accessed at https://www.cms.gov/marketplace/outreach-and-education/what-you-should-know-provider-networks.pdf on Apr. 11, 2024.

[21] This analysis includes only plans that had network providers in the selected counties.

[22] We requested 2023 network lists in November and December 2023. We considered a provider to be incorrectly listed in the network if they stopped practicing at the listed location before September 2023, as plans are typically required to update their network lists quarterly or within 30 days after being notified of a change. To confirm that providers were not working at any directory locations, we relied on claims information and survey responses to establish when the provider had left the location.

[23] The 95-percent confidence interval for this estimated percentage exceeds 10-percent absolute precision.

[24] Although the phone numbers listed in the network directory were inaccurate, we determined that these providers were working at the location by analyzing claims and encounter data for all of traditional Medicare, Medicare Advantage, and Medicaid managed care.

[25] Percentages in this finding are based on survey responses from providers who could be contacted. We did not include providers who no longer worked at the practice location or could not be contacted for other reasons. Additionally, providers could select more than one answer, and therefore, the percentages in this finding are not mutually exclusive. The 95-percent confidence intervals for these estimated percentages exceed 10-percent absolute precision.

[26] Council for Affordable Quality Healthcare, *The Hidden Causes of Inaccurate Provider Directories*. Accessed at https://www.caqh.org/hubfs/43908627/drupal/explorations/CAQH-hidden-causes-provider-directories-whitepaper.pdf on Nov. 5, 2024. See also James L. Madara, MD, CEO, Executive Vice President, American Medical Association, *Re: Request for Information; National Directory of Healthcare Providers & Services*. Accessed at https://www.regulations.gov/comment/CMS-2022-0163-0405 on Oct. 22, 2024.

[27] Key provisions include the establishment of maximum wait time standards, secret shopper surveys of network providers, new methods to address noncompliance with the standards, and comparative analysis of managed care payments for behavioral health services. 89 Fed. Reg. 41002 (May 10, 2024). Accessed at https://www.federalregister.gov/documents/2024/05/10/2024-08085/medicaid-program-medicaid-and-childrens-health-insurance-program-chip-managed-care-access-finance on May 10, 2024.

[28] The Consolidated Appropriations Act, 2023, Pub. L. No. 117-328, Division FF, Title V, Subtitle C, Sec. 5123. Accessed at https://www.govinfo.gov/content/pkg/PLAW-117publ328/pdf/PLAW-117publ328.pdf on May 6, 2025.

[29] 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.

[30] The 2024 Medicare Physician Fee Schedule clarified CMS rules around how other types of behavioral health providers (such as peer support specialists) can be paid through Medicare. 88 Fed. Reg. 78818 (Nov. 16, 2023). Accessed at https://www.federalregister.gov/documents/2023/11/16/2023-24184/medicare-and-medicaid-programs-cy-2024-payment-policies-under-the-physician-fee-schedule-and-other on Oct. 11, 2024.

[31] 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. 9, 2024. 88 Fed. Reg. 22120 (Apr. 12, 2023). Accessed at

https://www.federalregister.gov/documents/2023/04/12/2023-07115/medicare-program-contract-year-2024-policy-and-technical-changes-to-the-medicare-advantage-program on Dec. 19, 2024.

[32] CMS, *CMS Behavioral Health Strategy*. Accessed at https://www.cms.gov/cms-behavioral-health-strategy on June 9, 2023.

[33] In Medicare Advantage, CMS monitors compliance with network adequacy standards through a number of periodic reviews, such as its triennial reviews. See CMS, *Medicare Advantage and Section 1876 Cost Plan Network Adequacy Guidance*. Accessed at https://www.cms.gov/files/document/medicare-advantage-and-section-1876-cost-plan-network-adequacy-guidance06132022.pdf on Oct. 8, 2024.

[34] In Medicaid, CMS's Center for Program Integrity conducts regular audits of Medicaid managed care organizations to assess potential fraud, waste, or abuse. Additionally, CMS requires States to contract external quality review organizations to conduct regular reviews of Medicaid managed care organizations. See CMS, *The Center for Program Integrity*. Accessed at https://www.cms.gov/medicare/medicaid-coordination/center-program-integrity on Oct. 8, 2024. See also CMS, *Quality of Care External Quality Review*. Accessed at https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care-quality/quality-of-care-external-quality-review/index.html on Oct. 8, 2024.

[35] CMS, *CMS Asks for Public Input on Establishing First, National Directory of Health Care Providers and Services*. Accessed at https://www.cms.gov/newsroom/press-releases/cms-asks-public-input-establishing-first-national-directory-health-care-providers-and-services on Oct. 8, 2024.

[36] In 2023, Medicare did not cover marriage and family therapists and mental health counselors. 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. Also, we included the highest level of licensure for the key behavioral health providers. For example, we included licensed clinical social workers but did not include social work trainees.

[37] These 5 States are a subset of the 10 States we selected for the first report in this series, *A Lack of Behavioral Health Providers in Medicare and Medicaid Impedes Enrollees' Access to Care* (OEI-02-22-00050), Apr. 3, 2024.

[38] Note that some managed care plans are available to enrollees across the Nation or State. In a few cases, the same plan was analyzed in more than one county. For example, in Arizona, a Medicaid plan was available to enrollees in Maricopa County as well as enrollees in Santa Cruz County. We analyzed the plan's network in Maricopa County separately from the plan's network in Santa Cruz County.

[39] For Medicare Advantage, we also considered the parent organization and selected plans from different parent organizations whenever possible.

[40] Some State licensing boards provided a roster via email, while others had publicly available rosters on their websites.

[41] If a county did not have any behavioral health providers, plans in that county were excluded from this analysis. For example, one county had no psychiatrists. Plans in that county were excluded when we calculated the average percentage of psychiatrists in a plan.

[42] If a plan did not have any behavioral health providers listed in its network in the selected county, the plan was excluded from this analysis.

[43] Note that some providers were inactive in multiple managed care plans; a provider was eligible for selection for each managed care plan in which they were inactive. Providers were surveyed about their experiences with a specific managed care plan and we analyzed the results separately for each plan. In total, we surveyed 281 unique providers.

[44] A total of 84 of the 331 sampled providers were not included in the analysis. They included 4 providers who refused to complete the survey and 66 nonrespondents. Fourteen providers were excluded because they indicated they did see patients

in the selected managed care plan in 2023 and therefore did not meet the criteria for the inactive provider sample. Such a provider may have appeared inactive because they were not named on the encounter, even though they may have provided services to enrollees.

[45] We requested lists of in-network providers in November and December 2023. When we surveyed providers, we asked about their participation and willingness to see enrollees in 2023. In general, plans are required to update their network lists quarterly or within 30 days after being notified of a change. To allow for this update period, we considered a provider to be incorrectly listed as a network provider if they had stopped practicing at the network location before September 2023.

[46] In multiple instances, we supplemented and verified our data from additional sources. For example, when licensure data were missing or incomplete, we used NPPES data and Provider Enrollment, Chain, and Ownership System data to identify and verify provider NPI numbers. In other instances, we relied on encounter data to confirm the dates when providers had stopped working at locations listed by the plans.

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