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Availability of Surveyed Behavioral Health Providers to Treat New Patients Enrolled in Medicare and Medicaid

HHS Office of Inspector General

REPORT HIGHLIGHTS

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Why OIG Did This Review

- Medicare and Medicaid play a significant role in providing access to care for millions of enrollees seeking behavioral health services for serious mental health challenges and substance use disorders.
- This review is part of a three-part series about access to behavioral health services in traditional Medicare, Medicare Advantage, and Medicaid managed care that OIG is conducting, in part, because of congressional interest in ensuring access to care. The first report in this series found that, overall, there were few behavioral health providers in the selected counties who actively served Medicare and Medicaid enrollees in 2021.
- This review assesses whether providers who actively served Medicare and Medicaid patients could make new patient appointments for enrollees in 2023. Without enough actively participating behavioral health providers willing to treat new patients in Medicare and Medicaid, enrollees may experience delays in care and even forgo treatment altogether.

What OIG Found

Our findings illustrate that Medicare and Medicaid enrollee access to needed behavioral health care is hampered, not only by a lack of providers actively serving Medicare and Medicaid enrollees, but also by the inability of active providers to treat new patients.

Forty-five percent of surveyed behavioral health providers reported that they were not available to treat new patients enrolled in traditional Medicare, Medicare Advantage, and Medicaid managed care.

About three-quarters of behavioral health providers who were unavailable for new Medicare or Medicaid patients reported that they could not take on any new patients, many citing full caseloads.

Among the behavioral health providers who were available to treat new patients enrolled in Medicare or Medicaid, about a quarter reported wait times of more than 30 days for an appointment.

What OIG Concludes

The findings of this report reiterate the importance of OIG's previous recommendations that were made in the first report of this series. Those recommendations could help address behavioral health provider shortages in Medicare and Medicaid, improve new patients' access to behavioral health care, and reduce wait times for new patient appointments.

Primer: Behavioral Health in Medicare and Medicaid

Timely access to behavioral health services—which include services for mental health and substance use disorders—is critical for the well-being of people enrolled in Medicare and Medicaid. Since the onset of the COVID-19 pandemic, the need for behavioral health services has increased dramatically and remained elevated.[1] However, as of August 2024, more than one-third of the U.S. population lives in a Federally designated mental health professional shortage area.[2]

Behavioral health providers have reported concerns about being able to meet the increased need for behavioral health services. For example, research found that more than half of surveyed psychologists said they had no capacity for new patients and said that their wait lists were longer than when the pandemic started.[3] Other behavioral health providers may accept new patients but may not participate in programs such as traditional Medicare, Medicare Advantage, or Medicaid. 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.[4]

Both traditional Medicare and Medicare Advantage cover outpatient services for mental health and substance use disorders. State Medicaid programs typically cover a wide range of behavioral health services, including most outpatient services for the treatment of mental health and substance use disorders.[5] Most States deliver behavioral health services through Medicaid managed care plans.[6] Enrollees in all three programs may see providers, such as psychiatrists, who can prescribe medication, or other providers, including psychologists, social workers, and other licensed mental health providers.

Network adequacy standards in Medicare Advantage and Medicaid managed care

Network adequacy standards are metrics that health plans must meet to ensure that plans maintain a network of providers that is sufficient to provide adequate access to covered services for their members, such as standards for minimum provider-to-enrollee ratios for plans; time and distance; and wait times for appointments.[7] In general, the Centers for Medicare and Medicaid Services (CMS) establishes network adequacy standards for managed care plans that participate in Medicare Advantage.[8] In Medicaid managed care, each State must set quantitative metrics for certain provider types, including both adult and pediatric behavioral health providers.

With respect to wait time standards, which are the focus of this review, Medicare Advantage has a wait time standard of 30 business days for routine and preventive care, including behavioral health services.[9] For rating periods beginning on or after July 9, 2027, for Medicaid managed care plans, State-developed wait time standards must be no longer than 10 business days for routine outpatient mental health and substance use disorder appointments.[10]

Other work

The first report in this series, *A Lack of Behavioral Health Providers in Medicare and Medicaid Impedes Enrollees' Access to Care*, was released in March 2024. The prior report found that overall, there were few behavioral health providers in the selected counties who actively served Medicare and Medicaid enrollees.[11] On average, there were fewer than 5 active behavioral health providers per 1,000 enrollees in each program. These providers represented about one-third of the total behavioral health workforce

in the selected counties. Despite increased demand for behavioral health services, the report found that treatment rates for Medicare and Medicaid enrollees in the selected counties remained relatively low.

OIG recommended that CMS take several steps toward increasing the number of behavioral health providers available to treat Medicare and Medicaid enrollees. In particular, OIG recommended that CMS take steps to encourage more providers to serve Medicare and Medicaid enrollees, including using network adequacy standards to drive an increase in providers participating in Medicare Advantage and Medicaid managed care. CMS concurred with the recommendations contained in the report, or their intent. The third report in this series will examine the extent to which behavioral health providers listed in networks of managed care plans provided services to the plans' enrollees.

Beyond this body of work examining provider availability, OIG has also examined Federal behavioral health parity requirements.[12] An OIG audit found that CMS did not ensure that selected States complied with Medicaid managed care mental health and substance use disorder parity requirements.[13]

How OIG did this review

This report examines access to care among sampled providers who had treated the same group of enrollees who were the focus of the first report in this series— *A Lack of Behavioral Health Providers in Medicare and Medicaid Impedes Enrollees' Access to Care*. As a result, these findings directly build on that work.

To conduct this study, we selected a random sample of active providers who treated Medicare and Medicaid enrollees, as demonstrated by their billing of these programs.[14] We define an active provider as a provider who billed the selected program for at least two services in 2021 with at least one Medicare or Medicaid enrollee from one of the 20 selected counties, in keeping with the timeframe and sampling approach of the first report in this series. We stratified our provider sample by program (traditional Medicare, Medicare Advantage, Medicaid managed care organizations) and location (urban, rural). We further stratified the Medicaid provider sample by target population (adults, children). This resulted in eight strata. We randomly selected 150 providers from each of the 8 strata.[15]

We conducted telephone surveys to determine providers' availability to treat new patients enrolled in traditional Medicare, Medicare Advantage, or Medicaid managed care. Primary data collection took place in August and September 2023. We completed 707 telephone surveys that were conducted with the sampled provider, scheduler, or other representative.[16] We refer to these respondents as "surveyed providers" in this report.

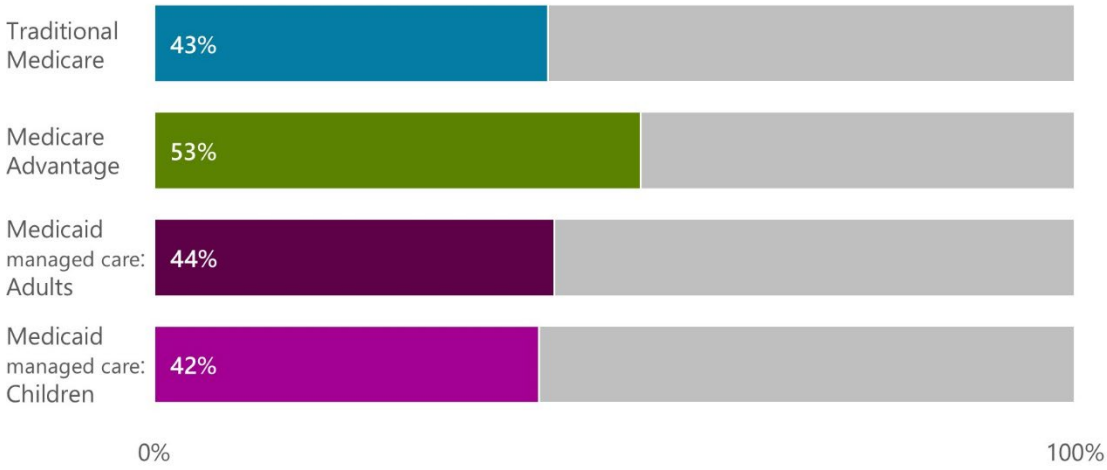
We generated estimates for the proportion of providers who were not available to treat a new patient in each of the three programs: traditional Medicare, Medicare Advantage, and Medicaid managed care, and within the eight subgroups. We examined wait times for providers who were available to treat new patients to identify the proportion of these providers who reported particularly long or short wait times in each program. See the Methodology for details about the sampling approach, data collection, statistical data analysis, and limitations. See Appendix B for analytics tables that contain the point estimates and confidence intervals for each program and a comparison across programs.

FINDINGS

About half of surveyed behavioral health providers were unavailable for new patient appointments with Medicare or Medicaid enrollees in 2023

Overall, 45 percent of surveyed providers were not available to treat a new patient who was an enrollee in 2023.[a] As shown in Exhibit 1, this limited availability applied to providers in traditional Medicare, Medicare Advantage, and Medicaid managed care, including providers of adults and children in Medicaid.

Exhibit 1: The proportion of surveyed providers who were not available to treat a new Medicare or Medicaid patient, by program



Source: OIG analysis of surveyed Medicare and Medicaid providers of enrollees in 20 selected counties, 2023.
Note: Differences in the estimates across the four groups were not statistically significant. See Appendix B for details about the number of surveyed and available providers.

About three-quarters of behavioral health providers who were unavailable for new Medicare or Medicaid patients reported that they could not accept any new patients, many citing full caseloads

Among the behavioral health providers who could not accept a new Medicare or Medicaid patient, 73 percent of providers told OIG that they could not make appointments for any new patients, regardless of their insurance or payment method.

[a] These providers billed the selected program (traditional Medicare, Medicare Advantage, or Medicaid managed care) for at least two services in 2021 with at least one enrollee in the selected program from one of the 20 selected counties.

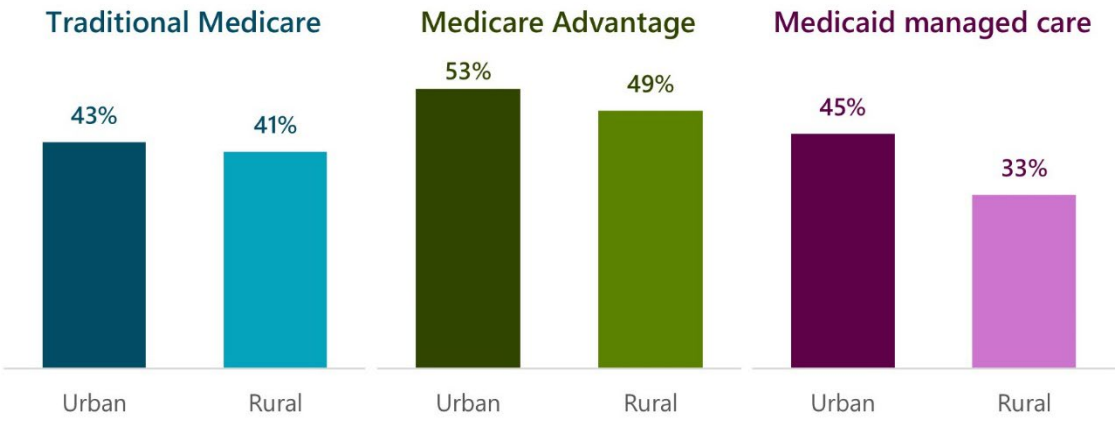
Many providers reported that their caseloads were too full to accept new patients, although some providers confirmed that they still treated existing patients enrolled in Medicare or Medicaid. For example, one Medicare Advantage provider said they might take a new patient in an urgent situation but did not have room in their schedule for regular treatment.

About one-quarter of providers who could not make new-patient appointments reported that they were no longer taking new Medicare or Medicaid enrollees, often reporting that they had stopped participating in traditional Medicare, Medicare Advantage, or Medicaid managed care.[17] For example, a behavioral health provider who had previously accepted Medicare Advantage reported that they had problems getting payment from Medicare Advantage plans, so they no longer accepted patients enrolled in the program. Another provider reported that they were no longer accepting Medicaid managed care patients but could make an appointment if the patient paid out of pocket. Some providers who had seen people enrolled in traditional Medicare, Medicare Advantage, or Medicaid managed care in 2021 had changed practices by the time of our calls in 2023, and those new practices did not accept enrollees in the programs.

Availability for new patient appointments was limited for enrollees in urban and rural counties

New patient appointment availability was limited among the groups of providers for urban and rural enrollees in traditional Medicare, Medicare Advantage, and Medicaid managed care. As shown in Exhibit 2, more providers for Medicaid enrollees in urban counties were not available to treat new patients, compared to providers for Medicaid enrollees in rural counties.

Exhibit 2: The proportion of surveyed providers not available to treat a new patient who had treated enrollees in urban and rural counties



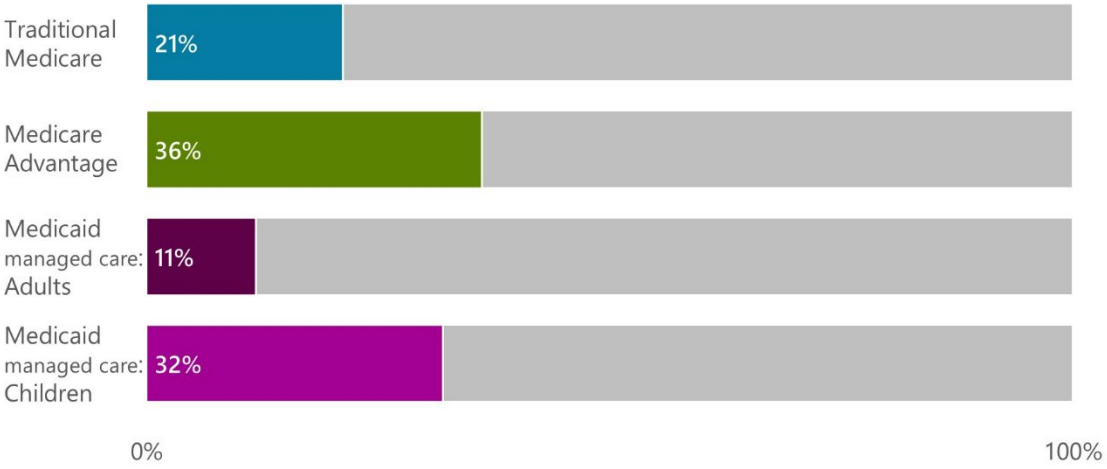
Source: OIG analysis of surveyed Medicare and Medicaid providers of enrollees in 20 selected counties, 2023.
Note: Differences in the estimates for Medicaid managed care were statistically significant, but not for traditional Medicare or Medicare Advantage. See Appendix B for details about the number of surveyed and available providers.

Availability for new patient appointments was similarly limited among the groups of providers who could prescribe medication and those who could not. Among the group of providers who could prescribe medication—primarily psychiatrists and advanced nurse practitioners—43 percent could not accept a new patient. Among clinicians who do not prescribe medication (e.g., therapists, counselors, or social workers), 46 percent could not see a new patient. See Appendix B for availability by program and other statistics.

Among the behavioral health providers who were available to treat new patients enrolled in Medicare or Medicaid, about a quarter reported long wait times for an appointment

Overall, among the providers who were available to treat a new patient enrolled in Medicare or Medicaid, 24 percent reported appointment wait times of more than 30 calendar days.[18] About 5 percent of providers had wait times of 90 days or longer. As shown in Exhibit 3, 36 percent of Medicare Advantage providers and 32 percent of Medicaid managed care providers treating children had new patient appointment wait times of more than 30 days. To ensure that enrollees have access to timely behavioral health services, CMS established maximums for State-developed network adequacy wait time standards.[19]

Exhibit 3: The proportion of available providers with wait times of more than 30 days, by program



Source: OIG analysis of surveyed Medicare and Medicaid providers of enrollees in 20 selected counties, 2023.
Note: Differences in the estimates for Medicare Advantage versus Medicaid: Adult and for Medicaid: Children versus Medicaid: Adult were statistically significant at the 95-percent confidence level. The difference in the estimates for Medicare Advantage versus traditional Medicare was significant at the 90-percent confidence level. See Appendix B for details about the number of surveyed providers and point estimates.

Other behavioral health providers reported relatively short wait times. Overall, about 48 percent of available providers could treat a new patient within 7 days, well within the wait time standards established by CMS.

The majority of providers who could make new appointments could see patients either in person or via telehealth, with little difference in wait times

Among the providers who were available to treat Medicare and Medicaid enrollees as new patients, 53 percent could do so both in person and via telehealth. When asked about wait times, most of these providers reported the same date for a new patient appointment, whether in person or via telehealth. Several providers voiced a preference for seeing a new patient in person, at least for the first visit, and 36 percent of providers reported that a new patient's first visit could only occur in person. An estimated 11 percent of available providers offered only telehealth appointments.[b]

[b] As described in the Methodology, telehealth-only providers were included only when their practice location was in one of the selected counties.

CONCLUSION

Access to behavioral health services is critical for the well-being of people enrolled in Medicare and Medicaid. However, this report illustrates that many behavioral health providers who had served this population in the past could not make appointments for new patients seeking care for the first time, including those enrolled in Medicare and Medicaid. Further, some providers reported leaving the Medicare and Medicaid programs altogether, removing them from a limited pool of active providers. Finally, the long wait times for new patient appointments suggest that even some of the providers who were available to take new patients were operating near capacity. The findings in this report reiterate the importance of prior recommendations that OIG made in the first report of this series.

In the first report, OIG made four recommendations to help address behavioral health provider shortages in Medicare and Medicaid.[20] In particular, OIG recommended that CMS take 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. An increase in providers could help increase access and could help reduce wait times, particularly for people enrolled in traditional Medicare.

OIG also recommended that CMS use network adequacy standards to drive an increase in behavioral health providers in Medicare Advantage and Medicaid managed care. This recommendation 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. For example, CMS recently set new appointment wait time maximums for the standards that States develop for Medicaid managed care plans. These wait time standards must be no longer than 10 business days for routine outpatient mental health and substance use disorder appointments and include other provisions, such as "secret shopper" surveys and enrollee surveys to ensure that people enrolled in Medicaid managed care can receive the care they need in a timely manner. If these policies are successful in increasing access to care, CMS could assess whether similar requirements for Medicare Advantage plans would improve access and reduce wait times for high-quality behavioral health services.

METHODOLOGY

This review assesses the availability of behavioral health providers to treat new patients in 2023. These providers include those who had actively served people enrolled in traditional Medicare, Medicare Advantage, and Medicaid managed care in 2021.

Identifying the population of behavioral health providers

We used Medicare and Medicaid claims and encounter data from 2021 to identify providers who treated enrollees who lived in 20 selected counties. To select the 20 counties and 10 States, we considered several factors. Because most States provide behavioral health care through Medicaid managed care plans, we included States that use a comprehensive care model to provide behavioral health services. We excluded States that delivered services only through a fee-for-service model and States that had distinct plans for specific populations, such as enrollees with serious mental illness. 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.[21] Finally, we considered geographic diversity and population size when selecting the States and counties. We selected one urban and one rural county from each of the 10 selected States.[22, 23] See Appendix A for the list and map of the 20 counties.

To identify the population of providers from which we selected our sample, we identified all outpatient behavioral health services provided to enrollees in the selected counties in each of the three programs.[24] 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 included all outpatient behavioral health services provided in 2021 by providers who specialize in behavioral health.

Identifying the sample of behavioral health providers

This study examined providers of enrollees in traditional Medicare, Medicare Advantage, and Medicaid managed care. For each program, we examined providers who served enrollees in urban and rural counties. Finally, because children enrolled in Medicaid may face different challenges accessing behavioral health services from those faced by adults enrolled in Medicaid, we subdivided Medicaid into providers who treated children and providers who treated only adults. We created eight strata for selection, as shown in Exhibit 4 on the next page.

Exhibit 4: Provider selection stratification

Traditional Medicare		1. Urban enrollees	2. Rural enrollees
Medicare Advantage		3. Urban enrollees	4. Rural enrollees
Medicaid managed care	Adults only	5. Urban adults	6. Rural adults
	Children	7. Urban children	8. Rural children

We selected 150 providers from each of the 8 strata for a total of 1,200 attempted surveys. Two providers were later excluded from the sample because we determined they did not meet the selection criteria. The sample included a total of 1,157 providers; 39 providers were selected in more than 1 stratum. These 39 providers completed separate surveys for each stratum into which they were selected.

Providers were eligible for multiple strata if they provided services in more than one program. Within each program, they were assigned to only one stratum, i.e., only urban or rural. Providers who treated children in 2021 were assigned to the Medicaid child strata only. The sample included a variety of provider types, such as psychiatrists, psychologists, counselors, and social workers.

Our goal was to examine provider availability for enrollees in specific counties. Providers were eligible for inclusion if their practice was located in the selected county.

To ensure that our population included providers who were most relevant to enrollees who lived in our selected counties, out-of-county providers for each program were eligible for inclusion if they met the following criteria:

- They provided at least two visits to enrollees from the selected county in calendar year 2021.
- They provided at least one in-person visit to enrollees from the selected county in calendar year 2021 (i.e., excluding out-of-county providers who were 100-percent telehealth).
- The provider's location is in the same State as the enrollee who received services, or in one of the neighboring States.

Data collection and analysis

OIG staff attempted to contact sampled providers via telephone in August and September 2023. We used CMS's Provider Enrollment, Chain, and Ownership System (PECOS) data for contact information, supplemented by Google and other online directories when additional contact information was needed. We attempted multiple telephone calls when necessary and left voice messages for respondents to return our calls. When we contacted a provider or their scheduler, we determined whether the

provider was still practicing and if so, proceeded to conduct the survey. As shown in Exhibit 5, we completed 707 telephone surveys that were conducted with the sampled provider or others at the provider's practice who were familiar with the provider's schedule and could answer the questions on their behalf.[25] Because the responses collected refer to a specific provider's availability, we refer to respondents as "providers," even when a scheduler or other representative responded to our surveys.

Exhibit 5: Completed surveys and contact attempts

Completed survey	707
Unable to contact provider*	308
Contacted but not surveyed**	183

*These surveys were for providers who did not return our calls, or who we were unable to confirm were at the phone number(s) we were calling.
**These include providers who refused to complete the survey (23) and providers for whom we determined our survey did not apply (160). These providers included those who 1) did not make appointments for one-on-one therapy, such as those who provided services in school-based and inpatient settings; 2) had moved into management or administration positions; 3) had retired; or 4) were deceased.

We asked the sampled provider if they were available to treat a new patient enrolled in one or more of the selected programs: traditional Medicare, Medicare Advantage, or Medicaid managed care. If a provider reported that they were not available to treat a new patient enrolled in the selected program, we recorded the reason why. We generated weighted point estimates for the proportion of providers who were not available for each of the four groups (traditional Medicare, Medicare Advantage, Medicaid managed care adults, and Medicaid managed care children). We also generated point estimates by urban and rural counties.

For providers who reported that they were available to treat a new patient, we recorded the date of the next in-person appointment and the date of the next telehealth appointment, if available. To calculate the wait time for the first in-person and/or telehealth appointment date, we subtracted the date OIG called the provider from the first available in-person and/or telehealth appointment that the provider indicated was available for new patients. We examined wait times to identify the proportion of providers who reported particularly long or short wait times in each program (i.e., more than 30 days or within 7 days). We also generated weighted point estimates for the proportion of these providers who could offer appointments in person, via telehealth, or both.

If a provider was available to treat a new patient but could not provide an appointment date, we excluded the provider from the wait time calculations. Not all providers could provide a specific appointment date. In some cases, providers provided a range of dates, and we calculated wait time based on the middle of the range of possible dates. Some providers could only provide appointment information for a specific patient who was already in the scheduling system.

We used a chi-square analysis to test for statistically significant differences across the four groups of providers, and for providers of enrollees in urban and rural counties in each program.

See Appendix B for point estimates and confidence intervals and results of comparison analysis.

Limitations

The findings apply only to the population of providers who were active in 2021 and treated Medicare and Medicaid enrollees in the 20 selected counties. These findings cannot be extrapolated to providers in other geographic areas.

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

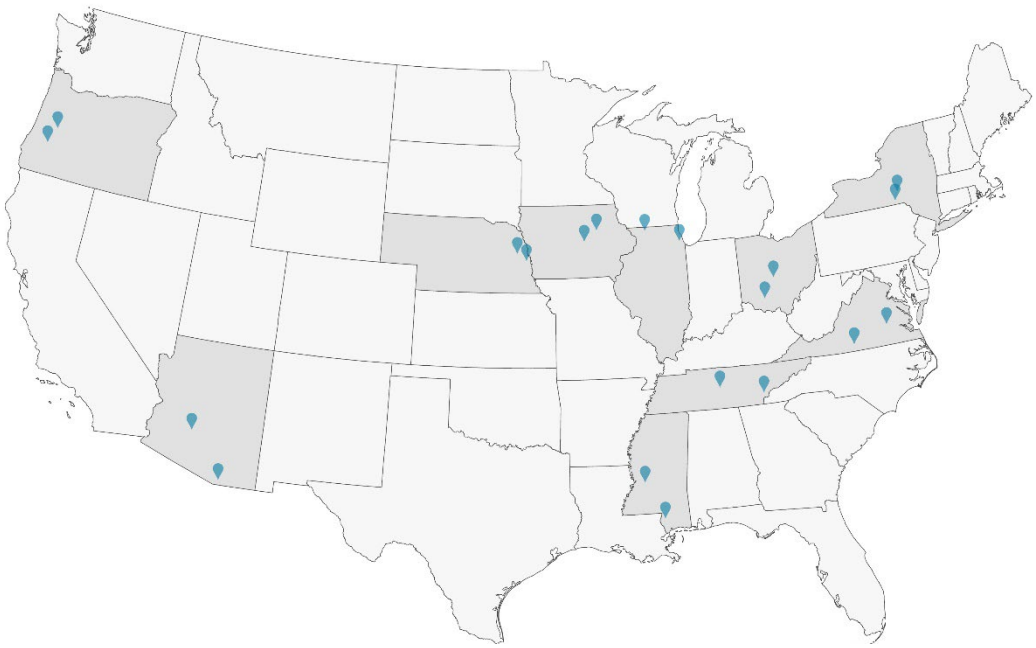
Selected Counties and States

Table 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.

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



APPENDIX B

Point Estimates, Confidence Intervals, and Comparison Analysis Results

We generated point estimates and calculated the upper and lower bounds of a 95-percent confidence interval. These confidence intervals will contain the true population value with a likelihood of 95 percent.

Table B-1: Percent of behavioral health providers who were not available to treat new patients in 2023

Percent who could not treat new patients	Sample size	Point estimate	Confidence interval: Lower bound	Confidence interval: Upper bound
Overall	707	44.9%	40.3%	49.6%
Traditional Medicare	202	42.8%	34.3%	51.8%
Medicare Advantage	179	52.9%	42.8%	62.7%
Medicaid managed care – Adults	146	43.5%	34.0%	53.5%
Medicaid managed care – Children	180	41.8%	33.9%	50.2%
Traditional Medicare – Urban	100	43.0%	33.7%	52.8%
Traditional Medicare – Rural	102	41.2%	33.1%	49.8%
Medicare Advantage – Urban	77	53.2%	42.2%	64.0%
Medicare Advantage – Rural	102	49.0%	41.2%	56.8%
Medicaid managed care – Urban	166	44.6%	37.1%	52.4%
Medicaid managed care – Rural	160	33.0%	26.6%	40.2%

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

Table B-2: Percent of behavioral health providers who were not available to treat new patients in 2023

Percent who could not treat new patients	Sample size	Point estimate	Confidence interval: Lower bound	Confidence interval: Upper bound
Overall prescriber	216	43.1%	34.9%	51.7%
Overall non-prescriber	491	45.8%	40.2%	51.4%

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

Table B-3: Percent of available providers with new patient appointment wait times of more than 30 days

Percent with a wait time of more than 30 days	Sample size	Point estimate	Confidence interval: Lower bound	Confidence interval: Upper bound
Overall	383	23.7%	18.9%	29.4%
Traditional Medicare	112	21.2%	13.2%	32.3%
Medicare Advantage	81	36.2%	23.2%	51.5%
Medicaid managed care – Adults	83	10.6%	5.1%	20.8%
Medicaid managed care – Children	107	31.9%	22.6%	42.8%
Percent with a wait time of 90 days or more	**Sample size**	**Point estimate**	**Confidence interval: Lower bound**	**Confidence interval: Upper bound**
Overall	383	5.2%	3.1%	8.6%
Percent available within 7 days	**Sample size**	**Point estimate**	**Confidence interval: Lower bound**	**Confidence interval: Upper bound**
Overall	383	48.2%	41.9%	54.6%

Source: OIG analysis of surveyed Medicare and Medicaid providers in 20 selected counties, 2023.
Note: This analysis is calculated out of the respondents who were able to provide an appointment date. A marginal number of providers could confirm that they were available to treat a new patient but could only provide appointment information for specific patients already enrolled in their patient portal.

Table B-4: Percent of providers available in person only, via telehealth only, or both ways

Percent available by care delivery mode	Sample size	Point estimate	Confidence interval: Lower bound	Confidence interval: Upper bound
Both in person and via telehealth	403	52.9%	46.7%	59.1%
In person only	403	35.9%	30.1%	42.2%
Via telehealth only	403	11.1%	7.7%	15.8%

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

We used a chi-square test to determine statistically significant differences in the proportions across provider subgroups. Statistically significant results, which we define as those with a p-value of 0.05 or less, indicate that differences across groups were not likely due to random sampling.

Table B-5: Results of comparison analysis using chi-square tests

Provider groups	Estimate description	P-value	Statistically significant differences
Traditional Medicare vs. Medicare Advantage vs. Medicaid managed care: Adults vs. Medicaid managed care: Children	Percent unavailable to treat new patients	.40	No
Traditional Medicare: Urban vs. rural	Percent unavailable to treat new patients	.78	No
Medicare Advantage: Urban vs. rural	Percent unavailable to treat new patients	.55	No
Medicaid managed care: Urban vs rural	Percent unavailable to treat new patients	.03	Yes
Traditional Medicare vs. Medicare Advantage vs. Medicaid managed care: Adults vs. Medicaid managed care: Children	Percent of available providers with wait times of more than 30 days	.01	Yes

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

ENDNOTES

[1] Kaiser Family Foundation, *The Implications of COVID-19 for Mental Health and Substance Use*. Accessed on May 30, 2025.

[2] HRSA, *State of the Behavioral Health Workforce*. Accessed on May 30, 2025.

[3] American Psychological Association, *Worsening mental health crisis pressures psychologist workforce*. Accessed on May 30, 2025.

[4] Zhu, J. M., Meiselbach, M. K., Drake, C., and Polsky, D., "Psychiatrist Networks In Medicare Advantage Plans Are Substantially Narrower Than In Medicaid And ACA Markets," *Health Affairs*, July 2023. Accessed on May 30, 2025.

[5] 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 May 30, 2025.

[6] Kaiser Family Foundation, *State Policies Expanding Access to Behavioral Health Care in Medicaid*. Accessed on May 30, 2025.

[7] CMS, *Network Adequacy*. Accessed on May 30, 2025. See also Kaiser Family Foundation, *Medicaid Managed Care Network Adequacy and Access*. Accessed on May 30, 2025.

[8] Traditional Medicare does not use network adequacy standards because enrollees can see any provider participating in Medicare.

[9] 42 CFR 422.112. Wait time standards were codified for routine behavioral health services in Medicare Advantage in 2023. Beginning January 1, 2024, the maximum wait time for routine behavioral health services is 30 business days. 88 Fed. Reg. 22120 (Apr. 12, 2023).

[10] 42 CFR § 438.68(e)(1). This requirement is applicable for the first rating period beginning on or after July 9, 2027. 89 Fed. Reg. 41002, 41003, and 41013 (May 10, 2024).

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

[12] HHS OIG Work Plan, *States' and MCOs' Compliance With Mental Health Parity Requirements*. Accessed on May 30, 2025.

[13] HHS OIG, *CMS Did Not Ensure That Selected States Complied With Medicaid Managed Care Mental Health and Substance Use Disorder Parity Requirements* (A-02-22-01016), March 2024.

[14] Because most States provide covered behavioral health services through Medicaid managed care plans, this review focuses 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.

[15] The selected providers may have provided services in more than one program and/or service area. For purposes of our review, providers may have responded to questions for more than one program. Responses from providers who saw enrollees in both urban and rural counties may be included in comparisons of urban and rural availability but counted once in the overall program-level analysis.

[16] Because the responses collected refer to a specific provider's availability, we refer to respondents as "providers," even when a representative responded to our surveys.

[17] About 4 percent of providers reported other reasons for which they could not accept a new patient or reported that the reason was unknown.

[18] Wait time analysis includes only providers who could provide an appointment date to OIG. Some providers could not provide appointment information for new patients until they registered in a patient portal.

[19] Behavioral health appointment wait time standards of 30 business days for Medicare Advantage were codified in 2023 and applicable beginning January 1, 2024. The 10 business days maximum for Medicaid managed care plans will take effect for the first rating period beginning on or after July 9, 2027. See 42 CFR § 422.112 (a)(6)(i)(C) and 88 Fed. Reg. 22120 for Medicare Advantage wait time standards. See 42 CFR § 438.68(e)(1) and 89 Fed. Reg. at 41003 and 41013 for Medicaid standards.

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

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

[22] 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 on May 30, 2025.

[23] In 2021, the selected States were operating under an 1135 waiver that permitted State Medicaid Agencies to temporarily enroll providers who are enrolled with another State Medicaid Agency or with Medicare for the duration of the public health emergency. That waiver had expired at the time of data collection in 2023.

[24] 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 | CMS Data*. Accessed on May 30, 2025.

[25] Thirty-nine providers were surveyed more than once because they participated in more than one Federal health program.

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