

REPORT HIGHLIGHTS



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

Why OIG Did This Review

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

What OIG Found



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



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



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



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

What OIG Recommends

OIG recommends that CMS:

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

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