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March 2022

# MENTAL HEALTH CARE

## Access Challenges for Covered Consumers and Relevant Federal Efforts

# GAO Highlights

Highlights of [GAO-22-104597](#), a report to the Chairman of the Committee on Finance, U.S. Senate

## Why GAO Did This Study

Mental health conditions affect a substantial number of adults in the U.S. In 2020, an estimated 53 million adults in the U.S. (21 percent) had any mental illness and 14 million adults (5.6 percent) had serious mental illness. Despite the need for services to treat mental health conditions, there have been longstanding concerns in the U. S. about the availability of these services. Additionally, although many consumers have coverage for mental health services through their public or private health plans, having such coverage does not guarantee access.

This report describes (1) the challenges consumers with coverage for mental health care services experience with accessing those services and (2) ongoing and planned federal efforts to address these challenges.

To conduct this work, GAO interviewed federal officials and representatives from 29 stakeholder organizations representing consumers, health plans, providers, insurance regulators, and mental health and Medicaid agencies. These included national organizations and organizations from four states—Connecticut, Oregon, South Carolina, and Wisconsin—selected based on mental health metrics and geographic variation, among other factors. GAO also reviewed relevant reports obtained from these agencies and organizations and reviewed academic and industry research focused on consumer access to mental health care.

DOL and HHS provided technical comments, which GAO incorporated as appropriate.

View [GAO-22-104597](#). For more information, contact John E. Dicken at (202) 512-7114 or [dickenj@gao.gov](mailto:dickenj@gao.gov).

March 2022

## MENTAL HEALTH CARE

### Access Challenges for Covered Consumers and Relevant Federal Efforts

#### What GAO Found

Based on stakeholders interviewed and research reviewed, GAO found that consumers with coverage for mental health care experience challenges finding in-network providers. For example, in-network providers may not be accepting new patients or there may be long wait times to see them. Such challenges could cause consumers to face higher health care costs, delays in receiving care, or difficulties in finding a provider close to home. Factors contributing to these challenges included low reimbursement rates for mental health services and inaccurate or out-of-date information on provider networks, according to stakeholders and research GAO reviewed.

GAO also found that consumers experience challenges with restrictive health plan approval processes and plan coverage limitations, which can limit their ability to access services. Many of the 29 stakeholder organizations interviewed and reports GAO reviewed noted that the process for getting approval for coverage for mental health services can be more restrictive than it is for medical services. For example, representatives from one health system reported that some health plans are less likely to grant prior authorization for mental health hospital stays compared with medical and surgical hospital stays. Stakeholders also noted various coverage restrictions that limit consumers' access to certain mental health treatments or that limit the types of providers eligible for payment. These include certain statutory restrictions on coverage of inpatient care in certain settings under Medicaid and the types of mental health providers not eligible for reimbursement under Medicare.

Federal efforts may address aspects of the challenges experienced by consumers attempting to access care.

**Access to in-network providers:** The Department of Labor (DOL) and the Department of Health and Human Services' (HHS) Centers for Medicare & Medicaid Services are taking steps to ensure access to in-network mental health providers by, for example, enforcing requirements for certain health plans to update and maintain provider directories.

**Workforce shortages:** The Health Resources and Services Administration within HHS manages several programs that provide funding intended to increase the mental health workforce.

**System capacity:** The Substance Abuse and Mental Health Services Administration within HHS manages several programs aimed at addressing structural issues that contribute to a lack of capacity in the mental health system, including grant programs to increase access to community-based mental health care.

**Enhanced oversight:** DOL and HHS are taking steps to enhance their oversight of the use of non-quantitative treatment limitations by health plans, such as prior authorization requirements, as part of their broader responsibilities to oversee compliance with mental health parity laws. These laws require that coverage of mental health treatment be no more restrictive than coverage for medical or surgical treatment. In addition, DOL has asked Congress to further expand its oversight authorities.

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# Contents

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Letter		1
	Background	4
	Consumers with Coverage for Mental Health Care Experience Challenges Finding In-Network Providers and Navigating Plan Details	9
	Federal Efforts May Address Aspects of the Access Challenges Experienced by Covered Consumers	23
	Agency Comments	31
Appendix I	GAO Contact and Staff Acknowledgments	33
Related GAO Products		34

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## Abbreviations

CAA	Consolidated Appropriations Act, 2021
CCBHC	certified community behavioral health clinic
CMS	Centers for Medicare & Medicaid Services
DOL	Department of Labor
HHS	Department of Health and Human Services
HRSA	Health Resources and Services Administration
IMD	institutions for mental disease
ISMICC	Interdepartmental Serious Mental Illness Coordinating Committee
MHPAEA	Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008
NQTL	non-quantitative treatment limitation
SAMHSA	Substance Abuse and Mental Health Services Administration

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March 29, 2022

The Honorable Ron Wyden  
Chairman  
Committee on Finance  
United States Senate

Dear Mr. Chairman:

Mental health conditions—such as anxiety disorders, mood disorders, and schizophrenia—affect a substantial number of adults in the U.S. For example, in 2020, the Substance Abuse and Mental Health Services Administration (SAMHSA) estimated that 53 million adults in the U.S. (21 percent) had any mental illness, including approximately 14 million adults (5.6 percent) who had serious mental illness.<sup>1</sup> Additionally, the effects of the COVID-19 pandemic and related economic crisis—such as increased social isolation, stress, and unemployment—have intensified concerns that more people are affected by mental health conditions and that people with underlying mental health conditions could experience increased severity of those conditions.

There have also been longstanding concerns in the U.S. about the accessibility of mental health services, even for those with health coverage. Although approximately 91 percent of the U.S. population is covered by public or private health plans, having such coverage does not guarantee access to mental health services. For example, a 2021 report by Mental Health America estimated that 54 percent of consumers covered by a health plan did not receive the mental health treatment they needed, indicating that ensuring coverage is not the same as ensuring

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<sup>1</sup>See Substance Abuse and Mental Health Services Administration, *Key Substance Use and Mental Health Indicators in the United States: Results from the 2020 National Survey on Drug Use and Health*, (Rockville, Md.: October 2021). SAMHSA classified adults aged 18 or older as having any mental illness if they had any mental, behavioral, or emotional disorder in the past year of sufficient duration to meet criteria in the *Diagnostic and Statistical Manual of Mental Disorders* (excluding developmental disorders and substance use disorders). SAMHSA classified adults with any mental illness as having serious mental illness if they had any mental, behavioral, or emotional disorder that substantially interfered with or limited one or more major life activities. The survey excluded people with no fixed address, military personnel on active duty, and residents of institutional facilities such as nursing homes and prisons.

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access to mental health care.<sup>2</sup> Additionally, the Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC) reported on research showing that individuals with coverage may still face challenges in accessing treatment.<sup>3</sup> For example, according to the report, among individuals with serious mental illness who have mental health coverage, many lack a usual source of care or delay care for their mental health condition because of cost.<sup>4</sup>

In light of these issues, you asked us to explore the experiences consumers with health coverage have accessing timely and appropriate mental health care. This report describes

1. challenges that consumers with coverage for mental health services may experience accessing these services; and
2. ongoing and planned federal efforts to address these challenges.

To identify challenges covered consumers may experience with access to mental health care services, we interviewed representatives from 29 stakeholder organizations on the challenges, potential reasons for those challenges, and whether the challenges vary by payer or plan design. This included 11 national stakeholder organizations representing consumers, health plans, providers, insurance regulators, and state mental health agencies—selected to identify a range of perspectives of key stakeholders. It also included 18 stakeholder organizations representing consumers, providers, insurance regulators, and state mental health and Medicaid agencies in four states—Connecticut, Oregon, South Carolina, and Wisconsin—to better understand the

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<sup>2</sup>M.Reinert, D. Fritze, and T. Nguyen, *The State of Mental Health in America 2022* (Alexandria, Va.: Mental Health America, 2021).

<sup>3</sup>Interdepartmental Serious Mental Illness Coordinating Committee, *The Way Forward: Federal Action for a System That Works for All People Living With SMI and SED and Their Families and Caregivers* (2017). The 21st Century Cures Act mandated ISMICC submit a report to Congress including recommendations for actions that federal departments can take to better coordinate the administration of mental health services for adults with a serious mental illness or children with a serious emotional disturbance. Pub. L. No. 114-255, § 6031, 130 Stat. 1033, 1217 (2016). SAMHSA's Assistant Secretary for Mental Health and Substance Use chairs ISMICC, which also includes participation from nine additional federal departments and agencies and 14 non-federal members representing mental health researchers, providers, patients, families, judges, law enforcement officers, and other professionals who work with people living with serious mental illnesses.

<sup>4</sup>E. Sherrill and G. Gonzales, "Recent Changes in Health Insurance Coverage and Access to Care by Mental Health Status, 2012-2015," *JAMA Psychiatry*, vol. 74, no. 10 (2017): 1076-1079.

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challenges consumers and providers at the local and state level encounter in accessing and providing mental health care.<sup>5</sup> The non-generalizable sample of four states was selected to reflect geographic variation and variation in the percentage of perceived unmet need for mental health care for patients with serious mental illness based upon data from SAMHSA, among other criteria.

In reporting our findings based on the testimonial evidence collected from the 29 stakeholder organizations, we generally indicate the numbers of organizations that identified specific challenges using indefinite quantifiers.<sup>6</sup> We also reviewed a variety of documents that focused on access to mental health care. These included reports, published research, and other documentation from academic researchers, industry and stakeholder groups, federal departments and agencies, and state governments. Some of these documents were obtained from the stakeholder groups we interviewed, and others were identified independently in order to corroborate testimonial evidence obtained through the interviews.

To identify ongoing and planned federal efforts taken to address the challenges, we interviewed or obtained written responses from federal department and agency officials at the Departments of Health and Human Services (HHS) and Labor (DOL) to obtain their perspectives on the challenges identified as well as information on ongoing or planned efforts that might address them. We also reviewed department and agency documentation—including regulations, guidance, grant announcements, and reports—to identify or better understand federal efforts that may address aspects of the challenges raised by stakeholders. Lastly, we reviewed relevant federal laws to understand department and agency responsibilities related to mental health care access.

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<sup>5</sup>Among the states in our review there was variation in the way state health agencies were organized. For example, for some, Medicaid agencies were separate from state mental health agencies and, for others, both programs were part of an umbrella state agency. For purposes of this report, we refer to both state mental health and Medicaid agencies as “state health agencies.”

<sup>6</sup>Specifically, we defined modifiers to quantify stakeholders’ views as follows: “some” stakeholders represents more than 0 but less than or equal to 20 percent of responses; “several” stakeholders represents greater than 20 percent but less than or equal to 40 percent of responses; “many” stakeholders represents greater than 40 percent but less than or equal to 60 percent of responses; “most” stakeholders” represents greater than 60 percent but less than or equal to 80 percent of responses; and, “nearly all” stakeholders represents greater than 80 percent but less than 100 percent of responses.

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We conducted this performance audit from October 2020 to March 2022 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

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## Background

### Mental Health Conditions in the U.S. and Health Plan Financial Requirements

People can experience different types of mental health conditions, and mental health conditions can occur over a short period of time or be ongoing. Examples of mental health conditions are anxiety disorders; mood disorders, such as depression; post-traumatic stress disorder; and schizophrenia. Mental health symptoms and conditions vary in terms of their severity and duration. SAMHSA estimated that, in 2020, approximately 14 million adults had a serious mental illness, which is defined as a mental, behavioral, or emotional disorder that substantially interfered with or limited one or more major life activities.<sup>7</sup> Additionally, the Centers for Disease Control and Prevention estimated that, in 2019, 2.8 percent of adults experienced severe symptoms of depression, 4.2 percent experienced moderate symptoms, and 11.5 percent experienced mild symptoms.<sup>8</sup>

Mental health treatment includes an array of options ranging from less to more intensive and may include prevention services, screening and assessment, outpatient treatment, inpatient treatment, and emergency services. Prescription drugs may also be included as part of treatment for mental health conditions. In addition to these treatments, other supportive services exist for mental health conditions that are designed to help individuals manage their conditions and maximize their potential to live independently in the community. These supportive services are multidimensional—intended to address not only health conditions, but also employment, housing, and other issues.

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<sup>7</sup>See Substance Abuse and Mental Health Services Administration, *Key Substance Use and Mental Health Indicators in the United States: Results from the 2020 National Survey on Drug Use and Health*, (Rockville, Md.: October 2021).

<sup>8</sup>See M.A. Villarroel and E.P. Terlizzi, *Symptoms of Depression among Adults: United States, 2019*, NCHS Data Brief, no. 379 (Hyattsville, Md.: National Center for Health Statistics, September 2020).



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According to the U.S. Census Bureau, as of 2020 approximately 298 million individuals in the U.S. had health coverage for all or part of that year.<sup>9</sup> The majority of those individuals received their coverage through private health plans, either by purchasing health coverage directly from state-licensed or state-regulated insurers—including health plans sold through health insurance marketplaces, known as exchanges—or by receiving coverage through their employers.<sup>10</sup> Most of the remaining covered individuals received coverage through public plans such as Medicare or Medicaid.<sup>11</sup>

Covered health benefits commonly include plan design features—such as financial requirements—that require enrollees to pay for a portion of their health care, quantitative treatment limitations that limit the amount or number of treatments enrollees can receive, and non-quantitative treatment limitations (NQTL) that limit the scope or duration of treatments that enrollees may receive.

The most common types of financial requirements include: (1) deductibles, which are required payments of a specified amount made by enrollees for services before the health plan or issuer begins to pay; (2) copayments, which are payments made by enrollees after the deductible is met and until an out-of-pocket maximum is reached and are a specified flat dollar amount—usually on a per-unit-of-service basis—with the health plan or issuer reimbursing some portion of the remaining charges; (3) coinsurance, which is a percentage payment made by enrollees after the deductible is met and until an out-of-pocket maximum is reached; and (4) out-of-pocket maximums, which are the maximum amounts enrollees have to pay per year for all covered medical expenses.<sup>12</sup>

Quantitative treatment limitations can be expressed numerically, such as through annual, episode, and lifetime day and visit limits. For example,

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<sup>9</sup>See United States Census Bureau, *Health Insurance Coverage in the United States: 2020*, P60-274 (Washington, D.C.: September 2021).

<sup>10</sup>Health insurance exchanges are markets that operate within each state where eligible individuals and small employers can compare and select among qualified insurance plans offered by participating issuers.

<sup>11</sup>Medicare is the federally financed health insurance program for persons age 65 or over, certain individuals with disabilities, and individuals with end-stage renal disease. Medicaid is a jointly federal-state program for low-income and medically needy individuals.

<sup>12</sup>An issuer is an insurance company, insurance service, or insurance organization that is required to be licensed to engage in the business of insurance in a state and is subject to state insurance law.

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quantitative treatment limitations include annual limits on the number of office visits an enrollee can make for a certain condition and lifetime limits on the coverage of benefits for a certain type of treatment.

NQTLs are non-numerical limitations on the scope or duration of services. Common NQTLs include: (1) medical management standards that limit or exclude benefits based on medical necessity or medical appropriateness or based on whether the treatment is experimental or investigative; (2) refusal to pay for higher-cost therapies until it can be shown that lower cost therapy is not effective—known as fail-first or step therapy protocols; (3) exclusions based on failure to complete a course of treatment; and (4) requiring pre-authorization of services—the requirement that an enrollee receives prior approval for care.

Health plans often contract with certain hospitals, doctors, pharmacies, and other health care providers to deliver medical services for an agreed-upon rate. These providers are known as a health plan's provider network. Some health plans, such as health maintenance organizations, will generally only pay for services performed by providers within their network (also known as in-network providers). Other plans, such as preferred-provider organizations, may pay for services by any provider, including providers who are not in-network. However, it is often more expensive for consumers to go to providers who are not in their health plans' networks (that is, out-of-network providers). For example, a health plan may require higher cost sharing—either in the form of co-payments or coinsurance—for consumers who use out-of-network providers.

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## Mental Health Parity

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) requires certain health plans that provide both medical and surgical benefits and mental health or substance use disorder benefits to ensure that the latter benefits do not have more restrictive financial requirements or treatment limitations than those for medical and surgical benefits.<sup>13</sup> Generally, this means that the requirements or limitations imposed on mental health and substance use

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<sup>13</sup>Pub. L. No. 110-343, div. C, tit. V, sub. B, §§ 511-12, 122 Stat. 3765, 3881-93 (Oct. 3, 2008). MHPAEA, enacted as part of the Emergency Economic Stabilization Act of 2008, expands the parity requirements established by the Mental Health Parity Act of 1996. Pub. L. No. 104-204, Tit. VII, §§ 701-02, 100 Stat. 2874, 2944-50 (Sept. 26, 1996). MHPAEA amended the Public Health Service Act, the Employee Retirement Income Security Act of 1974, and the Internal Revenue Code of 1986. In general, plans covered by MHPAEA include Medicaid managed care plans as well as plans sponsored by large employers and plans purchased directly from state-licensed or state-regulated insurers.

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disorder benefits—such as copayment amounts, number of annual visits allowed, or preauthorization of services—must be in parity with those imposed on medical and surgical benefits.<sup>14</sup> HHS, DOL, and the Department of the Treasury share joint responsibilities for overseeing compliance with MHPAEA and have jointly developed related regulations and guidance.<sup>15</sup>

Authority for oversight and enforcement of MHPAEA requirements falls on either state insurance regulators, DOL, or HHS depending on the plan type, market, and employer sector (in the case of employer-sponsored health plans). For example, state insurance regulators oversee fully insured health plans offered by state licensed insurers and generally have authority for oversight and enforcement of MHPAEA requirements for those plans. DOL has authority for oversight and enforcement of MHPAEA requirements for most group health plans sponsored by private employers, including fully insured plans (where the employer purchases coverage from a state-regulated issuer) and self-funded plans (where the employer pays for employee health care benefits directly, bearing the risk for covering medical benefits generated by beneficiaries).<sup>16</sup> Within DOL, the Employer Benefits Security Administration is the agency responsible for this oversight. HHS has primary authority for parity requirements for employer-sponsored plans for state and local governments—known as non-federal governmental plans—whether they are fully insured or self-

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<sup>14</sup>MHPAEA was enacted in 2008 to help address discrepancies in health care coverage between mental illnesses and physical illnesses. MHPAEA both strengthened and broadened federal parity requirements enacted in 1996, including extending parity to cover the treatment of substance use disorders. The Mental Health Parity Act of 1996 required parity in annual and aggregate lifetime dollar limits in employer-sponsored, large group health plans. In addition to extending parity requirements to cover the treatment of substance use disorders, MHPAEA applied parity requirements more broadly to financial requirements and treatment limitations. The Patient Protection and Affordable Care Act extended these parity requirements to individual insurance plans and some small group plans. Pub. L. No. 111-148, 124 Stat. 119 (Mar. 23, 2010).

<sup>15</sup>HHS, DOL, and Treasury develop and jointly issue regulations under parallel provisions, consistent with the tri-agency memorandum of understanding that implements section 104 of the Health Insurance Portability and Accountability Act of 1996. 64 Fed. Reg. 70,164 (Dec. 15, 1999); Pub. L. No. 104-191, § 104, 110 Stat. 1936, 1978.

<sup>16</sup>While states oversee the issuers of these fully insured, private employer-sponsored group plans and the products they offer, DOL oversees the plans themselves for compliance.

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funded.<sup>17</sup> Within HHS, the Centers for Medicare & Medicaid Services (CMS) is the agency responsible for this oversight.<sup>18</sup>

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### Other Federal Agencies with Responsibilities Related to Mental Health

Other federal agencies within HHS regularly conduct mental health-related work. In particular, SAMHSA leads federal public health efforts to advance the behavioral health of the nation. SAMHSA is responsible for, among other things, providing federal funding through grants to states, local communities, and private entities to support mental health and substance abuse treatment and prevention services. For example, SAMHSA's two largest grant programs supporting these treatment and prevention services are the Community Mental Health Services Block Grant and the Substance Abuse Prevention and Treatment Block Grant. SAMHSA also conducts surveillance and data collection of national behavioral health issues and provides data and prevalence statistics to help researchers, public health officials, and policymakers understand and solve these issues.

Additionally, the Health Resources and Services Administration (HRSA) is the primary federal agency responsible for improving access to health care and enhancing health systems of care for the tens of millions of people who are geographically isolated or economically or medically vulnerable. HRSA supports the training of health professionals and the distribution of providers to areas where they are needed most. As part of this role, HRSA collects data on behavioral health workforce shortage areas and provides funding to support behavioral health workforce training.

### Long-Standing Workforce Shortages

We have previously reported on shortages of qualified behavioral health professionals, including shortages of mental health professionals, particularly in rural areas. For example, as we reported in 2015, SAMHSA found that more than three quarters of counties in the U.S. had a serious

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<sup>17</sup>With respect to health insurance issuers selling products in the individual and fully insured group market, HHS has primary enforcement authority over parity requirements in two instances: (1) when a state notifies HHS that it does not have the authority to enforce parity requirements or the state notifies HHS that it is not otherwise enforcing the requirements, or (2) when HHS determines the state failed to substantially enforce parity requirements.

<sup>18</sup>For more information on MHPAEA oversight responsibilities see GAO, *Mental Health and Substance Use: State and Federal Oversight of Compliance with Parity Requirements Varies*, [GAO-20-150](#), (Washington, D.C.: Dec. 13, 2019).

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shortage of mental health professionals in 2013.<sup>19</sup> These workforce shortages are expected to continue. For example, before the COVID-19 pandemic, HRSA reported that, by 2025, shortages of seven selected types of behavioral health providers were expected, with shortages of some provider types expected to exceed 10,000 full-time equivalents.<sup>20</sup> Additionally, as of September 30, 2020, HRSA designated more than 5,700 mental health provider shortage areas, with more than one-third of Americans (119 million people) living in these shortage areas. In these areas, the number of mental health providers available were adequate to meet about 27 percent of the estimated need.<sup>21</sup>

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## Consumers with Coverage for Mental Health Care Experience Challenges Finding In-Network Providers and Navigating Plan Details

Based on interviews with 29 stakeholder organizations and our review of reports and research on access to mental health, we found that consumers experience a variety of challenges accessing mental health benefits provided under their health plans. Some of the challenges occur because of limited access to in-network providers or broader structural issues in the mental health system that make it difficult to access affordable mental health care or certain types of mental health care in a timely manner. Other challenges occur because of processes used by health plans to approve mental health treatment or limitations in services and treatments covered by some health plans—these can delay or limit the course of treatments or make treatments unavailable for certain consumers.

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<sup>19</sup>See GAO, *Behavioral Health: Options for Low-Income Adults to Receive Treatment in Selected States*, [GAO-15-449](#) (Washington, D.C.: June 19, 2015) and Substance Abuse and Mental Health Services Administration, *Results from the 2013 National Survey on Drug Use and Health: Mental Health Findings*, NSDUH Series H-49, HHS Publication No. (SMA) 14-4887 (Rockville, Md.: 2014).

<sup>20</sup>See Health Resources and Services Administration, National Center for Health Workforce Analysis, *National Projections of Supply and Demand for Selected Behavioral Health Practitioners: 2013-2025* (Rockville, Md.: November 2016). A total of nine types of behavioral health practitioners were considered in these estimates: psychiatrists; behavioral health nurse practitioners; behavioral health physician assistants; clinical, counseling, and school psychologists; substance abuse and behavioral disorder counselors; mental health and substance abuse social workers; mental health counselors; school counselors; and marriage and family therapists. These professions were chosen because they have the largest number of providers within behavioral health care.

<sup>21</sup>HRSA computes the percent of need met by dividing the number of mental health providers available to serve the population of the area, group, or facility by the number of mental health providers necessary to reduce the population-to-provider ratio below the threshold that would allow it to eliminate the designation as a Health Professional Shortage Area for mental health.

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## Covered Consumers Experience Challenges Finding Mental Health Care Because of Limited Access to In-Network Providers and Broader Structural Issues

According to stakeholders we interviewed and reports and research we reviewed, consumers with coverage for mental health care experience challenges related to both limited access to in-network mental health providers and broader structural issues. According to the stakeholders and the literature, these challenges can make it difficult for consumers to find affordable providers that are close to home and to get the care they need when they need it.

### Limited Access to In-Network Providers

Stakeholders we interviewed told us that consumers experience challenges finding in-network providers, forcing them to seek care from out-of-network providers. As a result of these challenges, consumers could face higher health care costs, delays in receiving care, or difficulties in finding a provider close to home.<sup>22</sup> Stakeholders and reports and research we reviewed identified low reimbursement rates and inaccurate provider directory information as key contributors to this challenge.

**Low reimbursement rates affect provider willingness to join networks.** According to 19 of the 29 stakeholder organizations we interviewed, reimbursement rates for mental health service providers contribute to ongoing access issues that covered consumers experienced in finding in-network providers. For example, many—including those representing consumers, health plans, providers, an insurance regulator, and state health agencies—cited low reimbursement rates as a factor contributing to a lack of willingness among some mental health providers to take patients or join a network. Some stakeholder organizations across the spectrum of perspectives also contended that the reimbursement rates paid are not profitable enough to encourage providers to join networks. They explained that mental health providers can often make

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<sup>22</sup>Our review of reports and research on access to mental health care identified similar challenges with mental health provider networks. As one example, a 2019 report found that between 2013 and 2017 consumer out-of-network utilization rates for outpatient services for behavioral health care providers—which includes mental health providers—ranged from 3.0 to 6.1 times higher than for medical and surgical providers. See S. Melek, S. Davenport, and T.J. Gray, *Addiction and Mental Health vs. Physical Health: Widening Disparities in Network Use and Provider Reimbursement* (Milliman, 2019). Another study found that, in 2017, the average in-network cost to the consumer for an adult psychotherapy session—defined as the total amount paid by the patient including deductibles, copayments, and coinsurance—was \$21.33 while the average out-of-network cost for the same service was \$60.15. For more information, see N. Benson and Z. Song, “Prices and Cost Sharing for Psychotherapy In-Network versus Out-of-Network in the United States,” *Health Affairs*, vol. 39, no. 7 (2020).

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more money and still have patients by converting to a self-pay or cash-only practice. Two specific examples cited include the following.

- According to one stakeholder organization representing consumers, many high-performing mental health providers in their state do not accept any form of insurance, and the cash-or-self-pay model may make it difficult for consumers to access these providers because of the cost.
- Another official representing a state health agency told us that psychiatrists who might treat Medicaid patients were incentivized to go to a full cash payment model because the demand for services by consumers willing to pay out-of-pocket was sufficient to support that model.

These points were also supported by reports and research we reviewed. For example, an issue brief by the Legal Action Center on network adequacy standards found that low reimbursement rates for mental health providers contribute to challenges in accessing in-network providers.<sup>23</sup> In addition, the Milliman study found that average in-network reimbursement rates for primary care in 2017 were 23.8 percent higher than for behavioral health visits—which include mental health visits.<sup>24</sup> Further, one study that examined provider participation in networks for plans sold on state marketplaces created by the Patient Protection and Affordable Care Act found that only 21.4 percent of mental health care providers participated in the networks compared to 45.6 percent of primary care providers. The researchers noted that relatively low reimbursement rates for mental health care could be one factor contributing to these differences.<sup>25</sup> Other research that examined children’s access to specialists found that the percentage of psychiatrists that did not accept public or private insurance was greater than the rest of the specialties, such as dermatology or neurology.<sup>26</sup>

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<sup>23</sup>See Legal Action Center, *Spotlight on Network Adequacy Standards for Substance Use Disorders and Mental Health Services* (May 2020).

<sup>24</sup>See Melek, Davenport, and Gray, *Addiction and Mental Health vs. Physical Health*. According to the report, behavioral health visits were defined as: professional office visits, inpatient or residential facility visits, and outpatient and partial hospitalization services.

<sup>25</sup>See J.M. Zhu, Y. Zhang, and D. Polsky, “Networks in ACA Marketplaces Are Narrower for Mental Health Care than for Primary Care,” *Health Affairs*, vol. 36, no. 9 (2017).

<sup>26</sup>See J. Bisgaier and K.V. Rhodes, “Auditing Access to Specialty Care for Children with Public Insurance,” *New England Journal of Medicine*, vol. 364, no. 24 (2011).

The ability to develop a provider network is also exacerbated by the overall health care workforce shortages. For example, 27 of the 29 stakeholder organizations across the spectrum of perspectives—health plans, consumers, providers, state health agencies, and insurance regulators—said that the overall shortage of mental health providers contributes to access challenges for covered consumers, including finding a provider in a consumer’s network. This is because the workforce shortage limits the pool of providers who could join a network. Many stakeholder organizations we interviewed described the workforce shortages as a supply and demand issue. In other words, there were not enough providers to meet the demand for services. In light of this, the existing providers may have more leverage to opt out of networks and receive higher rates for their services.

#### Evaluations of Provider Directories

One study that examined provider directories in three U.S. cities found that 22 percent of the phone numbers listed for psychiatrists who treat adult patients were wrong, and 21 percent of the psychiatrists were not accepting new patients.

In another study that examined provider directories in five U.S. cities and focused on providers who treat children and adolescents, researchers were only able to make appointments with 17 percent of psychiatrists whom they attempted to contact. The most common barrier to scheduling these appointments was that a wrong number was listed in the provider directory.

A third study that examined Medicaid provider directories in the state of Louisiana, and focused on mental health providers who treat children and adolescents, found that the actual number of providers with whom parents were able to schedule appointments was much smaller than the advertised list of providers. For example, of the 2,643 providers listed in the Medicaid directories, only 25.5 percent were seeing new patients.

Sources: GAO review of M. Malowney, S. Keltz, D. Fischer, and J. Boyd, “Availability of Outpatient Care From Psychiatrists: A Simulated-Patient Study in Three U.S. Cities,” *Psychiatric Services*, vol. 66, no. 1 (2015): 94–96; S. Cama et al., “Availability of Outpatient Mental Health Care by Pediatricians and Child Psychiatrists in Five U.S. Cities,” *International Journal of Health Services*, vol. 47, no. 4 (2017): 621–635; and M. Scheeringa, A. Singer, T. Mai, and D. Miron, “Access to Medicaid Providers: Availability of Mental Health Services for Children and Adolescents in Child Welfare in Louisiana,” *Journal of Public Child Welfare*, vol. 14, no. 2 (2020): 161–173. | GAO-22-104597

**Inaccurate provider information makes it difficult to find in-network providers.** Inaccurate or out-of-date information on which mental health providers are in a health plan’s network contributes to ongoing access issues for consumers and may lead consumers to obtain out-of-network care at higher costs to find a provider. Many stakeholder organizations referred to this issue as a “ghost network”—in other words, providers who are listed in a particular provider directory as an in-network provider but are either not taking new patients or are not in a patient’s network—and noted it as a challenge for consumers to access in-network providers. A few specific examples stakeholders cited include the following.

- One stakeholder organization representing providers said that consumers report they are unable to find mental health providers in their network who are accepting new patients.
- Officials representing a state health agency discussed specific challenges that consumers experience in accessing psychiatrists and added that, even if a provider is taking new patients, a consumer may have to wait several weeks or months for an appointment.
- A stakeholder organization representing health plans told us that it was challenging to maintain provider directories due to provider retirements and changes in a provider’s contract or participation in the network.

These challenges are consistent with other recent studies that evaluated consumers’ use of provider directories to schedule outpatient appointments with psychiatrists, which found that inaccurate or out-of-date information affected consumers’ ability to obtain care. (See sidebar.)



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## Broader Structural Issues

Representatives from most of the 29 stakeholder organizations we interviewed identified one or more structural challenges related to the overall infrastructure and capacity of the mental health system. While these broader challenges are not limited to consumers with coverage for mental health care, stakeholders told us they can adversely affect covered consumers' access to providers and facilities that provide mental health care. Our review of reports and research on access to mental health care identified some of the same issues.

### **The overall mental health workforce shortages contribute to constraints on the overall capacity of the mental health care system.**

In addition to contributing to challenges consumers face in finding in-network providers, representatives from 17 of the 29 stakeholder organizations we interviewed indicated that workforce shortages have contributed to constraints on overall capacity of the mental health care system. For example, most state health agencies and providers cited an inability keep up with the demand for mental health services, in some cases because providers are unable to fill open positions. A few specific examples cited include the following.

- Officials from one state health agency indicated that a psychiatrist retired from a hospital in the state, and the hospital has been unable to hire a replacement. As a result, the hospital has had to reduce its capacity to provide inpatient mental health treatment.
- Representatives from one hospital system that provides mental health care told us demand for outpatient psychiatry services is greatly outpacing their ability to supply those services. They noted that they have two outpatient psychiatrist positions they cannot fill and are using nurse practitioners to help provide services. They said they are having even more trouble finding child psychiatrists and are trying to find contracted care to meet the mental health needs of children.
- Representatives at another hospital system that provides mental health care indicated that provider shortages have led to long waiting lists for patients needing inpatient care and a 6-month wait for the hospital's anxiety disorder program.

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The shortage of mental health providers was also cited in some of the reports we reviewed.<sup>27</sup> Some adverse effects to consumers that were identified included delays to treatments and increased wait times.

**Lack of available inpatient beds limits access to inpatient mental health care.** Representatives from 18 of the 29 stakeholder organizations we interviewed, including those representing consumers, providers, and state health agencies, stated that a shortage of available inpatient treatment beds has limited consumers' access to the treatment they need. Some stakeholders attributed the shortage to increased demand for services, budget cuts, or staffing issues, in some cases related to the COVID-19 pandemic. A few specific examples cited include the following.

- Officials from one state health agency indicated that because of budget cuts and related staffing issues, they cannot use nearly one-half of their 400 psychiatric hospital inpatient beds, leading to long waits lists for adults needing care.
- A representative from one hospital system said increased demand had helped create a shortage of mental health inpatient beds, and some patients have been stuck in the emergency department for days until they can access inpatient care.
- Some stakeholders representing providers indicated psychiatric inpatient beds were repurposed for COVID-19-related issues, or that requirements for staff to be vaccinated had created workforce shortages, reducing the number of inpatient beds available.

The lack of available inpatient beds was also cited as a challenge in some of the literature we reviewed. For example, according to a report prepared by the Interdepartmental Serious Mental Illness Coordinating Committee, most states reported insufficient numbers of inpatient psychiatric hospital beds, and, in many areas, bed shortages have led to long delays in gaining access to treatment.<sup>28</sup> In addition, a report prepared by the National Association of State Mental Health Program Directors Research Institute indicated that at least 35 states were experiencing shortages of

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<sup>27</sup>See, for example, Medicaid and CHIP Payment and Access Commission, *Report to Congress on Medicaid and CHIP*, (Washington, D.C.: 2021), and National Council for Mental Wellbeing Medical Director Institute, *The Psychiatric Shortage: Causes and Solutions* (National Council for Mental Wellbeing Medical Director Institute, 2018).

<sup>28</sup>See, Interdepartmental Serious Mental Illness Coordinating Committee, *The Way Forward: Federal Action for a System That Works for All People Living With SMI and SED and Their Families and Caregivers* (2017).

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psychiatric hospital beds, which led to increased waits for beds in state, private, and general hospitals in many of these states.<sup>29</sup>

**Lack of available intermediate treatment facilities can limit access to that level of care when needed.** In addition to the lack of inpatient beds, representatives from many of the stakeholder organizations we interviewed, including those representing consumers, providers, state health agencies, and an insurance regulator indicated that a shortage of intermediate care options such as residential treatment facilities or intensive outpatient programs has created challenges for consumers in getting intermediate levels of care.<sup>30</sup> Similar to the lack of inpatient beds, some stakeholders cited staffing shortages, budget issues, and an increased demand for this level of care as challenges that result in limited or delayed access to care. A few specific examples cited by stakeholders include the following.

- Officials from one state health agency indicated their state has limited capacity to provide residential treatment, and this issue was particularly challenging for children needing such services. As a result, officials said they frequently hear instances of children being stuck in an emergency room at a hospital, unable to access the care they need.
- Representatives from one hospital system that provides mental health care told us that the demand for intensive outpatient treatment programs outpaces the supply in the state, which makes it difficult to access such treatments after discharge from inpatient care.
- A stakeholder at one organization representing consumers added that wait times for intensive outpatient treatment programs can be greater than 18 days in their state.

Challenges in obtaining residential treatment were also identified in some of the reports and research we reviewed. For example, a 2020 report

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<sup>29</sup>See, National Association of State Mental Health Program Directors, *Trend in Psychiatric Inpatient Capacity, United States and Each State, 1974 to 2014*, (Alexandria, Va.: National Association of State Mental Health Program Directors, 2017).

<sup>30</sup>Intermediate levels of care are less intensive than inpatient care, but more intensive than routine outpatient care, and may consist of acute residential treatment, partial hospitalization programs, intensive outpatient programs, and family stabilization services. Residential treatment programs may offer long-term mental health care in a structured, homelike setting, where the patient stays for the duration of the treatment. Intensive outpatient programs provide weekday treatments under which patients can return home each evening.

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prepared for the Wisconsin Department of Health Services found that residential mental health services were one of the most challenging to access due to insurance and cost issues, and the physical distance to facilities.<sup>31</sup> In addition, results of a survey conducted by the National Alliance on Mental Illness found that 27 percent of respondents reported difficulties finding an appropriate residential facility either in or out of their insurance company's network.<sup>32</sup>

**Uneven access to broadband can limit consumers' access to mental health care through telehealth.** Representatives from several stakeholder organizations we interviewed told us that the lack of access to broadband, particularly in rural areas, can limit consumers' ability to use telehealth for mental health services. This may make it more difficult to access mental health services, particularly when in-person treatment is unavailable such as during the COVID-19 pandemic, or when consumers have to travel long distances to see a provider. Some documents we reviewed also identified limitations in use of telehealth or access to broadband for certain patient populations. For example, in a May 2020 issue brief, the Kaiser Family Foundation found access to telemedicine may be particularly challenging for low-income patients and patients in rural areas, who may not have reliable access to the internet through smartphones or computers.<sup>33</sup> In addition, a May 2019 study by the T.H. Chan Harvard School of Public Health showed that 21 percent of rural

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<sup>31</sup>See University of Wisconsin, Population Health Institute, *2019 Wisconsin Behavioral Health Systems Gaps Report* (Madison, Wis.: Prepared for the Wisconsin Department of Health Services, 2020). This report presents results of an assessment of interviews, surveys, and focus groups with a wide range of stakeholder groups with experience in the behavioral health system, including public and private providers, advocates, and consumers.

<sup>32</sup>See National Alliance on Mental Illness, *The Doctor is Out, Continuing Disparities in Access to Mental and Physical Health Care* (Arlington, Va.: National Alliance on Mental Illness, 2017). According to the organization, they are the nation's largest grassroots mental health organization dedicated to building better lives for the millions of Americans affected by mental illness. In 2016, it conducted its third nationwide survey to explore the relationship between health coverage and access to mental health care. This report includes results of that survey.

<sup>33</sup>See G. Weigel et al., *Opportunities and Barriers for Telemedicine in the U.S. During the COVID-19 Emergency and Beyond* (Kaiser Family Foundation, 2020).

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Americans reported that access to high-speed internet is a problem for them or their family.<sup>34</sup>

Despite broadband limitations in some areas, representatives from 21 of the 29 stakeholder organizations we interviewed, including those representing providers, consumers, state health agencies, insurance regulators, and health plans, indicated that enhanced use of telehealth during the pandemic helped improve access to mental health care. In some cases, representatives said that, while demand for mental health services greatly increased during the pandemic, their ability to provide outpatient mental health services through telehealth was a key tool in meeting this increased demand. Some representatives described benefits from telehealth such as patients not having to travel to an in-person appointment during the pandemic and a reduction in appointment no-shows. In lieu of traditional telehealth via a computer or smart phone screen, some stakeholders said they also used “audio-only” so patients only need a phone to conduct the remote visit.

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### Administrative Approval Processes and Plan Coverage Limitations Can Adversely Affect Consumers’ Ability to Access Mental Health Care

#### Health Plans’ Administrative Approval Process

According to stakeholders we interviewed and the reports and research we reviewed, the need to obtain health plans’ approval for certain mental health services, as well as other coverage limitations, can adversely affect access to mental health care. Taken together, these challenges can delay or limit the course of treatments, or in some cases, make treatments unavailable for certain consumers.

Stakeholders representing state health agencies, providers, insurance regulators, and consumers indicated that consumers face challenges accessing the services recommended by providers because of administrative processes for determining whether the services are covered by their health plans. Our review of reports and research on access to mental health care identified some of the same issues.

**Non-quantitative treatment limitations can create challenges in accessing care.** Sixteen of the 29 stakeholder organizations,

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<sup>34</sup>See The Harvard T.H. Chan School of Public Health, *Life in Rural America, Part II* (The Harvard T.H. Chan School of Public Health, 2019). This report was based on a survey and it covers rural Americans’ personal experiences with health, social, civic, and economic issues in their local communities. It was conducted from January 31 to March 2, 2019, among a nationally representative, probability-based telephone (cell and landline) sample of 1,405 adults ages 18 or older living in the rural U.S.

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representing consumers, providers, insurance regulators, and state health agencies cited NQTLs used by health plans, including by private payers or Medicaid, as creating delays in accessing needed treatments or limiting time spent in treatment. For example, representatives from most of these organizations cited health plans' use of prior authorization requirements as a challenge that can delay care. Other stakeholders said plans' processes for determining whether continuing a treatment is medically necessary can limit the duration of consumers' treatment, even if the providers do not agree that the patient is ready for discharge. In some cases stakeholders said that health plans are applying these limits to consumers' mental health benefits in more restrictive ways than to medical and surgical benefits, which highlight ongoing mental health parity issues. A few specific examples cited by stakeholders as potential parity compliance issues include the following.

- Representatives from one health system that provides mental health care said that private health plans and Medicaid were less likely to grant prior authorization for mental health hospital stays compared with medical and surgical hospital stays, and this can delay access to initial mental health treatments.
- Officials from one insurance regulator told us that they reviewed denial rates for inpatient pre-authorizations and found slightly higher denial rates for mental health services compared to medical and surgical benefits. Officials said this can lead to lack of access to treatments.
- Representatives from another health system that provides mental health care indicated that they run into an inpatient insurance issue where the physician determines that additional mental health inpatient treatment is needed, but private health plans and Medicaid managed care plans say that they will not cover inpatient treatment any longer. The representatives said they do not have the same issues regarding inpatient medical or surgical stays.

Some of the reports we reviewed also identified the use of NQTLs by health plans that did not comply with mental health parity standards as presenting a potential challenge to consumers in accessing mental health care. For example, in a September 2020 report, the California Health Care Foundation found that patient and provider representatives expressed frustration over how the lack of compliance by health plans with NQTL parity standards created barriers to covered consumers accessing necessary mental health care, and that this noncompliance

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adversely affected mental health outcomes of patients.<sup>35</sup> The report also noted that California Department of Insurance regulators had found several instances of plans not meeting NQTL parity compliance standards dating back to 2014. Additionally, based on a series of stakeholder interviews, the report also found that among the 22 stakeholders interviewed, there was universal agreement that achieving parity with respect to NQTLs continued to be the dominant challenge health plans encounter in complying with MHPAEA.

#### Wit v. United Behavioral Health

The issues surrounding a lack of uniform standards of care, and how that can affect treatment decisions for mental health care, have been litigated in federal court. On February 28, 2019, a federal court ruled in favor of plaintiffs who alleged they were improperly denied benefits for treatment of mental health and substance use disorders by their health plans. The court noted there was no single source of generally accepted standards of care for mental health and substance use disorder treatment decisions, and, using a variety of existing standards, the court developed a list of standards that are generally accepted in mental health and substance use disorder treatment. The court ruled that the guidelines the health plan's administrator used to make decisions on which treatments it would cover were not consistent with, and were more restrictive than, what the court deemed were generally accepted standards of care. The court also found the guidelines used by the health plan actively sought to move patients to the least restrictive level of care at which they could be safely treated, even if that lower level of care may have been less effective for that patient. The health plan administrator has appealed this case, and it remains on appeal as of February 2022.

Source: GAO review of Wit v. United Behavioral Health, No. 14-cv-02346-JCS, 2019 WL 1033730 (N.D. Cal. 2019). | GAO-22-104597

**Variation in the use of treatment standards can affect covered consumers' access to mental health care.** Representatives from 11 of the 29 stakeholder organizations we interviewed—including those representing consumers, providers, state health agencies, and insurance regulators—indicated that, absent agreed-upon, generally accepted standards of mental health care, it can be difficult for providers and health plans to agree on the treatment a patient may need. This can adversely affect consumers' access to mental health care. Such standards serve as the basis of health care decisions by providers and payers to determine the appropriate level and duration of treatment based on a patient's condition. However, currently there are no agreed-upon single set of standards used in the U.S. to make mental health treatment decisions. Representatives from some of these organizations noted that absent agreed upon standards, health plans may limit a consumer's treatments to those shorter-term treatments. These treatments emphasize stabilizing the consumer's current symptoms rather than more costly intensive treatments that address their underlying conditions. For example, representatives from one provider told us they often feel pressured by health plans to move patients out of hospital-based services to less intensive outpatient treatment. Representatives from another provider said health plans will stop coverage of a patient's treatments once the patient is stable and no longer suicidal even though a provider believes the patient needs continuing care.

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<sup>35</sup>See, J. Volk et al., *Equal Treatment: A Review of Mental Health Parity Enforcement in California* (California Health Care Foundation, 2020). The California Health Care Foundation is dedicated to advancing meaningful, measurable improvements in the way the health care delivery system provides care to the people of California.

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## Payer Coverage Limitations and Restrictions

Several stakeholder organizations representing state health agencies, consumers, providers, and health plans, as well as reports and research we reviewed, identified challenges accessing mental health care faced by consumers with certain forms of coverage. These challenges include private health plans and Medicare not covering certain mental health services as comprehensively as Medicaid and, in other instances, statutory restrictions that preclude some services, facilities, or populations from Medicare or Medicaid coverage.

**Medicare and commercial coverage for certain mental health services may not be as comprehensive as Medicaid.** Representatives from 16 of the 29 stakeholder organizations—including those representing consumers, providers, and state health agencies—and documents that we reviewed contended that the scope of mental health services covered by Medicare and commercial plans is generally more limited than Medicaid. As a result, consumers with Medicare or commercial coverage may not have access to the range of mental health services available to consumers with Medicaid. Many stakeholder organizations cited Medicaid’s coverage of crisis care and peer support as examples where the services were more comprehensive than Medicare and commercial coverage.<sup>36</sup> For example, in Medicare, while there are crisis psychotherapy codes, only certain provider types such as psychiatrists, psychologists, and licensed clinical social workers are currently eligible for reimbursement. These types of providers are not always available at 24/7 crisis stabilization facilities.<sup>37</sup>

Some stakeholder organizations—including those representing consumers, providers, and state health agencies—told us that this gap in coverage may create incentives for individuals with mental illnesses to go

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<sup>36</sup>According to SAMHSA, crisis services may include: crisis telephone lines dispatching support based on the caller’s assessed need, mobile crisis teams dispatched to the community where there is a need (i.e., not in a hospital emergency department), and crisis receiving and stabilization facilities that serve patients from all referral services. SAMHSA also defines peer support services as a range of recovery activities and interactions outside of the clinical setting between people who have shared lived experiences with a mental illness. For more information, see Substance Abuse and Mental Health Services Administration, *Crisis Service Meeting Needs, Saving Lives: National Guidelines for Behavioral Health Crisis Care—A Best Practice Toolkit* (Rockville, Md.: August 2020) and *Who Are Peer Workers?* (Rockville, Md., September 2021).

<sup>37</sup>See K.K. Beronio, *Funding Opportunities for Expanding Crisis Stabilization Systems and Services Technical Assistance Collaborative Paper No. 8* (Arlington, Va.: National Association of State Mental Health Program Directors, September 2021).



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on Medicaid.<sup>38</sup> For example, officials representing a state health agency explained that they have heard anecdotally of children with significant mental health needs being enrolled in Medicaid because their parents' commercial coverage did not include more intensive treatments, such as inpatient psychiatric hospital services.

This gap in Medicare and commercial coverage was also identified in a few documents, as well as in a report and issue brief, that we reviewed.<sup>39</sup> For example, documents from the Kaiser Family Foundation reported that Medicaid coverage of mental health services is often more comprehensive than commercial insurance coverage, and Medicaid is the only source of funding for some specialized behavioral health services.<sup>40</sup>

**Medicaid and Medicare statutory coverage restrictions preclude payment for certain treatments or providers.** Medicaid generally does not cover inpatient mental health care for adults in an Institution for Mental Disease (IMD), which representatives from some stakeholder organizations we spoke with contended may limit consumers' access to inpatient treatments. However, CMS evaluations of the coverage exclusion did not support this contention. Medicaid's IMD exclusion is a long-standing statutory provision that generally prohibits the federal government from providing federal Medicaid funds to states for services rendered to certain Medicaid-eligible individuals, aged 21 through 64, who

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<sup>38</sup>Individuals may qualify for Medicaid coverage through their income or disability status. In 2017, the Kaiser Family Foundation cited that 21 percent of adults and 11 percent of children with behavioral health needs were eligible for Medicaid because of their low income as of 2011. Additionally, among Medicaid beneficiaries with health conditions who do not also qualify for Medicare, 41 percent of adults and 17 percent of children were eligible for Medicaid based on having a disability. For more information, see J. Zur, M.B. Musumei, and R. Garfield, *Medicaid's Role in Financing Behavioral Health Services for Low-Income Individuals* (Kaiser Family Foundation, June 2017).

<sup>39</sup>Substance Abuse and Mental Health Services Administration, *Crisis Service Meeting Needs, Saving Lives: National Guidelines for Behavioral Health Crisis Care—A Best Practice Toolkit* (Rockville, Md.: August 2020); K. Cannon, J. Burton, and M.B. Musumei, *Adult Behavioral Health Benefits and the Marketplace* (Kaiser Family Foundation, June 2015).

<sup>40</sup>See Zur, Musumei, and Garfield, *Medicaid's Role in Financing Behavioral Health Services*; and Kaiser Family Foundation, *Facilitating Access to Mental Health Services: A Look at Medicaid, Private Insurance, and the Uninsured* (Kaiser Family Foundation, June 2017).

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are patients in IMDs.<sup>41</sup> In 2017, we reported that, in addition to encouraging treatment in small community-based group living arrangements, the IMD exclusion was intended to ensure that states, and not the federal government, are primarily responsible for funding inpatient and residential behavioral health services.<sup>42</sup>

In response to stakeholder concerns about the limited availability of publicly funded inpatient psychiatric beds and the fairness of the IMD exclusion, CMS used a demonstration to test the extent to which reimbursing IMDs improved access to and quality of inpatient psychiatric care for Medicaid beneficiaries. Two separate analyses of this demonstration by the agency found little to no evidence that the IMD coverage exclusion affected access to or length of inpatient stays and emergency department use. In addition, CMS may approve demonstrations under its section 1115 authority to allow states to receive federal Medicaid funds for services provided to individuals who are patients in IMDs.<sup>43</sup> Stakeholders representing a provider and a state health agency we spoke with indicated they may assist Medicaid patients by trying to get local county facilities to provide care or work to obtain waivers from CMS so that their state's Medicaid program can more generally cover these consumers.

There are also statutory exclusions within Medicare's mental health coverage that, according to some stakeholders and reports we reviewed, can affect access to care. First, some stakeholder organizations told us

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<sup>41</sup>42 U.S.C. § 1396d(a)(30)(b). The term "institution for mental disease" means a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services." 42 U.S.C. § 1396d(i). For children and youth under age 21, only services delivered in a psychiatric residential treatment facility, a psychiatric hospital, or a psychiatric unit of a general hospital are exempted from the Medicaid IMD exclusion. 42 U.S.C. § 1396d(a)(16), (h)(1). In addition, between fiscal years 2019 and 2023, states have the option to provide medical assistance for certain individuals who are patients in certain IMDs, subject to various requirements, including that the stay not exceed 30 days during a 12-month period. 42 U.S.C. § 1396n(l). 42 U.S.C. § 1396d(a)(30)(b).

<sup>42</sup>See GAO, *Medicaid: States Fund Services for Adults in Institutions for Mental Disease Using a Variety of Strategies*, [GAO-17-652](#) (Washington, D.C.: Aug. 9, 2017).

<sup>43</sup>Section 1115 of the Social Security Act gives the Secretary of HHS authority to waive certain federal Medicaid requirements and allow costs that would not otherwise be eligible for federal funds for experimental, pilot, or demonstrations that promote the objectives of the Medicaid program. Demonstrations are granted (or renewed) for 3- or 5-year periods and are administered by CMS.

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### Statutory Exclusions within Medicare Mental Health Coverage

According to the Centers for Medicare & Medicaid Services (CMS), there is no separately enumerated benefit category under Medicare that provides coverage and payment for the services of licensed professional counselors. However, while Medicare does not provide direct payment for the services of licensed professional counselors and licensed marriage and family therapists, it can help pay for family counseling under its original fee-for-service plan if the goal of the therapy is related to the beneficiary's treatment. In addition, grief and loss counseling may be covered by Medicare for qualified hospice patients and their families, if it is provided by a Medicare-approved hospice and available in that state. Additionally, Medicare does not cover other types of relationship counseling, such as marriage counseling. Such services are covered only when the mental health services are furnished by a licensed psychiatrist, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, certified nurse-midwife, or physician assistant eligible for Medicare reimbursement.

Another government health program—the Veterans Health Administration—has expanded the types of mental health professional available to veterans and, since 2010, has made an effort to increase its hiring of licensed professional counselors and marriage and family therapists.

Source: CMS officials and GAO | GAO-22-104597

that Medicare restrictions on the types of providers eligible for reimbursement, including Licensed Professional Counselors and Licensed Marriage and Family Therapists, affects access to mental health services for Medicare enrollees by limiting the pool of accessible providers. For example, representatives from one health system told us that, of the 22 licensed therapists on staff, only three were the types of licensed providers that are eligible for Medicare reimbursement. The representatives said this limitation exacerbated their current capacity issues, as they had over 1,700 patients on a waiting list to see an outpatient provider.

In addition, some reports and issue briefs we reviewed, and some stakeholders we spoke with, highlighted the fact that Medicare has a lifetime limit for enrollees of 190 days of inpatient care in psychiatric hospitals. According to some stakeholders representing consumers and providers, this limit creates barriers and disruptions to care for people with serious mental illnesses who may need more inpatient care. Some of these stakeholders also noted that Medicare does not have any lifetime limits on any other specialty inpatient hospital service, and so this rule treats mental health differently than other care. Finally, some stakeholders we spoke with and CMS officials said that MHPAEA's parity requirements do not apply to Medicare. Some consumer groups indicated this exclusion can result in more restrictive limits on access to mental health care for consumers with Medicare coverage, such as the 190-day lifetime limit on inpatient psychiatric care.

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## Federal Efforts May Address Aspects of the Access Challenges Experienced by Covered Consumers

### Addressing Limited Access to Providers and Finding In-Network Care

Based on our interviews with agency officials and reviews of agency documentation, we identified various ongoing or planned efforts at CMS, DOL, HRSA, and SAMHSA to address some of the challenges consumers with coverage may experience accessing mental health care. These efforts aim to address challenges related to finding in-network providers, broader structural issues, and health plan administrative approval processes.

CMS and DOL officials told us they have ongoing and planned efforts that may help address some of the challenges consumers experience gaining access to in-network providers. Additionally, HRSA sponsors several

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programs that provide funding intended to increase the mental health workforce.

**Ongoing and planned efforts regarding access to in-network providers.** As part of CMS's ongoing efforts to ensure consumer access to mental health providers, CMS officials told us that the agency requires Medicare Advantage plans to meet a number of network adequacy criteria, including criteria pertaining to the number and availability of mental health providers.<sup>44</sup> For example, the agency requires plans to demonstrate that plan networks do not unduly burden beneficiaries in terms of travel time and distance to network providers or facilities that include inpatient psychiatric facility services and psychiatric services.<sup>45</sup>

Additionally, to help state Medicaid agencies and the managed care plans with which they contract meet the network adequacy requirements for behavioral health care providers, CMS published *Promoting Access in Medicaid and CHIP Managed Care: Behavioral Health Provider Network Adequacy Toolkit* in June 2021.<sup>46</sup> Specifically, CMS told us that this toolkit highlights promising practices and strategies implemented by state Medicaid agencies and managed care plans. For example, the toolkit highlights strategies to take full advantage of the existing workforce, expand the supply of behavioral health providers and increase their

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<sup>44</sup>Within the Medicare program, eligible consumers have the option to obtain coverage through its original fee-for-service plan or through one of its Medicare Advantage plans—private plan alternatives to the original option. CMS officials said the agency requires that these plans contract with a sufficient number of providers and facilities to ensure that 85 percent of beneficiaries reside within CMS's time and distance standards for micro and rural counties, as well as counties with extreme access considerations. Similarly, at least 90 percent of plans' beneficiaries must reside within time and distance standards for metro and large metro counties. The quantitative criteria take into account differences in utilization across provider and facility types and patterns of care in urban and rural areas.

<sup>45</sup>In a 2015 GAO review, we recommended that CMS should augment oversight of Medicare Advantage networks to address provider availability, verify provider information submitted by Medicare Advantage organizations, conduct more periodic reviews of network information, and set minimum information requirements for enrollee notification letters. As of February 2022, three of the four recommendations remained open. See GAO, *Medicare Advantage: Actions Needed to Enhance CMS Oversight of Provider Network Adequacy*, [GAO-15-710](#) (Washington, D.C.: Aug. 2015).

<sup>46</sup>Similar to private plan options in Medicare, within the Medicaid program states may contract with private organizations that operate Medicaid managed care plans. See L. Horner et al., *Promoting Access in Medicaid and CHIP Managed Care: Behavioral Health Provider Network Adequacy Toolkit* (Baltimore, Md.: Centers for Medicare & Medicaid Services, June 2021). For purposes of this report, behavioral health care is equivalent to mental health care.

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participation in managed care networks, and design and oversight of network adequacy standards.

CMS also has plans for addressing the adequacy of provider networks for health plans sold through health insurance exchanges. Specifically, CMS told us that the agency will implement federal network adequacy reviews starting in Plan Year 2023.<sup>47</sup> CMS officials said that these reviews were deferred to states for completion for Plan Years 2018 through 2022. In January 2022, as part of the Notice of Benefit and Payment Parameters for 2023 Proposed Rule (which, as of March 2022, is not yet final), CMS proposed conducting network adequacy reviews in all federally facilitated exchanges using time and distance standards and appointment wait time standards that would be detailed in future guidance.

DOL also plans to make issues related to network adequacy a focus of its near-term enforcement activities. Specifically, in an April 2021 frequently asked questions document, DOL identified standards for provider admission to participate in a network (including reimbursement rates) and out-of-network reimbursement rates (including plan methods for determining usual, customary, and reasonable charges) as a focus of the DOL's NQTL enforcement efforts.<sup>48</sup>

**Requirements to update and maintain provider directories.** DOL, HHS, and the Treasury Department are taking steps to improve oversight of the accuracy of provider directories for group health plans and issuers offering group or individual coverage. These steps are being implemented in response to provisions in the Consolidated Appropriations Act, 2021 (CAA), which requires plans to update and maintain provider directories and limit consumer cost sharing for out-of-network care.<sup>49</sup> These provisions generally require the plans to establish a process to update and verify the accuracy of provider directory information and to establish

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<sup>47</sup>CMS officials told us these reviews are being implemented pursuant to the *City of Columbus v. Cochran* decision. In this decision, a U.S. district court struck down four provisions of the HHS Notice of Benefit and Payment Parameters for 2019, including the notice's removal of the federal government's responsibility to ensure plans offered on federally facilitated exchanges offer adequate provider networks, which the court determined was arbitrary and capricious under the Administrative Procedure Act. 523 F.Supp. 3d 731 (D.Md. 2021).

<sup>48</sup>Usual, customary, and reasonable charges are defined as the amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service.

<sup>49</sup>Pub. L. No. 116-260, § 116, 134 Stat. 1182, 2878 (2020).

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a protocol for responding to requests from enrollees about a provider's network participation status. They also require limitations on cost sharing amounts for consumers who use out-of-network providers because of inaccurate provider information. An August 2021 frequently asked questions document jointly prepared by DOL, HHS, and Treasury said that plans and issuers are expected to implement these provisions using a good faith interpretation of the statute by January 1, 2022, but the Departments intend to undertake rulemaking in the future. As of February 2022, neither DOL nor CMS had additional information to share about their efforts related to this new requirement.

**Programs to address shortages of mental health providers.** HRSA sponsors several programs that provide funding intended to increase the mental health workforce in response to projection models showing shortages of certain occupations.<sup>50</sup> Some of the key programs include the following.

- The Behavioral Health Workforce Education and Training Program. According to HRSA documentation, the purpose of this program is to increase the supply of behavioral health professionals while also improving distribution of a quality behavioral health workforce. This is achieved by increasing access to behavioral health services through the awarding of grants to organizations that train graduate level students of social work, psychology, and other behavioral and mental health disciplines to work with vulnerable populations, particularly children, adolescents and transitional-aged youth at risk for behavioral health disorders. According to HRSA, for academic years 2014 through 2020, program awardees have supported the clinical training of 20,322 graduate-level social workers, psychologists, school and clinical counselors, psychiatric nurse practitioners, marriage and family therapists, and other behavioral health professionals, including community health workers and substance use and addiction workers. Additionally, according to HRSA, in its first 5 years the program has reduced the projected shortage of these types of professionals by 27 percent—from what was a projected shortfall of more than 41,000 full-time equivalent positions to what is now a projected shortfall of about 30,000.

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<sup>50</sup>A forthcoming GAO report will further examine what is known about the size and characteristics of the behavioral health workforce, federal efforts to collect and make available this information, barriers to and incentives for recruiting and retaining behavioral health providers, and actions HHS agencies are taking to address such barriers.

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- Graduate Psychology Education Program. The purpose of this program is to train doctoral health service psychology students, interns, and post-doctoral residents in integrated, interdisciplinary behavioral health for placement into community-based primary care settings in high need and high demand areas, according to HRSA documentation. The program also supports faculty development in health service psychology, which is defined by the American Psychological Association as the integration of psychological science and practice in order to facilitate human development and functioning.<sup>51</sup>

## Addressing Broader Structural Issues

**Programs to increase system capacity.** SAMHSA has several efforts underway aimed at addressing aspects of the broader structural issues that contribute to a lack of capacity in the mental health system. For example, SAMHSA currently funds 12 grants designed to establish or expand Assertive Community Treatment programs.<sup>52</sup> According to SAMHSA officials, the Assertive Community Treatment team model comprises 10 to 12 multi-disciplinary behavioral health care staff who work together to deliver a mix of individualized, recovery-oriented services to persons living with serious mental illness to help them successfully integrate into the community. Team members provide the comprehensive array of services directly, rather than through referrals, with approximately one staff member for every 10 individuals served. Services, including crisis services, are provided 24 hours, 7 days a week, and can be provided for as long as needed and where needed. Assertive Community Treatment teams aim to anticipate and avoid crises but can provide a timely crisis response. Although no formal evaluation of this program has been conducted, SAMHSA officials said that data reported by grantees suggests that the program has been effective at providing a reduction in the need for higher levels of care and providing greater consumer stability. For example, SAMHSA officials noted that data

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<sup>51</sup>Health service psychologists are licensed practitioners who provide preventive, consultative, assessment, and treatment services in a broad range of settings, including independent or group practice, multidisciplinary clinics, counseling centers, or hospitals. Health service psychologists differ from health psychologists in that their practice is not confined to the treatment of problems associated with physical health or wellbeing and differ from other specialties in that their services are delivered in the context of the doctor/patient relationship, rather than fields such as forensic psychology.

<sup>52</sup>According to 2019 SAMHSA data, assertive community treatment was offered by approximately 14 percent of all mental health treatment facilities (1,724 of 12,472). See Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, *National Mental Health Services Survey* (2019).

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### Certified Community Behavioral Health Clinics

The Protecting Access to Medicare Act of 2014 authorized Medicaid demonstration programs in up to eight states to improve community behavioral health services by establishing and evaluating certified community behavioral health clinics (CCBHC). In December 2016, the Department of Health and Human Services selected Minnesota, Missouri, Nevada, New Jersey, New York, Oklahoma, Oregon, and Pennsylvania to participate in the demonstration from among the 24 states that received planning grants from the Substance Abuse and Mental Health Services Administration (SAMHSA). CCBHCs provide comprehensive, integrated mental health services to individuals in need and receive an enhanced Medicaid reimbursement rate in order to cover the cost of expanding resources to serve clients with complex needs. CCBHCs provide or contract nine types of services, including 24 hours a day, 7 days a week crisis care, evidence-based practices in the treatment of mental and substance abuse disorders, and coordinated care between primary care, hospital facilities, and physical health integration. In 2020, two new states—Kentucky and Michigan—were selected as expansion states for this demonstration program, while Pennsylvania left the program.

Source: SAMHSA officials and GAO review of law and agency documentation. | GAO-22-104597

reported by grantees indicated that about 5 percent of Assertive Community Treatment program participants reported spending at least 1 day in the emergency department for a mental health problem in the past 30 days at the 6-month reassessment compared to about 13 percent of participants reporting this at intake into the program.

SAMHSA also currently oversees the Certified Community Behavioral Health Clinics (CCBHC) expansion grant program, which builds upon a Medicaid demonstration program to improve community behavioral health services by establishing CCBHCs (see sidebar). Clinics that meet certain requirements are eligible to receive CCBHC expansion grant funding.<sup>53</sup> SAMHSA officials reported that there are 401 active expansion grants that served 145,495 individuals in fiscal year 2021, and told us that data reported by grantees suggests that the program has been effective in improving outcomes. Specifically, in areas with CCBHCs, from patient baseline to 6-month reassessments, hospitalizations for mental health care decreased by approximately 73 percent, visits to emergency departments for a behavioral health issue decreased by approximately 69 percent, and stable employment increased by 14 percent. SAMHSA officials told us they are currently working with the HHS Office of the

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<sup>53</sup>The Protecting Access to Medicare Act of 2014 specifies criteria for certified community behavioral health clinics to participate in demonstration programs, including: 1) staffing; 2) availability and accessibility of services; 3) care coordination; 4) scope of services; 5) quality and other reporting; and 6) organizational authority. Pub. L. No. 113-93, § 223, 128 Stat. 1040, 1077–83. Additionally, CCBHCs must provide or contract nine types of services, including: 1) crisis mental health services, including 24-hour mobile crisis teams, emergency crisis intervention, and crisis stabilization; 2) screening, assessment, and diagnosis; 3) patient-centered treatment planning; 4) outpatient mental health and substance use disorder services; 5) primary care screening and monitoring; 6) targeted case management; 7) psychiatric rehabilitation services; 8) peer support services and family support services; and 9) services for members of the armed services and veterans.



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Assistant Secretary for Planning and Evaluation to create an evaluation design for the CCBHC expansion grant program.<sup>54</sup>

**CMS actions to enhance access to mental health care through telehealth.** In order to maintain improved access to mental health services, CMS recently extended telehealth flexibilities that were first implemented in response to the COVID-19 pandemic, as required by law. Specifically, in response to the CAA, CMS, in its 2022 Medicare physician fee schedule final rule, made several changes intended to promote greater use of telehealth in providing mental health services, including the removal of geographic restrictions and the addition of the home of the beneficiary as a permissible originating site for telehealth services furnished for the purposes of diagnosis, evaluation, or treatment of a mental health disorder.<sup>55</sup> CMS also amended the definition of an interactive telecommunications system for telehealth services to include audio-only communications technology when used for telehealth services for the diagnosis, evaluation, or treatment of mental health disorders, furnished to established patients in their homes and under certain circumstances.<sup>56</sup>

CMS officials also said that the agency published toolkits for Medicaid and private insurance plans regarding considerations for the use of

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<sup>54</sup>In May 2021, we found that data limitations complicated—and will continue to affect—HHS’s efforts to assess the effectiveness of the CCBHC Medicaid demonstration. For example, we found limitations related to a lack of baseline data, a lack of comparison groups, and a lack of detail on Medicaid encounters. Additionally, we found that HHS’s decisions in implementing the demonstration also complicated its assessment efforts. HHS allowed states to identify different program goals and target populations, and to cover different services. However, HHS did not require states to use standard billing codes and billing code modifiers it developed. The lack of standardization across states limited HHS’s ability to assess changes in a uniform way. See GAO, *Medicaid: HHS’s Preliminary Analyses Offer Incomplete Picture of Behavioral Health Demonstration’s Effectiveness*, [GAO-21-394](#) (Washington, D.C.: May 2021).

<sup>55</sup>Pub. L. No. 116-260, div. CC, § 123, 134 Stat. at 2956 (2020); 86 Fed. Reg. 64,996, 65,666 (Nov. 19, 2021) (to be codified at 42 C.F.R. § 410.78(b)(3)(xiv)).

<sup>56</sup>Under this amendment, CMS has limited the use of an audio-only interactive telecommunications system to mental health services furnished by practitioners who have the capability to furnish two-way, audio/video communications, but where the beneficiary is not capable of, or does not consent to, the use of two-way, audio/video technology. CMS also finalized a requirement for the use of a new modifier for services furnished using audio-only communications, which would serve to verify that the practitioner had the capability to provide two-way audio/video technology but instead, used audio-only technology due to beneficiary choice or limitations. 86 Fed. Reg. 64,996, 65,666 (Nov. 19, 2021) (to be codified at 42 C.F.R. § 410.78(a)(3)).

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Addressing Administrative  
Approval Processes

telehealth during the COVID-19 pandemic. For example, CMS's Medicaid toolkits provided states with information to consider as they evaluate the need to expand their telehealth capabilities and coverage policies with a section dedicated to telehealth coverage for pediatric behavioral health services.

**Improving access through enhanced oversight of NQTLs.** Within their parity oversight responsibilities, DOL and HHS are taking steps to enhance their oversight of the use of NQTLs in mental health coverage, which, according to these officials, could improve access to mental health care. These steps are being taken, in part, to meet requirements specified in the CAA.<sup>57</sup> The CAA requires group health plans and issuers that cover both medical and surgical and mental health and substance use disorder benefits to perform and document comparative analyses of the design and application of NQTLs and to make these analyses available to DOL and HHS upon request.<sup>58</sup> The law also requires that DOL and CMS request not fewer than 20 of these analyses per year.

Before the CAA, according to DOL and HHS in their *2022 MHPAEA Report to Congress*, MHPAEA did not explicitly state how plans or issuers were to demonstrate and document that they were ensuring compliance with the rules regarding NQTLs—although group health plans and issuers were prohibited from imposing limits on mental health coverage that did not comply with parity requirements.<sup>59</sup> The Departments noted that this served as a roadblock to obtaining compliance and ensuring that individuals received the mental health benefits to which they were entitled. In response to the CAA, DOL reported that it has redesigned its NQTL enforcement strategy and committed new resources to its MHPAEA enforcement efforts. Similarly, CMS reported that it has dedicated a team of analysts focused on conducting NQTL comparative analysis reviews as part of its efforts to use this new authority to enhance its enforcement of MHPAEA requirements and advance mental health parity. The *2022 MHPAEA Report to Congress* outlined the results of the

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<sup>57</sup>Pub. L. 116-260, § 203, 134 Stat. at 2900 (2020).

<sup>58</sup>Pub. L. 116-260, § 203, 134 Stat. at 2900 (2020).

<sup>59</sup>See Department of Health and Human Services, Department of Labor, and Department of the Treasury, *2022 MHPAEA Report to Congress* (Washington, D.C.: January 25, 2022).

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first year enforcing these new requirements.<sup>60</sup> Specifically, the report noted that DOL had issued 30 initial determination letters finding 48 NQTLs lacking parity, and CMS had issued 15 initial determination letters to plans and issuers finding 16 NTQLs out of parity. In response, 26 plans and issuers so far have agreed to make prospective changes to their plans.

Despite DOL's new authority to request NQTL analyses from health plans, DOL officials told us that its current enforcement authorities may not serve as a strong deterrent for health plan violations of MHPAEA. Specifically, according to officials, DOL is limited to seeking equitable relief in cases where they find violations of MHPAEA. This means that DOL currently is limited to recovering the benefit to which a consumer was entitled. To implement more meaningful penalties for parity non-compliance and to incentivize compliance, in the *2022 MHPAEA Report to Congress* DOL recommended that Congress amend the Employee Retirement Income Security Act of 1974 to provide DOL the authority to assess civil monetary penalties for MHPAEA violations. Additionally, DOL recommended that Congress provide the Department authority to directly pursue parity violations by entities that provide administrative services to group health plans (including issuers and third-party administrators).

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## Agency Comments

We provided a draft of this report to DOL and HHS for review and comment. Both DOL and HHS provided technical comments, which we incorporated as appropriate.

As agreed with your office, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days from the report date. At that time, the report will be available at no charge on the GAO website at <https://www.gao.gov>.

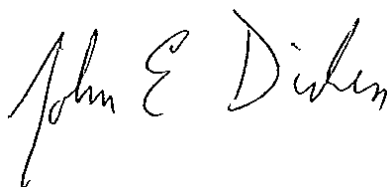
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<sup>60</sup>CMS requested 21 comparative analyses from four non-governmental plans and from nine issuers in states where CMS is the primary MHPAEA enforcer (Missouri, Texas, and Wyoming), while DOL sent 156 letters to plans and issuers. According to the report, none of the comparative analyses reviewed by CMS and DOL contained sufficient information upon initial submission. The report noted several common themes in the submission deficiencies, including a lack of a meaningful comparison or analysis or a failure to identify or provide sufficient detail about the various factors underlying an NQTL's application. DOL officials told us that factors that are not specifically defined, especially those with a quantitative quality, are difficult to compare without a level of specificity. In these cases, DOL sent letters to the plans asking for more detail, which has been a lengthy process, according to DOL officials.

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If you or your staff members have any questions about this report, please contact me at (202) 512-7114 or [dickenj@gao.gov](mailto:dickenj@gao.gov). Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made major contributions to this report are listed in appendix I.

Sincerely yours,

A handwritten signature in black ink that reads "John E. Dicken". The signature is written in a cursive style with a large, stylized "J" and "D".

John E. Dicken  
Director, Health Care

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# Appendix I: GAO Contact and Staff Acknowledgments

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## GAO Contact

John E. Dicken, (202) 512-7114 or at [dickenj@gao.gov](mailto:dickenj@gao.gov)

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## Staff Acknowledgments

In addition to the contact named above, Gerardine Brennan (Assistant Director), Nick Bartine (Analyst-in-Charge), Taylore Fox, Randi Hall, and David Lichtenfeld made key contributions to this report. Also contributing were Sonia Chakrabarty, Laurie Pachter, and Amber Sinclair.

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# Related GAO Products

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*Behavioral Health and COVID-19: Higher-Risk Populations and Related Federal Relief Funding.* [GAO-22-104437](#). Washington, D.C.: December 10, 2021.

*Medicaid: HHS's Preliminary Analyses Offer Incomplete Picture of Behavioral Health Demonstration's Effectiveness.* [GAO-21-394](#). Washington, D.C.: May 17, 2021.

*Behavioral Health: Patient Access, Provider Claims Payment, and Effect of COVID-19 Pandemic.* [GAO-21-437R](#). Washington, D.C.: March 31, 2021.

*COVID-19: Urgent Actions Needed to Better Ensure an Effective Federal Response.* [GAO-21-191](#). Washington, D.C.: November 30, 2020.

*Mental Health and Substance Use: State and Federal Oversight of Compliance with Parity Requirements Varies.* [GAO-20-150](#). Washington, D.C.: December 13, 2019.

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