U.S. Department of Health and Human Services
Office of the Assistant Secretary for Planning and Evaluation
Office of Behavioral Health, Disability, and Aging Policy

NETWORK ADEQUACY FOR BEHAVIORAL HEALTH:

EXISTING STANDARDS AND CONSIDERATIONS FOR DESIGNING

November 2021

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The Assistant Secretary for Planning and Evaluation (ASPE) advises the Secretary of the U.S. Department of Health and Human Services (HHS) on policy development in health, disability, human services, data, and science; and provides advice and analysis on economic policy. ASPE leads special initiatives; coordinates the Department's evaluation, research, and demonstration activities; and manages cross-Department planning activities such as strategic planning, legislative planning, and review of regulations. Integral to this role, ASPE conducts research and evaluation studies; develops policy analyses; and estimates the cost and benefits of policy alternatives under consideration by the Department or Congress.

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NOTE: BHDAP was previously known as the Office of Disability, Aging, and Long-Term Care Policy (DALTCP). Only our office name has changed, not our mission, portfolio, or policy focus.

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NETWORK ADEQUACY FOR BEHAVIORAL HEAL:
Existing Standards and Considerations for Designing Standards

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ACRONYMS

The following acronyms are mentioned in this report and/or appendices.

ACA	Affordable Care Act
ASPE	HHS Office of the Assistant Secretary for Planning and Evaluation
CFR	Code of Federal Regulations
CHIP	Children's Health Insurance Program
CMS	HHS Centers for Medicare & Medicaid Services
ECP	Essential Community Provider
HHS	U.S. Department of Health and Human Services
MAO	Medicare Advantage Organization
MAT	Medication Assisted Treatment
NAIC	National Association of Insurance Commissioners
NCQA	National Committee for Quality Assurance
OB/GYN	Obstetrics and Gynecology
OIG	HHS Office of Inspector General
PFFS	Private Fee-For-Service
QHP	Qualified Health Plan
SED	Serious Emotional Disturbance
SMI	Serious Mental Illness
SSA	Social Security Act
SUD	Substance Use Disorder
TEP	Technical Expert Panel

EXECUTIVE SUMMARY

Network adequacy is often defined as having enough providers within a health plan network to ensure reasonable and timely access to care. At a minimum, health plans should include a sufficient number of providers who deliver mental health and substance use disorder (SUD) services (collectively referred to in this report as behavioral health services) to support access to those services. Beyond a minimum number of providers, adequate networks should have an appropriate geographic distribution of providers who have the capacity to deliver a wide range of services that align with enrollees' needs. State and federal network adequacy requirements exist, but many consumers face barriers to accessing behavioral health services because networks do not have enough providers who offer the services they need (Zhu et al. 2017; Cama et al. 2017).

To better understand network adequacy standards for behavioral health and best practices in developing and enforcing such standards, the Office of the Assistant Secretary for Planning and Evaluation (ASPE) at the U.S. Department of Health and Human Services (HHS) contracted with Mathematica to conduct a targeted environmental scan and convene a technical expert panel (TEP).

Methods

The environmental scan was a targeted search focused on publicly available standards published within the past 10 years and on standards specific to behavioral health in the Medicare Advantage, Medicaid managed care, and commercial insurance markets. We also searched for network adequacy monitoring and enforcement practices. We reviewed a sample of federal and state laws and regulations, state Medicaid managed care contracts, and summary reports from standard-setting bodies and organizations. We also reviewed gray and published literature.

The TEP included 13 panelists representing a variety of behavioral health organizations, state and federal agencies, and other stakeholders. We facilitated two separate virtual meetings of the TEP, in June and July 2020. We sought input from the TEP on: (1) whether more specific behavioral health network adequacy standards are needed; (2) which types of network adequacy standards best facilitate access to behavioral health care; (3) which providers, services, and measures should be included in behavioral health network adequacy standards; (4) how standards should be adapted to reflect the characteristics of communities; and (5) how states and the Federal Government should enforce network adequacy requirements for behavioral health providers.

Existing Network Adequacy Standards for Behavioral Health

Our environmental scan found that standards specific to behavioral health typically include only a small number of provider types, such as psychiatrists or certain types of SUD treatment facilities, relative to the overall number of behavioral health providers and services. This is true for all three markets. For Medicare Advantage organizations (MAOs), network adequacy standards are defined at the federal level and include standards specific to a single behavioral health provider type and a single behavioral health facility type. Likewise, state standards for Medicaid and commercial behavioral health providers typically specify a handful of provider types. We also found that states with specific standards for behavioral health usually specify providers or settings, rather than behavioral health services such as alcohol and drug rehabilitation or Assertive Community Treatment. There are, however, exceptions. For example, both Kansas and New Mexico include a long list of behavioral health providers and services. Most states with standards specific to behavioral health define time and distance standards, but some states include other

quantitative standards, such as maximum appointment wait times or provider or bed ratios. Washington is an exception, with a complex set of qualitative standards and requirements specific to behavioral health.

Considerations for Designing Network Adequacy Standards for Behavioral Health

The TEP did not make specific recommendations for network adequacy standards and requirements, such as a specific ratio of health plan enrollees to behavioral health providers. Instead, panelists focused on the underlying challenges with network adequacy and recommended considerations and principles that should guide the design of additional standards.

The panelists highlighted several underlying causes of inadequate behavioral health networks that warrant further attention from plans, regulators, and policymakers. These include workforce shortages, low reimbursement rates, plans' contracting and credentialing practices, and licensing and scope-of-practice restrictions. For example, panelists noted that some behavioral health providers can maintain a full panel of private-pay clients who pay cash rates that are often much higher than the rates paid by health plans. As another example, some panelists identified that some behavioral health providers find the credentialing process required to join a network time-consuming and burdensome; one panelist reported hearing from providers that credentialing for therapists is more difficult than for medical-surgical providers. Other challenges for designing network adequacy standards are gaps in the available data on provider availability and treatment needs and variation in the definitions of some behavioral health providers across states. Analyzing utilization data or conducting secret shopper surveys could generate more complete data on provider availability.

Panelists also identified a number of principles for designing network adequacy standards. Some of these principles are applicable to physical health providers but are especially important in the behavioral health context. These include the importance of: (1) accounting for provider willingness and capacity to provide certain services; (2) accounting for the number of contracted providers by geographic area; and (3) defining the right number and location of specific types of providers relative to community characteristics, client preferences and patterns of care, and population needs. Understanding provider availability relative to treatment need may be particularly important in behavioral health given workforce shortages and the need to understand which providers provide specific services.

Other principles relate to the unique characteristics of behavioral health providers and services. Panelists recommended that network adequacy standards support access to team-based and integrated models of care, given their importance in provision of behavioral health services. For example, services such as peer bridger programs and Assertive Community Treatment rely on multidisciplinary teams. Standards should require that networks include every member of these teams or directly contract for the service (rather than the individual providers). Panelists also recommended that standards specify certain high-priority behavioral health provider and service types, and account for the interplay between network design and mental health and SUD service parity laws.

Finally, panelists recommended using a layered approach to setting standards. For example, combining qualitative and quantitative standards can help plans and regulators adapt networks to local contexts, respond to access problems in a flexible way, and ensure access to high-priority providers and services. In addition, panelists discussed the need to include telehealth when developing network adequacy standards, particularly in the context of the COVID-19 public health emergency. Federal regulators have already begun to adapt network adequacy standards to reflect more widespread use of telehealth, but panelists noted the need to further define how telehealth contributes to meeting network adequacy standards for different types of behavioral health services.

Monitoring and Enforcement of Network Adequacy Standards for Behavioral Health

Panelists emphasized that monitoring access and network adequacy is at least as important as improving standards. If the ideal standard design is not apparent, regulators should consider focusing their efforts on improving initial standards over time by monitoring access to care with both proactive and reactive monitoring strategies. There was little consensus among panelists on the best monitoring methods, but the effectiveness of different strategies may vary depending upon the combination of methods used and the nature of the network adequacy problems that regulators intend to address. Some regulators primarily rely on reactive strategies that address problems as they arise, as indicated by metrics such as consumer complaints, while others combine reactive strategies with proactive reviews of information at different points in the life cycle of health plan contracts to identify problems before an indication that there are any.

Limitations and Findings of This Project Point to Multiple Avenues for Further Research

This report is based on a targeted rather than exhaustive scan of existing standards and on expert opinion. A systematic comparison of physical health and behavioral health standards by state and market could suggest ways to improve standards in some states. Other potential avenues for further research include: (1) studying the relationship between network adequacy standards for behavioral health and access to behavioral health care; (2) analyzing claims and encounter data to understand the differences between contracted and available providers; (3) using predictive models to understand how many providers of certain types are necessary to avoid triggering access problems; and (4) assessing how different types of behavioral health consumers have experienced telehealth services during the pandemic.

Finally, while this report largely focuses on how network adequacy standards can account for service availability and ensure access to care, more attention may be needed to other dimensions of access such as acceptability and affordability (Penchansky and Thomas 1981).

I.   INTRODUCTION

Network adequacy is often defined as having enough providers within a health plan network to ensure reasonable and timely access to care. At a minimum, health plans must include a sufficient number of providers who deliver mental health and SUD services (collectively referred to in this report as behavioral health services) to support access to those services. Beyond a minimum number of providers, adequate networks must have an appropriate geographic distribution of providers who have the capacity to deliver a wide range of services that align with enrollees' needs.

Although state and federal network adequacy requirements exist, many consumers face barriers to accessing behavioral health services because networks do not have enough providers who offer the services they need (Zhu et al. 2017; Cama et al. 2017). For example, a recent report by the HHS Office of Inspector General (OIG) described how deficits in the supply of behavioral health providers in one state created barriers to receiving services. OIG proposed several strategies to bolster network adequacy standards and invest in the behavioral health workforce to improve access to care (OIG 2019). Separately, OIG has observed significant gaps in provider availability, network adequacy standards, and oversight and enforcement across states and has called on the HHS Centers for Medicare & Medicaid Services (CMS) to work with states to strengthen network oversight (OIG 2014a, 2014b).

Designing network adequacy standards is a complex task, and effective standards for behavioral health must take into account the unique nature of behavioral health conditions and services. For example, various treatments may be effective for a given mental health condition, and these treatments may be offered by a range of providers (psychologists, psychiatrists, social workers, peer support staff, and so on) or by multidisciplinary teams. Consumers of behavioral health services have different preferences when selecting among treatments and when selecting where and how to receive care (for example, in person or through telehealth technology). Network adequacy standards that focus exclusively on providers (or a limited set of providers) do not necessarily ensure access to the full range of effective services. As in other health care contexts, monitoring network adequacy and access to behavioral health care is necessary to identify gaps in service availability and inform refinements to standards over time. In addition, given widespread behavioral health provider shortages and other underlying systematic challenges, successfully establishing and enforcing network adequacy standards may require revisiting provider reimbursement rates, licensure, and credentialing requirements to support the goals of network adequacy standards.

To better understand network adequacy standards for behavioral health and best practices in developing and enforcing such standards, ASPE contracted with Mathematica to conduct a targeted environmental scan and convene a TEP. Specifically, the scan and TEP meetings focused on five research questions:

1. What network adequacy standards and requirements exist for behavioral health providers and services (both mental health and SUD)?
2. What is the evidence regarding the relationship of standards and the enforcement of those standards to access to behavioral health services?
3. Which network adequacy standards improve access to behavioral health services?
4. What types of requirements should be included in network adequacy standards for behavioral health providers and services?
5. Which network adequacy standards should differ based on community characteristics (for example, urbanicity or transportation infrastructure)?

This report synthesizes findings from the environmental scan and the TEP meetings. The remainder of the report describes our approach to both the scan and the TEP meetings (Chapter II); discusses network adequacy standards that apply to behavioral health providers and services across various markets (that is, Medicaid, Medicare, and commercial insurance) (Chapter III); and presents considerations for designing more specific standards for behavioral health providers and services (Chapter IV) as well as monitoring and enforcement of those standards (Chapter V). The report concludes with a summary of key findings, policy implications, and opportunities for future research (Chapter VI).

II. METHODS

A. Environmental Scan

We conducted a targeted search to address research questions about existing standards and the relationship of those standards and their enforcement to access to behavioral health services. Our scan used a structured approach to gather information across a wide range of sources. Before beginning the scan, we developed a search protocol to specify search terms and sources. We populated an Excel template to capture consistent information across sources. We focused on publicly available standards published within the past 10 years and on standards specific to behavioral health in the Medicare Advantage, Medicaid managed care, and commercial insurance markets. We reviewed a sample of federal and state laws and regulations, state Medicaid managed care contracts, and summary reports from standard-setting bodies and organizations. We also reviewed gray and published literature. In addition, we conducted targeted scans to inform development of the TEP meeting agenda and to contextualize specific findings.

Overview of network adequacy concepts and terms used in the scan. We searched for information on network adequacy standards that existed in both qualitative and quantitative forms. Qualitative standards may use language requiring provider networks to be "sufficient" or to provide "reasonable" or "timely" access to providers without defining a specific quantitative threshold or requirement. Qualitative standards also give plans and their oversight bodies discretion to define adequacy, which may result in standards that vary across plans or within a single plan over time. Plans and oversight bodies may prefer this approach, given the increased flexibility it offers. However, qualitative standards are subjective and may not fully address concerns about equity among enrollees, advocates, and policymakers. Quantitative standards, in contrast, offer more specific, objective definitions of adequacy. They also support more uniform measurement. Quantitative standards generally fall into one of the following categories:

- **Time and distance (geographic access) standards** outline the maximum amount of time it should take an enrollee to travel to a provider or the maximum distance between a provider and an enrollee's residence. These standards often vary by geography (for example, urban, rural, and frontier areas).

- **Provider-to-enrollee ratios** specify the minimum number of providers relative to a certain number of enrollees. Similar standards may specify the percentage of contracted providers who are accepting new patients.

- **Wait time standards** specify the maximum number of days before the earliest available appointment from a provider or facility type. These standards generally differentiate between urgent or emergency appointments and routine care. Standards for in-office wait times--the maximum amount of time patients should wait in an office before a scheduled appointment--also exist.

Although quantitative standards are objective and measurable, they have limitations in their ability to ensure access to care, especially when used in the absence of effective monitoring and enforcement. As part of our scan, we also searched for existing monitoring and enforcement practices, although we found relatively little information because monitoring and enforcement are not always codified or described in publicly available sources. Common monitoring practices include regulatory reviews of information such as:

- **Consumer complaints, appeals, and grievances** about problems with accessing care or about specific network adequacy issues.

- **Compliance with network adequacy standards** using information on plan networks. For reviews of compliance with time and distance standards, regulators might conduct sophisticated analyses such as geo-mapping, which uses software to compare the location of in-network providers to enrollees and calculates the time and distance between them.

- **Information on appointment wait times**, as reported by plans, consumers (through complaints), or secret shopper studies.

Enforcement actions for network adequacy can include corrective action plans, financial penalties, or legal actions such as lawsuits. As discussed in Chapter V, evidence suggests that enforcement actions for network adequacy are relatively rare (Barber et al. 2014).

B. Technical Expert Panel

We convened a TEP to answer research questions on which network adequacy standards improve access to behavioral health services, the types of requirements that should be excluded in the standards, and how the standards should differ based on community characteristics. In collaboration with ASPE, we developed a list of potential TEP members who represented behavioral health advocates, providers, health plans, researchers, trade organizations, and federal and state regulators. The appendix contains the names, titles, and organizations of the 13 panelists who ultimately participated in the TEP. We facilitated two separate virtual meetings of the TEP, in June and July 2020. Most TEP members attended both meetings and we obtained input from some TEP members outside of the meetings.

Because the environmental scan found few network adequacy standards that were specific to behavioral health providers and services, we sought input from the TEP participants on their vision for better standards and oversight. Specifically, we asked: (1) whether more specific standards were needed; (2) which types of network adequacy standards best facilitated access to behavioral health care; (3) which providers, services, and measures should be included in behavioral health network adequacy standards; (4) how standards should be adapted to reflect the characteristics of communities; and (5) how states and the Federal Government should enforce network adequacy requirements for behavioral health providers. We summarized the meetings and requested that the TEP participants review the summary to ensure that we accurately captured their input.

III. EXISTING NETWORK ADEQUACY STANDARDS FOR BEHAVIORAL HEALTH

This chapter summarizes the findings of our environmental scan of existing network adequacy standards for behavioral health providers and services, by market. We also briefly review the standards proposed by non-governmental organizations. Although our environmental scan included a search for evidence on the relationship between network adequacy standards and access to behavioral health services, we did not find high quality, published evidence on that topic.

The rules and regulations that govern network adequacy standards vary across Medicare Advantage, Medicaid managed care, and commercial plans.[1] For MAOs, network adequacy standards are defined at the federal level and include standards specific to a single behavioral health provider type (psychiatrists) and a single behavioral health facility type (inpatient psychiatric facilities). For Medicaid managed care and commercial plans, federal standards direct states to set network adequacy standards but do not specify the standards themselves. Standards therefore vary by state. In addition, specific quantitative standards for behavioral health providers and services exist only at the state level.

Overall, we found that many network adequacy standards treat behavioral health providers the same as other providers of specialty care--that is, the same standards apply to both. Across all three markets, the standards specific to behavioral health typically include only a small number of provider types, such as psychiatrists or certain types of SUD treatment facilities, relative to the overall number of behavioral health providers and services. Standards specific to each market are described below.

A. Medicare Advantage

CMS regulations require MAOs that offer coordinated care plans, network-based PFFS plans, network-based medical savings account plans, and Section 1876 cost organizations[2] to "maintain a network of appropriate providers that is sufficient to provide adequate access to covered services to meet the needs of

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[1] Traditional fee-for-service health insurance plans do not have networks and are therefore not subject to network adequacy standards. Some private fee-for-service plans contract with specific provider networks and are one of the Medicare Advantage plan types subject to Medicare network adequacy requirements (see "Private Fee-for-Service (PFFS) Plans" at https://www.medicare.gov/sign-up-change-plans/types-of-medicare-health-plans/private-fee-for-service-pffs-plans). Fee-for-service Medicaid arrangements do not have network adequacy requirements, but states are required to maintain and monitor access to providers through sufficient payment rates. States must submit Access and Monitoring Review plans every 3 years to document that payment rates are "sufficient to enlist enough providers so that care and services are available under the state plan at least to the extent that such care and services are available to the general population in the geographic area" (see "Access Monitoring Review Plans" at https://www.medicaid.gov/medicaid/access-care/access-monitoring-review-plans/index.html). States must certify that rates support sufficient access to behavioral health services, including mental health and SUD services (See 42 CFR 447.203 and 42 CFR 447.204 at https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=c54f7a2d261a636fbc18e3a6094fd3bd&mc=true&n=sp42.4.447.b&r=SUBPART&ty=HTML). However, in 2019, CMS proposed rescinding these requirements and instead intends to identify other strategies to monitor access (See "Comprehensive Strategy for Monitoring Access in Medicaid" at https://www.medicaid.gov/federal-policy-guidance/downloads/CIB071119.pdf). As of the writing of this report, the proposed rules had not been adopted.

[2] Cost contract plans are paid on the basis of the reasonable costs incurred by delivering Medicare-covered services to plan enrollees. Enrollees may use the cost plan's network of providers or receive their health care services through Original Medicare.

the population served."[3] MAOs must contract with a network of providers that is "consistent with the prevailing community pattern of health care delivery in the areas where the network is being offered," as indicated by factors such as: (1) the number and geographic distribution of eligible health care providers who could potentially contract with an MAO in its service area; or (2) the rural or urban composition of the service area.[4]

CMS has developed time and distance standards and minimum provider numbers for 27 Medicare Advantage provider types and 14 facility types; these include only one type of behavioral health provider (psychiatrists) and one type of behavioral health facility (inpatient psychiatric facilities). Standards for these providers and facilities vary according to the geographic size and population density of the county where each MAO operates.[5] Prior to June 2020, CMS also required that MAOs contract with enough providers and facilities so that 90 percent of enrollees in a county resided within the maximum time and distance standards of at least one provider representing each of the 27 provider types and one facility representing each of the 14 facility types.[6] In June 2020, CMS finalized rules to modify network adequacy standards for MAOs that included: (1) reducing the required percentage of enrollees who must reside within the maximum time and distance standards from 90 percent to 85 percent in more rural counties; and (2) providing plans that contract with certain types of telehealth providers, including psychiatrists, with a 10 percent credit toward the percentage of enrollees who must reside within the required time and distance standards.[7]

B. Medicaid Managed Care

1. Federal network adequacy standards

The Social Security Act (SSA) and associated federal rules outline network standards for managed care plans that enroll Medicaid and Children's Health Insurance Program populations. The SSA requires Medicaid managed care plans to: (1) offer "an appropriate range of services and access to preventive and primary care services;" and (2) maintain "a sufficient number, mix, and geographic distribution of providers of services."[8] Plans must also assure states that they have the "capacity to serve the expected enrollment" in their service areas. The SSA also requires states with Medicaid managed care plans to implement quality assessment and improvement strategies that include "standards for access to care so

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[3] See 42 CFR, Part 422.112, at https://www.ecfr.gov/cgi-bin/text-idx?c=ecfr&sid=ac79a8f841600f5f89b77ca11e21c619&rgn=div5&view=text&node=42:3.0.1.1.9&idno=42#se42.3.422_1112.

[4] See 42 CFR, Part 422.112, at https://www.ecfr.gov/cgi-bin/text-idx?c=ecfr&sid=ac79a8f841600f5f89b77ca11e21c619&rgn=div5&view=text&node=42:3.0.1.1.9&idno=42#se42.3.422_1112.

[5] Counties are classified into five types: (1) large metro; (2) metro; (3) micro; (4) rural; or (5) counties with extreme access considerations. For example, a county with a population greater than 1 million individuals and a density greater than or equal to 1,000 square miles is designated as large metro.

[6] See 42 CFR, Part 438.116, at https://www.ecfr.gov/cgi-bin/text-idx?c=ecfr&sid=ac79a8f841600f5f89b77ca11e21c619&rgn=div5&view=text&node=42:3.0.1.1.9&idno=42#se42.3.422_1112.

[7] See final rule: Medicare Program; Contract Year 2021 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, and Medicare Cost Plan Program, at https://www.govinfo.gov/content/pkg/FR-2020-06-02/pdf/2020-11342.pdf.

[8] Social Security Act of 1935, 42 U.S.C. 1396u-2 § 1932(b)(5)(A) and (B).

that covered services are available within reasonable time frames and in a manner that ensures continuity of care and adequate primary care and specialized services capacity."[9]

Federal rules that govern the implementation of SSA network standards further require states to ensure that provider networks are sufficient in scope to deliver all contracted services, with timely coverage of out-of-network care "if the provider network is unable to provide necessary services."[10] In developing network adequacy standards for plans, states must consider various factors such as enrollment, expected utilization, number and types of providers, number of providers not accepting new Medicaid patients, and the geographic location of providers and enrollees. Geographic factors include distance, travel time, the means of transportation ordinarily used by Medicaid enrollees, and whether the location provides physical access for Medicaid enrollees with disabilities.[11] States must also submit an assessment by an external quality review organization of the access in a managed care plan network. In addition, plans are required to submit documentation to the state to demonstrate the adequacy of their networks; however, the exact nature of this documentation is left to the state's discretion.[12]

CMS rules established in 2016 required states to develop, at a minimum, time and distance standards for a specified set of providers, including "behavioral health (mental health and SUD), adult and pediatric,"[13] and to document analyses that supported their assurances that each contracted plan's network was adequate.[14] The rule also specified that plans must require contracted providers to meet state standards for timely access to care and services, taking into account "the urgency of the need for services."[15]

In 2018, CMS proposed allowing states to remove time and distance standards and instead choose any quantitative standard through which reasonable and timely access to services could be evaluated.[16] The proposed rule outlines examples of quantitative standards that states could choose to implement, such as maximum appointment wait times, minimum provider-to-enrollee ratios, and a minimum percentage of contracted providers who are accepting new patients. As of the writing of this report, the proposed rules had not been adopted.

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[9] Social Security Act of 1935, 42 U.S.C. 1396u-2 § 1932(c)(1)(A).

[10] See 42 CFR, Part 438.206, at https://ecfr.federalregister.gov/current/title-42/chapter-IV/subchapter-C/part-438#section-438.206.

[11] See 42 CFR, Part 438.68, at https://ecfr.federalregister.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-B/section-438.68.

[12] See 42 CFR, Part 438.207, at https://ecfr.federalregister.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-D/section-438.207.

[13] See 42 CFR, Part 438.68, at https://ecfr.federalregister.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-B/section-438.68.

[14] See 42 CFR, Part 438.207, at https://ecfr.federalregister.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-D/section-438.207.

[15] See 42 CFR, Part 438.206, at https://ecfr.federalregister.gov/current/title-42/chapter-IV/subchapter-C/part-438#section-438.206.

[16] See proposed rule: Medicaid Program; Medicaid and Children's Health Insurance Plan (CHIP) Managed Care, at https://www.federalregister.gov/documents/2018/11/14/2018-24626/medicaid-program-medicaid-and-childrens-health-insurance-plan-chip-managed-care.

2. State network adequacy standards

Most states have established explicit standards for the time or distance that enrollees must travel to providers, appointment wait times, and provider-to-enrollee ratios, although the specific thresholds for such standards vary widely within and across provider types (OIG 2014b). A 2018 review of Medicaid managed care contracts found that 13 of the 19 states included in the review set time and distance standards for specialty or behavioral health providers, but standards for primary care were more common (Rosenbaum et al. 2018). Our scan likewise identified several states that have quantitative standards specific to behavioral health providers and services for their Medicaid managed care programs. These states typically define maximum time and distance for travel to behavioral health providers; some have additional standards such as appointment wait times and provider ratios. However, states vary in the specificity with which they defined provider and service types. Below, we provide examples of the types of standards Medicaid managed care programs have established for behavioral health providers and services.

States have developed time and distance standards for a range of behavioral health provider types. For example, California has established maximum time and distance standards based on county population density for psychiatry, mental health outpatient (non-psychiatry) programs, SUD outpatient services, and opioid treatment programs. The state Medicaid Managed Care Final Rule requires plan networks to provide access to psychiatry, outpatient mental health providers, and opioid treatment programs within 60 miles or 90 minutes of an enrollee's residence in rural counties, 45 miles or 75 minutes in small counties, 30 miles or 60 minutes in medium counties, and 15 miles or 30 minutes in large counties. For SUD outpatient services, the standard for rural and small counties is the same (60 miles or 90 minutes).[17]

States also couple time and distance standards with additional quantitative standards, such as appointment wait times and provider ratios. Examples include the following:

- **Florida**'s Medicaid managed care model contract outlines time and distance standards of 30 minutes or 20 miles in urban counties and of 60 minutes or 45 miles in rural counties. The state also has regional provider ratios for board-certified or board-eligible psychiatrists who treat adults and children and for licensed practitioners of the healing arts. For example, the state requires one adult psychiatrist per 1,500 enrollees and one child psychiatrist per 7,100 enrollees. The state has also established provider-to-enrollee ratios or bed ratios for the following facility types: licensed community substance abuse treatment centers, inpatient substance abuse detoxification units, fully accredited psychiatric community hospitals (adult) or crisis stabilization units or freestanding psychiatric specialty hospitals (adult and child), and medication and methadone treatment programs.[18]

- **Iowa** requires its Medicaid managed care plans to meet time and distance standards, as follows: 100 percent of enrollees must have access to inpatient mental health services within 30 minutes of their primary residence in urban settings or 45 minutes in rural settings, and they must have access to outpatient mental health and substance abuse services, including community-based services, within

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[17] See "Medicaid Managed Care Final Rule: Network Adequacy Standards," California Department of Health Care Services, at https://www.dhcs.ca.gov/formsandpubs/Documents/FinalRuleNAStandards3-26-18.pdf.

[18] See "2018-2023 Model Health Plan Contract," Florida Agency for Health Care Administration, at https://ahca.myflorida.com/medicaid/statewide_mc/pdf/Contracts/2020-02-01/Exhibit_II-A-MMA_2020-02-01.pdf.

45 minutes of their primary residence in urban and rural settings.[19] The state also requires appointment wait time standards of 15 minutes for emergency care, 1 hour for mobile crisis services, 1 hour for urgent care, 48 hours for persistent symptoms, and within 4 weeks for routine care.[20]

- **New Hampshire** has time and distance standards for adult and pediatric mental health providers of 45 minutes or 25 miles, for SUD counselors of 45 minutes or 15 miles, and for SUD programs of 60 minutes or 45 miles. Plans must also meet appointment wait time standards for behavioral health care: enrollees must be able to access care within 6 hours for an emergency that is not life-threatening, within 48 hours for urgent care, or within 10 business days for a routine office visit.[21]

- **West Virginia** has time and distance standards for certain types of behavioral health providers. Enrollees must have access to two of each type of behavioral health provider (psychologists, psychiatrists, licensed professional counselors, and licensed independent clinical social workers) within 45 miles or 60 minutes of travel time; one adult inpatient psychiatric unit within 30 miles or 45 minutes (urban) or within 60 miles or 90 minutes (rural); and one outpatient SUD provider within 45 miles or 60 minutes. The state also has appointment wait time standards, including 24-7 access to emergency care, access to urgent care within 48 hours of request, and access to routine care within 21 days. Plans must also contract with all residential SUD providers in the state and with an identified list of behavioral health clinics and psychiatric residential treatment facilities.[22]

While most states with network adequacy standards for behavioral health specify providers and settings of care, some states also have standards for specific behavioral health services. For example, in addition to establishing time and distance standards for a number of provider types, such as psychiatrists and psychologists, Kansas has established standards for a variety of behavioral health services, including home-based family therapy; alcohol and drug rehabilitation; positive behavior support; Screening, Brief Intervention, and Referral to Treatment (SBIRT) for both adults and children; and consultative clinical and therapeutic services and intensive individual support for children. Enrollees must be able to access these services within 30 miles or 60 minutes in urban areas, 45 miles or 75 minutes in densely settled rural areas, and 60 miles or 90 minutes in rural and frontier areas.[23] Similarly, New Mexico requires travel time and distance standards of 30 miles (urban), 60 miles (rural), and 90 miles

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[19] These standards apply unless the plan has been unable to develop additional capacity in rural areas for the services despite its documented best efforts, as accepted by the state.

[20] See "Request for Proposals: the Iowa Plan for Behavioral Health," Iowa Department of Human Services, at https://dhs.iowa.gov/sites/default/files/RFP%20MED-09-010.pdf?073020200041.

[21] See "Requirements for Access to Services and Network Adequacy," New Hampshire Department of Health and Human Services, at https://www.dhhs.nh.gov/ombp/caremgt/documents/mcm-network-adequacy.pdf.

[22] See "State Fiscal Year 2020 Model Purchase Service Provider Agreement," West Virginia Department of Health and Human Services, at https://dhhr.wv.gov/bms/Members/Managed%20Care/MCOcontracts/Documents/WV_SFY20_MCO_Model_Contract_v9.pdf.

[23] See "KanCare Network Adequacy Standards," Kanas Department of Health and Environment, at https://www.kancare.ks.gov/docs/default-source/policies-and-reports/network-adequacy-reporting/geo-access-standards--effective-01-01-2019.pdf?sfvrsn=a4654d1b_9.

(frontier) for a lengthy list of behavioral health provider types, as well the following specific services: Assertive Community Treatment, Multi-Systemic Therapy, and intensive outpatient services.[24]

A handful of state Medicaid managed care contracts have established other access standards for behavioral health, such as requiring plans to ensure reasonable accommodations for people with behavioral health conditions and provider trainings for their treatment and care. For example, Pennsylvania required plans to train providers in a way that bolstered the number and skills of providers who were eligible to contract with the plan, including training on the "identification and appropriate referral for mental health, drug, and alcohol and substance abuse services." Kentucky required its plans to attempt to enroll specific provider types, including community mental health centers, in their networks.

C. Commercial Insurance

1. Federal network adequacy standards

The Affordable Care Act (ACA) established the first federal network adequacy standards for commercial (or private) health plans; previously, federal standards were limited to Medicare and Medicaid (Wishner and Marks 2017). The ACA authorized rules requiring qualified health plans (QHPs) to maintain a network of providers that is "sufficient in number and types of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay."[25] CMS defined quantitative time and distance standards to assess whether QHPs in the federally facilitated Marketplace met this very broad standard, starting with the 2016 plan year. CMS defined different time and distance standards for categories of providers, including mental health and SUD providers, by level of population density.[26] Subsequently, beginning with the 2018 plan year, CMS announced that it would not apply quantitative standards and would instead rely on states to assess network adequacy even if they do not operate a Marketplace.[27,28]

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[24] See "Medicaid Managed Care Services Agreement," State of New Mexico Human Services Department, at https://www.hsd.state.nm.us/uploads/FileLinks/c06b4701fbc84ea3938e646301d8c950/Sample_Contract__SOW__Appendix_O_for_MCO_RFP_%2318_630_8000_0001_for_CC_2.0___9_1_17.pdf.

[25] See 45 CFR, Part 156.230, at https://www.ecfr.gov/cgi-bin/text-idx?SID=3e2ebe8004f31d2eb92ecf407e031dfd&node=pt45.1.156&rgn=div5

[26] See "Addendum to 2018 Letter to Issuers in the Federally-Facilitated Marketplaces," pp. 24-25, at https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2018-Letter-to-Issuers-in-the-Federally-facilitated-Marketplaces-and-February-17-Addendum.pdf.

[27] If states do not have "the authority and means" to review network adequacy, CMS will rely on the issuer's accreditation status. See "Guidance to States on Review of Qualified Health Plan Certification Standards in Federally-Facilitated Marketplaces for Plan Years 2018 and Later," at https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/QHP-Certifcation-Reviews-Guidance-41317.pdf. See also "2019 Letter to Issuers in the Federally-Facilitated Exchanges," p. 13, at https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2019-Letter-to-Issuers.pdf. For a useful overview, see Hall and Brandt (2017) at https://www.healthaffairs.org/do/10.1377/hblog20170914.061958/full/.

[28] In addition to ceding assessment responsibility to states for QHPs in the federally facilitated Marketplace, CMS also eliminated a requirement, starting with the 2019 plan year, for states with their own Marketplaces that use the federal enrollment platform to follow federal network adequacy standards. CMS now permits these states to establish their own standards.

Federal rules also require QHPs in the federally facilitated Marketplace to ensure that there is a "sufficient number and geographic distribution of essential community providers (ECPs), where available, to ensure reasonable and timely access to a broad range of such providers for low-income individuals or individuals residing in designated Health Professional Shortage Areas within the QHP's service area."[29] CMS currently requires that QHP issuers include 20 percent of the ECPs in their service area or justify their departure from that standard. QHPs can count behavioral health providers as ECPs, although they are not explicitly listed in the federal ECP categories.[30]

Beyond regulations for QHPs, the Federal Government has not established national standards for plans in the private market; this responsibility generally lies with state insurance commissioners.

2. State network adequacy standards

States may adopt more stringent or specific network standards for QHPs than the federal requirement that QHPs ensure reasonable access, but they do not have to. Our environmental scan found that several states have established standards specific to behavioral health providers and services. States may also define their own categories for the ECPs that are required to be represented in QHP networks. Two states, Kentucky and New Mexico, have specifically included behavioral health providers in their ECP categories (Kaiser Family Foundation n.d.). Some states have established network adequacy regulations that apply to all health plan carriers that serve the state's commercial market, including but not limited to QHPs.

Similar to Medicaid managed care, states with specific standards for behavioral health providers in commercial plans typically establish time or distance standards. For example, Arkansas has distance standards that require health plan carriers to ensure that enrollees have access to specialty services, including behavioral health, within 60 miles of their residence. Carriers must provide the state with geographic access maps of psychiatric and state-licensed clinical psychologists; SUD providers; and other mental health, behavioral health, and substance user providers. The maps must indicate which providers are accepting new patients.[31] Delaware's QHP rules include distance standards for behavioral health, mental health, substance abuse providers, and psychiatric hospitals. Enrollees must be able to access these providers within 35 miles in urban and suburban areas and within 45 miles in rural areas. The rules include a lengthy list of examples of behavioral health providers that the standards might apply to.[32] Minnesota requires "all health carriers that offer health plans that require an enrollee to use or that create incentives, including financial incentives, for an enrollee to use a designated provider network" to meet

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[29] See 45 CFR, Part 156.235(a)(1), at https://www.ecfr.gov/cgi-bin/text-idx?SID=ec6cf4bd9dfbbecd13bc660632ba2b88&mc=true&node=se45.1.156_1235&rgn=div8.

[30] Federal ECP categories are federally qualified health centers; Ryan White providers; family planning providers; Indian Health providers; qualifying hospitals such as disproportionate share hospitals; and "other ECP providers," such as clinics that treat sexually transmitted diseases or tuberculosis or other entities that serve low-income and underserved communities. See https://www.cms.gov/CCIIO/Programs-and-Initiatives/Files/Downloads/Chapter_07_ECP_Instructions_Ver1_04162014.pdf. See also Pellitt (2016) at https://www.thenationalcouncil.org/capitol-connector/2016/09/cms-releases-draft-list-essential-community-providers-2018-plan-year/.

[31] See "Rule 106: Network Adequacy Requirements for Health Benefits Plans," State of Arkansas, at http://arr.blr.arkansas.gov/Portals/0/Rules/ARR/Entities/117/Rules/9520/Final/Rule%20106.pdf.

[32] See "2020 Medical Issuer QHP Submission Guide," Delaware Department of Insurance, at https://insurance.delaware.gov/wp-content/uploads/sites/15/2019/04/DE-Issuer-QHP-Submission-Guide-2020.pdf.

time and distance standards. The maximum travel distance or time for an enrollee must be the lesser of 30 miles or 30 minutes to the nearest primary care, mental health, or general hospital services and the lesser of 60 miles or 60 minutes to specialty physician services, ancillary services, specialized hospital services, or other types of services.[33]

Some states have also set quantitative standards for behavioral health services in addition to providers. For example, New Hampshire has both time and distance and appointment wait time standards that apply to all insurers with plans whose "plan design and benefits include a provider network with differential payment or coverage associated with use of an in-network provider." The state has specific maximum wait time standards for in-network behavioral health providers of 6 hours for an emergency visit, 48 hours for urgent care, and 10 days for an initial or evaluation visit.[34] The state also has time and distance standards for three behavioral health service categories: (1) core services (such as alcohol or drug treatment in an ambulatory setting, case management, individual or group counseling); (2) common services (such as general psychiatric care on an inpatient basis or psychiatric diagnostic evaluation with medical services); and (3) specialized services (such as alcohol or drug acute detoxification). Maximum times and distances vary by service type and rurality.

States have also established qualitative standards that govern network adequacy for behavioral health providers and services. For example, Washington State's regulations say the following:

> "Adequate networks include crisis intervention and stabilization, psychiatric inpatient hospital services, including voluntary psychiatric inpatient services, and services from mental health providers. There must be mental health providers of sufficient number and type to provide diagnosis and medically necessary treatment of conditions covered by the plan through providers acting within their scope of license and scope of competence established by education, training, and experience to diagnose and treat conditions found in the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders* or other recognized diagnostic manual or standard."

The state has also defined additional qualitative standards and requirements, including that plans must: (1) establish a reasonable standard for the number and geographic distribution of mental health providers who can treat serious mental illness (SMI) in adults and serious emotional disturbance (SED) in children by taking into account the various types of mental health practitioners acting within the scope of their licensure; (2) provide emergency mental health services, including crisis intervention and crisis stabilization services, in the network; (3) include a sufficient number and type of mental health and SUD treatment providers and facilities within a service area based on normal utilization patterns; and (4) ensure that an enrollee can identify information about mental health services and SUD treatment, including benefits, providers, coverage, and other relevant information, by calling a customer service representative during normal business hours. Plans must also monitor access by measuring the adequacy of the mental health network at least twice per year and submitting an action plan if the standard is not met.[35]

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[33] See "Provider Network Adequacy Instructions," Minnesota Department of Health, at https://www.health.state.mn.us/facilities/insurance/managedcare/docs/netadequacyinst17.pdf.

[34] See the New Hampshire Administrative Code, Part 2701.06–2701.09, at http://www.gencourt.state.nh.us/rules/state_agencies/ins2700.html.

[35] See the Washington Administrative Codes, Section 284-170-200, at https://apps.leg.wa.gov/wac/default.aspx?cite=284-170-200.

D. Standards Proposed by Non-Governmental Organizations

Non-governmental organizations have outlined processes and standards related to network adequacy that can serve as important points of reference for regulators. For example, CMS currently refers states and issuers to the following processes or standards if states are unable to review the network adequacy of QHPs in federally facilitated Marketplaces:[36]

- As part of its accreditation process, the National Committee for Quality Assurance (NCQA) requires insurance carriers to establish quantitative standards to measure the availability and accessibility of primary care and specialty care, as well as standards for appointment wait times for specific types of appointments (for example, urgent or routine) and providers, including behavioral health providers.[37] Accredited plans must also demonstrate that they monitor appointment availability. Some states require Medicaid managed care or private plans to be accredited by NCQA (or another accrediting body) and to meet NCQA standards for network adequacy as part of their own network adequacy requirements.

- The National Association of Insurance Commissioners (NAIC) has created model state legislation that outlines various types of standards and practices, which states can use not only to establish requirements for provider networks but also to monitor them (NAIC 2015). The model law suggests standards for network adequacy, such as geographic accessibility of providers, provider-to-enrollee ratios by specialty, wait times, and hours of operation, among others. The model law also incorporates requirements for provider directories, enforcement mechanisms, and penalties. As of 2019, three states had adopted the model law (Weatherford et al. 2019).

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[36] See "2019 Letter to Issuers in the Federally-Facilitated Exchanges," at
https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2019-Letter-to-Issuers.pdf.

[37] For a helpful overview, see "Spotlight on Provider Access to Care Requirements" from SPH Analytics at
https://www.sphanalytics.com/provider-access-to-care-requirements/.

IV. CONSIDERATIONS FOR DESIGNING NETWORK ADEQUACY STANDARDS SPECIFIC TO BEHAVIORAL HEALTH

This chapter identifies considerations for regulators tasked with designing network adequacy standards, based on input from the TEP. Overall, the panelists declined to provide specific recommendations for network adequacy standards and requirements (such as a specific ratio of health plan enrollees to behavioral health providers) in favor of highlighting the underlying challenges with network adequacy and recommending principles that should guide the design of additional standards.[38]

A. Challenges with Designing Network Adequacy Standards for Behavioral Health

The panelists identified two overarching challenges to designing behavioral health network adequacy standards: (1) workforce and system barriers that may constrain the supply of behavioral health providers who are participating in networks; and (2) limitations of available data to estimate supply and demand for behavioral health services. These challenges do not constitute reasons to avoid setting or improving network adequacy standards, but rather are issues that may require separate policy solutions and that regulators and health plan issuers should be aware of as they work together to improve access to care.

1. Underlying issues that may contribute to gaps in behavioral health networks

Behavioral health workforce shortages are pervasive and particularly acute for some provider types. The panelists noted that health plans struggle to include enough providers with advanced training or credentials, such as psychiatrists and psychologists; providers of medication assisted treatment (MAT); residential treatment services; and providers of pediatric behavioral health services. One panelist pointed out that the per capita number of psychiatrists has decreased over the last 15-20 years while demand for care from psychiatrists and other behavioral health professionals has increased. These comments are broadly consistent with the findings of federal studies of provider supply and demand for services (National Center for Health Workforce Analysis 2015; Substance Abuse and Mental Health Services Administration 2019). Other comments emphasized shortages of child and adolescent behavioral health professionals, including both psychiatrists and psychiatric nurses. Several panelists noted that networks lack accessible residential treatment providers, especially in rural areas and for adolescents. As a result, some consumers need to travel to different regions or even out of state to receive this level of care.

In some states, stringent or out-of-date licensing, board certification, or scope-of-practice requirements restrict the supply of providers who are eligible to participate in health plan networks. Panelists suggested that some states are beginning to relax some of these requirements. For example, some states now allow providers who are in the process of obtaining their licenses to provide care with supervision; whereas they did not allow unlicensed providers to provide any care in the past. In addition, one panelist said that past state licensure requirements for behavioral health facilities have been based on requirements established for physical health facilities rather than programmatic needs such as staffing and service hours--even though programmatic needs may be a more appropriate basis for licensing behavioral health facilities.

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[38] Throughout the report, we summarize statements made by one or more panelists. Readers should not infer that all panelists necessarily agreed with or supported each statement.

Some panelists also suggested that insufficient or non-existent state credentialing or licensure standards for certain types of programs or providers (for example, peer specialists) may prevent or discourage health plans from contracting with these programs or providers. Panelists explained that health plans rely partly on state credentialing and licensure standards to set a minimum threshold for enrollment into the network. In some states, the definitions and licensure standards for certain types of providers (such as SUD counselors) are so broad that they do not indicate a specific level of training or ability to provide high quality services. As a result, some panelists suggested a need to clarify the definitions of certain types of providers and to revisit the licensure standards for them to support network adequacy. It is also possible that tightening requirements on some providers could have the effect of limiting the pool of potential providers with whom to contract.

Low reimbursement rates and burdensome credentialing and documentation requirements may discourage behavioral health providers from contracting with health plans. More specific network adequacy standards could encourage plans to address such barriers; however, addressing insurer reimbursement and credentialing practices separately could also help to improve networks irrespective of network adequacy standards, or could make standards easier to meet. For example, panelists reported that low reimbursement rates may inhibit provider participation in health plan networks.

> **Panelist perspective: Reimbursement**
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> "I think one measure of whether or not the amount of pay will make a difference in [provider participation] is the spread between the out-of-network payment level and the in-network payment level. [Studies have shown] that the spread for primary care if you go out-of-network [is] about 10 percent more. The spread on psychiatry and psychology if you go out-of-network is 80 percent more."

Some behavioral health providers can maintain a full panel of private-pay clients who pay cash rates that are often much higher than the rates paid by health plans. However, one panelist noted that higher reimbursement rates alone would not improve the adequacy of child and adolescent providers in networks because there is such high demand from private-pay clients. Another issue is that some behavioral health providers find the credentialing process required to join a network time-consuming and burdensome. For example, one panelist, a state regulator, mentioned hearing from providers that credentialing for therapists is more difficult than for medical-surgical providers, and reported "credentialing for mental health is harder, and could be made easier and still be sufficient." Health plans may also request that providers comply with specific documentation requirements (for example, documentation of treatment plan updates) and they may require medical record audits or have other reporting requirements. Some behavioral health providers may not have the capacity to adhere to the documentation and reporting requirements of multiple plans.

2. **Lack of comprehensive, accurate data on the behavioral health workforce, provider capacity, and consumer characteristics**

Existing data sources do not provide a comprehensive profile of the behavioral health workforce relative to consumer needs in every community. Panelists reported that many psychiatrists and other types of behavioral health providers, such as psychologists and social workers, do not accept insurance (and therefore do not submit claims to insurers), which makes it difficult to count the number of providers in a community and assess whether they are providing any services to health plan enrollees. One panelist suggested that comprehensive community-wide data on the number of providers, how many work full-time versus part-time, and their age distribution (reflecting how long they will likely continue to provide services) are necessary to assess provider supply relative to need. Panelists also suggested that counts of providers should not assume that different types of behavioral health providers are interchangeable (for

example, counting two psychologists as equivalent to one psychiatrist). Finally, panelists suggested that community-level data on the characteristics of behavioral health consumers (for example, their age, race, and ethnicity) and their health conditions are necessary to assess the availability of providers relative to the needs of the community, although such information is more readily available at the state level.

Measuring network adequacy is challenging when providers belong to multiple networks or do not accept new patients. One state insurance regulator said that the state does not have information on the number of networks an individual provider belongs to or how many clients a provider is serving across those networks or across different payers. As a result, the state cannot assess a provider's capacity to take on additional patients within a given network. Panelists noted that some providers may belong to many networks (and get counted toward network adequacy standards) but might not realistically have the capacity to serve clients across multiple networks. Some providers only join a network to obtain reimbursement for a single patient in their practice, without the intention of taking on new patients who are enrollees in the same health plans. Panelists also noted that provider network directories are often out-of-date or inaccurate or may list providers who are not accepting new clients, either because they have not updated their information or because it was not accurate in the first place. As a result, the networks are not as robust as they seem. One panelist noted that

> **Panelist perspective: Scope of practice**
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> "Problems in state definitions of scope of practice [are] true, but there are also problems with many, many, many of our providers not actually working up to their scope of practice. So, if you make assumptions about the services that someone can provide [based on the scope of practice that is allowed] … that may or may not actually be true. That may be a false assumption."

improving the accuracy of provider directories is a shared responsibility: plans must collect and publish provider information and providers must supply updates. A related issue is that providers may not be providing services up to their full scope of practice or training, whether due to provider choice, licensure issues, or other reasons. Panelists therefore cautioned against assuming a certain level of service capacity across a network based on the numbers of providers, in the absence of information on whether those providers are accepting new patients and practicing at the highest level of their scope of practice.

B.   Principles for Designing Network Adequacy Standards for Behavioral Health

In light of the challenges noted above, panelists identified a number of principles for designing network adequacy standards for behavioral health providers and services. Some of the following principles also apply to physical health providers and services, such as accounting for provider willingness and capacity to provide certain services, but the panelists emphasized their importance in the behavioral health context.

1.   Use data to develop more meaningful and sophisticated standards

Panelists offered specific recommendations for using better information on the behavioral health workforce and on the characteristics of communities and populations that the plans serve to improve existing standards and develop new ones.

Standards should account for provider willingness and capacity to provide specific services. Several panelists strongly recommended that standards for behavioral health providers and services differentiate between providers who are willing and have the capacity to accept new clients versus those who merely have a contract with the state or plan but are not accepting new clients. Given the lack of accurate information on provider capacity and willingness to accept new clients, as noted above, implementing this approach might require creative use of utilization data or investments in secret shopper surveys. For

example, several panelists suggested that meaningful standards should account for service availability based on the number of providers who bill for specific services within a certain time frame. Measuring the number of providers actively serving health plan enrollees and the number of unique enrollees each provider serves would help to identify providers who enroll in the network but seemingly do not accept new patients with that health plan. One panelist also mentioned that many behavioral health providers do not practice full-time, and therefore network adequacy standards should consider staff based on full-time equivalents rather than simply counting the number of providers in a network.

> **Panelist perspective: Counting providers**
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> "Provider counts are fine as long as you are counting providers that are actually available to take cases within the prescribed time frames--the emergency time frame, the routine time frame. The best way to do it is by a random secret shopper that also lets you do something about the accuracy [of provider directories]. [But secret shopper studies are] a lot of work and expensive to do. The other way you can get somewhat closer is to see how many different [providers] have actually filed a claim for how many services in the last period, 90 days, 6 months, 180 days."

Standards based on provider supply and distribution should account for the number of contracted providers by geographic area. Some panelists suggested that standards should account for the geographic distribution of providers and the ratio of network providers to the overall number of providers within a geographic area. Such standards could be more helpful than basic time and distance standards because they would better reflect overall provider capacity and identify specific access problems. For example, if a plan contracts with a small percentage of the overall number of available providers in a geographic area, that is a different problem than if the plan is contracting with a large percentage of overall providers in a geographic area where that overall number is small. Knowing which situation is true could help regulators decide how to approach the problem. However, one panelist also noted that the recent growth in the use of telehealth as a result of the COVID-19 public health emergency--a change that may persist over time--means that geographic standards should account for the provision of some services by providers outside of a given area (in states that permit out-of-state providers to deliver services via telehealth).

Standards should define the right number and location of specific types of providers relative to community characteristics, client preferences and patterns of care, and population needs. Panelists suggested that geographic access standards reflect how and where enrollees are accessing care, particularly as a result of community characteristics, such as rurality, obstacles such as mountains and rivers, and transportation barriers.[39] Some panelists also recommended that standards address historically underserved or impoverished areas and ensure access to ECPs such as federally qualified health centers and tribal agencies in such areas. One panelist suggested that standards should consider consumers' preferences for where to seek care, such as whether they tend to prefer rural versus urban areas or certain settings or levels of care (for example, in person versus telehealth). Another panelist proposed creating, as an initial step, objective standards for populations with certain characteristics or conditions. For example, there could be a standard for the range of provider types and the minimum number of providers of each type necessary to meet the needs of a population of 10,000 people with SMI. Such a standard would then

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[39] According to our environmental scan, people with behavioral health conditions often rely on public transportation or a Medicaid transportation benefit. Therefore, standards may need to consider the specific transportation needs of this population to ensure access to care. See the Medical Transportation Access Coalition's website at https://mtaccoalition.org/national-council-for-behavioral-health/.

serve as a basis for comparison of the networks that plan issuers or states have in place and for other population types (for example, people with SUD) within a state.

2.   Account for the characteristics of behavioral health providers and services

Panelists suggested that network adequacy standards could also do more to ensure access to behavioral health providers and services by accounting for unique or important dimensions of behavioral health, such as the use of team-based care models or mental health and SUD parity laws.

> **Panelist perspective: Integrated care delivery**
>
> "We're going to need to develop ways of including in network adequacy some of the integrated delivery of care approaches like collaborative care. I could work full-time in a primary care practice [as a behavioral health provider] and impact the care of 800 patients. But I would not be counted in network because I was doing [so as] a behavioral health consultant to the primary care doctor."

Standards should reflect the unique structure of team-based care and integrated care. Panelists suggested that if health plans contract with only individual providers, the plans inadvertently limit access to certain types of team-based services that require the participation of multiple providers. For example, for services such as peer bridger programs and Assertive Community Treatment, which rely on multidisciplinary teams, standards should require that networks include every member of these teams or directly contract for the service (rather than the individual providers). Similarly, panelists noted that standards may also need to account for the integration of primary care into specialty behavioral health settings or the integration of behavioral health services into primary care.

Panelists highlighted several types of providers and services for which network adequacy standards might be especially useful. More than half of the panelists indicated that network adequacy standards should prioritize the inclusion of psychiatrists and SUD counselors. Having a sufficient number of psychiatrists in a network is important because they can prescribe medications and treat a broad range of conditions. Panelists also recommended establishing standards for residential treatment, crisis services, inpatient and acute care hospitals, MAT providers, case managers or care coordinators, and telebehavioral health services. However, the right emphasis to place on some of these providers and services is not clear. For example, residential treatment services for SUD may be critical for some clients, but one panelist noted that they should ideally help people transition to outpatient services and that clients should have access to lower intensity services as well. Panelists agreed that prioritizing services and providers relative to the need within a community is most important. They also agreed that standards should separately define services and settings because settings may offer various services or levels of care. Finally, one panelist suggested that the best way to identify the providers and services to prioritize in network adequacy standards would be to ask plan participants what treatments and providers they have trouble accessing.

Standards must reflect restrictions established by mental health and SUD service parity laws. Federal mental health parity rules are intended to ensure that insurance plans treat behavioral health benefits no more restrictively than physical health benefits. However, federal parity requirements may complicate the development of network adequacy standards that are specific to behavioral health providers and services because they restrict non-quantitative treatment limitations for behavioral health services to those for physical health services (U.S. Department of Labor n.d.). Non-quantitative treatment limitations could be, for example, network tier design or restrictions based on geographic location, facility type, or provider specialty. States may also have enacted additional parity requirements above and beyond

the federal floor. Network standards that specifically address behavioral health providers and services must comply with parity laws and may need to account for the interplay between parity laws and network design. Although some panelists underscored the need for specific standards for behavioral health providers and services, they also cautioned that establishing additional requirements for behavioral health providers that are above and beyond those for medical-surgical providers could run afoul of federal and state parity laws. In addition, several panelists suggested that network adequacy compliance and parity compliance go hand in hand--that is, problems with one may signal problems with the other.

> **Panelist perspective: Parity**
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> "[Federal guidance identifies] network adequacy [standards] and reimbursement [as] non-quantitative treatment limits that need to be analyzed as treatment limitations for purposes of mental health parity. So, any way you slice it, we need to be looking at networks--and especially networks for mental health and SUD--to make sure that people are getting access, because there are federal laws that protect those for purposes of consumer rights and consumer access."

3. Use a layered approach to standards and incorporate telehealth

The panel also discussed the value of combining standards in different ways, including adding standards for telehealth.

Using multiple types of standards and a layered approach to standards based on high-priority behavioral health provider types and treatment needs can help plans and regulators ensure access to care. Regulators need to find a balance between network adequacy standards that are specific enough to ensure access to care but not so specific that they limit supply through onerous credentialing requirements. To achieve this balance, panelists discussed the need for layered approaches, where regulators set base requirements for certain providers and then add specific requirements for different subspecialties or types of services. For example, regulators could establish basic geographic access standards for certain provider types (for example, psychologists) and then layer on additional types of standards or requirements for different psychologist subspecialties or levels of care based on patient needs or geographic variation in the prevalence of conditions. Similarly, panelists discussed the benefits of layering qualitative and quantitative standards to allow regulators to respond more nimbly to specific deficiencies. For example, standards might require a plan to meet a defined quantitative threshold for certain providers or services, with an added qualitative requirement that plans ensure access for enrollees.

Panelists emphasized the importance of understanding client needs and preferences for telehealth as a precursor to including telehealth in network adequacy standards. Use of telehealth has grown rapidly over the past several months in response to the COVID-19 public health emergency, and this trend may continue for the foreseeable future. Panelists noted that increased use of telehealth has enabled consumers to discover new preferences for receiving care. One panelist mentioned that some consumers may prefer telehealth to in-person mental health services because they can stay in their own environment, which offers additional privacy and allows consumers to control how they engage with their provider. Others noted that telehealth may be less appropriate for consumers with SMI or SUD who need in-person supports. In addition, some consumers may have less access to the technology required to make use of telehealth options. Another panelist mentioned that it would be useful to research how different types of behavioral health consumers have experienced telehealth services during the pandemic to inform evolving standards over the long term.

Federal regulators have already begun to adapt network adequacy standards to reflect more widespread use of telehealth, but panelists noted the need to further define how telehealth contributes to meeting network adequacy standards for different types of behavioral health services. One panelist explained that the Contract Year 2021 Medicare Advantage and Part D Final Rule (CMS-4190-F1) offers plans that contract with telehealth providers in certain specialties, including psychiatry, a 10 percent credit toward meeting the Medicare Advantage standards, which require a certain percentage of enrollees to have access to a network provider within certain time and distance standards. For example, offering telehealth for psychiatry would reduce the required percentage of beneficiaries who must reside within the maximum time and distance from psychiatrists from 85 percent to 75 percent. This rule tries to strike a balance between recognizing that telehealth can adequately substitute for some types of in-person visits but that in-person visits are critical for some types of conditions or client needs. Panelists did not further comment on how to quantify or define the contribution of telehealth to network adequacy standards but broadly agreed that the availability of telehealth needs further consideration in network adequacy standards.

V. MONITORING AND ENFORCEMENT OF NETWORK ADEQUACY STANDARDS FOR BEHAVIORAL HEALTH

In this chapter, we synthesize information on monitoring and enforcement practices derived from the environmental scan and the TEP, beginning with an overview of the monitoring strategies described in scan sources and by TEP participants, followed by recommendations on monitoring from the TEP. We conclude this chapter with a brief review of enforcement strategies.

A. Monitoring

1. Overview of monitoring strategies

Federal and state regulators use a variety of methods for monitoring network adequacy standards that are not specific to behavioral health. Some primarily rely on reactive strategies, such as consumer complaints, while others use a combination of proactive and reactive strategies to ensure adequate networks.

Proactive monitoring strategies are reviews at different points in the life cycle of health plan contracts to identify problems before an indication that there are any. They include: (1) reviews of plan networks at contract initiation and plan certification; (2) ongoing reviews of plan-contracted providers against state provider enrollment files and provider supply files; (3) periodic provider directory reviews; (4) plan enrollee surveys; and (5) secret shopper surveys that check the accuracy of provider directories and assess appointment availability. For example, through its certification process, CMS

> **Panelist perspective: Monitoring differences in plan networks**
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> "If a company can say to me, 'Well, there are 700 psychiatrists, and we have 500 of them,' I think, 'Okay, that's better than nothing.' But if a second provider in that same service area says, 'Well, we have 25,' I'm trying to figure out why they only have 25. And that's a red flag where I need to go in and ask more questions so that I can figure out what's going on, because even if having 25 providers does meet the time and distance standard, I still don't understand why it's not 500 like their peers."

reviews and approves all new and amended contracts that Medicaid managed care programs enter into with plans to verify that they include network adequacy requirements and an acknowledgement of the state's role in monitoring. In addition, each state must submit a quality strategy to CMS and report its quality outcomes as well as certify that its plans have complied with the requirements for the availability of services (OIG 2014a). Under Medicare Advantage, CMS evaluates MAO networks every three years to assess whether the plans meet network adequacy requirements. MAOs upload "health service delivery tables" that list providers and facilities contracted to the plans, and CMS conducts an automated review. CMS also uses claims data to validate and approve exception requests.[40]

Although proactive monitoring strategies could be used for either behavioral or physical health providers and services, panelists described some nuances in monitoring behavioral health network adequacy. For example, one state regulator reported reviewing monthly provider enrollment files to check whether the listed network providers actually provide certain behavioral health services, such as SUD treatment, based on familiarity with the state's providers. Such an approach suggests the need for dedicated teams of

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[40] See "Medicare Advantage and Section 1876 Cost Plan Network Adequacy Guidance" at https://www.cms.gov/files/document/medicare-advantage-and-section-1876-cost-plan-network-adequacy-guidance-pdf for a description of this process and the MAO requirements.

reviewers who understand the markets in which plans operate and the types of services specific providers do and do not offer.

Reactive monitoring strategies are reviews triggered by specific events. Triggers include: (1) termination of provider contracts; (2) increases in plan enrollment by a certain percentage; (3) reductions in the number of providers of a certain type by a certain percentage; (4) observing that networks that provide similar services to a similar population vary in their relative size; and (5) trends in consumer appeals, grievances, and complaints. Plan issuers sometimes report triggering events themselves. For example, Missouri's Medicaid managed care contract specifies that plans must alert the state within five days of any changes to the composition of the plan's network that "materially affect the health plan's ability to make available all covered services in a timely manner."[41] One panelist emphasized the value of requiring plan issuers to self-monitor and report network changes to the state. This allows the state to observe potential problems and intervene--for example, when plans include many single-case agreements (where a provider agrees to see a single client for a particular service).

Monitoring consumer complaints and grievances is common for state regulators. Nearly all states track consumer complaints related to network adequacy, although the specificity of the information they collect varies significantly (Barber et al. 2014; U.S. Government Accountability Office 2017). Complaint-based monitoring systems entail challenges and gaps; for example, panelists noted that investigating the root cause of individual complaints is time-consuming and some access issues, such as inadequate reimbursement rates and wait times for follow-up appointments, do not surface in complaints. At the federal level, consumer complaints are one of several triggering events for ad hoc CMS reviews of MAO network adequacy (that is, reviews that occur at times other than the regular triennial reviews described above). CMS also requires states with Medicaid waivers authorized under the SSA to report grievances, appeals, or critical incidents, depending on the waiver type. Some of these grievances and appeals are specific to behavioral health, although not necessarily specific to network adequacy: states with Section 1115 Medicaid demonstrations for SUD and for SMI and SED must monitor grievances and appeals related to SUD and SMI/SED services.[42] In addition, federal reporting requirements for Medicaid managed care programs require states to report data on appeals and grievances, although states had not yet begun to do so as of the writing of this report.[43]

2. Monitoring recommendations for behavioral health network adequacy

Panelists viewed monitoring access and network adequacy as at least as important as improving standards. Panelists strongly advised that no matter the approach regulators take to establishing standards, network adequacy standards must be paired with effective monitoring and enforcement

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[41] See "MO HealthNet Managed Care--Central, Eastern, Western, and Southwestern Regions," Missouri Department of Social Service, at https://dss.mo.gov/business-processes/managed-care/docs/Managed-Care-Contract-Approved.docx.

[42] See "Monitoring Metrics for Section 1115 SUD Policies" at https://www.medicaid.gov/medicaid/section-1115-demo/downloads/evaluation-reports/sud-monitoring-metrics.pdf and "Monitoring Metrics for Section 1115 Demonstrations with SMI/SED Policies" at https://www.medicaid.gov/medicaid/section-1115-demo/downloads/evaluation-reports/smi-monitoring-metrics.pdf.

[43] See 42 CFR, Part 438.66(e), at https://www.ecfr.gov/cgi-bin/text-idx?rgn=div5&node=42:4.0.1.1.8#se42.4.438_166. See also the implementation dates for parts of the Medicaid managed care rule at https://www.medicaid.gov/Medicaid/downloads/implementation-dates.pdf.

activities to be successful. Furthermore, establishing new network adequacy standards for behavioral health providers and services is a complex endeavor, and the right way to do it may not be obvious given gaps in data and uncertainty about how to prioritize multiple considerations. In contrast, monitoring can provide concrete information that: (1) helps payers or regulators assess access to care from the perspective of consumers; and (2) supports iterative improvements to initial standards. For example, one panelist described setting standards for high-priority behavioral health services such as crisis intervention and stabilization but emphasized the use of monitoring to ensure access to such services, saying, "There's only so much you can do with respect to what the initial standard is, whether it's qualitative or quantitative."

There was little consensus among panelists on the best monitoring methods, but the effectiveness of different strategies may vary depending upon the combination of methods used and the nature of the network adequacy problems that regulators intend to address. For example, some panelists placed high value on consumer complaints or appeals, but one panelist countered that it is difficult to know how to improve networks on the basis of complaints alone and that it would be more effective to review networks against comprehensive lists of the behavioral health services they provide. Panelists also described the strengths and limitations of secret shopper surveys, which can be useful to assess the accuracy of provider directories and the ability of patients to obtain appointments. Multiple studies have shown that provider directories often have errors and are not an accurate reflection of which providers are accepting patients (OIG 2014a; CMS 2018; Malowney et al. 2015). However, secret shopper surveys can be expensive and labor-intensive. Contracting with external quality review organizations may be an efficient approach for conducting such studies in some states, particularly because states can receive enhanced federal matching funds for doing so.[44]

Panelists recommended claims or utilization-based analysis to assess provider capacity and to monitor changes in emergency department visits, visits to county jails, and use of crisis services. Several panelists emphasized the need to conduct analyses of claims or encounter and utilization data to monitor realized access to providers and services, noting that the numbers of providers or provider-to-enrollee ratios alone do not sufficiently demonstrate network adequacy. Instead, assessing the number of providers within a network who submit claims for plan enrollees is important for: (1) understanding how network adequacy standards are implemented on the ground; (2) validating that network adequacy standards are being met; and (3) determining whether they do or do not reflect provider availability. Panelists identified medical specialties that may offer models for such practices--for example, using claims data to assess providers' actual caseloads has been done for OB/GYNs. Similarly, plans' methods for assessing the network adequacy of some specialties that deliver a substantial portion of care on a cash-only basis, such as plastic surgeons and some dermatologists, could offer models for behavioral health. In addition, panelists suggested that observing changes in emergency department visits, visits to county jails, and use of crisis services would signal that consumers are experiencing problems accessing routine care and should trigger adjustments to network standards.

B. Enforcement

Enforcement mechanisms used for network adequacy include non-financial and financial approaches that are not unique to behavioral health. Our environmental scan found few examples of enforcement actions related to behavioral health network adequacy. One recent example was in

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[44] See 42 CFR, Parts 433.15 and 438.370, at https://ecfr.federalregister.gov/current/title-42/chapter-IV/subchapter-C.

Pennsylvania, where the state's Insurance Department fined Aetna $190,000 in 2019 for violating rules on the coverage of treatment for drug and alcohol abuse and for not complying with parity requirements, among other infractions. Another example was in California, where the state's Department of Managed Care reached a settlement with Kaiser Permanente in 2017 over persistent issues in providing patients with timely access to mental health services. Kaiser Permanente was required to hire a consultant to improve access to care and oversight. Previously, in 2013, the state fined Kaiser $4 million for failing to provide adequate access to mental health services.

Examples of enforcement strategies mentioned by panelists were not specific to behavioral health. They included corrective action plans proposed by plan issuers and reviewed by regulators, cease and desist orders accompanied by corrective action plans with subsequent compliance review by outside auditors, and several types of financial penalties. Some states prefer to use liquidated damages as a financial penalty, but one panelist cautioned against them because plans are sometimes required to report them when bidding on new contracts and are more inclined to fight them legally. Instead, capitation withholds and small fines for each instance of a deficiency may be more effective. As one panelist said, "It's easier to withhold money than it is to get money back once you've given it." Panelists did not report that they published notices of corrective actions or used incentives to encourage compliance with network adequacy standards; it is more common to link incentives to other quality measures and outcomes.

VI. SUMMARY AND POLICY IMPLICATIONS

The TEP did not reach consensus on a specific set of approaches for establishing network adequacy standards or monitoring them; instead, the panelists' discussion highlighted the complexity of the task and numerous considerations for regulators. Other key takeaways from this research are described below.

Quantitative network adequacy standards vary by payer and in the case of Medicaid and commercial insurance by state as well. Although federal standards for Medicaid and QHPs are qualitative, they also direct states to specify quantitative network adequacy standards. For both markets, the Federal Government cedes authority for defining standards to states. The degree to which state standards specify behavioral health providers and services also varies. Many states use the same standards for behavioral and physical health care, or do not specify behavioral health providers.

We found multiple examples of quantitative network adequacy standards specific to behavioral health providers and services, although most of these standards list a small number of provider types. For Medicare Advantage standards, psychiatrists and psychiatric inpatient facilities are the only behavioral health provider or facility types specified. Likewise, state standards for Medicaid and commercial behavioral health providers typically specify a handful of provider types. We also found that states with specific standards for behavioral health usually specify providers or settings, rather than behavioral health services such as alcohol and drug rehabilitation or Assertive Community Treatment. There are, however, exceptions. For example, both Kansas and New Mexico include a long list of behavioral health providers and services. Most states with standards specific to behavioral health define time and distance standards, but some states include other quantitative standards, such as maximum appointment wait times or provider or bed ratios. Washington State is an exception, with a complex set of qualitative standards and requirements specific to behavioral health.

The TEP raised several challenges with setting network adequacy standards for behavioral health that warrant attention from plans, providers, and policymakers. These include underlying causes of inadequate networks, such as workforce shortages, licensing and scope-of-practice restrictions, low reimbursement rates, and plans' contracting and credentialing practices. State and plan-level variation in some of these factors makes it difficult to recommend a common approach to designing standards. Variation in the definitions of some behavioral health providers across states is another challenge.

Panelists emphasized the need for accurate data on the number of providers who are delivering services and accepting new patients. Such metrics are necessary to set standards, but they are difficult to generate. Without them, standards may be based on providers who contract with plans but who are not available to provide services to plan enrollees. Potential solutions could include analyzing utilization data or using secret shopper surveys to understand provider availability. Approaches to analyzing utilization data could be as simple as counts of services provided per enrollee population in some defined time frame, or more sophisticated approaches such as predictive models of utilization data that use realized access and predefined signals of access problems to understand how many providers of certain services are necessary to ensure access. Better information on consumers' treatment needs would also be helpful for setting standards but is likewise difficult to obtain.

Effective network adequacy standards for behavioral health must consider the characteristics of behavioral health providers and services and the overall behavioral health context. In other words, ensuring access to behavioral health care requires a somewhat different approach to designing network adequacy standards than approaches to setting standards for physical health. For example, standards

should account for services that involve multidisciplinary teams so that clients can access the service rather than only some providers on the service team. Standards for behavioral health should also consider integrated care delivery models and the provision of some behavioral health services in primary care settings. As another example, standards should prioritize certain provider types, such as psychiatrists, given that they are often the first provider consumers have contact with. Considering the overall regulatory context for behavioral health is necessary as well; network adequacy standards that are specific to behavioral health providers and services should account for the interplay between network design and mental health and SUD service parity laws.

Layered approaches to designing network adequacy standards are helpful for ensuring access and are already used in practice, including telehealth. The findings from the environmental scan and input from the TEP suggested that using multiple types of standards can help regulators ensure access to high-priority services. Combining qualitative and quantitative standards can help plans and regulators adapt networks to local contexts and respond to access problems in a flexible way. Qualitative standards may be especially helpful for delegating responsibility for ensuring access to plans. Standards can also define base requirements for certain providers and add further requirements for subspecialties. Standards should also account for the increased availability of telehealth and consumer needs and preferences for telehealth. Federal regulators have already begun to adapt network adequacy standards to reflect more widespread use of telehealth, but panelists noted the need to further define how telehealth contributes to meeting network adequacy standards for different types of behavioral health services.

Setting and improving standards iteratively by monitoring access to care may be realistic and effective given the challenges involved in designing initial standards, lack of consensus on what the standards should be, and state variation in important inputs. Panelists emphasized that monitoring access and network adequacy is at least as important as improving standards. If the ideal standard design is not apparent, regulators should consider focusing their efforts on improving initial standards over time by monitoring access to care with both proactive and reactive monitoring strategies.

Limitations and findings of this project point to multiple avenues for further research. It is important to note that this research is based on a targeted rather than exhaustive scan of existing standards and on expert opinion. A systematic comparison of physical health and behavioral health standards by state and market could suggest ways to improve standards in some states. A second avenue for research might be a study of the relationship between network adequacy standards for behavioral health and access to behavioral health care. We did not find high quality, systematic, published evidence on this relationship as part of our scan, but generating such evidence could help states design and improve standards. Related opportunities for research might be: (1) conducting claims-based analyses of realized access to understand the differences between contracted and available providers; (2) monitoring use of acute or crisis services, or other service systems, such as county jails, for indications of gaps in access to routine care; and (3) building or evaluating predictive models that can shed light on how many providers of certain types are necessary to avoid triggering access problems. A different avenue for further work is understanding how, with recent growth in the use of telehealth, different types of behavioral health consumers have used and experienced telehealth services during the pandemic. Considering the best ways to incorporate telehealth into quantitative network adequacy standards will also benefit from further thought on the part of plans, regulators, and policymakers.

Finally, while this report largely focuses on how network adequacy standards can account for service availability and ensure access to care, more attention may be needed to other dimensions of access such as acceptability and affordability (Penchansky and Thomas 1981). As one panelist noted, "If you don't solve

the problem of availability at the front end, … you literally can't solve the problem of accessibility. [But] if I don't get to the level of services that are acceptable to the people who use them, then I don't know that accessibility actually means that much."

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Appendix A. Technical Expert Panel

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2. Lindsey Browning, M.P.P., program director for Medicaid operations, National Association of Medicaid Directors

3. Mady Chalk, Ph.D., M.S.W., principal and managing director, The Chalk Group

4. Katie Dzurec, J.D., M.P.A., senior advisor to the Pennsylvania Insurance Commissioner and acting director, Health Market Conduct Bureau

5. Pamela Greenberg, M.P.P., president and CEO, Association for Behavioral Health and Wellness

6. Ron Manderscheid, Ph.D., executive director, National Association of County Behavioral Health and Developmental Disability Directors and the National Association for Rural Mental Health

7. John O'Brien, M.S., senior consultant, Technical Assistance Collaborative, Inc.

8. Joe Parks, M.D., medical director, National Council for Behavioral Health

9. Debbie Plotnick, M.S.S., M.L.S.P., vice president of state and federal advocacy, Mental Health America

10. Shawn Ryan, M.D., M.B.A., president and chief medical officer, BrightView Health, and chair of legislative advocacy, American Society of Addiction Medicine

11. Mary C. Shelton, M.A., director, Behavioral Health Operations, Division of TennCare, State of Tennessee

12. Erica Sontag, M.S., division director, Division of Medicare Advantage Operations, Centers for Medicare & Medicaid Services

13. Joe Touschner, M.P.P., senior health policy advisor, National Association of Insurance Commissioners