Equitable Access to Care for Mental Health and Substance Use Disorders:

STANDARDS, MEASURES, AND ENFORCEMENT OF NETWORK ADEQUACY

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Executive Summary

Nearly 15 years after the enactment of the Mental Health Parity and Addiction Equity Act (MHPAEA), **inadequate access to timely affordable care continues to disproportionately affect Americans living with mental health and substance use disorders (MHSUDs).** Key barriers to accessing care include the lack of availability of MHSUD practitioners to provide timely services "in-network" ("INN") and the affordability of the MHSUD services they need—especially when services are received "out-of-network" ("OON") and subject to higher out-of-pocket costs to the patient.

For most Americans, health insurance—public or private—makes healthcare affordable when the care is provided by practitioners participating in the insurer's network. Insurers and health plans that manage insurer networks are expected to maintain a network that provides beneficiaries with access to the full array of covered services. When the number, type, or availability of participating practitioners in the health plan's network (in-network, or "INN" practitioners) is insufficient to meet the timely service needs of beneficiaries, patients endure excessive wait times for INN appointments, seek care from out-of-network (OON) practitioners or forego care entirely.

Determination of the adequacy of an insurer's network (Network Adequacy, or "NWA") is based on compliance with standards set by state and federal oversight agencies and quality accreditation organizations. These standards typically focus on (i) the **ratio** of INN practitioners to covered beneficiaries), (ii) **geographic distribution** of INN practitioners (e.g., maximum drive time/travel distance from a beneficiary's home/workplace) and (iii) **availability** (e.g., **appointment wait times)** of INN practitioners. However, the first two—INN practitioner ratios and geographic accessibility—can result in an overestimation of the adequacy of the network. Each INN practitioner may participate in multiple networks, and some may no longer be contracted within the network being examined. Further, practitioners who are currently contracted may no longer be available to provide care to new patients in a timely manner.

Inadequate access to MHSUD care is a national crisis, yet there remains considerable variability in the way NWA standards are defined and measured. Standards are commonly issued in broad <u>qualitative or subjective terms</u>, while specific metrics and performance thresholds used to assess compliance with the standards are defined by health plans managing the insurer's network. This leads to variability in measures and NWA determinations that are based on outdated or inaccurate practitioner contracting data. Most importantly, **NWA standards and compliance metrics (a) are typically not specific to MHSUD practitioners and (b) are not based on only those practitioners listed in the network directory who are currently contracted and actually seeing any, or more than a few, new INN patients per year. This is particularly relevant in determining the adequacy of MHSUD networks. It is well recognized that, compared to medical/surgical practitioners, a much smaller percentage of MHSUD practitioners participate in insurance networks—in large part due to low INN reimbursement rates they are offered**.

This Issue Brief provides an overview of state, federal and private accreditation standards commonly used to assess NWA, how they are measured and enforced, how they impact access to MHSUD care, and where improvements are needed. **These standards are designed to measure the adequacy of access to MHSUD practitioners. We did not identify NWA standards that analyzed comparability of access to MHSUD versus Medical/Surgical practitioners that would be required or needed to determine compliance with non-quantitative treatment limitation (NQTL) requirements under MHPAEA.**

To improve access to MHSUD care, we should begin by improving the adequacy of existing practitioner networks that people rely on to receive care. This, in turn, requires improving the way we measure adequacy—by using quantitative standards and metrics specific to MHSUD that can identify the true gaps that exist. For example, distance/time NWA measures do not capture the many cases where people need and seek care but never receive it, and appointment wait time is the only commonly-used standard that even attempts to measure how difficult it is to get a timely in-network appointment. Both of these are crucial indicators of network adequacy, yet are inadequately captured in the NWA standards most commonly used.

Healthcare purchasers, policymakers, regulators, employers, and quality/accreditation organizations are urged to support the following recommendations to improve consistency in defining, measuring, and enforcing NWA standards for MHSUD care.

Recommendations

1. **State and federal oversight agencies,** as well as **national health plan accrediting organizations,** should provide additional guidance and support for the development and required use of **MHSUD-specific quantitative NWA standards**, **performance metrics/thresholds,** as well as the **methodology** to be used in assessing health plan compliance with these standards. **The responsibility for specifying MHSUD standards and performance metrics should not be delegated to health plans without such guidance**.

2. **Compliance with standards** should be assessed and reported for **specific types of MHSUD practitioners** who are **currently contracted**, **actively submitting claims**, and **available to see new patients**.

3. **States** should:
   - Require health plans they oversee to report **NWA performance metrics specific to MHSUD practitioners and service levels**, using standardized data collection templates**.**
   - Require **corrective action plans where gaps exist**, subject to enforcement that includes meaningful financial penalties and ongoing monitoring to verify gap closure.
   - **Not accept health plan quality accreditation** as evidence of a plan's MHSUD network adequacy, since quality accreditation agencies have not, to date, even attempted to measure MHSUD network adequacy to any material degree.

4. **National accrediting organizations, such as the National Committee for Quality Assurance (NCQA) and URAC,** should:
   - Define **MHSUD-specific detailed quantitative standards**, reporting **metrics** and **performance thresholds** for health plans.
   - Require that **NWA reporting** includes all MHSUD practitioner sub-types and service levels.
   - Make compliance with these standards a **mandatory requirement** for accreditation.

5. **Employers and other health care purchasers** should require of their health plans:
   - **Current, accurate network directories** that identify active **MHSUD practitioners available to new patients on a timely basis.**
   - **Ongoing quantitative evidence of MHSUD network adequacy**, as well as analyses of factors known to impact network participation (e.g., reimbursement and administrative tasks which take a material amount of uncompensated time).
   - **Periodic member access surveys and practitioner participation** ("Secret Shopper") surveys, each conducted by an independent third-party entity with recognized expertise in conducting surveys.

Background

Americans are facing an unprecedented and steadily-growing MHSUD crisis, as underscored in [President Biden's Strategy to Address Our National Mental Health Crisis](). Fewer than half of Americans with MHSUDs get the care they need, and access to this care is far from equitable. While approximately half of Whites with any mental illness access MHSUD care, for Blacks and Latinos, the figure is around one third.[1] Considerable evidence has also shown that access to INN care for MHSUDs remains far more challenging than access to INN care for physical health conditions,[2] despite enactment of the **Mental Health Parity and Addiction Equity Act** (MHPAEA) nearly 15 years ago requiring insurers to provide the same level of coverage for MHSUD care as provided for medical/surgical care.

Most Americans rely on health insurance—public or private—to cover the costs of healthcare, and most seek care from practitioners participating in their insurers' networks to minimize their out-of-pocket costs. Insurers and health plans that contract with insurers to manage practitioner networks are expected to maintain a network of practitioners that is adequate in size, composition, and geographic distribution to make the full array of covered services accessible to beneficiaries in a timely manner. The capacity of a network to provide this access is referred to as **Network Adequacy (NWA)**. When the number, type or availability of **INN** practitioners is insufficient to meet the timely service needs of beneficiaries, patients endure excessive wait times for appointments, seek care from out-of-network practitioners, or forego care entirely.

There has been longstanding and increasing concern regarding the adequacy of insurers' networks in meeting the MHSUD needs of covered beneficiaries. When participants in a national survey were asked to rate the adequacy of their insurer's health practitioner networks, respondents rated their mental health provider networks as inadequate twice as often as they did for medical provider networks.[3]

The concern is well-founded:

- There is a well-recognized shortage of MHSUD practitioners*, which disproportionately affects those living in underserved communities.

  **** "MHSUD practitioners" in this Brief refers to psychiatrists and other MHSUD specialists***

- MHSUD care is received out-of-network five times as often as care for other medical conditions (ten times as often for SUD care).[4]

- Health plan network participation is lower for MHSUD practitioners than for medical/surgical practitioners,[5, 6] driven considerably by:

  a. Lower INN reimbursement by insurers for MHSUD practitioners as compared to providers of medical/surgical care.[7]
  b. Administrative requirements of health plans, which have been cited as a key factor for psychiatrists in decisions regarding insurance network participation.

Ensuring access to timely, affordable and equitable MHSUD care has never been more important than it is today, **and our healthcare system is not prepared to meet this need**.

1 SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health , 2018
2 https://www.mhtari.org/Survey_Conducted_by_NORC.pdf
3 Busch, Susan H., and Kelly Kyanko. "Assessment of Perceptions of Mental Health vs Medical Health Plan Networks Among US Adults with Private Insurance." JAMA Network Open, vol. 4, no. 10 (2021): e2130770
4 Melek, S., Davenport, S., & Gray, T.J. (2019). Addiction and mental health vs. physical health: Widening disparities in network use and provider reimbursement. Milliman
5 Jacobson, G., Rae, M., Neuman, T., Orgera, K., and Boccuti, C. Medicare Advantage: How Robust Are Plans' Physician Networks? Kaiser Family Foundation Report. October 05, 2017
6 Zhu, J.M., Zhang, Y., & Polsky, D. (2017). Networks In ACA Marketplaces Are Narrower For Mental Health Care Than For Primary Care. Health Affairs, 36(9), 1624-1631
7 Melek, S., Davenport, S., & Gray, T.J. (2019). Addiction and mental health vs. physical health

Measuring Network Adequacy: Standards and Metrics

There is not a consistent national standard for determining network adequacy. Standards vary across payers, states and types of coverage [8], as do the measures and methodologies for collecting and reporting data and the types of practitioners to be included. Further, standards are often defined in general terms, with decisions regarding specific metrics and performance thresholds delegated to the health plans responsible for managing the networks. This contributes to significant variability in NWA metrics and performance thresholds among plans.[9]

NWA standards can be defined in **qualitative** or **quantitative** terms. **Qualitative** standards use subjective terms such as "sufficient", "timely", "reasonable", etc. in describing adequate access to care. They do not necessarily specify metrics used to assess NWA or specific minimum or maximum performance thresholds.

Quantitative standards are more objective and defined in greater detail, including specific metrics to determine whether performance thresholds (e.g., maximum appointment wait times, etc.) have been met. Quantitative standards typically include measures such as those recommended by the National Association of Insurance Commissioners in its **Health Benefit Plan Network Access and Adequacy Model Act**[10]:

- Provider-to-covered person ratios (for primary care and designated specialties)
- Geographic accessibility of providers
- Geographic variation and population dispersion
- Wait times for appointments
- Hours of operation
- Ability to serve specific populations (e.g., low-income, complex conditions, etc.)
- Service delivery options (e.g., telemedicine, mobile clinics, etc.)
- Volume of technological/specialty care services available to persons requiring advanced or specialty care services

The most commonly used NWA standards are **provider-to-covered person ratios**, **geographic accessibility**, and **appointment wait times**. However, none of these standards measure care that was sought but not received—which is arguably one of the most important indicators of NWA, especially in MHSUD networks.

Assessment of NWA is often based on information from health plan network directories—despite evidence that this information is often inaccurate and/or out of date.[11] Problems are found across payer types, with the most common being incorrect contact information and listed practitioners not accepting new patients.[12, 13]

Factors That Impact Network Adequacy

Workforce shortages, inadequate reimbursement levels, state licensing requirements or scope-of-practice limitations, contracting and credentialing practices, and onerous administrative requirements all impact practitioner decisions to participate in networks and, therefore, the adequacy of networks.[14]

These factors are particularly important in maintaining an adequate network of MHSUD practitioners. In most states, there are not enough MHSUD professionals, and not enough psychiatrists in particular, to meet the needs of the population.

- More than 160 million Americans live in the over 6,600 areas designated by The Health Resources and

8 https://www.kff.org/health-reform/issue-brief/network-adequacy-standards-and-enforcement/#footnote-546131-1
9 U.S. Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation, November, 2021
10 https://content.naic.org/sites/default/files/inline-files/MDL-074_0.pdf
11 Haeder, S.F., Weimer, D.L., & Mukamel, D.B. (2016). Secret Shoppers Find Access To Providers And Network Accuracy Lacking For Those In Marketplace And Commercial Plans. Health Affairs, 35(7), 1160-1166.
12 https://www.cms.gov/Medicare/Health- Plans/ManagedCareMarketing/Downloads/Provider_Directory_Review_Industry_Report_Year2_Final_1-19-18.pdf
13 https://www.mhanj.org/content/uploads/2022/07/MHANJ-Managed-Care-Network-Adequacy-Report-7-13.pdf
14 U.S. Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation 2021

Services Administration as Mental Health Professional Shortage Areas.[15]

- It is projected that shortages of psychiatrists, psychologists, social workers, counselors and therapists will persist through 2025.[16]
- More than half of U.S. counties have no psychiatrists.[17]

Even when the workforce appears adequate in a given area, low reimbursement rates and high administrative burdens impact practitioners' decisions regarding participation in a health plan's network. Again, this has been especially true for psychiatrists: The percentage of psychiatrists accepting insurance (private non-capitated, Medicare, Medicaid) is far lower than it is for other medical physicians,[18] raising concerns not only regarding initial access, but also the continuity of care when changing health insurance plans.

- Reimbursement to psychiatrists participating in health plan networks is typically lower than for other physicians for comparable services. In-network reimbursement for primary care office visits (compared to Medicare allowed rates) is nearly 24% higher than for MHSUD visits, with the differential being as high as 50% in some states.[19]
- Administrative requirements of health plans are especially burdensome for the psychiatrists who work in small practice settings. In a survey conducted by the American Psychiatric Association Foundation's Center for Workplace Mental Health, early career psychiatrists in Residency and Fellowship Programs cited administrative burdens as the number one reason why they would be unlikely to join a commercial insurance network.[20]

Quantitative Measures for MHSUD Networks

Accurately and consistently assessing compliance with NWA standards for MHSUD networks requires quantitative measures. Such measures are available today, capable of providing important indicators of existing and potential network inadequacies for MHSUD care generally. For example, the Model Data Request Form (MDRF), was developed with funding from the Mental Health Treatment and Research Institute (MHTARI), a tax-exempt subsidiary of The Bowman Family Foundation, has been used by state regulators and employer coalitions to evaluate MHSUD network adequacy. The MDRF includes measures to help employers and other Plan Sponsors determine the adequacy of a plan's MHSUD networks, identify barriers to accessing in-network MHSUD practitioners, and request improvements from their plans as needed. Measures used in the MDRF include:

- Use of Out-of-Network care for MHSUD and medical/surgical (M/S) care
- In-network reimbursement (indexed to Medicare) for MHSUD practitioners and to M/S practitioners
- Claim denial rates for MHSUD services and M/S services
- Actual/active participation rates by MHSUD practitioners listed in a plan's network directory
- Operational Proportionality for MH/SUD versus M/S for UM Protocols

These measures are designed to ensure that a plan's network includes enough **available** (currently in network and accepting new patients) MHSUD practitioners to avoid (1) long "**search times**" to find an INN MHSUD practitioner accepting new patients, (2) long "**wait times**" for appointments with an INN MHSUD practitioner, (3) higher out-of-pocket costs for receiving OON care because an INN practitioner could not be found, and (4) individuals foregoing care because they are unable to afford the higher out-of-pocket costs associated with OON care.

15 https://data.hrsa.gov/topics/health-workforce/shortage-areas
16 https://rupri.org/wp-content/uploads/Behavioral-Health-in-Rural-America-Challenges-and-Opportunities.pdf
17 Bishop T., et al. (2016). Population of US practicing psychiatrists declined, 2003-13, which may help explain poor access to mental health care. Health Affairs, 35(7), 1271-1277
18 Bishop, T. F.; Press, MJ; Keyhani, S., & Pincus, H. Acceptance of Insurance by Psychiatrists and the Implications for Access to Mental Health Care; JAMA Psychiatry. 2014;71(2):176-181.
19 Melek, S., Davenport, S., & Gray, T.J. (2019).
20 Center for Workplace Mental Health. (2022). Pulse Survey for Fellows: Understanding Commercial Insurance Network Participation [Unpublished raw data]. American Psychiatric Association Foundation.

Monitoring and Enforcing MHSUD Network Adequacy Standards

Monitoring network adequacy for MHSUD care is at least as important as improving standards, yet there is little agreement on how monitoring network adequacy for MHSUD should be done.[21] Inconsistent definitions, variable quantitative metrics, minimal consequences for noncompliance, and lack of incentives to improve NWA result in limited enforcement and accountability. Increasingly, a key avenue of redress for NWA gaps has been legal actions[22, 23] and/or substantial monetary fines.[24]

Responsibility for overseeing provider network adequacy in private health plans is shared among states, the Centers for Medicare and Medicaid Services (CMS), and the U.S Department of Labor (DOL), based on type of coverage, whether the plan is offered under a health insurance exchange, and plan funding (self- or fully-insured).[25]

- States typically oversee carriers offering individual benefit plans sold directly or through some Federally-facilitated Exchanges and group plans. They also oversee contracted Medicaid managed care organizations.
- CMS oversees Medicare Advantage plans as well as Qualified Health Plans (QHPs) under the Patient Protection and Affordable Care Act (ACA). For QHPs, beginning with plan year 2023, this responsibility includes network adequacy assessment as part of the annual certification reviews of QHPs in most Federally-facilitated Exchange states.
- DOL is responsible for enforcing compliance with MHPAEA, which includes network-related NQTL requirements.

21 U.S. Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation, November, 2021
22 https://www.healthcaredive.com/news/san-diego-sues-molina-kaiser-centenes-healthnet-over-alleged-ghost-netw/602494/
23 https://bhbusiness.com/2023/01/31/senators-call-out-aetna-anthem-bcbs-humana-united-healthcare-for-mental-health-ghost-networks/
24 https://www.latimes.com/california/story/2022-03-04/state-fines-l-a-care-health-plan-a
25 https://www.gao.gov/products/gao-23-105642

Current Landscape: National and State Standards

National Standards

At the national level, qualitative standards for network adequacy have been established for Medicare Advantage (MA) and Medicaid managed care plans (MCOs), as well as QHPs administered on Federally-facilitated Exchanges under the ACA. All of these plans are required to establish "adequate" provider networks. While states have been required to establish regulatory standards for Medicaid MCOs and QHPs (until recently—see **QHP** section below), CMS defines specific quantitative metrics for MA plans regarding access to in-network providers. **Table 1** summarizes how each program addresses NWA standards.

Medicare Advantage (MA) plans

Private **MA plans** must "maintain and monitor" a sufficient network of providers to provide plan members with adequate access to covered services.[26] However, CMS has also established quantitative standards for MA plans that specify the number of physicians and other providers, as well as hospitals, that should be available, and the maximum driving time and distance standards for enrollees.[27]

While network adequacy evaluations for MA plans currently include only psychiatry and inpatient psychiatric facility services, CMS has recently proposed adding clinical psychology, clinical social work, and prescribers of medication for Opioid Use Disorder to the list of MHSUD specialty types to be included.[28]

Medicaid Managed Care Organizations (MCOs)

As with MA plans**, MCOs** are required to maintain and monitor "a network of appropriate providers… sufficient to provide adequate access to all services covered."[29] CMS provides this qualitative guidance to states contracting with MCOs, but defers to state regulators for development, oversight, and enforcement of specific quantitative standards (CMS has recently proposed changes that would establish national maximum appointment wait time standards for routine primary care, obstetrics/gynecology (OB/GYN) and outpatient MHSUD services, and would also require states to conduct annual Secret Shopper surveys to monitor plans' compliance with the wait time standards and network directory accuracy[30]). Quantitative standards may include maximum time or distance to an in-network provider, minimum provider-to-enrollee ratios in a service area, or maximum time to wait for an appointment. Medicaid agencies in each state are responsible for developing and enforcing a quantitative network adequacy standard for, minimally, the following provider types: primary care practitioners (PCPs), OB/GYNs, MHSUD practitioners, specialists (as defined by the State), hospital, pharmacy, and pediatric dental.[31]

Most states utilize time and distance standards; the use of other quantitative standards and the degree to which they are enforced is highly variable.[32] Further, even time and distance standards differ across provider specialty types and service.[33]

Some states simply require that contracted Medicaid plans are accredited by accrediting bodies (URAC, NCQA) and that they comply with the accrediting body's network adequacy standards—**though it is notable that these accrediting bodies themselves defer to health plans to define and monitor specific quantitative measures of adequacy and do not require MHSUD-specific NWA standards.**

26 42 C.F.R. § 422.112 (a)(1) (2010)
27 https://www.kff.org/medicare/issue-brief/faqs-on-mental-health-and-substance-use-disorder-coverage-in-medicare/
28 https://public-inspection.federalregister.gov/2022-26956.pdf
29 https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-D/section-438.206
30 Federal Register: Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality
31 https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-B/section-438.68
32 https://www.ajmc.com/view/variation-in-network-adequacy-standards-in-medicaid-managed-care
33 Id.

Table 1. Federal Network Adequacy Standards

Medicare Advantage

Provider Ratios	Providers/1,000 insureds				
	Large Metro	Metro	Micro	Rural	CEAC*
Primary care	1.67	1.67	1.42	1.42	1.42
Psychiatry	0.14	0.14	0.12	0.12	0.12
Clinical psychologist	15	0.15	0.13	0.13	0.13
Clinical SW	0.25	0.25	0.22	0.22	0.22

Time/ Distance	(Maximum Minutes, Miles)				
	Large Metro	Metro	Micro	Rural	CEAC*
Primary care	10, 5	15, 10	30, 20	40, 30	70, 60
Psychiatry	20, 10	45, 30	60, 45	75, 60	110, 100
Clinical psychologist	20, 10	45, 30	60, 45	75, 60	145, 130
Clinical SW	20, 10	30, 20	50, 35	75, 60	125, 110

Wait Times	Primary Care and Behavioral Health Services
Urgent or emergent	Immediately
No-urgent/ emergent care	Within 7 business days
Routine & Preventive	Within 30 business days

Managed Medicaid

Managed Medicaid
States develop & enforce NWA standards for MCOs for travel time/ distance for certain provider types - including MHSUD professionals (Few states require standards specific to MHSUD).
Some states require MCO accreditation by NCQA or other accrediting bodies and compliance with those standards
CMS recently proposed maximum appointment wait time standards for:
Routine OP MHSUD - 10 business days
Routine primary care & OB/GYN - 15 business days

Qualified Health Plans (ACA)

Provider Ratios
Delegated to States

Time/ Distance	(Minutes, Miles)				
	Large Metro	Metro	Micro	Rural	CEAC*
Primary care	10, 5	15, 10	30, 20	40. 30	70, 60
Psychiatry	20, 10	45, 30	60, 45	75, 60	110, 100
OP BH	10, 5	15, 10	30, 20	40. 30	70, 60
IP/ Residential BH	30, 15	70, 45	100, 75	90, 75	155, 140

Wait Times	Beginning plan year 2025, HHS will evaluate QHPs for compliance with the following appointment wait time standards
Behavioral Health	10 business days
Primary Care (Routine)	15 business days
Specialty (Non-Urgent)	30 business days

* CEAC: Counties with Extreme Access Considerations

Qualified Health Plans (QHPs)

Under the Patient Protection and Affordable Care Act, **QHPs** provide health insurance for over 16 million Americans.[34] The U.S. Department of Health and Human Services (HHS) requires QHPs using provider networks to maintain sufficient numbers and types of providers—including MHSUD practitioners—so that services are accessible to enrollees "without unreasonable delay." [35]

HHS, until recently, has deferred to individual states to establish specific quantitative standards for Network adequacy, which has led to wide variability in standards. As with MCOs, some states have accepted accreditation from accrediting agencies like NCQA and URAC as evidence of network adequacy. However, for plan years beginning on or after January 1, 2023, HHS requires QHPs to meet standards for time and distance that have been established by the Federally-facilitated Exchange (FFE) and, for plan years beginning in 2025, QHPs will also need to meet standards established by the FFE for appointment wait times.[36]

While HHS requires MHSUD practitioners to be included in QHP networks, HHS does not define specific practitioner subtypes in an effort to avoid limiting access to a full range of MHSUD services.[37]

Accrediting Organizations: NCQA and URAC

The National Committee for Quality Assurance (NCQA) and **URAC** are the two most prominent national accreditation organizations for health plans. A summary of standards used by these organizations is shown in **Table 2**.

While each of these two organizations provides standards for health plans to follow regarding network access, the standards are described generally, and they defer to plans to establish their own specific criteria, thresholds and evaluation methodologies. And while each of these organizations requires plan reporting by type of provider, including MHSUD practitioners, neither requires measures or reporting specific to MHSUD networks. Further, while there are provisions for plans to demonstrate corrective actions where network gaps are identified, there are no explicit consequences for plans that are out of compliance with their own NWA standards.

NCQA requires plans to develop quantitative standards to measure the availability and accessibility of primary care and specialty providers, as well as for appointment wait times for specific levels of urgency and types of practitioners, including behavioral health providers.[38] As part of NCQA's accreditation process, health plans are also required to monitor appointment availability.

Similarly, **URAC** requires provider ratios, time/distance, wait time standards as part of its accreditation process, leaving development of specific measures to the health plans being accredited. It is also left to the plan's discretion whether the plan establishes separate standards for MHSUD, but URAC does require plans to report network adequacy performance by provider type, including MHSUD specialists.

State Standards

Individual states oversee NWA for private commercial insurers, Medicaid MCOs and some QHPs and, as noted previously, there is considerable variability among states in the adoption of quantitative network adequacy standards specific to MHSUD. Only 16 states utilize MHSUD-specific standards, as shown in **Table 3**. Of note:

- **12 states** have **time/distance standards** for health plan NWA **specific to MHSUD**
- **8 states** have standards for **maximum appointment wait time specific to MHSUD**
- **4** states have **provider-to-enrollee ratio or minimum number of provider standards specific to MHSUD**

34 https://www.kff.org/health-reform/state-indicator/marketplace-enrollment/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D
35 https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-B/part-156/subpart-C/section-156.230
36 https://www.cms.gov/newsroom/fact-sheets/hhs-notice-benefit-and-payment-parameters-2024-final-rule
37 https://www.federalregister.gov/documents/2012/03/27/2012-6125/patient-protection-and-affordable-care-act-establishment-of-exchanges-and-qualified-health-plans
38 U.S. Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation, November, 2021

Table 2. Accrediting Organizations Network Adequacy Standards

Organization	Provider : population ratios	Travel Distance	Travel Time	Wait Times
NCQA	YES	YES	YES	YES
Standard defined by	Plan [1]	Plan [1]	Plan [1]	NCQA
Specific to BH	yes, by provider type [2]	yes, by provider type [2]	yes, by provider type [2]	yes
Compliance monitoring	Documented process, reports [3]	Documented process, reports [3]	Documented process, reports [3]	Documented process, reports [1]
Measurement guidance provided	yes	yes	yes	yes [2]
Telehealth Providers included	For look-back period 1/1/20 - 6/30/22 (COVID accommodation)	For look-back period 1/1/20 - 6/30/22 (COVID accommodation)	For look-back period 1/1/20 - 6/30/22 (COVID accommodation)	For look-back period 1/1/20 - 6/30/22 (COVID accommodation)
URAC	Yes	Yes	Yes	Yes
Standard defined by	Plan	Plan	Plan	Plan
Specific to BH	Yes [4]	Yes [4]	Yes [4]	Yes [3]
Compliance monitoring	Documented process, reports [5]	Documented process, reports [5]	Documented process, reports [5]	Documented process, reports [4]
Measurement guidance provided	No	No	No	No
Telehealth Providers included	Yes	Yes	Yes	Yes
Notes	1 plan choice: available OR only accepting new patients	1 plan choice - distance or time	1 plan chooses either distance or time standard	1 initial & annually, all product lines
	2 plan defines high-volume BH provider types	2 plan defines high-volume BH provider types	2 plan defines high-volume BH provider types	2 partial
	3 initial & annually	3 initial & annually	3 initial & annually	3 Report by provider type; plan determines if stds differ for BH
	4 Report by provider type; plan determines if stds differ for BH	4 Report by provider type; plan determines if stds differ for BH	4 Report by provider type; plan determines if stds differ for BH	
	5 Desktop review	5 Desktop review	5 Desktop review	4 Desktop review

This variability can be expected to continue in the absence of consistently defined NWA standards incorporating quantitative metrics. However, it can also highlight best-practices that can inform policymakers and program administrators regarding which approaches and standards are most effective.[39]

Example: Maryland

Few states have incorporated quantitative network adequacy standards and monitoring requirements as robust as those in Maryland, which include requirements to incorporate additional measures specific to MHSUD. Recently, the state significantly strengthened its regulations governing NWA standards and oversight, substantially improving the availability and accessibility of MHSUD practitioners.[40]

39 Rosenbaum, S., Schmucker, S., Beckerman, J.Z. Provider Networks and Access in Medicaid Managed Care: A look at Federal and State Standards. The Commonwealth Fund. Blog October 10, 2018.

40 Legal Action Center Building Better Networks and Improving Access to Substance Use Disorder and Mental Health Providers: Lessons from Maryland. June, 2023

Table 3. States with MHSUD-specific Network Adequacy Standards

		Standards		
	Standards apply to	Time/Distance	Provider Ratios	Wait Times
CA	Health Insurance Policies	**Time/Distance**	Y	**Y**
CO	Health Benefit Plans	**Distance**	**Y**	**Y**
DE	MCOs and QHPs (separately)	**Distance**	**Y**	
IL	Network Plans	Time/Distance	**Y**	Y
ME	HMOs, MCOs, Health Plans		Y	**Y**
MD	Health Benefit Plans	**Distance**	**Y**	**Y**
MN	Health Carriers	**Time/Distance**		Y
MO	HMOs	**Distance**		**Y**
NV	Health Benefit Plans	**Time/Distance**		
NH	Managed Care Plans	**Time/Distance**		**Y**
NJ	Managed Care Plans	**Time**	Y	Y
NY	Health Benefit Plans	Time/Distance	Y	**Y**
OR	Managed Care Entities	**Time/Distance**		
PA	Managed Care Plans	**Time/Distance**		Y
TX	HMPs, PPOs	Distance		**Y**
VT	MCOs	**Time**		Y

Maryland utilizes quantitative network standards for Travel Distance, Appointment Wait Times and Provider: Enrollee ratios, as well as inclusion of essential community providers. Recent amendments to the regulations require reporting by provider specialty and explicitly include multiple MHSUD provider types.

The standards are explicitly described with metrics, and methodological guidance is provided for the collection of required information.

The state monitors compliance with standards through Annual Access Plans filed by payer organizations, although certain standards require more frequent monitoring. Appointment wait times are measured through semi-annual surveys conducted with enrollees and provider offices, and internal network compliance audits are required at least quarterly. If appointment wait time standards are not met for greater than or equal to 90% of appointments in each reporting category, a carrier must notify the state within 10 business days and note the efforts being taken to correct the deficiency.

Maryland also requires health plan reporting on key indicators of existing and potential gaps in network adequacy,[41] including OON claims reporting, complaints (for prior year), policies and procedures to assist members using the plan's directory, provider contract provisions, availability of an appointment portal for members, language, diversity, demographic assessments/provisions/provider recruitment and provider incentives to join the plan's network. Plans are also required to contact providers who have filed no claims in the past 6 months. These reporting requirements help to identify potential network inadequacies that may be masked by simply reporting the number of MHSUD practitioners. They also make it easier for health plan members to find INN practitioners who are more likely to meet their specific needs and are currently accepting new patients.

41 https://insurance.maryland.gov/Consumer/Pages/Network-Adequacy-Regulations.aspx

Initiatives to Improve NWA for MHSUD

A number of initiatives are underway in the private and public sector to improve the measurement, monitoring, and enforcement of NWA standards at national and state levels.

Nationally, legislation continues to be introduced to strengthen, standardize, and enforce measures of NWA, and the DOL has significantly increased its efforts to ensure compliance with MHAPEA over the past two years, bringing NWA concerns regarding MHSUD care more visibly to the attention of employers, states, and plans.

For Medicaid MCOs, CMS has recently proposed national maximum appointment wait time standards for routine primary care, OBGYN and outpatient MHSUD services. States would also be required to conduct annual Secret Shopper surveys to monitor compliance with appointment wait time standards and network directory accuracy.

Beginning in plan years 2023 and 2024, respectively, HHS will assume responsibility for defining and enforcing the time/distance and appointment wait time standards (which had been delegated to states).

Concerns with plan directory completeness and accuracy have led to provisions in the Consolidated Appropriations Act, 2021 that require plans to verify the accuracy of provider directory information at least every 90 days, update directories within two business days after receiving updated provider information, remove providers from the directory who have not verified their information, and respond to requests from enrollees about a provider's network participation status within one business day.[42]

In July of 2023 the Departments of the Treasury, Labor and Health and Human Services released a notice of proposed rulemaking (NPRM) to amend the Federal regulations implementing MHPAEA. The proposed rules would strengthen existing MHPAEA protections and provide additional guidance relating to data analyses required for demonstrating compliance MHPAEA. These proposed changes, in conjunction with the July 2023 MHPAEA Comparative Analysis Report to Congress, underscore the federal government's major focus on network adequacy through stronger enforcement of existing regulations and introduction of new requirements.

The Path Forward for Mental Health and Substance Use (Path Forward) is a private, nonprofit national initiative dedicated to expanding access to MHSUD care by helping shape national policy and incorporation of evidence-based strategies to transform MHSUD care and achieve health equity for all Americans. The initiative is supported through national partnerships that include the largest healthcare purchaser coalitions in the nation, provider associations, research and policy institutions, and private philanthropic and advocacy organizations.

Through the Path Forward, its partners, and more than 30 purchaser coalitions around the country, initiatives have included development and dissemination of educational and policy briefs to inform legislative and regulatory efforts nationally. Specific areas of focus relate to increasing access to in-network MHSUD practitioners, integration of MHSUD care into primary care setting through the evidence-based Collaborative Care model, expanding and improving access to Tele-Behavioral Health, large-scale data analyses and aggregation, and development of quantitative tools such as the previously referenced MDRF to more effectively measure and monitor NWA for MHSUD care.

Other initiatives sponsored by the Path Forward and its partner organizations have included:

- Convening panels of national experts on integrating MHSUD and primary care, assessing practitioner network adequacy, and the use of standardized metrics for MHSUD screening and treatment monitoring
- Working with national employers, health plans, and MHSUD industry trade groups to provide detailed guidance in the collection and analysis of quantitative metrics to identify NWA problems and facilitate compliance with MHPAEA
- Sponsoring consumer access surveys, surveys of employers regarding MHSUD network needs, and surveys of MHSUD practitioners to identify barriers to participation in plan networks.

42 Consolidated Appropriations Act, 2021, Pub. L. No. 116-260 div. BB tit. I, 134 Stat. 1182, 2758 (2020)

Opportunities & Recommendations

A number of opportunities still exist to significantly improve access to MHSUD care and the way we measure the adequacy of practitioner networks responsible for delivering this care.

Lack of Quantitative Standards and Metrics Specific to MHSUD

- Standards defined by oversight entities are often subjective, providing broad, general requirements, with responsibility for quantitative metrics and minimum performance thresholds delegated to the health plans themselves.
- NWA standards are not routinely established or reported specifically for MHSUD practitioners and service levels; those that do exist are inconsistent in defining and measuring performance.
- There are few reporting requirements for factors known to impact NWA for MHSUD networks, such as out-of-network utilization, reimbursement rates, inactive practitioners (those submitting few or no claims), claim denial rates and unpaid administrative requirements.
- There are virtually no meaningful consequences for a health plan's failure to comply with network adequacy standards, nor are there meaningful incentives for plans to improve performance.

Recommendations

1. **State and federal oversight agencies,** as well as **national accrediting organizations,** should **provide additional guidance and support for the development and required use of quantitative NWA standards**, **minimum performance levels/ thresholds, analyses of factors that contribute to network inadequacy,** and the **methodology** to be used in assessing compliance with the standards. **This responsibility should not be delegated to health plans** without such guidance.

   Government oversight agencies and private accreditation organizations should also require compliance testing and reporting with regard to these quantitative standards for **specific MHSUD service levels and types of practitioners to ensure the network includes adequate numbers of practitioners with the requisite knowledge and skill to treat all MHSUDs**, and include only practitioners who are **currently contracted**, **actively submitting claims**, and **available to see new patients**.

a. **States** should:

   i. Require health plans they oversee to report **NWA performance metrics specific to MHSUD practitioners and service levels**, using standardized data collection templates**.**

   ii. Require systematic compliance testing with regard to quantitative NWA measures and **corrective action plans where NWA gaps exist**, subject to enforcement that includes financial penalties and ongoing monitoring to verify gap closure.

   iii. **Not accept quality accreditation** as evidence of a plan's MHSUD network adequacy, since quality accreditation agencies have not, to date, even attempted to measure MHSUD network adequacy to any material degree.

b. **National accrediting organizations such as NCQA and URAC,** should:

   i. Define for health plans **MHSUD-specific quantitative standards**, **minimum performance thresholds, reporting metrics and methodology**, and **factors known to contribute to network inadequacy.**

   ii. Require that **NWA reporting** includes all MHSUD practitioner sub-types and service levels.

   iii. Make compliance with MHSUD-specific standards a **mandatory requirement** for accreditation.

c. **Employers and other health care purchasers** should require of their health plans:

   i. Current, accurate network directories that identify **active MHSUD practitioners available to new patients**.

   ii. Ongoing quantitative evidence (using the MDRF) of MHSUD network adequacy, as well as analyses of factors that impact network participation (e.g., reimbursement, unpaid administrative requirements).

   iii. Periodic surveys of member access to MHSUD care and MHSUD practitioner participation (Secret Shopper) surveys conducted by an independent third-party with recognized expertise in conducting surveys.

Summary

As the demand for MHSUD services continues to outpace the capacity of our healthcare system to accommodate this demand, there is an urgent need to improve the ways we define, measure, and enforce measurement of network adequacy to ensure we are meeting the needs of all Americans seeking MHSUD care.

This Issue Brief is intended as a call to action for healthcare purchasers, professionals, policymakers, regulators, employers, and quality/accreditation organizations to acknowledge the scope of this crisis and institute policy and practice changes needed to ensure that all Americans with MHSUDs have equitable access to timely, affordable care.