Improving Accountability for Behavioral Health Care Access:

Evaluating the Current Evidence for Behavioral Health Network Adequacy Standards

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Executive Summary

Despite behavioral health parity laws, there are widening gaps between access to behavioral health care and access to medical care, and there are higher out-of-network utilization and out-of-pocket costs for behavioral health services.[1,2] Network adequacy standards mandate that health plans maintain a sufficient number of providers and facilities to ensure that individuals have reasonable access to necessary health care services, including mental health and substance use disorder services. But there is considerable variation in network adequacy standards, and states can employ qualitative standards, quantitative standards, or a combination of both.[3,4] Because qualitative standards are intentionally flexible, this report focuses on the quantitative standards used to assess network adequacy.

NCQA, with support from The Sozosei Foundation, conducted an environmental scan and stakeholder interviews to synthesize the state of evidence on behavioral health network adequacy standards and metrics. The scan included an examination of published peer-reviewed literature and gray literature, and of publicly available measures and standards assessing network adequacy. Seventeen interviews were held with a variety of stakeholders from geographically diverse states.

Key Findings

- **Existing network adequacy standards fail to capture important concepts of adequate network evaluation** (provider patient capacity, specialized service offerings, after-hour or crisis services availability, proximity to public transit, patient eligibility requirements, cultural competency, network breadth).[5] To effectively monitor access and ensure it is timely, equitable, and sufficient, **a combination of metrics is essential**.[5–7]
- Current network adequacy standards **lack standardization and uniform templates** for calculating and monitoring metrics to allow comparison of network performance across plans and states. Stakeholders emphasized that standardization and proactive collection are particularly needed for assessing **consumer perspectives and satisfaction with coverage and access to services**.
- **Behavioral health network adequacy standards require a different approach than standards used in other specialized medical services.** Network adequacy standards should consider the diverse range of behavioral health providers, who are subject to different licensing and certification requirements, depending on their specialization, state, or health care setting.[8,9] Evidence supports the use of multidisciplinary teams in delivery of behavioral health care, with provider types and services that are often not covered in traditional fee-for-service payment models.[10] **Therefore, tracking behavioral health services, rather than provider types and facilities, may be more effective in ensuring adequacy of behavioral health networks.**
- **Behavioral health networks are difficult to measure.** A significant issue when evaluating network adequacy is the prevalence of inaccurate provider data ("ghost networks") used both as a data source to monitor network adequacy compliance and as a mechanism for consumers to select in-network providers through provider directories.[11] **Provider directory inaccuracy leads to misrepresentation in quantitative network adequacy metrics of geographic standards, wait times, and provider-to-enrollee ratios, limiting the ability to monitor and enforce.**[12–16] Despite legislative efforts to improve directory accuracy, administrative barriers allow overestimation of access to care.[17]

- Findings from stakeholder interviews and the environmental scan highlighted **the importance of wait times and geographic standards**, despite shortcomings and administrative barriers. The research underscores, however, that relying on provider-to-enrollee ratios is an ineffective approach to monitoring adequacy, considering the high number of ghost providers and the absence of a mechanism to factor in providers' capacity to see patients.
- **Federal and state regulators employ variable approaches to assessing network adequacy, and a lack of national standards substantially limits monitoring and enforcement for reliable comparison.**[5,18,19] There are significant challenges to assessing outcomes associated with adoption of network adequacy standards, due to variations in methodologies, data sources, and transparency levels across markets. This also hinders the ability to make meaningful comparisons between markets and states.
- Evidence demonstrates that despite known difficulties in accessing behavioral health care, few enforcement actions are executed.[20] **Stakeholders emphasized the lack of incentives to ensuring an adequate behavioral health network.**
- There remains insufficient evidence to suggest that adoption network adequacy standards are associated with improvements in access to care.[21–23]

The COVID-19 pandemic accelerated efforts to advance delivery and regulation of behavioral health services, with the goal of providing equitable care.[10,24,25] This report highlights models demonstrated to enhance access to those services. These models have the potential to influence the design of behavioral health networks and future network adequacy standards.

Effective and realistic network adequacy standards are crucial for protecting consumer access to timely, equitable and affordable behavioral health services.[18] Further research will be essential to understanding the outcomes associated with adoption of network adequacy standards. This report summarizes recommendations from the environmental scan and interviews, with the goal of enhancing measurement and accountability of network adequacy standards.

Introduction

In the United States, there is growing recognition of behavioral health's critical role in overall health. According to the 2022 National Survey on Drug Use and Health, over 23% of adults (59.3 million) have had a mental illness, and 17.3% of individuals 12 and older (48.7 million) have had a substance use disorder (SUD).[26] However, engagement in treatment services is low: Over half of adults with any mental health condition and over 94% of individuals with an SUD do not receive treatment.[26,27]

The behavioral health care system is a patchwork of private and public health systems that are often insufficient and too under-resourced to be able to provide high-quality care.[10] And our nation faces a mounting workforce shortage. 52% of counties across the U.S. are designated as a behavioral health workforce shortage area, and there are not enough psychiatrists to meet demand in any of the 50 states.[28–30] This disjointed system of care has resulted in confusion, pervasive stigma, delays in access, high costs and poor health outcomes.[1,31,32] The COVID-19 pandemic exacerbated the behavioral health crisis and barriers to care.[33]

Historically, behavioral health has functioned as a distinct system from medical/surgical care, with services excluded or restrictions imposed by insurance coverage, creating disparities in access to services.[10,32] The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) and the 2010 Affordable Care Act (ACA) sought to expand access to behavioral health services by ensuring that plans provide equal coverage for behavioral health care as for medical/surgical services, and establishing network adequacy standards for private health plans.[34–36] But almost 15 years later, there is extensive documentation that barriers to equitable behavioral care remain for millions of Americans. Adults are 5 times more likely to go out-of-network behavioral health services than medical/surgical services,[1,34,37–39] and families are 10 times more likely to have to go out-of-network care1 for pediatric behavioral health services.

Network adequacy standards require health plans to have an appropriate number of providers and facilities to ensure sufficient access to needed health care services (including mental health and SUD services).[3] However, standards differ significantly among states, as do the methods employed by regulators to monitor and enforce compliance with standards.[3,18] Inadequate network design and enforcement can lead to disparities in access to behavioral health services, despite parity laws.

Because of limited access, the first point of entry into behavioral health care is often through a hospital's emergency department (ED). Many times, individuals are accompanied by law enforcement officers.[40] But neither the ED nor the justice system has the training or resources to adequately respond to behavioral health crises, and the result is high-cost, low-quality outcomes and further diversion of resources from prevention, early intervention and community-based support systems. Additionally, dependence on and excessive use of the police produces worse outcomes and contributes to the criminalization of individuals with behavioral health conditions—jails and prisons are commonly referred to as the de facto behavioral health provider in the United States.[40,41] Although there is recent federal attention on strengthening the behavioral health crisis response infrastructure, there continues to be limited access to in-person crisis services, as well as to ongoing, routine care.

Equitable access to high-quality behavioral health care is essential. This report assesses the evidence and evaluates the ability of existing network adequacy standards to effectively measure access to behavioral health services. It defines access using the Penchansky & Thomas (1981) Five A's Framework (availability, accessibility, accommodation, affordability, acceptability).[42] Each "A" represents a key dimension of access that contributes to realized engagement in behavioral health care (Figure 1).

Figure 1: Five A's Framework

AVAILABILITY: The presence of adequate behavioral health care services in a given community or geographic area—the number of providers, treatment facilities and programs available to meet the population's needs.

ACCESSIBILITY: Removing physical, financial and logistical barriers to behavioral health care, including proximity to services, transportation, affordability and language/cultural barriers. Ensuring accessibility helps ensure that care is within reach for all individuals, regardless of their circumstances.

ACCOMMODATION: The responsiveness of behavioral health care services to the needs and preferences of patients, such as appointment availability, extended hours, telehealth options and consideration of special needs or disabilities.

AFFORDABILITY: The financial aspect of accessing behavioral health care services: whether care is affordable and reasonable, with consideration of insurance coverage, out-of-pocket expenses and availability of sliding-scale fees or low-cost options. Affordable care minimizes financial barriers that may prevent individuals from seeking and receiving necessary treatment.

ACCEPTABILITY: Cultural appropriateness and sensitivity of behavioral health care services, with regard to the diverse backgrounds and needs of individuals, to ensure that services are delivered in a respectful, non-discriminatory and inclusive manner.

Methods

The aim of this report is to gather relevant evidence and insights to inform the current state of behavioral health network adequacy. This section outlines the methods used to conduct a comprehensive analysis of behavioral health network adequacy, which include a literature review, an environmental scan and stakeholder interviews.

A targeted review of the literature was conducted, encompassing peer-reviewed articles and gray literature. An extensive search strategy incorporated PubMed, Google Scholar and PsycInfo databases, guided by specific keywords and inclusion criteria. The review focused on publications from 2013–2023. In tandem, a targeted search was performed in gray literature and policy documents, as well as in state and federal laws, regulations and statutes.

A measures scan was conducted to identify pertinent measurement tools for assessing network adequacy. This entailed searches across multiple databases, targeting U.S.-specific measures within behavioral health and access to care domains. Measures and standards from the Centers for Medicare & Medicaid Services (CMS), the Centers for Disease Control and Prevention and the Agency for Healthcare Research and Quality, Substance Abuse and Mental Health Services Administration were included, as were CMS's list of measures under consideration and measures endorsed by the National Quality Forum. The search encompassed both proposed and in-development measures and standards for access to care.

Stakeholder interviews were conducted with 17 stakeholder groups possessing expertise or a vested interest in behavioral health care and network adequacy, including providers, consumer advocates, health plans, employers, regulators and research and policy experts. Selection of stakeholders was informed by their knowledge and relevance to research topics, and to provide a geographically diverse perspective. Interviews employed a semi-structured guide comprising open-ended questions related to research objectives, ensuring both consistency and flexibility for participants. Interviews were recorded with participant consent, and were later transcribed and analyzed using thematic analysis to identify prevailing themes, patterns and insights and to capture the full spectrum of perspectives, revealing areas of consensus and divergence among stakeholders.

Network Structures

This section presents a summary of the findings derived from stakeholder interviews and the environmental scan on the design of behavioral health networks. It explores the distinctions and implications of the differences between service delivery models and medical/surgical contexts, and reviews barriers to participation of behavioral health providers in health plan networks.

"Networks" refers to providers and health care facilities that contract with a health plan to provide services and benefits to members. Networks represent consumers' potential access, or their opportunity to obtain health care services.[12,43] "Realized access" refers to actual utilization of health care services.[43] A network's design impacts cost, quality and access to services for the consumer.[44,45] Networks differ across health plans, and vary in size and composition, number of providers and health settings, and are generally narrower for behavioral health than for other medical specialities.[12,46,47]

Typically, behavioral health networks are designed to have a limited set of provider types (psychiatrists, psychologists, clinical social workers, other master's level counselors). Networks also typically include a limited list of behavioral health facilities (outpatient, residential, inpatient and some specialty substance use clinics).[47] The continuum of behavioral health services includes specialty and noncredentialed providers offering services that can be delivered across a range of clinical and community-based settings: prevention, early intervention, screening and diagnosis, care coordination, psychotherapy, medication management, peer support and crisis intervention. Many of these services are delivered outside the health care sector. Stakeholders highlighted the importance of networks having available mental health and substance use services across the full care continuum.

A prominent theme from the stakeholder interviews is the difficulty of defining networks by provider types and settings, based on the evolving delivery methods of behavioral health care and how the profession is regulated. Significant differences in state regulations and credentialing criteria make it difficult to navigate providers,[8,9] although many types of providers and facilities are evolving to address diverse behavioral health needs and conditions, even if they are often not included in a plan's network or reimbursed. For example, beginning January 1, 2024, marriage and family therapists and mental health counselors will be added to the covered provider list under Medicare Part B—the first update to the list of eligible Medicare behavioral health providers in over 30 years.[48] Refer to Appendix 1 for a summary of selected behavioral health professionals and the services they provide.

"There is a lack of common definitions for behavioral health care providers. There's a lot of non-psychologists and non-psychiatrists providing a lot of the mental health services that are hard to pull into these network adequacy categories, let alone then have consumers search for these kinds of providers when they try to access them[,] because there's no consistency."
— stakeholder interviewee

Stakeholders noted that differences in provider training contribute to silos between mental health and substance use, and emphasized this as a reason for making services available across the care continuum for both mental health issues and SUD. Stakeholders also discussed the variability of treatment availability based on condition; for example, individuals with serious mental illness have a more difficult time finding a provider. Concerns about workforce shortages were mentioned as well, especially for providers who specialize in child and adolescent behavioral health. Stakeholders further emphasized the importance of culturally competent networks that include providers with the training and expertise to serve populations with consideration to race, ethnicity, language, gender, sexual orientation or other aspects that may require specialized care. Stakeholders expressed that tracking behavioral health services rather than provider type may be a more effective method of ensuring an adequate network.

BARRIERS TO PROVIDERS PARTICIPATING IN NETWORK

Stakeholders frequently discussed their concerns about workforce shortages and the inability of health plans to meet network adequacy standards for behavioral health providers, especially in rural areas. Stakeholders also discussed the difficulty of evaluating areas with real provider shortages, as opposed to areas where providers are available but are not in-network. It is well established that psychiatrists and other behavioral health providers have significantly lower participation rates in insurance, especially in Medicaid.[31,49–52] Behavioral health providers cite a variety of reasons for this, including low reimbursement for high administrative burden.[44,53] Reimbursement rates for behavioral health care are an average of 24% lower than primary care reimbursements, and are from 10%–80% lower for behavioral health providers.[1,44,53]

Stakeholders stressed the issue of low reimbursement as a major deterrent for participation in networks, especially for evidence-based treatments that require additional training or certification. They also highlighted the administrative burden of having to submit claims for insurance reimbursement. More than half of office-based psychiatrists have solo practices, which has substantial consequences for administrative costs among those who accept health insurance.[51] The time required to negotiate contracts with health insurance companies, file prior-authorization forms, file claims and recover payments for services requires additional staff and a concomitant increase in office space. The revenue associated with participating in insurance networks is not sufficient to offset these additional overhead expenses for many behavioral health providers in solo practices.[52]

ASSOCIATION OF NETWORK STRUCTURE WITH ACCESS OUTCOMES

Stakeholders referenced a lack of evidence and understanding of behavioral health network performance. Additional research is needed to understand how network design impacts consumers' access to care.[12] Ludomirsky et al. (2022) found that a small percentage of Medicaid providers treats a high volume of mental health patients; the loss of one high-volume provider in a network has a larger impact on realized access to care than expanding the network of providers.[54] Analysis of provider networks across plans reached a similar conclusion.[55] Current standards do not have a mechanism to monitor provider capacity and performance.

Provider Directories as a Barrier to Network Adequacy

Provider directories are a critical tool for assessing network adequacy and realized individual access. While many health plans use technology to improve navigation of provider directories for consumers, directories often lack critical variables to help individuals identify a behavioral health provider.[11] Additionally, provider information is often inaccurately listed, which is a barrier to care.[11,14,56]

Much of the literature evaluating network adequacy centers on the issue of inaccurate provider directories (commonly referred to as "ghost networks"): Providers listed as in-network have incorrect contact information, are not accepting new patients, do not accept a listed insurance and so on. Numerous studies using a variety of methods (secret shopper surveys, claims data analysis, out-of-network behavioral health utilization, geospatial analysis, patient-reported outcomes) consistently found significant inaccuracies.[1,11,13,14,16–18,56–61] These are frequently cited as a cause for networks to overestimate access to care, since they are part of the foundation on which networks are built and therefore have a "ripple effect" on the accuracy of standards upon evaluation.[11,62] And while inaccuracies are common across all specialties, they are especially problematic among behavioral health providers. Psychiatrists are frequently identified as most likely to be "ghost providers" across specialties and mental health professionals.[12,54] Stakeholders emphasized the importance of this topic, which poses an obstacle to identifying and accessing providers and engaging in care, and misrepresents compliance with network adequacy standards.

Federal law requires Medicaid-managed care, Medicare Advantage and Marketplace plans to update their provider directories. In 2021 the No Surprises Act required commercial health plans to update directories every 90 days and to protect consumers from being billed for seeing a provider erroneously listed in a directory.[18,57,63] Prior to the Act, 20 states had established laws with requirements on directory accuracy for commercial plans.[14,57] At this writing, the Senate Finance Committee has approved the Better Mental Health Care, Lower-Cost Drugs, and Extenders Act, which includes improvement to the accuracy of provider directories. Research has demonstrated, however, that despite these laws, directories remain highly inaccurate: A 2023 directory analysis report found that after adoption of the No Surprises Act, 81% of entries included inaccuracies.[13,17] This is largely due to lack of standardization in provider data collection and the administrative burden on providers and practices to update information across all participating health plans.[56] Stakeholders also discussed the lack of clarity and their frustration regarding data source accountability and accuracy.

Network Adequacy Standards

Network adequacy standards provide a framework for regulators to evaluate whether plans offer enough providers and facilities to provide "reasonable" access to care.[3,18] Because qualitative standards' flexible definitions of "sufficient" and "reasonable" access result in inconsistent interpretation by health plans and regulators,[3,4] this report focuses on quantitative standards, which offer measurable benchmarks for assessing network adequacy. There are currently no national quantitative network adequacy standards.[3,4,20,64] This section of the report briefly defines the most commonly used quantitative standards, summarizes findings of the environmental scan and stakeholder interviews on the latest research on standards' effectiveness and limitations and discusses potential standards identified in the literature.

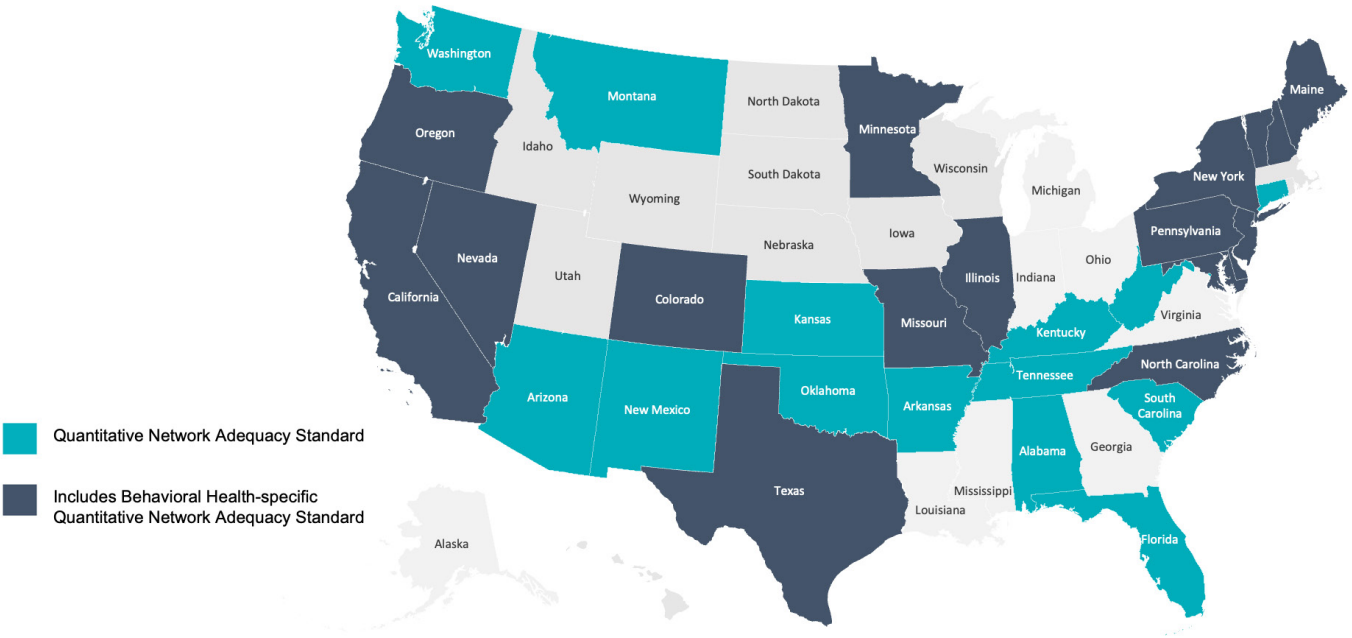
Thirty-one states have adopted at least one quantitative standard for at least one type of insurance product to monitor network adequacy (Figure 3).[18,65] Standard adoption varies by state, based on insurance market (Medicaid, Medicare, qualified health plans, commercial insurance).[3] Most states apply the same standards to behavioral health care as they do to all other types of specialty care. However, 17 states have developed network adequacy standards specific to behavioral health services.[3,18] Across states and markets, the majority of quantitative standards fall into one of three categories:[3,6,18,57] **1.) provider to enrollment ratios or minimum number of providers; 2.) appointment wait time; 3.) geographic criteria.**

Refer to Appendix 2 for a summary of Network Adequacy in the Medicaid Managed Care 2023 External Quality Review.

Figure 2. Quantitative Network Adequacy Standard Definitions

Network Standard	Definition
Provider/Enrollee Ratio or Minimum Number of Providers	The ratio of each type of behavioral health care practitioner to number of members, or minimum number of certain provider types to include in-network.
Appointment Wait Times	Appointment date within X days of enrollee request, or sooner if medically necessary. Number of days depend on whether request is for routine vs. urgent care.
Geographic (Time/Distance)	Acceptable travel time by car and/or mileage to care setting.

Figure 3: Map of Standard Adoption



Does not include standards applied to states' Medicaid Managed Care, for emergency only standards, or states that have adopted national accreditation standards for their network adequacy standards. Data pulled from Legal Action Center and the National Conference of State Legislatures.[18,65]

RESEARCH & EFFECTIVENESS

Results from the literature review identified only two empirical evaluations of the impact of network adequacy standards on access to care. Both evaluate Medicaid-enrolled populations across states, and found no meaningful improvement in access to care based on results from the Consumer Assessment of Healthcare Providers and Systems Survey (CAHPS).[21,22] Stakeholders could not identify examples of "real-life" scenarios where adoption of network adequacy standards improve outcomes. Although research is needed to determine the effectiveness of current standard adoption, there is significant literature outlining the varied and complex systematic barriers preventing a clear pathway to evaluate the impact.[4,7,11,13,57,66] Below is a summary of the current evidence surrounding the three most commonly adopted standards.

PROVIDER-TO-ENROLLEE RATIOS

Provider-to-enrollee ratios, or minimum number of providers, is a commonly employed metric to ensure that a network has an adequate supply of participating providers for the number of enrolled members. Ratio ranges vary dramatically by provider type from state to state and from health plan to health plan. Thirteen states have adopted the standard broadly and 5 have set standards specific to behavioral health providers.[18] However, research demonstrates that this metric allows networks to appear more robust on paper than they really are, due to provider directory inaccuracies and provider participation in multiple networks.[11,62]

Zhu et al. (2022) found that over 67% of mental health prescribers (psychiatrists, psychiatric nurse practitioners) and 58.2% of mental health non-prescribers (master's-level counselors and social workers) were identified as ghost providers. The authors then calculated ratios based on accurately listed providers, and found that only 0.7 mental health prescribers were available and accessible per 1,000 enrollees. These findings were 5 times less than what health plans reported with 4 mental health prescribers per 1,000 enrollees, when not accounting for ghost providers.[11]

It is common for providers to accept multiple insurance plans, so even when active providers are accurately displayed in a directory, this metric does not measure their capacity to serve members of any health plan with which they participate.[62] A single provider accepting numerous health plans lets each plan appear compliant on paper, but that does not equate to access for consumers.[4,62] Stakeholders expressed that this is a concern when comparing mental health providers to physical health providers, due to the length of appointments, which are often a minimum of 45–60 minutes, rather than 15 minutes. This greatly reduces the number of individuals providers can see, and highlights the importance of measuring provider capacity.[4,67–69]

Current calculations and monitoring of provider-to-enrollee ratio/minimum number of provider standards result in misrepresentation of access to care and compliance with standards.[11,62] Stakeholders reiterated the findings of the research summarized here, and stressed that without improvement to data accuracy, inclusion of provider capacity and analysis of provider care delivery in the calculations, this metric will continue to fail at evaluating network adequacy.

"Capacity for behavioral health is very different than capacity for medical. A primary care physician generally has 35 patients coming through a day to meet the needed revenue, a psychiatrist is pushing it if it's 15 patients, a therapist is generally 6 to 8 patients a day, and those patients are seen weekly. So the numbers are vastly different, and all it takes is 1 case brought in by the therapist to lock up their capacity right away… It's just very so much more fluid than a primary care practice."
— stakeholder interviewee

WAIT TIME

Wait time includes a defined maximum number of days before an initial appointment can be scheduled (e.g., 10 business days for routine care in an urban setting). It is well documented that across behavioral health provider types and care settings, many individuals must wait long periods before they can secure an initial appointment, especially with a psychiatrist or in an inpatient or residential setting.[70] Medicaid enrollees experience longer wait times than individuals with private insurance or who are willing to pay cash.[23,71] Research has shown the importance of timely access to care for both engagement in care and health outcomes, especially for individuals with behavioral health conditions.[72]

Wait times were frequently cited as the most meaningful metric to evaluate access, because it is the only outcome measure.[13,59,66,73,74] But although 18 states have adopted wait time standards, their definitions vary and are specific to behavioral health in only 7 states.[18]

Burman & Haeder (2022) evaluated the impact of inaccurate provider directories on timely access to care in California, a state with a directory accuracy law and numerous network adequacy standards. The authors found that roughly 32% of listings were inaccurate, and that securing timely appointments happened for less than 54% of the accurate listings. Results were compared to those publicly reported by the state insurance regulator. There were concerning differences. Because regulators' methodology did not account for directory inaccuracies, timely access standards appeared to have been met. The authors argue that this misrepresents the reality of trying to schedule an appointment, and supports previous findings that networks mistakenly appear to be compliant with wait time standards.[13] While these findings were not specific to behavioral health care, Burman (2023) found similar results when looking at mental health providers in California.[59]

The consensus among stakeholders and findings from the environmental scan suggest that while wait times are a crucial metric, relying solely on wait times to assess network adequacy is not an effective evaluation method.[66] Barriers emphasized by stakeholder interviewees include frequent wait time fluctuation, lack of data availability, administrative burden to update data across participating health plans, misplaced accountability on health plans for provider availability and consumer preferences for selected appointment offerings. These barriers make wait-time standards a complex and burdensome metric to both track and enforce for providers, insurers, employers and regulators. Furthermore, analysis of wait times has primarily relied on secret shopper surveys (using varied methodologies) that are time- and resource-intensive to conduct. Stakeholders emphasized the need for advances and investment in data infrastructure to effectively track and monitor wait times.

GEOGRAPHIC STANDARDS

Geographic standards include a list of specific provider types and facilities within a certain amount of driving time or distance based on geographic region, such as urban or rural county designations. For example, an urban area standard might require one psychiatrist within 20 miles or 25 minutes driving time of a member's home. These standards are the most common: 27 states have adopted them, and 13 states have adopted specific geographic standards for behavioral health care providers.[18]

While there is limited research on outcomes associated with adopting geographic standards on access to care, there is a large body of research on disparities in geographic accessibility of behavioral health provider types and settings.[23,29,75–79] The unequal distribution of behavioral health providers and facilities, well documented, results in limited access to care for individuals residing in rural areas and in communities with predominantly racial and ethnic minority populations.[12,29,58,77,80]

Because standards cannot influence where providers choose to practice, stakeholders reiterated findings of the environmental scan that advocated for state variability and flexibility in geographic standards, to allow for regional and seasonal considerations that require nuanced understanding. For example, mountainous or waterfront areas that might be inaccessible for extended periods can impact a state's ability to meet geographic standards; crossing state borders might offer more convenient locations for individuals to access care.[4,6,66]

While geographic proximity is a critical dimension of access, geographic standards do not provide key variables such as wait time, whether a provider is accepting new patients, is accessible via public transit or can be culturally responsive to an individual.[81] The literature suggests that current car-based travel time standards overestimate access to realized care, especially for populations that rely on public transit or that are seeking residential and/or substance use treatment.[45,80,82] Stakeholders suggested a hybrid standard covering both geographic accessibility and provider capacity to see individuals in a timely manner as critical to monitoring network access.

EVOLVING ROLE OF TELEHEALTH NETWORK ADEQUACY CREDITS

In 2023, Maryland updated regulations to allow for telehealth credits with written protections in place for consumers to be entitled to receive in-person care.[69]

Since the pandemic, telehealth has had a rapidly evolving role in the delivery of health care services. Regulators have begun offering telehealth network adequacy credits toward meeting network adequacy requirements; for example, California permits telehealth providers for certain specialties to meet up to 5% of required time or distance standards.[83] However, there is limited insight into how regulators will use telehealth to meet network adequacy standards.[83,84] Stakeholders debated the role of telehealth, and how telehealth network adequacy credits might impact current network adequacy standards—geographic standards in particular. Stakeholders noted that while telehealth can be a great benefit, individuals need protected access to in-person services and the ability to choose their preferred care delivery.[85]

Stakeholders also advocated for understanding the long-term impact of such credits on populations with existing health disparities (e.g., older adults) or with limited access to broadband internet services.

ADDITIONAL METRICS

Several states and health plans have adopted additional metrics and standards to address gaps in measurement of access across the five dimensions, but these metrics have varied definitions, data collection methods and adoption across states. And although many recommend these metrics as solutions, especially for consumers, their effectiveness in improving access has not been evaluated.[80,86,87]

Stakeholders mentioned the importance of metrics (table below) to ensure that access is equitably attainable to various populations (e.g., networks are culturally competent, especially for behavioral health). Many spoke of the importance of the cultural fit between provider and individual. Access to services via public transit, especially for Medicaid enrollees, should be more widely incorporated into geographic standards. Stakeholders also stated that the patient perspective and satisfaction with services should be proactively collected and reported on.

Figure 4: Additional Quantitative Network Adequacy Metrics

Metric	Description
Number of Providers Accepting New Patients	A minimum number or percentage of providers who are accepting new patients. Some plans must list this in their provider directories for consumers.
Cultural Competency	A variety of standards offer vague statements that networks must ensure access to providers who are "linguistically and culturally competent" or culturally diverse. Criteria to meet these metrics vary from completing training(s) to personal identifiers. Some health plan directories note if a provider has met cultural competency standards.
Provider Characteristics	Similar to cultural competency standards, provider characteristics varied; for example, provider directory listing self-reported race, ethnicity, immigration status, gender, primary language, LGBTQ+ identities and/or special services offered by providers.
Telemedicine Services	Required reporting on and tracking whether telemedicine services are available. Increasingly common for telemedicine service offerings to be listed in provider directories. Some state regulators offer credits toward network adequacy requirements for available teleservices.
Hours of Operation	Availability of certain types of services outside routine business hours, or available 24 hours for routine and emergency services. Often included in wait time standards.
Public Transit Proximity	Inclusion of public transit in the geographic distance and travel time standards, where available.
Essential Community Providers	Qualified health plans are required to include 35% of a regional area's essential care providers, which often include behavioral health settings such as community mental health centers or substance use specialty clinics.
Consumer Feedback	Consumers self-reported satisfaction with coverage, quality of care received and perception of timely access to services. Survey design and methodology varies.

METRICS IDENTIFIED

Metrics that have not been adopted by states were identified across stakeholder interviews and the environmental scan as potential metrics to improve monitoring of network adequacy. The most commonly referenced metrics included a bundle of five quantitative metrics developed by the Mental Health Treatment and Research Institute.[88] These were developed to create a standardized format for health plans, employers and regulators to provide comparable outcomes. The bundle of metrics and template, referred to as the Model Data Request Form, includes:

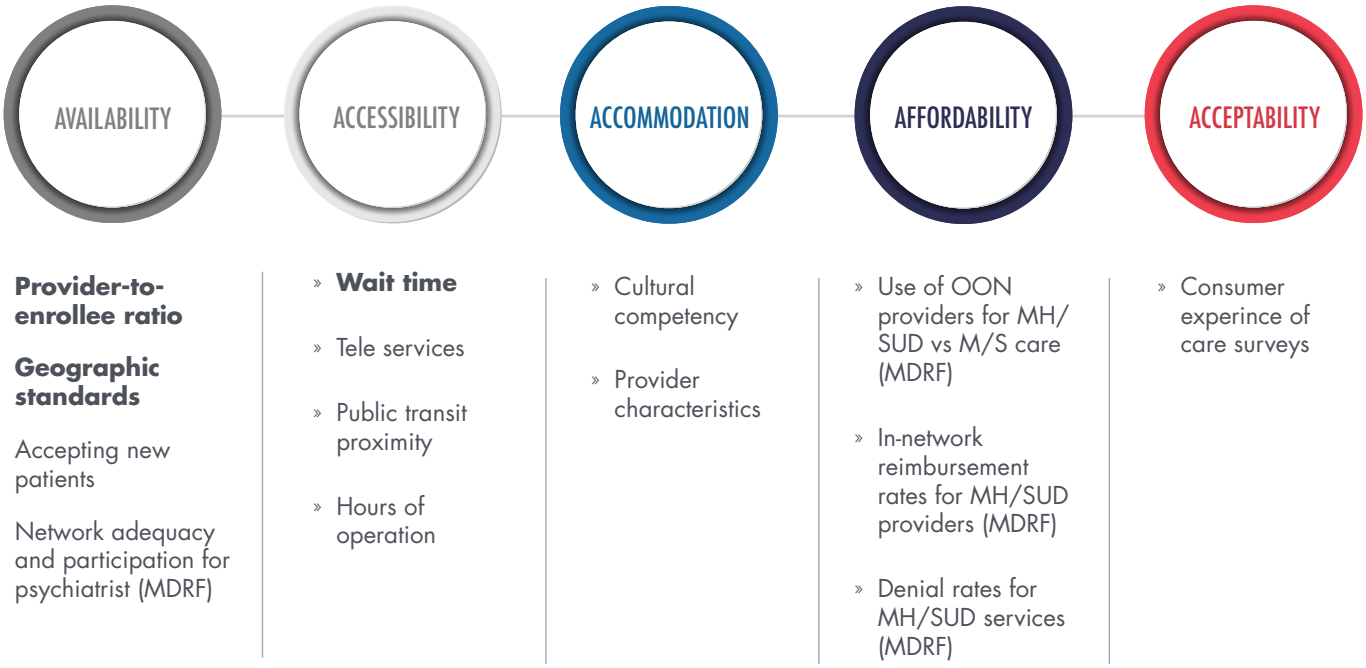
- Out-of-network use of mental health/SUD providers vs. medical/surgical providers.
- In-network reimbursement rates for mental health/SUD providers vs. medical/surgical providers.
- Denial rates for mental health/SUD vs. medical/surgical services.
- Network adequacy and participation for psychiatrists and other mental health/SUD professionals.
- Operational proportionality for mental health/SUD vs. medical/surgical providers for utilization management protocols.

A highly cited 2019 report evaluating out-of-network use and reimbursement rates demonstrated worsening disparities over the last 5 years, and point to a lack of MHPAEA compliance.[1] In July 2023, the Biden administration proposed updated data requirements to increase enforcement of MHPAEA, and included several of these metrics. Stakeholders emphasized the importance of using the metrics to create a baseline understanding of how networks perform and function, and suggested that initial metric collection be a starting point for developing realistic and effective standards for adequacy. As of this writing, proposed updates are under consideration.

STANDARD IMPACT ON ACCESS

Consensus across the environmental scan and stakeholder interviews is that, regardless of the current lack of evidence, network adequacy standards help create measurable benchmarks and consumer safeguards.[89] A key theme was, however, that existing standards fail to capture important variables to adequately evaluate a network across all five dimensions of access.[81] Currently, no metric can simultaneously measure multiple dimensions. In order to effectively measure access across all five dimensions, it will be necessary to adopt a bundle of standards.[66] Most states have only adopted one quantitative standard.[18] Figure 4 demonstrates how current standards fit into the 5 A's framework, further highlighting the limited capacity of existing standards to gauge access comprehensively.

Figure 5: Standards in the 5 A's Framework



Monitoring & Enforcement of Network Adequacy Monitoring

Federal and state regulators have varied approaches to monitoring network adequacy across product lines, not exclusive to behavioral health.[3,18] Insurance products are overseen by different regulators, often at different levels of government.[7,20] Monitoring can range from proactive strategies in which regulators annually review plan metrics and reports, to reactive strategies in which plans self-report deficiencies.[3,7,18] Each method has benefits and drawbacks, but all lack a standardized approach across regulating bodies, and many offer limited transparency. [6,7,81]

Some regulators have robust proactive monitoring strategies that involve continuous oversight and periodic reviews of standards.[3,7,18] Reviews often consist of annual submission of data showing if a plan is in compliance with network adequacy standards. Regulators also use secret shopper surveys or consumer satisfaction surveys. California, Colorado, Maryland and New Hampshire were mentioned most frequently in stakeholder interviews as taking a proactive approach.

Most states engage in reactive monitoring that is prompted by an event (e.g., changes in provider contracting, customer complaints, plan self-attested issue).[3,7] Most states report relying on consumer complaints to trigger monitoring.[18] While stakeholders emphasized that consumers should always have the right to make a complaint, it should not be the primary method of monitoring network adequacy. Busch and Kyanko's study found that even when consumers encountered issues, only 9% filed a complaint.[14]

Stakeholders emphasized that the lack of standardization, transparency and fragmented oversight are not only barriers to ensuring adequacy, but also to meaningful comparison across plans. Stakeholders also discussed the time-intensive administrative burden of monitoring network adequacy, which many regulators do not have the resources, capacity or authority to conduct.

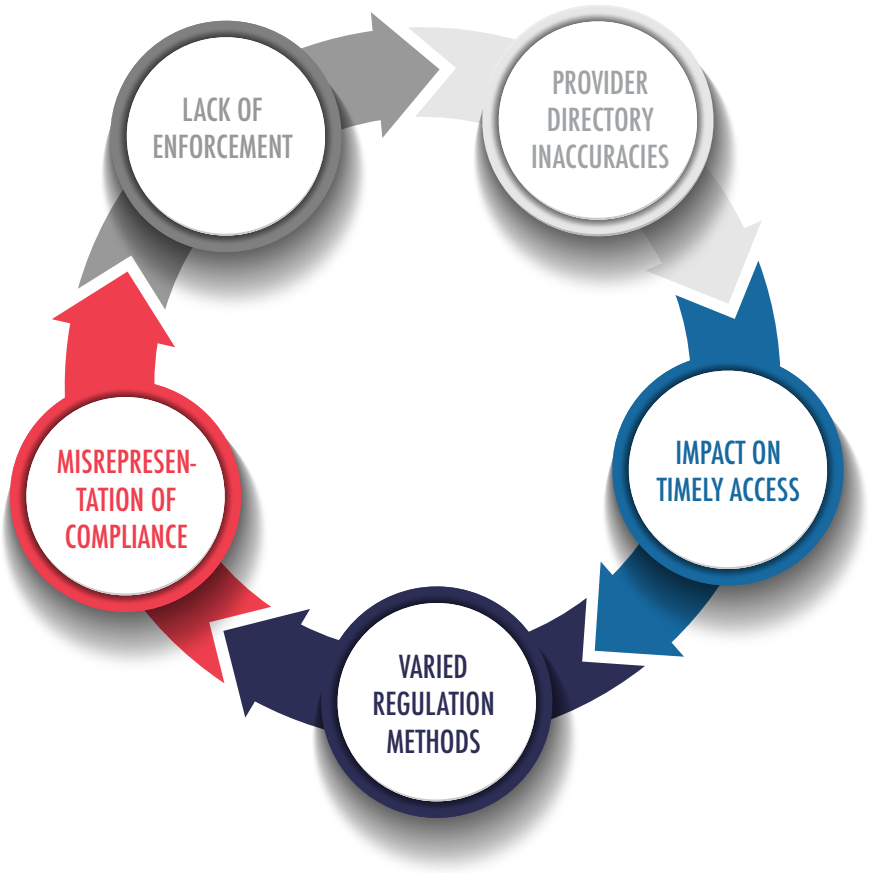
ENFORCEMENT

When noncompliance with network adequacy standards is identified, regulators can work with health plans to create corrective action plans to resolve the issue, or employ financial penalties.[3,20] Oversight actions for noncompliance vary from state to state, creating an uneven landscape for accountability and consequences.[3] An NCIC survey reported that 99% of HMOs and 73% of PPO plans received one penalty—or no penalties—for not meeting network adequacy standards.[90] A report from the Office of the Inspector General found that most states did not identify any standards violations over a 5-year period.[20] During stakeholder interviews, many experts highlighted the lack of enforcement and stated that it is often less expensive for plans to pay a fine than to fix fundamental network issues. Stakeholders argued that the landscape lacks both incentives and penalties to fix underlying issues of network adequacy.

The effectiveness of monitoring and enforcement of network adequacy standards is undermined by the pervasive issue of inadequate and inconsistent data.[7,11,13,57] Data are the backbone of regulatory oversight, informing decisions and ensuring compliance with established standards, but the lack of uniformity in data collection and reporting processes across plans and states has given rise to the inability to conduct thorough and accurate assessment of network adequacy.[57] This challenge becomes evident when considering the inaccuracy of network directories.

Directories are an integral component in calculating and verifying compliance with standards—and they are highly inaccurate.[11,13] Figure 5 demonstrates the ripple effect of provider directory inaccuracies that allow plans to appear compliant, when in reality, they do not provide the expected level of access to services, impeding an individual's ability to receive timely care and failing to trigger the need for enforcement.[7,13]

Figure 6: Impact of Ghost Networks on Enforcement



Strategies for Increasing Access

There is heightened attention on the need to systematically increase equitable access to behavioral health care and leverage the existing workforce. Recent federal investment in behavioral health programs and policies demonstrates efforts to curb the behavioral health crisis and protect consumers; for example, with the passage of the No Surprises Act, federal investment in the 9-8-8 line, updates made by CMS and investment in Certified Community Behavioral Health Clinics. But many decisions depend on proposed legislation and regulations that will have a considerable impact on access to care, such as proposed data collection requirements to strengthen MHPAEA and federal regulations regarding telehealth and prescribing.[8,91]

This section highlights major methods identified in the environmental scan and stakeholder interviews, with demonstrated evidence to improve access amid a rapidly changing policy landscape. It is important to note that the list is not exhaustive. The effectiveness of behavioral health treatments depends on condition severity, physical conditions, social determinants of health, culture, identity and age. Stakeholders emphasized that no one solution can improve access across populations—only a variety of services across the care continuum will truly improve equitable access.

BEHAVIORAL HEALTH INTEGRATION

In recent years, there has been growing acceptance of integrating behavioral health services with medical services to reduce silos and stigma, and increase access and care coordination. Although behavioral health integration exists on different levels and in a variety of medical settings, the collaborative care model has been studied in over 90 randomized controlled trials. This model partners a behavioral health care manager with a medical provider and a consulting psychiatrist, and

has an established evidence base for improving care outcomes for mild to moderate conditions of depression, postpartum depression, anxiety, PTSD and SUD in a variety of care settings, both in-person and through telehealth.[92–95] Collaborative care has demonstrated effectiveness in engaging and treating underserved racial-ethnic groups.[96] This model helps ensure that individuals receive services in the least intensive, most appropriate setting, and has demonstrated cost effectiveness.[97] Widespread adoption of this model is lacking, however.[98] Initial obstacles to implementation include upfront costs and concerns about financial sustainability, since the team-based workflow presents barriers to reimbursement.[99]

Payers play a critical role in facilitating behavioral health integration. In 2017 CMS introduced fee-for-service reimbursement, and in 2018 it launched collaborative care Current Procedural Terminology codes. Medicaid currently pays for these codes in 26 states; 20 commercial plans provide coverage for them. Payers and states use alternative payment models to support implementation and upfront costs, but additional investment is necessary to gain widespread adoption of the collaborative care model.[100]

Stakeholders noted that while behavioral health integration is one method of proactively identifying needs and improving access to behavioral health services, they cautioned against advocating behavioral health integration as the sole solution to the mental health care crisis, due to workforce shortages and demands on primary care providers. Many advocated for increased clarity and a standardized definition, noting how integrated offices might contribute to network adequacy. Currently there is no consensus on how integrated behavioral health providers/practices and services would count toward network adequacy, and if they would count toward primary care or toward behavioral health standards.

WORKFORCE SUPPORTS

Amid national workforce shortages and geographical disparities, several models of care have leveraged and extended the expertise of the existing workforce to share knowledge of evidence-based practices, allow individuals to work at the top of their license and deliver care outside traditional silos; for example, **1.) provider training, consultation and support programs; 2.) increased utilization of care teams that include paraprofessionals, nurse practitioners, physician assistants and pharmacists; and 3.) digital applications to support treatment services.**

PROVIDER TRAINING & CONSULTATION PROGRAMS

With increasing integration of behavioral health into medical settings, many primary care and specialty providers report not having enough training in behavioral health to support the needs of patients.[100] Models of provider training and consultation programs, often funded through grants or state funds, have demonstrated effectiveness in improving provider education, confidence, care coordination and patient outcomes:

1. **Psychiatry Access Programs** offer free telephone consultation, education and training, and resource and referral support with psychiatrists and other behavioral health providers.[101,102] Initially developed to address the shortage of child and adolescent psychiatrists and support pediatricians, the model has been expanded to addiction medicine and perinatal mental health; currently, 42 states have a child psychiatry access program. Services vary from provider-only consultation and training to direct patient care through telemedicine or a hub and spoke model.[102]

2. **Project ECHO** (Extension for Community Healthcare Outcomes) is a tele-mentoring model for providers to share knowledge and discuss case examples, with a growing body of evidence to support the efficacy of increasing provider knowledge on mental and substance use treatment.[103–105] The model has been adopted globally to train providers across a variety of specializations.

3. **Hub and Spoke Model** was developed to increase addiction treatment capacity through development of a network of providers across communities (spokes) to treat individuals with opioid use disorder after initial specialized addiction care at a licensed specialty opioid treatment program (hubs). Individuals move between the hubs and spokes as their care needs evolve. The model has reduced wait times, improved patient outcomes and reduced treatment silos.[106,107]

WORKFORCE EXTENDERS

In addition to integrating services through primary care providers, care teams increasingly utilize a variety of health professionals to help meet the demand for behavioral health services and to extend the existing workforce amid shortages. Use of peer support specialists in behavioral health care settings helps individuals navigate care settings, reduces ED and hospitalizations and improves engagement and retainment in care.[108] Peers often reflect the diversity of the communities they serve, providing a culturally responsive, person-centered approach to care.[108] Stakeholders highlighted the important role peers and other noncredentialed providers play in care delivery teams. Another example of workforce extenders is the use of board-certified psychiatric pharmacists who have demonstrated effectiveness in expanding access and adherence to medications. Despite the important role pharmacists can play, reimbursement for their role as care team members presents a barrier to scaling their services.[109–111] Elimination of the waiver requirement for prescribing buprenorphine for opioid use disorder treatment allows many more prescribers to incorporate substance use treatment into their practice; for example, OB/GYNs, midwives, nurse care managers and dentists.[112] Stakeholders supported expanding the list of in-network providers to support the use of multidisciplinary teams for effective treatment.[3,10]

TELE-BEHAVIORAL HEALTH SERVICES

In response to the COVID-19 pandemic, the behavioral health care industry rapidly converted care to tele-based platforms, which escalated widespread acceptance of this service modality. Evidence illustrates the effectiveness, utility and diagnostic reliability of tele-behavioral health programs to address behavioral health workforce shortages, especially in rural areas.[113,114] Tele-behavioral health allows individuals to access providers who are a racial, ethnic, language, cultural or specialty match, but who may not be geographically accessible.[24,115] Studies have found that tele-behavioral health reduces appointment wait times, compared to in-person visits.[58,116] Telehealth has shown to decrease the stigma of seeking behavioral health care, increase provider and patient satisfaction, increase service utilization and remove geographic barriers.[58,85,116,116]

While tele-behavioral health services are here to stay, many questions remain about the future of policies, developed during COVID-19, that ensure ongoing access. Although some have been permanently adopted, others have only been extended through December 2024 (the need for initial in-person evaluations, coverage of audio-only services, ability to prescribe controlled substances).[8,117] Final decisions will affect access to care and how telehealth services might contribute to meeting network adequacy standards. Several states allow out-of-state providers to provide telehealth services across state line, but this varies from state to state. Many have advocated for increased flexibility in licensure laws across state lines to meet growing demand amid workforce shortages.[117,118]

A common theme in stakeholder interviews was the need for increased clarity for scenarios where telehealth is acceptable clinically, and when it can count toward meeting network adequacy credits.

BEHAVIORAL HEALTH EMERGENCY SERVICES

Emergency behavioral health services, which include mobile crisis teams or crisis stabilization units, offer a needed alternative to EDs, psychiatric hospitalization and law enforcement involvement for individuals experiencing a behavioral health emergency. Research demonstrates that these services successfully redirect individuals away from inappropriate, ineffective and high-cost settings.[40,119,120] However, access to in-person crisis services is limited because their financing relies on multiple funding sources, including grants, Medicaid and state funds.[119] Most insurers do not offer coverage. Currently, 33 state Medicaid programs cover mobile crisis services and 28 state Medicaid programs cover crisis stabilization units.[119,121] Although the American Rescue Plan Act of 2021 offered federal funding to support implementation of crisis services for the first 3 years, concerns about financial coverage and workforce availability present significant barriers to sustainability. Consumer advocates recommend making these services a mandatory Medicaid benefit, and call for a permanent mechanism to fund and reimburse services, similar to how fire and emergency medical services are staffed and funded.[122] At this writing, there are several proposed legislative acts (e.g., Behavioral Health Crisis Services Expansion Act) to increase insurance coverage for emergency services.

CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINICS

In recent years, the federal government has made significant investments in Certified Community Behavioral Health Clinics (CCBHC) to improve timely access to comprehensive care, including 24-hour crisis services regardless of condition or insurance status. There are CCBHCs in 46 states, the District of Columbia, Puerto Rico and Guam, with plans to expand.[123] According to the 2022 impact report, CCBHCs improve access to timely and integrated services. Implementation of a CCBHC has allowed clinics to serve 900 more people per clinic than prior to implementation. 87% of clinics report being able to see individuals within 10 days of an initial request for services, and 32% offer same-day access to an appointment.[123] CCBHCs will play an important role in improving delivery of treatment and coordinating care across systems, including hospitals, schools, justice systems and crisis services.

TECHNOLOGY

There have been technologic advancements in platforms that coordinate or facilitate services, various behavioral health apps, asynchronous telepsychiatry and artificial intelligence. Stakeholders discussed one example with a growing evidence-base and pathways for insurance coverage: digital therapeutics. These extend the reach of the current workforce by offering evidence-based psychotherapies, such as cognitive behavioral therapy, that individuals engage with virtually through software applications. Digital therapeutics can help overcome barriers to accessing face-to-face care, and are effective in treating anxiety, depression, insomnia, panic and substance use disorders.[124,125] They offer increased access to care without wait times, and the literature shows high retention and completion rates among users.[125] It is important to note, however, that only a few digital therapeutics are evidence based in the rapidly growing market of mental health apps that can be difficult for both providers and consumers to navigate.

Currently, NINE digital therapeutics are FDA approved. Some require a prescription, and send information to the provider to incorporate into the treatment plan.[120]

Future Considerations

Network adequacy standards are essential for protecting consumer access to behavioral health services, but do not have demonstrated effectiveness in improving access to services. The prevalence of inaccurate provider data, paired with inconsistent adoption of network adequacy standards, varied methodologies and accountability of regulation, as well as a lack of transparency in reporting outcomes, highlights the complexity of evaluating network adequacy and illuminates why access to care is often overestimated.

Historically, behavioral health has operated as a separate system from medical/surgical services, and this has shaped the structural, regulatory and financial differences that contribute to consumer-level disparities in access, cost, quality and care coordination.[10,32] Stakeholders frequently emphasized the differences in care delivery that underscore challenges to applying the same standards to all care without improved incentives to enforce compliance.

Potential future considerations identified across the environmental scan and stakeholder interviews include recommendations for developing new measures or metrics, establishing standardized monitoring and evaluation techniques and investing in new technology and to bolster effective models of care.

Development of measures or metrics

- ***A bundle of metrics*** is necessary to adequately measure ***all five domains of access.***[81] Based on recommendations from the environmental scan and stakeholder interviews, metrics should include wait times, geographic time and distance standards, analysis of claims data to understand network performance and metrics to ensure a culturally competent network. ***A uniform methodology*** for metric calculations and for monitoring compliance is also necessary to make meaningful comparison across markets.

- ***Measures of consumer perspective and satisfaction*** with care received should be collected, monitored and reported on proactively. Consumer perceptions of timeliness, linguistic and cultural accessibility and other facets of network adequacy would provide important information about network adequacy.

Standardized monitoring and evaluation

- An alternative method of evaluating network adequacy may include ***tracking behavioral health services over provider types and facilities*** to ensure availability of the full continuum of behavioral health care services, including those covered by noncredentialed professionals or that traditionally have not been covered in-network.

- ***Develop a standardized methodology for monitoring network adequacy standards*** with increased transparency of reported outcomes; consistent enforcement across states could support stronger behavioral health networks.[64] This would allow meaningful comparison across markets and states.
    - » There is a need for better financial incentives to improve performance in the long term, and greater penalization for noncompliance.

Investment in models of care and technology

- ***Invest in technology*** to ensure timely, accurate and standardized updates to provider directories. Streamlining data collection in a uniform, digital platform across health plans could help reduce data inaccuracies and the administrative burden associated with updating directories across health plans.[17]

- ***Standards should account for multidisciplinary care teams*** and integrated behavioral health care services. As integrated services become more common, there should be guidelines defining the level of integrated services that count toward network adequacy standards and toward primary care or behavioral health specialties.

- ***Increase insurance coverage*** of services and models that improve access to care, including, but not limited, to emergency services, telehealth and digital innovations and applications for both mental and substance use disorders.

Given the scope and complexity of the behavioral health care system in the U.S., it is clear that no single solution can ensure equitable access to behavioral health. Current measures of access give limited consideration to those that have real implications on consumers' access to services. As standards evolve, there must be additional research into the outcomes associated with adoption of network adequacy standards. Also needed are broad initiatives to address underlying workforce challenges, fragmented infrastructure and outdated, discriminatory regulations that prevent equitable access from being a reality.[3,19]

Acknowledgments

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Appendix 1: Behavioral Health Providers

This table provides a high-level summary of the diverse range of behavioral health professionals, illustrating the levels of education and training that are subject to different licensing and certification requirements, depending on specialization, state, and health care setting. Each state has certification and licensure requirements—which may have different eligibility requirements—and therefore, providers who want to provide services in multiple states must apply for certification and/or licensure in each state. States may also have tiered licensure systems that allow distinct scopes of clinical practice based on level of licensure. Additional certification, licensure, training, specialization, and supervision may be needed in order to work with specific populations, within certain health care settings, or to provide evidence-based treatment modalities. Coverage and reimbursement for provider types and the services they deliver vary by state and by health plan.

Provider Type	Role Description	Education	Certification and Licensure	Scope of Practice	Reimbursement
Certified Peer Support Specialist/Peer Recovery Specialist	Individual with lived experience of recovery from a mental health and/or a substance use disorder. Provided nonclinical, strengths-based support to individuals experiencing similar challenges.[126] Can work in a variety of settings as part of care team.	Requirements vary by state and may include: • High school diploma/GED • In recovery from a substance use disorder and/or managed mental health diagnosis/ diagnoses • Meet minimum state certification requirements, which may include: » completion of training program; » passing an exam; and » paid or volunteer experience	Certification by state[126]	Generally includes: » Advocacy » Outreach » Patient engagement » Resource linkage » Skill building » System navigation	Medicare does not reimburse peer support services; however, in 2024 CMS is finalizing payment policy for navigation services that may be provided by peer support specialists.[127] Medicaid coverage is available in most states through state plan and waivers.[128] Commercial plans may reimburse through special programs, but the majority do not reimburse for peer support services.[129]
Qualified Mental Health Professional (QMHP)	Mental health professional whose eligibility requirements vary by state to provide both nonclinical and clinical services for a variety of behavioral health conditions. Various other licensed mental health providers may be required to register as a QMHP, depending on the state board requirements. Can work in a variety of settings.[130]	Requirements vary by state and may include: • Bachelor's degree • Master's degree (nurses, occupational therapists, and other health care professionals may be eligible to qualify as a QMHP based on state regulations). • 1,500–3,000 hours supervised clinical practice, based on state regulations and level of education and training	Certification by state[130,131]	Generally includes: » Assessment » Care coordination » Case management » Counseling » Diagnose » Patient engagement » Resource linkage » Skill building » System navigation management	Medicare and Medicaid cover QHMP with varying requirements. Commercial plan reimbursement policies vary by payer and state.

Provider Type	Role Description	Education	Certification and Licensure	Scope of Practice	Reimbursement
Licensed Clinical Addictions Specialist (LCAS)	Mental health professional specializing in substance use disorders. Can provide clinical services to individuals with substance use history. Can work in a variety of settings, including addiction treatment centers and private practices.[132]	Requirements vary by state and may include: • Master's degree specializing in addiction counseling • 4,000 hours supervised clinical practice	Licensure by state[132]	Generally includes: » Assessment » Care coordination » Counseling » Diagnose » Patient engagement » Skill building	Medicare does not currently reimburse addiction specialists. Medicaid and commercial reimbursement policies vary by plan and state.[132]
Licensed Alcohol and Drug Counselor (LADC)/Certified Alcohol and Drug Counselor (CADC)	Mental health professional specializing in substance use disorders. Can provide clinical services to individuals with substance use history. Can work in a variety of settings, including addiction treatment centers and private practices.[132]	Requirements vary by state and may include: • High school diploma and 6,000 hours of supervised clinical practice • Bachelor's degree and 4,000 hours supervised clinical practice • Master's degree and 2,000 hours supervised clinical practice	Certification and licensure by state[132]	Generally includes but varies by licensure and state: » Assessment » Care coordination » Case management » Counseling » Diagnose » Patient engagement » Skill building	Medicare does not currently reimburse addiction specialists. Medicaid and commercial reimbursement policies vary by plan and state.[132]
Licensed Marriage and Family Therapist (LMFT)	Mental health professional specializing in interpersonal relationships and family systems. Can provide clinical services for behavioral health concerns within the context of marriage, couples and family systems. Can work in a variety of settings, including private practice.[134]	Requirements vary by state and may include: • Master's or doctoral degree specializing in marriage/family counseling • 2,000–4,000 hours supervised clinical practice	Licensure by state[135]	Generally includes: » Assessment » Care coordination » Counseling » Diagnose	Starting in 2024, LMFTs receive reimbursement for Medicare.[127] Medicaid and commercial insurance generally reimburse these professionals, but coverage may vary by plan and state.
Licensed Professional Counselor (LPC)/ Licensed Mental Health Counselor (LMHC)/ Licensed Clinical Mental Health Counselor (LCMHC)/ Licensed Professional Clinical Counselor (LCPC)/ Licensed Professional Clinical Counselor (LPCC)	Mental health professional that may specialize, through licensure and certifications, in a variety of conditions and provide clinical services to a variety of populations. The variety of licensures, certifications and titles across states will impact the scope of practice and health care settings.[136]	Requirements vary by state and may include: • Master's degree from a graduate program in behavioral health • 2,000–4,000 hours supervised clinical practice	Certification and licensure by state[137]	Generally includes but varies by licensure and state: » Assessment » Care coordination » Counseling » Diagnose » Patient engagement » Skill building	Starting in 2024, mental health counselors receive reimbursement for Medicare.[127,133] Medicaid and commercial insurance generally reimburse these professionals, but coverage for counselors and specific services may vary by plan and state.

Provider Type	Role Description	Education	Certification and Licensure	Scope of Practice	Reimbursement
Licensed Clinical Social Worker (LCSW)	Mental health professional eligible to provide clinical services, specialize in a variety of behavioral health conditions, and work with a variety of populations. Scope of practice varies from counseling to case management services. Can work in a variety of settings, including private practice.[138]	Requirements vary by state and may include: • Master's or doctoral degree in social work • 2,000 hours supervised clinical practice	Licensure by state[135]	Generally includes: » Assessment » Advocacy » Care coordination » Case management » Counseling » Diagnose » Patient engagement » Skill building	Medicare, Medicaid and commercial insurances reimburse LCSWs. Coverage for specific services varies.[133]
Psychologist (PhD, PsyD, EdD)	Mental health professional with a doctoral degree, trained to provide evaluations and a variety of clinical services for a variety of behavioral health conditions. Can work in a variety of settings, including private practice.[135,139]	Requirements vary by state and may include: • Psychology doctoral degree • 2,000 hours supervised clinical practice • Residency/supervision for 1 or 2 years	Licensure by state[135]	Generally includes: » Assessment » Counseling » Diagnose » Prescribe medications (in 6 states)	Medicare, Medicaid, and commercial insurances reimburse psychologists. Coverage for specific services varies.
Primary Care Physician/ Pediatrician (MD/DO/PA)	General practitioner who manages overall health care needs. Variable involvement in identification, management, and/or treatment of behavioral health care.[139]	Requirements vary by state and may include: • Master of physician assistant studies • Doctor of medicine or doctor of osteopathic medicine and 4 years of residency	Certification and licensure by state[140,141]	Generally includes: » Assessment » Diagnose » Prescribe medications » Resource linkage	Medicare, Medicaid and commercial insurances cover primary care providers. Coverage for specific mental health services provided may vary by plan. Primary care providers can bill collaborative care codes as a part of integrated care models.[97]
Psychiatric Nurse Practitioner/Psychiatric Mental Health Nurse Practitioner	Advanced practice nurse with specialized training in mental health care. Can work in a variety of health care settings, including private practice.[139]	Requirements vary by state and may include: • Master's or doctoral degree • 500 hours supervised clinical practice • State-specific certification	Certification and licensure by state[135]	Generally includes: » Assessment » Care coordination » Diagnose » Prescribe medications	Medicare, Medicaid and commercial insurances provide reimbursement for psychiatric nurse practitioners. Coverage for specific services varies.

Provider Type	Role Description	Education	Certification and Licensure	Scope of Practice	Reimbursement
Psychiatrist (MD or DO)	Medical doctor with specialized training in psychiatry to assess, diagnose, and prescribe medications or alternative treatments. May receive advanced training and credentialing to specialize in specific populations, conditions, and evidence-based treatment modalities. Can work in a variety of settings, including private practice.[142]	• Doctor of medicine or doctor of osteopathic medicine • 4 years of residency	Certification and licensure by state[135]	Generally includes: » Assessment » Diagnose » Prescribe medications » Administer medications » Resource linkage	Medicare, Medicaid and commercial insurances cover psychiatrists. Coverage for specific services varies.
Addiction Medicine Specialist (MD or DO)	Medical doctor with specialized training and credentialing in addiction medicine to assess, diagnose, and prescribe medications to individuals with substance use disorders. Can work in a variety of settings, including addiction treatment centers, hospitals, and private practice. [143]	• Doctor of medicine or doctor of osteopathic medicine • 4 years of residency	Certification and licensure by state[135]	Generally includes: » Assessment » Diagnose » Prescribe medications » Administer medications » Resource linkage	Medicare, Medicaid and commercial insurances reimburse addiction medicine specialists. Coverage for specific services varies.

**A license is a rigorous process of meeting state eligibility requirements to be granted the legal authority to practice in a specific scope of practice. A certification is similar in that it represents a commitment to training and completion of eligibility requirements for a chose specialization; however, certified professionals are overseen by a non-governmental board and it is often voluntary to further validate a expertise.[132]*

Appendix 2: Summary of Network Adequacy in the 2023 Medicaid Managed Care Programs Quality Strategy and External Quality Review

Federal regulations require states with Medicaid Managed care programs to develop a quality strategy to assess and improve the quality of managed care services offered in a state. States must ensure that an external quality review (EQR) occurs annually to "monitor the quality, timeliness, and access to care provided, and to identify opportunities for quality improvement." In 2016 CMS updated the EQR requirements to mandate validation of network adequacy.

NCQA conducted an environmental scan of the 44 states required to develop a quality strategy and EQR documents, to identify publicly published behavioral health network adequacy standards and EQR behavioral health network adequacy validation activities. Table 1 summarizes our findings. We found that each state has documented network adequacy standards in either the quality strategy or in EQR documents. Thirty-eight had network adequacy standards that were specific to behavioral health services.

The most frequently reported behavioral health network adequacy standards included geographic standards, including time and distance measures and appointment wait-time measures. A common geographic standard was a 15–30 minute/mile distance standard for urban counties and a 30–60 minute/mile standard for rural counties. Additional time and distance classifications included stratification by provider type (e.g., mental health vs. substance use) and age of client (e.g., child vs. adult). Iowa's network adequacy standards are stratified by multiple client demographic factors. For appointment availability standards, states commonly have immediate, 24/7 availability for behavioral health emergencies and required appointments within 24–72 hours for urgent care. There is a range of standards for routine and inpatient care.

Some states have unique network adequacy standards to ensure linguistic and cultural accessibility and continuity of care. For example, Texas ensures that behavioral health providers include Spanish language providers for populations with a high percentage of patients for whom Spanish is the primary language. Iowa stratifies network adequacy results by race, ethnicity, urbanicity, age and concentrated disadvantage index to track gaps in care among MCO populations. Georgia and Virginia have standards for hours of operation for mental health service providers, and reporting standards for the percentage of providers accepting new clients.

Although external quality review organizations (EQRO) are tasked with providing recommendations to states regarding overall health plan network adequacy, there is no specific requirement for them to evaluate the adequacy of behavioral health providers. In our review of EQRO evaluations and recommendations, we noted that EQRs reviewed behavioral health provider network adequacy for 19 of the 38 states that outlined behavioral health-specific standards. Review activities included counts of providers, reviews of wait-time data, phone call studies, reviews of provider directories and secret shopper studies.

The EQR reports indicated that several states had provider deficiencies. Depending on the state, deficiencies were noted among psychiatrists, psychologists, outpatient services and opioid treatment providers. Recommendations addressed deficiencies and included ensuring accuracy of information provided to EQR for provider directories; identifying and addressing health plans, counties or providers who fail to meet geographic and/or time/distance standards; improving the user experience for provider directories; and identifying MCOs that fail to meet one or more standards for quality, timeliness and access.

Texas's EQRO recommended identifying MCOs to ascertain why providers do not meet availability standards, expand appointments to weekends or through telehealth services, and to introduce incentives to behavioral health providers to improve on network adequacy measures. Overall, the effort to collect and hold MCOs accountable to network adequacy standards improves quality measures across EQR activities, and improves access for the most vulnerable members. For example, New Mexico identified that behavioral health services account for 33% of all telemedicine visits, and created an EQR goal to increase those services by 20% for the next review. Additionally, through network adequacy EQR activities, Idaho discovered a sizeable provider shortage for behavioral health services, and recommended that health plans evaluate and fill vacancies to meet network adequacy standards.

Table 1. Medicaid Managed Care Behavioral Health Network Adequacy Standards by State

Behavioral Health Network Adequacy Measure	Number of States	States
Time-Distance	24	AZ, CA, CO, DE, GA, IA, IN, KS, MA, MI, MN, MO, NH, NM, NV, NC, OR, PA, RI, TN, UT, VA, WA, WI
By Provider Type and Geographic Location	7	CA, CO, IN, KS, MO, NM, RI)
By Geographic Location	5	GA, MI, OR, PA, WA
By Provider Type	4	AZ, MA, UT, VA
Not Stratified	4	DE, MN, NH, WI
By Provider Type and Age of Client	2	NV, TN
By Provider Type, Number, and Geographic Location	1	NC
By Age, Race, Ethnicity of Client and Disadvantage Index	1	IA
Appointment Availability	19	AZ, DE, DC, GA, HI, KY, MA, MI, NJ, NM, NY, ND, OH, PA, RI, TN, TX, VA, WI
Provider-Member Ratio	5	DE, GA IA, IN, NE
Distance Only	2	HI, SC
Percent Providers Accepting New Patients	2	GA, VA
Specified Hours of Operation	2	GA, VA
Reporting of Network Adequacy Standards	**44**	
Reporting of Behavioral Health Specific Network Adequacy Standards:	Yes: 38	
	Unclear: 3	MN, VT, WY
	No: 3	AL, FL, MD

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