Balancing the tension between flexibility and accountability in network adequacy standards has been a growing policy focus to ensure timely and appropriate access to mental health services in Medicaid, one of the largest payers for mental health care in the United States. Early evidence suggests that health care networks tend to be narrower for mental health than for other specialties. Under Medicaid managed care, in particular, enrollees are generally limited to contracted health professionals and do not have cost-sharing options for going out of network for nonemergent mental health care. Thus, inadequate health care networks may translate into substantive barriers in access to care, which is already challenged by a critical mental health workforce shortage and low rates of health professional acceptance of Medicaid. Moreover, health care networks that limit access to more specialized care may disproportionately affect individuals with serious mental illness or co-occurring complex health conditions—among the most vulnerable populations that the program serves.

Understanding how states are navigating these network adequacy standards is increasingly important as a rising share of the population is enrolled under Medicaid managed care for their behavioral health coverage. Under the 2016 Medicaid managed care final rules, the US Centers for Medicare & Medicaid Services (CMS) strengthened existing state regulations around managed care organizations’ network adequacy standards. States must establish network adequacy standards—at a minimum, time and distance standards—for 11 health professional specialty groups, including adult and pediatric mental health and substance use disorder treatment specialists. However, there is flexibility in the specific standards that they can set.

While the network adequacy standards are intended to protect a baseline level of access for Medicaid, there remains significant variation across states in network adequacy metrics and standards for mental health services. California specifies time and distance standards for both psychiatrists and nonpsychiatrist mental health professionals, ranging from 90 minutes or 60 miles in rural counties to 30 minutes or 15 miles in populous counties. Tennessee stipulates that travel for nonphysician mental health services should not exceed 45 minutes or 30 miles for at least 75% of its members, and 60 minutes or 60 miles for all members. In Nebraska, managed care organizations are required to provide choice—a minimum of 2 mental health professionals—within required time and distance standards. By comparison, Missouri does not appear to publicize any time or distance standards. Many states additionally apply timely access standards (varying from 7 to 30 days for a routine mental health outpatient appointment, for example), but few states currently use other quantitative network adequacy metrics, such as provider-to-enrollee ratios; metrics that capture health professional accessibility, availability, and demand have not been routinely employed.

These existing standards are likely to change further with the 2020 Medicaid managed care final rule, which removes the existing requirement that states use time and distance standards. Instead, states may use any quantitative standard to define network adequacy and create their own definitions of who qualifies as a clinical specialist. On one hand, greater flexibility may afford states the ability to adopt network adequacy standards applicable to specific geographic settings, community needs, and resource constraints. Plans may also gain the ability to expand access to more diverse types of health professionals. On the other hand, more flexible network adequacy...
regulations may also loosen accountability where needed, incentivize the adoption of metrics that have little correlation with access to and quality of care, and adversely affect downstream outcomes. As they apply to Medicaid, network adequacy standards have been an imperfect but important measure of accountability, with managed care contracts often assessed by the inclusion of sufficient numbers and types of mental health professionals. However, these standards do not always translate to acceptable levels of access,7 and adoption of standards has not been associated with significant improvements in access to specialty services.8 Granting greater flexibility, rather than addressing existing gaps in data, monitoring, and enforcement, could inadvertently exacerbate access challenges for mental health services.

For regulatory flexibility to be meaningful, greater transparency is needed to help states apply best practices to identify enrollee needs, determine health care professional supply and capacity, and develop network standards that reflect availability, demand for services, and quality of care. The CMS has already instituted a number of notable changes, including requiring states to post managed care contracts on public-facing websites, mandating external quality review of network adequacy, requiring assurances of adequate health professional capacity and service availability, and establishing state monitoring requirements.9 However, state agency websites do not always post information required by federal regulations, despite the importance of this information. To this end, the CMS has an opportunity to help states streamline public reporting processes, promote the development and use of public-facing access indicators, and strengthen oversight, monitoring, and enforcement activities. Greater transparency is also needed at the level of the managed care organization, specifically around standardizing, verifying, and reporting the composition of health care networks. Observers have noted that so-called ghost networks may satisfy network adequacy requirements but consist of health care professionals who are inactive, do not accept Medicaid, or have closed panels to new patients.10 Enhancing transparency around health care networks at the level of the managed care organization would hold both health plans and contracting state agencies accountable for inadequate performance.

Flexibility of network adequacy standards may also present opportunities to adapt to new mental health care delivery modalities, such as telehealth. In light of the COVID-19 pandemic, state Medicaid programs have expanded coverage for telehealth and lifted restrictions on reimbursement for telehealth visits. While expansion of tele-mental health may help fill network coverage gaps, particularly in traditionally underserved areas, neither the CMS nor any individual state has yet issued guidance on how this might be done. Where time and distance standards do not apply, new metrics could include telehealth professionals in provider-to-enrollee ratios and appointment availability standards. Actions must also be taken to standardize tele-mental health network reporting for Medicaid programs and to modify reimbursement to support telehealth access. At the same time, thoughtful regulation is needed to ensure that telehealth services supplement—rather than supplant—necessary face-to-face care, and that they neither exacerbate existing inequities in health care access for racial/ethnic minorities and rural populations nor shift care away from beneficiaries with serious and disabling mental illness.

Given these contexts, it is increasingly critical to understand which features of health care networks are associated with improved access, care delivery, and quality within health professional supply and geographic constraints. More empirical evidence is needed. Newer spatial access methods that account for workforce supply and health care service demand may improve on traditional time and distance measures of accessibility. These measures could be used to compare the breadth and composition of networks across local geographies and health care markets. Multiple methods and data sources, including administrative claims data, survey data, and input from enrollees and other stakeholders, may help identify how network adequacy standards intersect with realized access to care and better reflect care quality. Recent release of the Transformed Medicaid Statistical Information System data—which contains national eligibility, enrollment, program, utilization, and expenditure data for Medicaid in a standardized format—may provide opportunities to evaluate these questions rigorously and to share learnings across states. These approaches have
implications not only for mental health care, but also for other specialties in Medicaid, such as neurology, dermatology, and oncology, that have historically raised network adequacy concerns.

Ultimately, while network adequacy is a mechanism to enable Medicaid beneficiaries to access the care they need, when they need it, the tools for the effective design and management of health care networks are underdeveloped. Regulatory shifts offer policy makers an opportunity to strike a balance between accountability and flexibility, so that this important plan design feature improves—rather than undermines—access to quality services in mental health.