Spotlight on Network Adequacy Standards for Substance Use Disorder and Mental Health Services

Federal and State Regulation and Enforcement of the Parity Act

LEGAL ACTION CENTER

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Executive Summary

To ensure that members have access to mental health and substance use disorder treatment, health insurance providers must cover a full continuum of services and a robust network of providers to deliver those services. When networks are limited, consumers are forced to wait or travel long distances for care, pay higher costs for treatment from a non-network provider, or forgo care altogether.

Network gaps for mental health (MH) and substance use disorder (SUD) providers are particularly problematic. Recent research by **Milliman** reveals that consumers with private health plans access MH and SUD services from out-of-network providers at a significantly higher rate than for other medical services. Network utilization disparities have persisted even though the Mental Health Parity and Addiction Equity Act (Parity Act) bars discrimination by virtually all health plans in network adequacy standards, the admission of providers to networks and reimbursement practices.

The *Spotlight on Network Adequacy* describes the federal and state regulatory framework for defining and monitoring network adequacy for public and private health plans and offers recommendations to improve and enforce network adequacy standards. The *Spotlight* includes a 50-state survey of quantitative metrics adopted for state-regulated private health plans and offers a "parity assessment" of those state MH and SUD provider metrics.

Key Findings:

- Medicaid managed care plans, Affordable Care Act qualified health plans (QHPs) and Medicare Advantage plans are required to establish adequate provider networks. Federal rules for Medicaid managed care plans and QHPs defer to state regulatory standards, while Medicare Advantage establishes quantitative metrics for providers, including MH providers.

- Twenty-nine (29) states have adopted at least one quantitative metric to define network adequacy for state-regulated private insurance plans – most frequently, geographical distance standards. Only 7 states have adopted quantitative standards for the three most common metrics: geographical distance, appointment wait time and provider-enrollee ratios.

- Sixteen (16) states have adopted at least one quantitative metric for *MH and SUD providers*, but only 2 states have adopted all three metrics. Based on the numerical metrics alone, the standards for MH and SUD providers are comparable to or more generous than standards for medical providers.

Multiple strategies are needed to create robust networks and protect consumers who cannot find a network MH or SUD provider for covered services. The *Spotlight* recommends

the adoption of parity-compliant quantitative standards for a wide range of MH and SUD providers in both public and private insurance to both improve access to affordable treatment and identify the cause of network gaps. Improved regulatory oversight of health plan compliance with network adequacy and Parity Act standards, greater transparency of plan compliance, and better consumer education will result in greater access to network services.

Introduction

Access to critical health care services depends upon both plan coverage of a broad range of services and a network of providers to deliver all covered services. Network adequacy refers to whether a health plan contracts with a sufficient number and type of qualified health care providers to ensure members have access to covered benefits within a reasonable travel distance and appointment wait time.[1] Robust networks are essential for consumers to obtain accessible, timely and affordable care. When plans do not have sufficient numbers or types of providers, patients are forced to wait or travel long distances for care, pay higher costs to receive care from an out-of-network provider, or forgo care all together.

While access barriers to in-network providers exist for various provider types, they are particularly acute for mental health (MH) and substance use disorder (SUD) providers and facilities. Approximately half of all psychiatrists do not accept insurance, and network participation has been declining for psychiatrists at a greater rate than other medical specialties.[2] Recent research shows a consistent pattern among private health plans, both nationally and in most states, of higher utilization of out-of-network services and higher out-of-pocket costs for MH and SUD services as compared to other medical providers.[3] This data strongly suggests that carrier networks for MH and SUD providers are inadequate.

Network adequacy is a plan design feature that is subject to the requirements of the federal Mental Health Parity and Addiction Equity Act (the Parity Act). While an inadequate network of MH and SUD providers does not alone constitute a parity violation, the plan may violate parity requirements if it adopts more restrictive factors, strategies or processes in building and implementing its MH and SUD provider network and/or setting reimbursement rates for those providers as compared to the plan's network of medical/surgical providers.

There is tremendous variation in how network adequacy is defined and monitored.[4] This issue brief will explore how network adequacy is defined by state and federal regulators, with a specific focus on the use of quantitative standards and requirements for MH and SUD providers.

Defining Network Adequacy

The purpose of network adequacy requirements is to establish minimum standards to measure and track accessibility and availability of services. There are two different approaches to defining network adequacy: qualitative and quantitative standards. *Qualitative standards* allow health plans to define and monitor whether their network is "adequate" or "sufficient" to provide services in a "timely manner" or "without unreasonable delay."[5] Increasingly, state and federal regulators are adopting *quantitative metrics* to more specifically define timely access and availability of care.[6] Quantitative standards generally include: (1) travel times and distance between enrollees and providers in certain types of geographic areas; (2) minimum number of providers or provider-to-enrollee ratios; and (3) appointment wait times. Geographic criteria (travel time/distance standards) and minimum number of providers or provider-to-enrollee ratios are metrics for determining whether providers are reasonably accessible, while appointment wait times measure whether care is reasonably available.

Network adequacy requirements are typically established by legislation and specific standards are promulgated through regulation.[7] Network adequacy requirements and oversight are more common for health maintenance organization (HMO) plans than preferred provider plans (PPOs) because HMO products do not provide out-of-network coverage and thus an adequate network is essential for plan members to utilize benefits.[8]

Federal Network Adequacy Standards

Both federal and state regulators establish network adequacy standards for health plans within their jurisdiction. The Centers for Medicare and Medicaid Services has established network adequacy standards in health insurance products subject to federal regulation, including Medicare, Medicaid and qualified health plans (QHPs) subject to the Affordable Care Act (ACA). Medicare standards include specific quantitative standards for mental health providers. Medicaid and QHPs standards defer to state regulators to establish such standards.

Medicare Advantage

Private health plans that administer benefits to Medicare beneficiaries in Medicare Advantage plans are required to "maintain and monitor" a sufficient network of providers to provide plan members with "adequate access to covered services."[9] Annually, the Centers

for Medicare and Medicaid Services (CMS) establishes quantitative standards to define network adequacy based on accessibility standards.[10]

CMS establishes maximum travel time/distance standards based on the type of provider or facility and the geographical region by size of county (large metro, metro, micro, rural, or counties with extreme access considerations (CEAC)).[11] At least 90 percent of enrollees in the county must be able to access at least one provider/facility within the maximum travel time/distance standards.[12] CMS also establishes minimum facility and provider-to-beneficiary ratios by type of provider and county.[13] Specific geographic standards have been established for psychiatrists and inpatient psychiatric facilities and provider-enrollee ratios for psychiatry.[14]

CMS's standards provide a reference point for some states that have adopted quantitative metrics.[15] The specific quantitative standards for Medicare Advantage plans as well as state standards are listed in Exhibit A.

Medicaid Managed Care

Private health plans that administer benefits to Medicaid beneficiaries in Medicaid managed care plans must "maintain and monitor" an "appropriate" network of providers to "provide adequate access" to covered services.[16] A Final Rule regarding network adequacy requirements for Medicaid managed care plans issued by the Obama Administration became effective in July 2018.[17] Unlike in Medicare, CMS declined to set national standards or benchmarks for Medicaid managed care plans. Instead, states were required to develop their own quantitative network adequacy standards for travel time/distance for certain provider types, including MH and SUD providers of adult and pediatric services.[18] Many states already used specific travel time/distance standards for specific provider types in Medicaid managed care plans prior to the effective date of the Final Rule; although, fewer states have set travel time and distance standards for behavioral health.[19]

On November 14, 2018, just a few months after the Final Rule became effective, the Trump Administration issued a Proposed Rule to change the network adequacy requirements for Medicaid managed care plans.[20] As of March 1, 2020, the Proposed Rule has not yet been adopted. Importantly, the Proposed Rule would eliminate the requirement for specific travel time/distance standards and replace it with "a more flexible requirement" that allows states to choose any quantitative minimum access standard.[21] For example, states could use provider-to-enrollee ratios to better account for network adequacy in areas that rely on telehealth services or other standards such as a percentage of providers that are accepting new patients, or appointment wait time standards.[22] In proposing the revised standard, CMS noted concern from states about "the appropriateness of uniformly applying time and distance standards" and that such standards may not "accurately reflect provider

availability."[23] Of note, the existing rule already allows states to use additional network adequacy standards.[24]

The Affordable Care Act

The ACA requires the federal government to establish network adequacy requirements for qualified health plans (QHPs).[25] The Department of Health and Human Services (HHS) adopted a qualitative standard that requires plan networks to include a "sufficient" number of providers and assure services are "accessible without unreasonable delay."[26] HHS deferred to states to establish more specific requirements and procedures for monitoring network adequacy in the QHPs.[27]

Notably, the regulations specifically require QHP networks to include a sufficient number of MH and SUD providers, recognizing the need to provide access to MH and SUD treatment at parity with medical/surgical benefits.[28] HHS noted that it explicitly included MH and SUD providers in the regulations so that QHPs would contract with these providers and ensure that a broad range of MH and SUD services are available, particularly in low-income and underserved areas.[29] Nonetheless, research shows lower participation of MH and SUD providers in QHP networks as compared to other provider types and insurance products.[30] Only 16 states have adopted quantitative standards specific to MH and SUD providers, as of March 1, 2020. *See* Exhibit A.

Federal oversight of QHP networks has also lagged over the six-year implementation of the ACA. In an initial effort to define the reasonable access standard for QHPs offered on the federal marketplace for 2016 - 2018, CMS developed quantitative standards for maximum travel time/distance for provider types with "network adequacy concerns," including MH and SUD providers.[31] For MH and SUD providers, the maximum time/distance standards were 20 minutes/10 miles in large counties; 45 minutes/30 miles in metro counties; 60 minutes/45 miles in micro counties; 75 minutes/60 miles in rural counties; and 110 minutes/100 miles in counties with extreme access considerations (CEACs). In 2016, CMS suggested that it may adopt minimum quantitative standards for network adequacy, but ultimately declined.[32]

CMS has, most recently, retreated from setting quantitative standards for QHPs offered in federally facilitated exchanges (FFE) and actively monitoring plan compliance. Effective for plan year 2019 and going forward, CMS defers entirely to states for oversight, based on state network adequacy standards, or relies on the plan's accreditation status.[33] Under the ACA, QHPs must to be accredited by an HHS-recognized entity in network adequacy and access to services, and such standards must, at a minimum, be consistent with the regulatory network adequacy standard for QHPs.[34] HHS recognizes the National Committee for Quality Assurance (NCQA), URAC and the Accreditation Association for Ambulatory

Health Care as accreditation organizations, yet these accrediting entities appear to rely on a health plan's self-assessment of adequacy rather than establish quantitative standards.[35] Further, plans are not required to demonstrate network adequacy to receive accreditation.[36] Despite concerns about states relying on a plan's accreditation without additional requirements and oversight,[37] states that do not have the authority or resources to review network adequacy can rely on the plan's accreditation.[38] Three states (Idaho, Indiana, and Louisiana) have adopted NCQA or other national accreditation standards for their network adequacy standards. *See* Exhibit A.

In states that lack authority or resources to monitor network adequacy, plans that are not accredited can submit an access plan demonstrating the plan has "standards and procedures" to comply with the network adequacy requirements in the National Association of Insurance Commissioner's (NAIC) Health Benefit Plan Network Access and Adequacy Model Act (hereinafter, the NAIC Model Act).[39] The NAIC Model Act does not establish specific quantitative standards, but instead lists categories of quantitative metrics that states can use to define network adequacy, including provider-to-enrollee ratios; geographic standards; appointment wait times; provider/facility hours of operation; the network's ability to meet the needs of specific populations; and the "volume of technological and specialty care services available."[40] Other factors states can use include the number of providers accepting new patients, admitting privileges of participating providers to participating hospitals, and whether members are required travel to another state to obtain specialty care.[41] According to CMS, as of 2018, all states participating in the federal marketplace had the required authority and resources to monitor network adequacy.[42]

State Quantitative Standards for Network Adequacy

Based on federal standards, states have been given the responsibility to adopt quantitative standards for determining network adequacy. As of March 2020, twenty-nine states have adopted at least one quantitative metric – geographic distance, appointment wait time[43] or provider-enrollee ratios – to define network adequacy for at least one type of insurance product (HMO, PPO or other health plans).

- Seven states have adopted all three quantitative metrics: California, Colorado, Illinois, Maryland, Montana, New Jersey, and New Mexico.
- Thirteen states have adopted two metrics: Arizona, Delaware (for QHPs), Florida (HMO only), Maine, Minnesota, Missouri (HMO only), New Hampshire, New York, Pennsylvania, Texas, Vermont, Washington, and West Virginia (HMO only).

- Nine states have adopted one quantitative metric: Alabama (HMO only), Arkansas, Connecticut, Kentucky, Nevada, Oklahoma (HMO only), Oregon, South Carolina, and Tennessee.
- **Sixteen states have adopted specific quantitative standards for MH and SUD providers and facilities: California, Colorado, Delaware, Illinois, Maine, Maryland, Minnesota, Missouri, Nevada, New Hampshire, New Jersey, New York, Oregon, Pennsylvania, Texas, and Vermont.**

Geographic Standards

Twenty-six states have adopted geographic standards.

- Nine states have travel distance standards: Alabama, Arkansas, Colorado, Delaware, Maryland, Missouri, Montana, Texas, and Washington.
- Three states have travel time standards: Florida, Oklahoma, and Vermont.
- Fourteen states have adopted both travel time and distance standards: Arizona, California, Illinois, Kentucky, Minnesota, Nevada, New Hampshire, New Jersey, New Mexico, New York, Oregon, Pennsylvania, Tennessee, and West Virginia.
- **Twelve states have adopted specific travel time/distance standards for MH and SUD providers: California, Colorado, Delaware, Maryland, Minnesota, Missouri, Nevada, New Hampshire, New Jersey, Oregon, Pennsylvania, and Vermont.**

For the geographic distance metric, states generally identify specific provider types and facilities that will be tracked in different geographical regions, which are defined by county population. A travel distance and/or or time is designated for each provider/facility type in each geographical region. States typically track medical providers, such as primary care providers, specialists and hospitals. In states that track MH and SUD providers, psychiatrists, psychologists, licensed social workers and psychiatric hospitals are typically tracked. Most standards are measured based on driving time; two states, New York and New Jersey, include public transit time.

Appointment Wait Time

Seventeen states have adopted appointment wait time standards: Arizona, California, Colorado, Florida, Illinois, Maine, Maryland, Minnesota, Missouri, Montana, New Hampshire, New Jersey, New Mexico, Pennsylvania, Texas, Vermont, and Washington. **Seven states have specific wait time standards for MH and SUD providers: California, Colorado, Maine, Maryland, Missouri, New Hampshire, and Texas.** Appointment wait time metrics vary by health service, with states typically tracking urgent care, non-urgent care, routine/preventive care and specialty care.

Provider Enrollee Ratios

Thirteen states have adopted provider/enrollee ratios or a minimum number of providers: California, Colorado, Connecticut, Delaware, Illinois, Maine, Maryland, Montana, New Jersey, New Mexico, New York, South Carolina, and West Virginia. Seven states have provider-to-enrollee ratio; two states have a minimum number of providers or set a calculation to determine the minimum number of providers; three states use both ratios and minimum number of providers. **Five states have specific provider/enrollee ratios or minimum numbers of providers for MH and SUD care: Colorado, Delaware, Illinois, Maryland and New York.** Most states set the ratio based on broad provider types, such as primary care physicians, obstetrician/gynecologists, specialists, pediatricians, behavioral health practitioner and MH and SUD providers/services.

Exhibit A provides a state-by-state survey of for a full survey of quantitative metrics adopted by states, including states that have adopted quantitative standards specific to MH and SUD providers/facilities, and Exhibit C summarizes the state information.

Parity Act Compliance

Network adequacy is a plan design feature that is subject to the requirements of the Parity Act as a non-quantitative treatment limitation (NQTL).[44] The processes, factors and standards used to build the plan's network of MH and SUD treatment providers must be comparable to, and applied no more stringently than, those used to create the plan's network of medical/surgical providers.[45] Assessing network adequacy is critical for evaluating parity compliance.[46]

Research strongly suggests pervasive problems with parity compliance related to network adequacy based on disparities in out-of-network service utilization for MH and SUD services as compared to medical/surgical services.[47] Analyses of commercial health plan claims have found that, nation-wide, patients are five times more likely to receive care from an out-of-network behavioral health care provider as compared to a medical care.[48] Patients receiving SUD care are ten times more likely to receive inpatient care and outpatient office visits from an out-of-network provider than person seeking medical/surgical care. Remarkably, disparities have worsened in recent years, despite the existence of the Parity Act and enduring opioid and suicide epidemics.

While such disparities are not *de facto* evidence of parity violations, they warrant further investigation to assess plan standards and practices related to network admission, credentialing standards, contracting practices, and reimbursement rate setting for MH and

SUD providers.[49] Federal regulators have stated that a provider network that "includes far fewer MH/SUD providers than medical/surgical providers – are [sic] a red flag that a plan or issuer may be imposing an impermissible NQTL."[50] They also warn that, when building a network, plans that incentivize network participation for medical providers through increased reimbursement rates and an accelerated process for network participation must do the same for MH and SUD providers.[51]

Insurers routinely submit access plans to state insurance departments that include information necessary to evaluate whether a health plan's network complies with the Parity Act. The NAIC Model Act, for example, requires plans to file access plans that include a description of the factors used to establish the network[52] and for plans to publicly disclose the criteria used to build the plan's network in plain language.[53] The health plan's contracting and tiering standards must be provided to the insurance commissioner and a "plain language" description of the standards should be publicly available.[54]

In addition, for states that establish quantitative metrics for network adequacy, the metrics for MH and SUD providers must be comparable to, and no more restrictive than, quantitative metrics for medical providers. As noted above, 16 states have adopted quantitative standards that are specific to MH and SUD providers and facilities. For the most part, the quantitative standards are equal to the standards for primary care providers or other specialty providers (e.g., California, Maryland, Minnesota and Vermont). For example, California imposes a maximum travel time of 30 minutes or a maximum travel distance of 15 miles of each covered person's work/residence for both primary care and MH and SUD providers compared to the maximum travel time/ distance for specialists of 60 minutes or 30 miles from the member's work/residence. In a few cases, the standards for MH and SUD providers/facilities are more generous than the standards for medical/surgical providers, including primary care in limited cases. For example, in Maryland, New Hampshire and Texas, the appointment wait time standards for routine behavioral health care are shorter than the standards for routine medical care. *See* Exhibit B for an analysis comparing the quantitative standards for MH and SUD providers/facilities to medical/surgical providers/facilities.

Monitoring and Enforcing Network Adequacy

Monitoring compliance with network adequacy requirements is essential.[55] Nonetheless, ongoing oversight is less common than initial review.[56] State and federal regulators utilize a number of different methods for monitoring compliance, including review of complaint

data, market conduct investigations, consumer and provider surveys and carrier reporting. However, in some cases, regulators defer to the plans to self-monitor compliance.

The federal government has established requirements for monitoring network adequacy for Medicare Advantage plan and has deferred to states for Medicaid managed care plans, QHPs and all state-regulated plans.

- *Medicare Advantage*. CMS reviews plan networks every three years and upon certain "triggering events"[57] and may take compliance or enforcement actions against plans that fail to meet network adequacy standards.[58] Plans are also responsible for continuously monitoring compliance with such standards.[59]

- *Medicaid MCOs*. The states are responsible for monitoring compliance with network adequacy standards in Medicaid managed care plans and ensuring that managed care plans monitor compliance with network adequacy requirements.[60] CMS declined to adopt a requirement for an annual report or certification on compliance with network adequacy requirements.[61]

- *QHPs*. As previously explained, CMS monitored and reviewed network adequacy in the QHPs available on the federal marketplace for a limited time, but states are now responsible for regulatory oversight of network adequacy.[62]

State regulators may use several enforcement tools to monitor compliance and identify gaps in networks.

- Review of Access Plans. Based on the NAIC Model Act, plans should submit an access plan when establishing a new plan network or making material change to a network, and should make access plans publicly available, with redaction of proprietary information.[63]

- Annual Reporting Requirements. Some states establish annual reporting requirements to evaluate compliance with quantitative metrics. For example, Maryland requires carriers to annually report, and make public, compliance with the state's three metrics, participation of essential community providers, utilization of telehealth and other data.[64] California requires carriers to submit an extensive report that describes the number and location of providers, (including a separate compliance report for MH and SUD providers), demonstrates compliance with state metrics and identifies the location and extent of non-compliance.[65]

- Consumer Surveys. Surveys, including "secret shopper surveys," provide out-of-network service utilization data.[66]

- Consumer Complaints. Although regulators often monitor network adequacy through consumer complaints, this enforcement tool places an undue burden on consumers to monitor compliance and likely reflects an under-representation of compliance issues.[67]

Several states have conducted in-depth market conduct and other investigations to evaluate plan compliance with the Parity Act, specifically examining practices that affect network adequacy. In January 2020, the New Hampshire Department of Insurance entered regulatory agreements with two carriers that found (1) strong evidence of parity violations in reimbursement rate setting and/or the development and management of provider networks and (2) the carrier's failure to document parity compliance.[68] New Hampshire regulators have required both carriers to implement a written Compliance Assurance Plan to document and ensure compliant reimbursement setting practices and to take affirmative steps to develop a network of MH and SUD providers to meet patients' needs. The carriers must report on their implementation efforts on a quarterly basis for two years.[69]

In February 2020, the Massachusetts Attorney General entered settlement agreements with three carriers over their disparate reimbursement rate setting practices for outpatient physician visits for MH and SUD services and violation of state provider directory requirements.[70] Penalties were imposed against all three carriers.[71] Each carrier also agreed to take specific corrective actions to develop and implement a reimbursement methodology that complies with the Parity Act, submit a designated number of annual reports on changes to reimbursement methodology and the average allowed amounts paid to MH, SUD and medical providers for a wide range of billing codes, and address directory violations, audit provider information and continued participation in their networks.[72]

The New Hampshire and Massachusetts' enforcement actions are models for other state insurance regulators and attorneys general.

Other Factors that Contribute to Inadequate Networks

Workforce shortages and disparate reimbursement rates contribute to inadequate networks and are particularly profound for MH and SUD providers. Other factors create barriers to accessing care, including lack of transparent information about provider network participation and out-of-network costs. Although in-depth exploration of these issues is outside the scope of this issue brief, they are briefly summarized below because of their close relationship to network adequacy.

Reimbursement Rates

Low reimbursement rates, particularly for MH and SUD providers, contribute to inadequate networks. Research shows that psychiatrists receive lower reimbursement rates for in-network services than other types of physicians.[73] In 2017, reimbursement rates for primary care providers were nearly 24 percent higher than reimbursement rates for behavioral health office visits.[74] Disparities in reimbursement rates varied across the states; nearly half of the states had reimbursement rates for PCPs that were at least 30 percent higher than reimbursement rates for behavioral health office visits, and 11 states had PCP reimbursement rates that were more than 50 percent higher.[75] Lower reimbursement rates, along with other factors, contribute to low participation of psychiatrists in plan networks, leading to issues with network adequacy.[76] Low reimbursement rates may be compounded by the administrative costs of insurance participation, which are burdensome for the small practices in which many psychiatrists typically practice.[77]

Workforce Shortage

Workforce shortages also contribute to inadequate networks. Most states have a shortage of mental health and substance use disorder treatment providers and particularly acute shortages of psychiatrists.[78] This shortage has created greater demand and a disincentive for psychiatrists to participate with insurance because they can sustain their practices with patients who pay out-of-pocket and may wish to avoid administrative burdens associated with insurance participation.[79] Further, in some areas, certain types of providers may not exist and, therefore, cannot participate in plan networks.

Provider Directories

Provider directories are an essential tool for consumers to find and access in-network providers. Nonetheless, provider directories often contain inaccurate and outdated information about participating providers and may not contain information about whether providers accept new patients.[80] One study of commercial MCOs found that one-third of participating psychiatrists listed in plan directories contained incorrect information.[81] Pursuant to regulations and CMS guidance, Medicare Advantage plans must maintain accurate provider directories and denote providers who are not accepting new patients.[82] CMS actively reviews the accuracy of information in online directories for Medicare Advantage plans.[83] Pursuant to the Final Rule, Medicaid managed care plans must maintain and update, on a monthly basis, provider directories in paper and electronic form and directories must include information on behavioral health providers.[84] In the Proposed Rule, CMS proposed allowing plans to update paper provider directories on a quarterly basis if the plan's electronic directory is accessible from a mobile device.[85] QHPs are required to

maintain current and accurate online provider directories, specifically identifying whether providers are accepting new patients.[86] Inaccurate or outdated provider directories violate ERISA plan and QHP requirements.[87]

Out-of-Network Costs

The goal of network adequacy requirements is to ensure that consumers have access to providers of covered services at an affordable, network rate and do not shoulder the financial burden associated with paying for out-of-network services. Consumers are more likely to go out-of-network to receive care if the plan's network is inadequate, as demonstrated by research.[88] Out-of-network care usually has higher cost-sharing (e.g., separate deductibles and/or out-of-pocket limits, higher co-payments or co-insurance). The consumer is also at risk for "balance billing," which occurs when the non-network provider bills the patient for the difference between the provider's charge and the amount reimbursed by the health plan.[89] Neither providers nor insurers are forthcoming with their respective service charges or reimbursement rate, making it difficult for consumers to determine their financial liability for out-of-network services.[90]

Lawmakers can require plans to disclose information about out-of-network costs to members to reduce the risk for unexpected out-of-pocket expenses. Several states have passed laws imposing transparency requirements for out-of-network services.[91] The ACA also requires plans to provide information on out-of-network cost-sharing requirements.[92]

Other federal and state requirements go beyond transparency and require insurers to hold the consumer harmless from out-of-network expenses. The ACA requires plans to charge in-network cost-sharing for out-of-network emergency services.[93] Some states require plans to cover out-of-network services at no greater cost to the consumer than the cost of in-network services when such services cannot be provided in-network without unreasonable travel or delay.[94]

Recommendations

Given the barriers to accessing in-network services, particularly for MH and SUD care, federal and state regulators must do more to establish and enforce quantitative metrics for network adequacy, monitor carrier performance, protect consumers who cannot access network providers for covered services, and identify and address the underlying causes of limited provider networks. The following recommendations seek to help regulators better define and monitor network adequacy. While adoption of quantitative standards is an important component, other policy reforms are needed to address workforce shortages,

and adequate reimbursement rates, accuracy of provider directories, financial protections for out-of-network costs, and narrow plan networks.

Adopt quantitative standards for determining network adequacy.[95] Quantitative metrics create greater accountability and uniformity across health plans and reduce the ability of plans to define and monitor their own performance under a qualitative standard. States should adopt quantitative metrics to address both accessibility and availability of services in all health insurance products (HMOs, PPOs and EPOs), through geographical distance, appointment wait time, provider-enrollee ratio metrics and other appropriate metrics. Although more than one-half of the states have adopted quantitative standards, only seven states have adopted all three metrics. States should also address the availability of providers that have traditionally served lower-income and underserved communities through the inclusion of metrics for essential community providers, broadly defined to include community-based providers of MH and SUD services.[96]

Admittedly, quantitative standards have limitations because they may only demonstrate that a network is adequate at one point in time and may not adequately account for geographic and provider variability.[97] Such limitations can be addressed with requirements for ongoing monitoring and creating flexibility in the standards. For example, travel time/distance standards should consider accessibility of services via public transportation in urban areas and for the use of telemedicine to meet shortages in rural regions.[98]

Adopt specific quantitative metrics for mental health and substance use disorder providers and facilities. Specific metrics for MH and SUD providers and facilities are needed to address historical discriminatory insurance coverage for these services, the large treatment gap for MH and SUD treatment, and high utilization of out-of-network MH and SUD services. The specific MH and SUD metrics must meet Parity Act requirements and, to do so, regulators should ensure that the MH and SUD standards cover the full range of MH and SUD practitioners and facilities and that quantitative measures for geographic distance, wait time and provider/enrollee ratios align with those for primary care physicians and comparable medical facilities.

To the extent workforce shortages create a challenge to meeting network adequacy requirements, plans should be required to adopt the same strategies to incentivize MH and SUD providers to participate in networks that are used for providers of medical services, including reimbursement rate setting, expedited network credentialing and other contracting practices. Carriers should also be required to file access plans that explain the reasons for non-compliance and steps they have taken to address gaps, including descriptions of outreach, specific contracting efforts and reimbursement practices. These data will help identify additional policy changes needed to increase MH and SUD provider participation in plan networks.

Require carriers to cover the cost of services obtained from a non-network provider as an in-network benefit when a plan's network is inadequate. High utilization of out-of-network MH and SUD providers places patients at risk for increased out-of-pocket expenses and unexpected financial liability for network services. Many patients are forced to delay or forgo care based on cost. To mitigate this harm when a plan's network is inadequate, states should require carriers to cover the cost of such services as an in-network benefit.

Require greater transparency about network design and compliance with network adequacy requirements. Access plans, as described in the NAIC Model Act, should be filed by carriers with state regulators and made publicly available with minimal redaction for proprietary information to improve transparency and accountability for demonstrating compliance with network adequacy requirements.[99] Indeed, under the Parity Act, plans may not refuse to disclose information to members based on a claim that the information is proprietary or has commercial value.[100] A summary of plan compliance with quantitative metrics should also be made available on the state insurance department's website so that consumers have a concise snapshot of compliance and information that will alert them to potential problems in accessing specific types of care.[101] Plans should also be required to continually monitor their network and notify regulators of any changes in compliance with state requirements. The plan's standards for criteria for provider contracting should also be made publicly available in "plain language" to better inform consumers, increase transparency in plan network design and demonstrate Parity Act compliance.[102]

Improve consumer education, awareness and information about network adequacy. Consumers need to be better informed when selecting a health plan about the carrier's provider network and the trade-offs associated with plans that offer lower premiums for limited plan networks. The public also needs education on the complaint process and how to identify issues with network adequacy.[103] Education and transparent information that consumers can use in a meaningful way to utilize covered benefits are needed to create more informed health care consumers.[104]

Support ongoing regulatory oversight. Regulators must have sufficient resources to monitor network adequacy and should be required to conduct targeted reviews of MH and SUD provider availability in response to disparate network utilization and reimbursement data. Regulators should review out-of-network utilization and reimbursement rates annually (or more frequently as needed) and require carriers to explain any disparities and demonstrate such disparities do not violate the Parity Act. Regulators should continually monitor compliance with standards and utilize a number of different compliance tools, including collecting and analyzing data on out-of-network claims and consumer surveys and complaints.[105] Regulators should also take enforcement action against plans with inadequate networks and, when violations are found, impose corrective actions, stiff monetary penalties and on-going data reporting and oversight to compel compliance. Above

all, consumers should be protected from out-of-network costs for covered MH and SUD benefits.

Conclusion

Health plans must have an adequate network of participating providers to ensure covered services are affordable and accessible to plan members in a timely manner. Despite the importance of network adequacy requirements, they are neither well defined or closely monitored by state and federal regulators. With the exception of Medicare Advantage plans, the federal government has deferred to states to define and monitor network adequacy in both private and public insurance. Just over half of the states have established a quantitative standard to define network adequacy in private state-regulated plans, while the remaining states rely on a qualitative standard that largely allows plans to define and monitor their own performance. Even in states with quantitative standards, most states rely on only one quantitative metric, and some do not apply standards uniformly to various insurance products. Further, most states do not engage in rigorous, ongoing monitoring or take meaningful enforcement actions.

Only half of the states that use quantitative standards have developed specific standards for MH and SUD providers and little attention has been paid to assessment of Parity Act compliance (based on the face of many state standards). In the midst of unrelenting suicide and opioid epidemics, policymakers are searching for ways to increase access to MH and SUD treatment. Implementing robust network adequacy requirements is an underutilized tool. Failing to address network adequacy undermines other policy initiatives to expand access to affordable care.[106] Strengthening requirements for network adequacy, including the use of specific parity-compliant quantitative standards and ensuring compliance with these standards through ongoing monitoring, transparent reporting and improved consumer awareness and education are important policy changes for increasing access to affordable MH and SUD care.

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EXHIBITS

Exhibit A: Network Adequacy Quantitative Standards – Fifty-State Survey: Geographic Criteria, Appointment Wait Times & Providers/Enrollee Ratios (Updated March 2020)

Quantitative Standards in Commercial Insurance Plans:

- Twenty-nine (29) states and Medicare Advantage have adopted one or more of the quantitative standards included in this survey to measure network adequacy in commercial insurance plans: Alabama (HMO), Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Florida (HMO), Illinois, Kentucky, Maine, Maryland, Minnesota, Missouri, Montana, Nevada, New Hampshire, New Jersey, New Mexico, New York, Oklahoma (HMO), Oregon, Pennsylvania, South Carolina, Tennessee, Texas, Vermont, Washington and West Virginia (HMO).

- Sixteen (16) states have specific quantitative standards for Mental Health /Substance Use Disorder (MH/SUD) services: California, Colorado, Delaware, Illinois, Maine, Maryland, Minnesota, Missouri, Nevada, New Hampshire, New Jersey, New York, Oregon, Pennsylvania, Texas and Vermont.

- Nine (9) states have adopted quantitative standards to measure network adequacy for emergency services only: Hawaii, Louisiana, Michigan, Mississippi, Nebraska, North Carolina, North Dakota, South Dakota and Virginia.

- Three (3) of these states require health plans to meet NCQA and/or other national accreditation standards: Idaho, Indiana and Louisiana

Geographic Standards:

- Twenty-six (26) states have adopted or require geographic standards of network adequacy: Alabama (HMO), Arizona, Arkansas, California, Colorado, Delaware, Florida (HMO), Illinois, Kentucky, Maryland, Minnesota, Missouri (HMO), Montana, Nevada, New

Hampshire, New Jersey, New Mexico, New York, Oklahoma (HMO), Oregon, Pennsylvania, Tennessee, Texas, Vermont, Washington and West Virginia (HMO).

- Twelve (12) states have specific geographic standards for MH/SUD services: California, Colorado, Delaware, Maryland, Minnesota, Missouri, Nevada, New Hampshire, New Jersey, Oregon, Pennsylvania and Vermont.

Appointment Wait Times:

- Seventeen (17) states have established appointment wait time standards (excluding emergency services only): Arizona, California, Colorado, Florida, Illinois, Maine, Maryland, Minnesota, Missouri, Montana, New Hampshire, New Jersey, New Mexico, Pennsylvania, Texas, Vermont and Washington.

- Seven (7) states have specific appointment wait time standards for MH/SUD services: California, Colorado, Maine, Maryland, Missouri (telephone access), New Hampshire and Texas.

Provider/Enrollee Ratio or Minimum Number of Providers:

- Thirteen (3) states and Medicare Advantage have adopted provider/enrollee ratios or a standard to determine the minimum number of providers available: California, Colorado, Connecticut, Delaware, Illinois, Maine, Maryland, Montana, New Jersey, New Mexico, New York, South Carolina and West Virginia.

- Four (4) states have specific provider/enrollee ratios for MH/SUD services: Colorado, Delaware, Illinois and Maryland.

State	Source	Geographic Criteria	Appointment Wait Times	Provider/Enrollee Ratio
Alabama (*Standards apply to Health Maintenance Organizations*)	Ala. Admin. Code r. 420-5-6-.06 (1999) Current through Nov. 29, 2019	• The distance from the HMO's geographic service area boundary to the nearest primary care delivery site and to the nearest institutional service site shall be a radius of no more than 30 miles • Frequently utilized specialty services shall be within a radius of no more than 60 miles	• Emergency telephone consultation on a 24-hour a day, 7-day a week basis including qualified physician coverage for emergency service	• No quantitative criteria provided
Alaska	N/A	• No quantitative criteria provided	• No quantitative criteria provided	• No quantitative criteria provided
Arizona (*Standards apply to Health Care Service Organizations*)	A.A.C. R20-6-1901 to A.A.C. R20-6-1921 (2005); Regulatory Bulletin 2006-7 (2006) Current through Feb. 28, 2020	HCSO may require an enrollee to travel a greater distance in-area to obtain covered services from a contracted provider than the enrollee would have to travel to obtain equivalent services from a non-contracted provider, except where a network exception is medically necessary If the HCSO prior-authorizes services that require an enrollee to travel outside the	• **Preventative care services from a contracted PCP**: Appointment date within 60 days of the enrollee's request, or sooner if necessary, for the enrollee to be immunized on schedule • **Routine-care services from a contracted PCP**: Appointment date within 15 days of the enrollee's request to the PCP or	• No quantitative criteria provided

State	Source	Geographic Criteria	Appointment Wait Times	Provider/Enrollee Ratio
		HCSO service area because the services are not available in the area, the HCSO shall reimburse the enrollee for travel expenses • **Urban areas**: Primary care services from a contracted PCP located within 10 miles or 30 minutes of the enrollee's home; High profile specialty care services from a contracted SCP located within 15 miles or 45 minutes of the enrollee's home; Inpatient care in a contracted general hospital, or contracted special hospital, within 25 miles or 75 minutes of the enrollee's home • **Suburban areas**: Primary care from a contracted PCP located with 15 miles or 45 minutes of the enrollee's home; High profile specialty care services from a contracted SPC within 20 miles or 60 minutes of the enrollee's home; Inpatient	sooner if medically necessary • **Specialty care services from a contracted SCP**: Appointment date within 60 days of the enrollee's request or sooner if medically necessary • In-area urgent care services from a contracted provider seven days per week • Timely non-emergency inpatient care services from a contracted facility • Timely services from a contracted physician or practitioner in a contracted facility including inpatient emergency care • Services from a contracted ancillary provider during normal business hours, or sooner if medically necessary	

State	Source	Geographic Criteria	Appointment Wait Times	Provider/Enrollee Ratio
		care in a contracted hospital, or a contracted special hospital within 30 miles or 90 minutes of the enrollee's home • **Rural areas**: Primary care services from a contracted physician or practitioner within 30 miles or 90 minutes of the enrollee's home.		
Arkansas (*Standards apply to health benefit plans*)	Ark. Admin. Code 054.00.106-5 (2014) Current through Dec. 15, 2019	• **Emergency Services**: Within a 30-mile radius between the location of the emergency services and the residence of the covered person • **Primary Care**: At least one Primary Care Professional within a 30-mile radius between the location of the Primary Care Professional and the residence of the covered person • **Specialty Care Services**: within a 60-mile radius between the location of the Specialty Care	• **Emergency Services**: Covered person will have access to emergency services, twenty-four (24) hours per day, seven (7) days per week	• No quantitative criteria provided

State	Source	Geographic Criteria	Appointment Wait Times	Provider/Enrollee Ratio
		Professional and the residence of the Covered Person • **For QHPs**: At least one Essential Community Provider within a 30-mile radius between the location of the Essential Community Provider and the residence of the covered person		
California (*Standards apply to health insurance policies*)	10 CCR § 2240.1 to 2240.15 (2016) Current through March 6, 2020	• Facilities used by providers to render health care services are located within reasonable proximity to the work places or the principal residences of the primary covered persons, are reasonably accessible by public transportation and are reasonably accessible, both physically and in terms of provision of service, to covered persons with disabilities. Insurers shall establish written standards for their providers that ensure that provider facilities are	• Health care services (excluding emergency health care services) are available at least 40 hours per week, except for weeks including holidays. Such services shall be available until at least 10:00 p.m. at least one day per week or for at least four hours each Saturday, except for Saturdays falling on holidays • **Emergency health care services** are available and accessible within the service area at all times	• Equivalent of at least one full-time physician per 1,200 covered persons • Equivalent of at least one full-time primary care physician per 2,000 covered persons.

State	Source	Geographic Criteria	Appointment Wait Times	Provider/Enrollee Ratio
		accessible to people with disabilities and compliant with all applicable state and federal laws regarding access for people with disabilities. • **Primary Care**: Primary care network providers with sufficient capacity to accept covered persons within a maximum travel time of 30 minutes or a maximum travel distance of 15 miles of each covered person's residence or workplace • **Specialists**: There are medically required network specialists who are certified or eligible for certification by the appropriate specialty board with sufficient capacity to accept covered persons within a maximum travel time of 60 minutes or a maximum travel distance of 30 miles of each covered person's residence or workplace	• **Urgent care appointments** for services that do not require prior authorization: within 48 hours of the request for appointment • **Urgent care appointments** for services that require prior authorization: within 96 hours of the request for appointment • **Non-urgent appointments for primary care**: within 10 business days of the request for appointment • **Non-urgent appointments with specialist physicians**: within 15 business days of the request for appointment • **Non-urgent appointments with a non-physician mental health care or substance use disorder provider**: within 10 business days of the request for appointment • **Non-urgent appointments for ancillary services for the diagnosis or treatment of injury, illness, or other**	

State	Source	Geographic Criteria	Appointment Wait Times	Provider/Enrollee Ratio
		• **MH/SUD Providers**: There are mental health and substance use disorder professionals with skills appropriate to care for the mental health and substance use disorder needs of covered persons and with sufficient capacity to accept covered persons within a maximum travel time of 30 minutes or a maximum travel distance of 15 miles of each covered person's residence or workplace. • **Hospitals:** There is a network hospital with sufficient capacity to accept covered persons for covered services within a maximum travel time of 30 minutes or a maximum travel distance of 15 miles of each covered person's residence or workplace.	**health condition**: within 15 business days of the request for appointment • Insurers shall provide or arrange for the provision, 24 hours per day, 7 days per week, of triage or screening services by telephone • Insurers shall ensure that telephone triage or screening services are provided in a timely manner appropriate for the insured's condition, and that the triage or screening waiting time does not exceed 30 minutes • Insurers shall ensure that, during normal business hours, the waiting time for a covered person to speak by telephone with an insurer customer service representative knowledgeable and competent regarding the covered person's questions and concerns shall not exceed ten (10) minutes, or	

State	Source	Geographic Criteria	Appointment Wait Times	Provider/Enrollee Ratio
			that the covered person will receive a scheduled call-back within 30 minutes	
Colorado *(Standards apply to health benefit plans)*	Network Plan Standards and Reporting Requirements for ACA Compliant Health Benefit Plans 3 CCR 702-4:4-2-53; 702-4:4-2-54 Current through Feb. 25, 2020	***See***: Section 8, Geographic Access Standards (3 CCR 702-4:4-2-53) for complete list: • **PCP/OB-GYN**: Large Metro, 5 miles; Metro, 10 miles; Micro, 20 miles, Rural, 30 miles; CEAC 60 miles; • **Psychiatry/Psychology/Licensed Social Worker**: Large metro, 10 miles; Metro, 30 miles; Micro, 45 miles; Rural, 60 miles; CEAC, 100 miles. • **Acute Inpatient Hospitals**: Large metro, 10 miles; Metro, 30 miles; Micro, 60 miles; Rural, 60 miles; CEAC 100 miles. • **Inpatient Psychiatric Facility**: Large metro, 15 miles; Metro, 45 miles, Micro, 75 miles; Rural 75 miles, CEAC 145 miles.	• **Emergency care** (Medical, Behavioral, Substance Use): 24/7 (100% of the time) • **Urgent care** (Medical, Behavioral, Substance Use): within 24 hours (100% of time) • **Primary care** (routine): within 7 calendar days (90% of time) • **MH/SUD (routine)**: within 7 calendar days (90% of time) • **Prenatal care**: within 7 calendar days (90% of time) • **Primary care access to after-hours care**: office number answered 24/7 by answering service or instructions on how to reach physician (90% of time)	Large Metro, Metro, Micro: • Primary care – 1:1000 • Pediatrics – 1:000 • OBGYN – 1:1000 • MH/SUD – 1:1000

State	Source	Geographic Criteria	Appointment Wait Times	Provider/Enrollee Ratio
			• **Preventative visits/well visits**: within 30 days (90% of time) • **Specialty care/non-urgent**: within 60 calendar days (90% of time)	
Connecticut (*Standards apply to health insurance policies*)	Regs. Conn. State Agencies § 38a-472f-3 (2018) CT. ST. § 38a-472f Current through March 10, 2020	• No quantitative criteria provided	• Covered persons have access to emergency services twenty-four (24) hours a day, seven (7) days a week.	• One primary care physician per two thousand (2,000) covered persons • Percentage of providers accepting new patients at least 70%.
Delaware (*Separate standards apply to MCOs and QHPs*)	MCO: 18 DE ADC 1403-11.0 (2007) Current through March 1, 2020 QHP: Delaware UHP Standards for Plan Year 2019[1]	**MCOs**: No quantitative criteria provided **QHPs**: • **PCP**: 15 miles for urban/suburban, 25 miles for rural • **OBGYN**: 15 miles for urban/suburban, 25 miles for rural • **Pediatrician**: 15 miles for urban/suburban, 25 miles for rural	**MCOs**: • Enrollees shall have access to emergency care 24 hours per day,7 days per week **QHPs**: No quantitative criteria provided	**MCOs**: No quantitative criteria provided **QHPs**: • **PCPs**: One full time equivalent PCP for every 2,000 patients • **BH Practitioner or Mid-Level Professional Supervised by a BH Practitioner**: One for every 2,000 patients

[1] **http://dhss.delaware.gov/dhcc/files/qualifiedstandards.pdf**

State	Source	Geographic Criteria	Appointment Wait Times	Provider/Enrollee Ratio
		• **Specialty Care**: 35 miles for urban/suburban, 45 miles for rural • **MH/SUD**: 35 miles for urban/suburban, 45 miles for rural • **Acute-Care Hospitals**: 15 miles for urban/suburban, 25 miles for rural • **Psychiatric Hospitals**: 35 miles for urban/suburban, 45 for rural • **Dental**: 35 miles for urban/suburban, 45 miles for rural		
Florida (*Standards apply to Health Maintenance Organizations and Prepaid Health Clinics)*	Fla. Admin. Code r. 59A-12.006 (2003) Current through March 9, 2020	• **Travel Time to PC and General Hospital**: Average travel time from the HMO geographic services area boundary to the nearest primary care delivery site and to the nearest general hospital under arrangement with the HMO to provide health care services no longer than 30 minutes under normal circumstances	• Emergencies will be seen immediately • Urgent cases will be seen within (24) hours • Routine symptomatic cases will be seen within (2) weeks • Routine non-symptomatic cases will be seen as soon as possible • Patients with appointments should have a professional evaluation within (1) hour of scheduled appointment	• No quantitative criteria provided

State	Source	Geographic Criteria	Appointment Wait Times	Provider/Enrollee Ratio
		• **Travel Time to Specialty/Ancillary/Other**: Average travel time from the HMO geographic services area boundary to the nearest provider of specialty physician services, ancillary services, specialty inpatient hospital services and all other health services no longer than 60 minutes under normal circumstances	time; if a delay is unavoidable, patient shall be informed and provided an alternative	
Georgia NA advocacy efforts by Georgians for a Healthy Future[2]	N/A	• No quantitative criteria provided	• No quantitative criteria provided	• No quantitative criteria provided
Hawaii *(Standards apply to network plans/health benefit plans)*	HRS § 431:26-103 Current through 2019 Regular Session	• No quantitative criteria provided	• **Emergency Services**: Covered persons shall have access to emergency services 24/7	• No quantitative criteria provided

[2] **http://healthyfuturega.org/our-priorities/increasing-access-to-care/network-adequacy/**

State	Source	Geographic Criteria	Appointment Wait Times	Provider/Enrollee Ratio
Idaho (*Standards apply to health benefit plans*)	2020 Idaho Standards for ACA Compliant Individual and Small Group Health Benefit Plans and QDPs Document[3]	• Carriers must meet NCQA, AAAHC, or URAC standards	• Carriers must meet NCQA, AAAHC, or URAC standards	• Carriers must meet NCQA, AAAHC, or URAC standards
Illinois *(Standards apply to network plans)*	Illinois Department of Insurance Network Adequacy Checklist[4] 215 ILCS 124/10 (eff. 6-29-18) authorizing legislation Current through P.A. 101-629	• **Primary Urban**: 30 minutes or 30 miles for primary care, OB-GYN and general hospital care for urban areas • **Primary Rural**: 60 minutes or 60 miles for primary care, OB-GYN and general hospital care for rural areas • **Specialist Urban**: 45 minutes or 60 miles for specialist in urban areas • **Specialist Rural**: 75 minutes or 100 miles for specialist in rural	• Access to primary care, emergency services and woman's principal health care providers 24/7.	• 1 per county -- Hospital Facility, and Mental Health Facility • 1 per 1,000 – PCP/Pediatrician • 1 per 2,500 – OB/GYN • 1 per 5,000 – General Surgery, and Behavioral Health • 1 per 10,000 – Cardiology, Chiropractor, Dermatology, Endocrinology, Gastroenterology, Nephrology, Ophthalmology, Orthopedic Surgery, Pulmonary, Rheumatology, and Urology • 1 per 15,000 – Infectious Disease, Allergy/Immunology, ENT/Otolaryngology, Oncology/Radiation, and Physiatry/Rehabilitative

[3] https://doi.idaho.gov/DisplayPDF?Cat=company&ID=2020%20Idaho%20ACA%20HBP%20and%20QDP%20Standards
[4] http://insurance.illinois.gov/HealthInsurance/NetworkAdequacyTransparencyChecklist.pdf

State	Source	Geographic Criteria	Appointment Wait Times	Provider/Enrollee Ratio
				• 1 per 20,000 – Plastic Surgery, and Neurology • Insurers who are not able to comply with the provider ratios and time and distance standards established by the Department may request an exception to these requirements.
Indiana (*Standards apply to Health Maintenance Organizations*)	IC 27-13-36-2 to IC 27-13-36-4; and 13-36-8 (1999) Current through 2020 Second Regular Session of 121st General Assembly	• Must comply with standards developed by NCQA	• Must comply with standards developed by NCQA	• Must comply with standards developed by NCQA
Iowa	N/A	• No quantitative criteria provided	• No quantitative criteria provided	• No quantitative criteria provided
Kansas	N/A	• No quantitative criteria provided	• No quantitative criteria provided	• No quantitative criteria provided
Kentucky (*Standards apply to Qualified Health Benefit Plans and Managed Care and Non-Managed Care Plans*)	KRS § 304.17A-515 Effective January 1, 2019 900 Ky. Admin. Regs. 10:200 Sec. 4	• **Urban areas**: Provider network that is available to all persons enrolled in the plan within 30 miles or 30 minutes of each person's place of residence or work, to the extent that services are available	• No quantitative criteria provided	• No quantitative criteria provided

State	Source	Geographic Criteria	Appointment Wait Times	Provider/Enrollee Ratio
	Current through Chapter 5 of 2020 Regular Session	• **Non-urban areas**: Provider network that makes available primary care physician services, hospital services, and pharmacy services within 30 minutes or 30 miles of each enrollee's place of residence or work, to the extent those services are available. All other providers shall be available to all persons enrolled in the plan within 50 minutes or 50 miles of each enrollee's place of residence or work, to the extent those services are available		
Louisiana (*Standards apply to Health Benefit Plans*)	LA. REV. STAT. ANN. § 22:1019.2 (2013) Current through 2019 Regular Session	• Carriers must meet the standards for accreditation of NCQA, American Accreditation Health Commission, Inc., or URAC	• Carriers must meet the standards for accreditation of NCQA, American Accreditation Health Commission, Inc., or URAC • In the case of emergency services/any ancillary emergency health care services, covered persons shall have access 24/7	• Carriers must meet the standards for accreditation of NCQA, American Accreditation Health Commission, Inc., or URAC

State	Source	Geographic Criteria	Appointment Wait Times	Provider/Enrollee Ratio
Maine (*Standards apply to Health Maintenance Organizations, Managed Care Plans, and health plans*)	02-031 CMR Ch. 850, § 7 (2012) Current through Feb. 26, 2020	• No quantitative criteria provided	• **Emergency Services**: MCPs must provide access to emergency services at all times • **Behavioral Health – Non-life-threatening emergencies**: within 6 hours • **Behavioral Health – Urgent care**: within 48 hours • **Behavioral Health – Routine office visit**: within 10 business days	• **PCPs**: To the extent possible, carriers that offer MCPs utilizing PCPs shall maintain a minimum of one full-time PCP to 2000 enrollees
Maryland *(Standards apply to health benefit plans)*	COMAR 31.10.44.04-06 Current through Feb. 25, 2020	*See Appendix 1(A) for complete list.* • **PCP/OBGYN**: 5 miles (urban), 10 miles (suburban), 30 miles (rural) • **Psychiatry, Psychology, LCSW:** 10 miles (urban), 25 miles (suburban), 60 miles (rural) • **Applied Behavior Analyst:** 15 miles (urban), 30 miles (suburban), 60 miles (rural) • **Specialists Range:** 10-15 miles (urban), 10-40 miles (suburban), 60-90 miles (rural)	• **Urgent care** (including medical, BH/SUD services): 72 hours • **Routine Primary Care:** 15 calendar days • **Preventative Visit/Well Visit**: 30 calendar days • **Non-Urgent Specialty Care**: 30 calendar days • **Non-Urgent BH/SUD Services**: 10 calendar days	Provider-to-enrollee ratios shall be equivalent to at least 1 full-time physician, or as appropriate, another full-time provider to enrollees: • 1:1,200 primary care • 1: 2,000 pediatric care • 1:2,000 OB/GYN care • 1: 2,000 BH services • 1: 2,000 SUD services

State	Source	Geographic Criteria	Appointment Wait Times	Provider/Enrollee Ratio
		• **Behavioral Health Facilities:** 10 miles (urban), 25 miles (suburban), 60 miles (rural)		
Massachusetts	N/A	• No quantitative criteria provided	• No quantitative criteria provided	• No quantitative criteria provided
Michigan	Michigan Network Adequacy Guidance Document (Revised June 2019)[5] MCLA 500.3513 (HMO)	• No quantitative criteria provided. • Identifies a 30-minute travel time as guidance for adequacy but not applied to any provider/service.	• **Emergency episodes of illness or injury**: Services available and accessible to covered persons 24 hours a day and 7 days a week.	• No quantitative criteria provided
Minnesota (*Standards apply to health carriers*)	M.S.A. § 62K.10 Current through Jan. 1, 2020	• **Primary Care, Mental Health, General Hospital Services**: Maximum travel distance or time shall be the lesser of 30 miles or 30 minutes to the nearest provider • **Other Health Services**: Maximum travel distance or time shall be the lesser of 60 miles or 60 minutes to the nearest provider of specialty physician services, ancillary services,	• **Primary Care Physician Services**: Must be available and accessible 24/7 within the network's area	• No quantitative criteria provided

[5] **https://www.michigan.gov/documents/difs/Network_Adequacy_Guidelines_415418_7.pdf**

State	Source	Geographic Criteria	Appointment Wait Times	Provider/Enrollee Ratio
		specialty hospital services, and all other health services		
Mississippi	Miss. Admin. Code 19-3:14.05 Current through Nov. 2019	• No quantitative criteria provided	• **Emergency Facility Services**: Covered persons shall have access 24/7	• No quantitative criteria provided
Missouri (*Standards apply to Health Maintenance Organizations Offering Managed Care Plans*)	20 Mo. Code of State Regulations 400-7.095 (2007) Current through Dec. 15, 2019 MO. ST. § 354.603	*See* Appendix 1 (B), Distance Standards for complete list.[6] • **PCP:** within 10 miles in urban areas; 20 miles in basic areas; 30 miles in rural areas • **OB/GYN:** within 15 miles in urban areas; 30 miles in basic areas; 60 miles in rural areas • **Specialists:** within 25 miles in urban areas; 50 miles in basic areas; 100 miles in rural areas • **Psychiatry – Adult/General**: within 15 miles in urban areas; 40 miles in basic areas; 80 miles in rural areas. • **Psychiatry – Child/Adolescent:** within	• **Routine care, without symptoms**: Within 30 days from the time the enrollee contacts the provider; • **Routine care, with symptoms**: Within 5 business days from the time the enrollee contacts the provider; • **Urgent care for illnesses/injuries which require care immediately, but which do not constitute emergencies**: Within 24 hours from the time the enrollee contacts the provider; • **Emergency care**: A provider or emergency care facility shall be	• No quantitative criteria provided

[6] **https://www.sos.mo.gov/cmsimages/adrules/csr/current/20csr/20c400-7.pdf**

State	Source	Geographic Criteria	Appointment Wait Times	Provider/Enrollee Ratio
		22 miles in urban areas; 45 miles in basic areas; 90 miles in rural areas • **Psychologist/Other Therapist**: within 10 miles in urban areas; 20 miles in basic areas; 40 miles in rural areas • **Basic Hospital:** 30 miles in urban, basic and rural areas • **Inpatient Mental Health Treatment Facility**: within 25 miles in urban areas; 40 miles in basic areas; 75 miles in rural areas • **Ambulatory Mental Health Providers**: within 15 miles in urban areas; 25 miles in basic areas; 45 miles in rural areas • **Residential Mental Health Treatment Providers:** within 20 miles in urban areas; 30 miles in basic areas; 50 miles in rural areas.	available 24 hours per day, 7 days per week • **Obstetrical care**: Within 1 week for enrollees in the first or second trimester of pregnancy; within 3 days for enrollees in the third trimester. Emergency obstetrical care is subject to the same standards as emergency care, except that an obstetrician must be available 24 hours per day, 7 days per week • **Mental health care**: Telephone access to a licensed therapist shall be available 24 hours per day, 7 days per week.	
Montana	MCA 33-36-201 Current through 2019 Session	• To the extent that services are covered, the health carrier must have an	• **Emergency services**: available and accessible at all times;	• In order to be deemed adequate, a health carrier's network must include one

State	Source	Geographic Criteria	Appointment Wait Times	Provider/Enrollee Ratio
(Standards apply to Managed Care Plans)	Mont. Admin. R. 37.108.215-227 Current through Feb. 28, 2020	adequate network of primary care providers, a hospital, critical access hospital, or medical assistance facility, and a pharmacy within a 30-mile radius of each enrollee's residence or place of work	• **Urgent care appointments**: available within 24 hours; • **Non-urgent care with symptoms appointments**: available within 10 calendar days; • **Immunization appointments**: available within 21 calendar days; and • **Routine or preventive care appointments**: available within 45 calendar days.	mid-level PCP per 1,500 projected enrollees or one physician PCP per 2,500 projected enrollees.
Nebraska	Neb. Rev. St. § 44-7105 (1998) Current through Feb. 13, 2020 of 3nd Regular Session, 106th Legislature	• No quantitative criteria provided	• **Emergency services**: Covered persons shall have access twenty-four hours per day, seven days per week	• No quantitative criteria provided
Nevada	N.R.S. 687B.490 Nev. Admin. Code 687B.768 Current through Feb. 29, 2020	• Network plan must provide reasonable access to 1 provider in each specialty area for at least 90% of enrollees s based on maximum time/distance standards. • For Mental Health and Substance Use Disorder providers (psychiatrists,	• No quantitative criteria provided	• No quantitative criteria provided

State	Source	Geographic Criteria	Appointment Wait Times	Provider/Enrollee Ratio
		psychologists and licensed clinical social workers) standards are: Metro 45 minutes/30 miles; Micro 60 minutes/45 miles; Rural 75 minutes/60 miles and CEAC 110 minutes/100 miles. *See Appendix 2(A) for all specialties.*		
New Hampshire (*Standards apply to Managed Care Plans*)	N.H. Code Admin. R. Ins 2701.04-.10 (2010) Current through March. 1, 2020	• **Service Designation**: Core, common and specialized. ***Core services*** include: alcohol or drug treatment in ambulatory setting for crisis intervention, detoxification or medical or somatic treatment; assessment, case management, group counseling, IOP, methadone or equivalent treatment, subacute detox, medication training and support, BH or SUD comprehensive community support services, BH or SUD comprehensive medication services, BH counseling or therapy, BH	• **Behavioral Health**: 6 hours for non-life-threatening emergency; 48 hours for urgent care; 10 business days for initial or evaluation visit. • **PCP**: 48 hours for urgent care; 30 days for other routine care	• No quantitative criteria provided

State	Source	Geographic Criteria	Appointment Wait Times	Provider/Enrollee Ratio
		partial hospitalization, BH short-term residential. ***Common services*** include general psychiatric care on inpatient basis, psychiatric diagnostic evaluation with medical services; ***Specialized services*** include alcohol or drug acute detox • **Urban Counties**: For core services, 10 miles or 15 minutes driving time; for common services, 20 miles or 30 minutes driving time; for specialized services 40 miles or 1 hour driving time. • **Middle Counties**: Core services, 20 miles or 40 minutes driving time; common services, 40 miles or 80 minutes driving time; specialized services 70 miles or 2 hours driving time. • **Rural Counties**: Core services, 30 miles or one hour driving time; common services, 80 miles or 2 hours driving time;		

State	Source	Geographic Criteria	Appointment Wait Times	Provider/Enrollee Ratio
		specialized services 125 miles or 2.5 hours driving time.		
New Jersey (*Standards apply to Managed Care Plans*)	NJ ADC 11:24A-4.10 Current through March 16, 2020	• **PCPs**: Sufficient number of physicians to assure that at least 2 physicians eligible as PCPs are within 10 miles or 30 minutes driving time or public transit time (if available), whichever is less, of 90 percent of the carrier's covered persons • **Specialists**: Sufficient number of the medical specialists, as applicable to the services covered in-network, to assure access within 45 miles or 60 minute driving time, whichever is less, of 90 percent of covered persons within each county or approved sub-county service area • **Acute Care Hospital/Surgical Facilities**: At least 1 licensed acute care hospital with licensed medical-surgical, pediatric,	If the carrier provides benefits for emergency services: • **Urgent care:** provided within 24 hours of notification of the PCP or carrier • **Emergent and urgent care:** PCPs shall be required to provide 7-day, 24-hour access to triage services • **Routine appointments:** scheduled within at least 2 weeks • **Routine physical exams:** scheduled within at least 4 months	• The carrier shall demonstrate sufficiency of network PCPs to meet the adult, pediatric and primary OB/GYN needs of the current and/or projected number of covered persons by assuming: (1) Four primary care visits per year per member, averaging one hour per year per member; and (2) Four patient visits per hour per PCP • The carrier shall have a contract or arrangement with at least one home health agency licensed by the Department of Health and Senior Services to serve each county where 1,000 or more covered persons reside • The carrier shall have a contract or arrangement with at least one hospice program certified by

State	Source	Geographic Criteria	Appointment Wait Times	Provider/Enrollee Ratio
		obstetrical and critical care services in any county or service area that is no greater than 20 miles or 30 minutes driving time, whichever is less, from 90 percent of covered persons within the county or service area; The carrier shall have a contract or arrangement with surgical facilities, including acute care hospitals, licensed ambulatory surgical facilities, and/or Medicare-certified physician surgical practices available in each county or service area that are no greater than 20 miles or 30 minutes driving time, whichever is less, from 90 percent of covered persons within the county or service area • **Specialized services** available within 45 miles or 60 minutes average driving time, whichever is less, of 90 percent of covered persons within each county		Medicare in any county where 1,000 or more covered persons reside, if hospice care is covered under the health benefits plan in-network

State	Source	Geographic Criteria	Appointment Wait Times	Provider/Enrollee Ratio
		or service area: at least one hospital providing regional perinatal services, a hospital offering tertiary pediatric services, in-patient psychiatric service, residential SUD treatment centers, diagnostic cardiac catherization services in a hospital, specialty out-patient centers for HIV/AIDS, sickle cell disease, hemophilia, and cranio-facial and congenital anomalies, and comprehensive rehabilitation services • **Specialized services** available within 20 miles or 30 minutes average driving time, whichever is less, of 90 percent of covered persons within each county or service area: licensed long-term care facility with Medicare-certified skilled nursing beds, therapeutic radiation, magnetic resonance imaging center, diagnostic radiology,		

State	Source	Geographic Criteria	Appointment Wait Times	Provider/Enrollee Ratio
		emergency MH service (including a short term care facility for involuntary psychiatric admissions), outpatient therapy for MH/SUD conditions, and licensed renal dialysis • In any county or approved service area in which 20%+ of a carrier's projected or actual number of covered persons must rely upon public transport to access health care services, the driving times set forth shall be based upon average transit time using public transport, and the carrier shall demonstrate how it will meet the requirements		
New Mexico *(Standards apply to Managed Health Care Plans)*	N.M. Admin Code 13.10.22.8 Current through Jan. 14, 2020	• In population areas of 50,000 or more residents, 2 PCPs are available within no more than 20 miles or 20 minutes average driving time for 90 percent of the enrolled population, or, in population areas of less than 50,000, 2 PCPs are	• **Emergency care** is immediately available without prior authorization requirements. The medical needs of covered persons are met 24 hours per day, seven days per week. • **Urgent care** shall be available within 48 hours of	• Must have a sufficient number of PCPs to meet the primary care needs of enrollees: 1) each covered person will have four primary care visits annually, averaging a total of one hour; 2) each PCP will see an average of four patients

State	Source	Geographic Criteria	Appointment Wait Times	Provider/Enrollee Ratio
		available in any county or service area within no more than 60 miles or 60 minutes average driving time for 90 percent of the enrolled population. • For remote rural areas, the superintendent shall consider on a case by case basis whether the MHCP has made sufficient PCPs available given the number of residents in the county or service area and given the community's standard of care. • Attempt to provide at least one licensed medical specialist in those specialties that are generally available in the geographic area served, taking into consideration the urban or rural nature of the service area, the geographic location of each covered person, and the type of specialty care needed by the covered person population.	notification to the PCP or MHCP; • **Emergent and urgent care**, triage services by PCP 7 days per week and 24 hours per day • **Routine appointments** scheduled as soon as is practicable given the medical needs of the covered person and the nature of the health care professional's medical practice; • **Routine physical exams** scheduled within 4 months.	per hour; and 3) one full-time equivalent PCP will be available for every 1,500 covered persons.

State	Source	Geographic Criteria	Appointment Wait Times	Provider/Enrollee Ratio
		• In population areas of 50,000 or more residents, at least one licensed acute care hospital providing, at a minimum, licensed medical-surgical, emergency medical, pediatric, obstetrical, and critical care services is available no greater than 30 miles or 30 minutes average driving time for 90 percent of the enrolled population within the service area, and, in population areas of less than 50,000, that the acute care hospital is available no greater than 60 miles or 60 minutes average driving time for 90 percent of the enrolled population within the service area. • For remote rural areas, the superintendent shall consider on a case by case basis whether the MHCP has made at least one licensed acute care hospital available given the number		

State	Source	Geographic Criteria	Appointment Wait Times	Provider/Enrollee Ratio
		of residents in the county or service area and given the community's standard of care.		
New York	Network Adequacy Standards and Guidance Document[7]	**PCPs**: • **Metropolitan Areas**: 30 minutes by public transportation. • **Non-Metropolitan Areas**: 30 minutes or 30 miles by public transportation or by car. • In rural areas, transportation may exceed these standards if justified. **Non-PCPs**: • It is preferred that an insurer meet the 30-minute or 30-mile standard for other providers that are not primary care providers. A time and distance standard of 45 minutes/45 miles may be	• No quantitative criteria provided	• At least 1 hospital in each county. • At least 3 hospitals in Bronx, Erie, Kings, Monroe, Nassau, New York, Queens, Suffolk and Westchester. • Choice of 3 primary care physicians (PCPs) in each county, and potentially more based on enrollment and geographic accessibility • At least 2 of each specialist provider type, and potentially more based on enrollment and geographic accessibility • At least 2 behavioral health providers per county. • Choice of 2 primary dentists in service area and a ratio of at least 1 primary care

[7] **https://www.dfs.ny.gov/insurance/health/Network_Adeq_standards_guidance_Instructions_9.15_Final.pdf**; **https://www.dfs.ny.gov/docs/insurance/health/network_adeq_submission_instructions.pdf**

State	Source	Geographic Criteria	Appointment Wait Times	Provider/Enrollee Ratio
		used for the following rural counties for the following provider types: • **Pedodontist**: Allegany, Cayuga, Chemung, Essex, Franklin, Fulton, Hamilton, Herkimer, Jefferson, Lewis, Montgomery, Oneida, Otsego, Schoharie, Schuyler, St. Lawrence, Steuben and Tompkins. • **Oral Surgery**: Essex, Franklin, Lewis, Schoharie and Steuben. • **Orthodontics**: Broome, Cayuga, Chemung, Clinton, Essex, Franklin, Jefferson, Lewis, Madison, Oneida, Otsego, Schoharie, Schuyler, St. Lawrence and Tompkins.		dentist for every 2,000 insureds • At least 2 orthodontists, 1 pedodontist, and 1 oral surgeon
North Carolina *(Standards apply to Managed Care Health Benefit Plans)*	11 NC ADC 20.0302 Current through Jan. 22, 2020	• No quantitative criteria provided	• **Emergency services** must be available on a 24-hour, seven day per week basis	• No quantitative criteria provided
North Dakota	NDAC 45-06-07-06 (1994) Current through Jan. 2020	• No quantitative criteria provided	• **Emergency care services** available and accessible within the service area	• No quantitative criteria provided

State	Source	Geographic Criteria	Appointment Wait Times	Provider/Enrollee Ratio
(*Standards apply to Health Maintenance Organizations*)			twenty-four hours a day, seven days a week	
Ohio	N/A	• No quantitative criteria provided	• No quantitative criteria provided	• No quantitative criteria provided
Oklahoma (*Standards apply to Health Maintenance Organizations*)	OAC 365:40-5-40; 365:40-5-110 Current through March 2, 2020	• The "mean travel time" must be 30 minutes or less to the nearest primary or emergency care site from six equidistant points within the boundary of the service area.	• **Emergency services** must be available 24 hours a day, 7 days per week.	• No quantitative criteria provided
Oregon	OR ADC 836-053-0330 Current through Feb. 2020	• One way that plans can demonstrate compliance with network adequacy requirements is by meeting standards for Medicare Advantage plans, adjusted to reflect age and demographics of enrollees (includes standard for inpatient psychiatric facility services)	• No quantitative criteria provided	• No quantitative criteria provided
Pennsylvania	28 Pa. Code §§ 9.678; 9.679 (2001) Current through March 7, 2020	• Plan shall provide for at least 90% of its enrollees in each county in its service area, access to covered	• **PCPs**: Must provide office hours accessible to enrollees a minimum of 20 hours-per-week, be	• No quantitative criteria provided

State	Source	Geographic Criteria	Appointment Wait Times	Provider/Enrollee Ratio
		services that are within 20 miles or 30 minutes travel from an enrollee's residence or work in a county designated as a metropolitan statistical area by the Federal Census Bureau, and within 45 miles or 60 minutes travel from an enrollee's residence or work in any other county • Standards apply to PCP, hospital, diagnostic and listed specialty services, including psychiatry.	available directly or through on-call arrangements with other qualified plan. PCPs 24 hours-per-day, 7 days-per-week for urgent and emergency care	
Rhode Island	N/A	• No quantitative criteria provided	• No quantitative criteria provided	• No quantitative criteria provided
South Carolina	Department of Insurance Bulletin Number 2013-04[8]	• No quantitative criteria provided	• No quantitative criteria provided	• One PCP per 2,000 members within 30-mile radius for 95% of the population in the service area. • One contracted hospital within county or 30-mile radius of 95% of the population in the service

[8] https://doi.sc.gov/DocumentCenter/View/3040/2013-04-Process-for-Filing-Amendments-to-Forms-to-Comply-with-ACA

State	Source	Geographic Criteria	Appointment Wait Times	Provider/Enrollee Ratio
				area if the county doesn't have a hospital. • Adequate number and type of specialists within a 50-mile radius of 95% of the population in the service area. • One OB-GYN within a 30-mile radius for 95% of the population in the service area.
South Dakota	SDCL § 58-17F-5 (2011) Current through 2020 Regular Session eff. March 16, 2020	• No quantitative criteria provided	• **Emergency Services**: Emergency services available 24 hours a day, 7 days a week	• No quantitative criteria provided
Tennessee (*Standards apply to Health Maintenance Organizations and Managed Health Insurance Issuers*)	T. C. A. § 56-7-2356 Current through2020 First Reg. Session, 111th Tenn. General Assembly through Jan. 24, 2020 Tenn. Comp. R. & Regs. 1200-08-33-.06 (HMO) Current through Oct. 13, 2019	**HMOs**: • **PCPs**: HMO shall ensure that members do not have to travel more than 30 miles or 30 minutes • **Nearest Participating Hospital**: HMO shall ensure that members do not need to travel more than approximately 30 minutes (this requirement may be waived if not feasible in a specific geographic area)	**HMOs**: • **Emergency Services**: HMO shall ensure that emergency care (including ambulance service) is available and accessible 24/7 **Managed Health Insurance Issuers**: • **Emergency Services**: Covered persons shall have access to health care services 24/7	• No quantitative criteria provided

State	Source	Geographic Criteria	Appointment Wait Times	Provider/Enrollee Ratio
		Managed Health Insurance Issuers: • **PCPs**: Must demonstrate an adequate number of PCPs within not more than 30 miles distance or 30 minutes travel time (at a reasonable speed)		
Texas *(Separate standards apply to Health Maintenance Organizations and Preferred Provider Organizations)*	HMO: 28 TAC § 11.1607 (2006) Current through Jan. 20, 2020 PPO: 28 TAC § 3.3704 (2013) Current through Jan. 10, 2020	**HMO**: • 30 miles for primary care and general care hospital • 75 miles for specialty care, special hospitals, and single health care plan physicians or providers **PPO**: • Provide for preferred benefit services sufficiently accessible and available as necessary to ensure that the distance from any point in the insurer's designated service area to a point of service is not greater than: primary care and general hospital care (30 miles in non-rural areas and 60 miles in rural areas); and	**HMO**: • **Emergency care, general, special, and psychiatric hospital care:** 24 hours per day, 7 days per week with in the HMO's service area • **Urgent care**: Medical, dental, and behavioral health conditions within 24 hours • **Routine Medical Conditions**: within 3 weeks • **Routine Behavioral Health Conditions**: within 2 weeks • **Routine Dental Conditions**: within 8 weeks • **Preventative health services**: within 2 months for a child; within 3 months for an adult; and within 4 months for dental services	**HMO and PPO**: • No quantitative criteria provided

State	Source	Geographic Criteria	Appointment Wait Times	Provider/Enrollee Ratio
		specialty care and specialty hospitals (75 miles)	**PPO**: • **Emergency care:** 24 hours/day and 7 days/week • **Urgent care for medical and behavioral health conditions:** within 24 hours within designated health service area • **Routine Care Medical Conditions**: within 3 weeks • **Routine Care Behavioral Health Conditions**: within 2 weeks • **Preventative health services**: within 2 months for a child, or earlier if necessary for compliance with recommendations for specific preventative care services; and within 3 months for an adult	
Utah	N/A	• No quantitative criteria provided	• No quantitative criteria provided	• No quantitative criteria provided
Vermont	Vt. Admin. Code 4-5-3:5 Current through Jan. 2020	Travel times (under normal conditions) from residence or place of business, generally should not exceed:	Waiting times should generally not exceed the following:	• No quantitative criteria provided

State	Source	Geographic Criteria	Appointment Wait Times	Provider/Enrollee Ratio
(*Standards apply to Managed Care Organizations*)		• **PCP**: 30 minutes • **Routine, office-based MH/SUD**: 30 minutes • **Outpatient physician specialty care; Intensive outpatient; Partial hospital, residential or inpatient MH/SUD services; laboratory; pharmacy; general optometry; inpatient; imaging; and inpatient medical rehabilitation services**: 60 minutes • **Major trauma treatment; neonatal intensive care; and tertiary-level cardiac services**, including procedures such as cardiac catheterization and cardiac surgery: 90 minutes • Reasonable accessibility for other specialty services	• **Emergency Services**: Immediate access to emergency care for conditions that meet the definition of "emergency medical condition" • **Urgent Care**: 24 hours or a time frame consistent with the medical exigencies of the case for urgent care (outpatient MH/SUD care designated by the member or provider as non-urgent is not considered to be urgent care) • **Non-Emergency/Non-Urgent Care**: 2 weeks • **Preventative Care** (including routine physical examinations): 90 days • **Routine laboratory, imaging, general optometry, and all other routine services**: 30 days	
Virginia (*Standards apply to Health Maintenance Organizations*)	VA. CODE ANN. § 38.2-4312.3 (2011) Current through end of 2019 Reg Session	• No quantitative criteria provided	• **Urgent Need, Medical Emergency**: On a 24-hour basis, access must be provided to medical care or access by telephone to a	• No quantitative criteria provided

State	Source	Geographic Criteria	Appointment Wait Times	Provider/Enrollee Ratio
			physician or licensed health care professional with appropriate medical training who can refer or direct a member for prompt medical care in cases where there is an immediate, urgent need or medical emergency	
Washington (*Standards apply to Essential Health Benefit Services*)	WASH. ADMIN. CODE § 284-170-200 (2016) Current through Jan. 2, 2020	• **Hospitals and Emergency Services:** Each enrollee access within (30) miles in urban area and (60) miles in a rural area from either residence or workplace • **PCPs:** 80% of enrollees within the service area must be within (30) miles of a sufficient number of PCPs in an urban area and within (60) miles of a sufficient number of PCPs in a rural area from either their residence or work • **MH/SUD Providers:** requirements but no metrics. Adequate networks include crisis intervention and	• **Urgent**: For the essential health benefits category of ambulatory patient services, network must afford access to urgent appointments without PA within (48) hours, or with PA, within (96) hours of the referring provider's referral • **Non-Preventative Services**: Access to an appointment a PCP within (10) business days of requesting one • **Preventative Services**: Professionally recognized standards of practice • **Non-Urgent Specialist**: When an enrollee is referred to a specialist, has access to an appointment	• No quantitative criteria provided

State	Source	Geographic Criteria	Appointment Wait Times	Provider/Enrollee Ratio
		stabilization, psychiatric inpatient hospital services, including voluntary psychiatric inpatient services, and services from MH providers. Must review adequacy of the MH network at least 2 times/year and submit action plan if not met.	within (15) business days for non-urgent services • **Emergencies**: Emergency services must be accessible (24) hours per day, (7) days per week without unreasonable day	
West Virginia (*Standards apply to Health Maintenance Organizations*)	Informational Letter No. 112 (Nov. 1998)[9]	**Primary** Care • Urban: 30 miles/45 minutes • Rural: 45 miles/60 minutes **Pediatrician** • Urban: 30 miles/45 minutes • Rural: 60 miles/90 minutes **OB/GYN** • Urban: 30 miles/45 minutes • Rural: 60 miles/90 minutes **Specialist** • Urban: 30 miles/45 minutes	• No quantitative criteria provided	New county/region service area • **PCP** 1:120 • **OB/GYN** 1:240 • **Pediatrician** 1:360 • **Specialist** 1:2,000 Established county/region • **PCP** 1:2,500 • **OB/GYN** 1:5,000 • **Pediatrician** 1:7,500 • **Specialist** 1:8,000

[9] **https://www.wvinsurance.gov/Portals/0/pdf/pol_leg/info_letters/info_112.pdf?ver=2004-09-14-094500-000**

State	Source	Geographic Criteria	Appointment Wait Times	Provider/Enrollee Ratio
		• Rural: 60 miles/90 minutes **Hospital** • Urban: 30 miles/45 minutes • Rural: 60 miles/90 minutes		
Wisconsin	N/A	• No quantitative criteria provided	• No quantitative criteria provided	• No quantitative criteria provided
Wyoming	N/A	• No quantitative criteria provided	• No quantitative criteria provided	• No quantitative criteria provided
Medicare Advantage	Medicare Advantage Network Adequacy Criteria Guidance[10] (updated February 20, 2018) and HSD Reference File[11] (updated August 1, 2018)	**Primary Care:** • Large metro: Within 10 minutes/5miles • Metro: Within 15 minutes/10 miles • Micro: Within 30 minutes/20 miles • Rural: Within 40 minutes/30 miles • CEAC: Within 70 minutes/60 miles **Psychiatry:** • Large metro: Within 20 minutes/10 miles	• No quantitative criteria provided	**Primary Care**: • Large metro: 1.67 • Metro: 1.67 • Micro: 1.42 • Rural: 1.42 • CEAC: 1.42 **Psychiatry**: • Large metro: .14 • Metro: .14 • Micro: .12 • Rural: .12 • CEAC: .12

[10] https://www.cms.gov/files/document/medicare-advantage-and-section-1876-cost-plan-network-adequacy-guidance-pdf
[11] https://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/index?redirect=/MedicareAdvantageApps/

State	Source	Geographic Criteria	Appointment Wait Times	Provider/Enrollee Ratio
		• Metro: Within 45 minutes/30 miles • Micro: Within 60 minutes/45 miles • Rural: Within 75 minutes/60 miles • CEAC: Within 110 minutes/100 miles **Other Specialty Care (see specific specialty):** • Large metro: Ranges from 20-30 minutes, 10-15 miles • Metro: Ranges from 30-60 minutes, 20-40 miles • Micro: Ranges from 50-100 minutes, 35-75 miles • Rural: Ranges from 75-110 minutes, 60-90 miles • CEAC: Ranges from 95-145 minutes, 85-130 miles **Inpatient Psychiatric Facility Services**: • Large metro: Within 30 minutes/15 miles • Metro: Within 70 minutes/45 miles • Micro: Within 100 minutes/75 miles		**Other Specialty Care (see specific specialties)**: • Large metro: Ranges from .01 to .28 • Metro: Ranges from .01 to .28 • Micro: Ranges from .01 to .24 • Rural: Ranges from .01 to .24 • CEAC: Ranges from .01 to .24

State	Source	Geographic Criteria	Appointment Wait Times	Provider/Enrollee Ratio
		• Rural: Within 90 minutes/75 miles • CEAC: Within 155 minutes/140 miles **Other Facilities (see specific facility type):** • Large metro: Ranges from 20-30 minutes, 10-15 miles • Metro: Ranges from 45-70 minutes, 30-45 miles • Micro: Ranges from 65-160 minutes, 50-120 miles • Rural: Ranges from 55-145 minutes, 50-120 miles • CEAC: Ranges from 95-155 minutes, 85-140 miles		

Federally-Facilitated Marketplaces[12]: "In recognition of the traditional role states have in developing and enforcing network adequacy standards, CMS will defer to States that have a sufficient network adequacy review process. In States with the authority and means to conduct network adequacy reviews, CMS will no longer conduct these reviews. For 2019 and beyond, CMS will defer to States' reviews in States with authority to enforce standards that are at least equal to the 'reasonable access standard' identified in §156.230 and means to assess issuer network adequacy. HHS also strongly encourages all issuers to consider increasing the use of telehealth services as part of their networks to ensure all consumers have access to all covered services.
In States that do not have the authority and means to conduct sufficient network adequacy reviews, CMS will apply a standard similar to the one used for the 2014 benefit year. CMS will rely on an issuer's accreditation (commercial, Medicaid, or Exchange) from an HHS-recognized accrediting entity. These include the three previously recognized accrediting entities for the accreditation of QHPs: Accreditation Association for Ambulatory Health Care (AAAHC), the National Committee for Quality Assurance (NCQA), and URAC. Unaccredited issuers in States determined not to have authority to enforce standards that are at least equal to the 'reasonable access standard' at §156.230 and means to assess issuer network adequacy would be required to submit an access plan (and cover sheet) as part of the QHP application. To show that the QHP's network meets the requirement in §156.230(a)(2), the access plan would need to demonstrate that an issuer has standards and procedures in place to maintain an adequate network consistent with the NAIC's Health Benefit Plan Network Access and Adequacy Model Act. For plan year 2018, CMS found all States participating in FFEs to have the required network adequacy means and authority. For plan year 2019, CMS does not anticipate any changes in its assessment of States with the means and authority for network adequacy review."

***Unable to access updated NCQA standards for 2018-19**

[12] Dept. of Health and Human Services, 2019 Letter to Issuers in the Federally-facilitated Exchanges (April 9, 2018) at 13. Available at **https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2019-Letter-to-Issuers.pdf**.
Centers for Medicare & Medicaid Services, Center for Consumer Information & Insurance Oversight. (2019, April 18). *2020 Letter to Issuers in the Federally-facilitated Exchanges.* Retrieved from **https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2020-Letter-to-Issuers-in-the-Federally-facilitated-Exchanges.pdf**.

Appendix 1(A): Travel Distance Standards (Maryland)

PROVIDER TYPE

PROVIDER TYPE	URBAN AREA MAX. DISTANCE (MI)	SUBURB. AREA MAX. DISTANCE (MI)	RURAL AREA MAX. DISTANCE (MI)
ALLERGY AND IMMUNOLOGY	15	30	75
APPLIED BEHAVIOR ANALYST	15	30	60
CARDIO. DISEASE	10	20	60
CHIROPRACTIC	15	30	75
DERMATOLOGY	10	30	60
ENDOCRIN.	15	40	90
ENT/OTOLARYNGOLOGY	15	30	75
GASTROENTEROLOGY	10	30	60
GENERAL SURGERY	10	20	60
OB/GYN	5	10	30
GYN ONLY	15	30	75
LCSW	10	25	60
NEPHROLOGY	15	25	75
NEUROLOGY	10	30	60
ONCOLOGY-MED. AND SURG.	10	20	60
ONC.-RAD.	15	40	90
OPHTHA.	10	20	60
PEDIATRICS-ROUTINE/PC	5	10	30
PHYSIATRY, REHAB. MED.	15	30	75
PLASTIC SURGERY	15	40	90
PODIATRY	10	30	60
PCP	5	10	30
PSYCHIATRY	10	25	60
PSYCHOLOGY	10	25	60
PULMONOLOGY	10	30	60
RHEUMATOLOGY	15	40	90
UROLOGY	10	30	60
OTHERS	15	40	90

FACILITY TYPE

FACILITY TYPE	URBAN AREA MAX. DISTANCE (MI)	SUBURB. AREA MAX. DISTANCE (MI)	RURAL AREA MAX. DISTANCE (MI)
ACUTE INPATIENT HOSPITALS	10	30	60
CRIT. CARE SERVICES - ICU	10	30	100
DIAGNOSTIC RADIOLOGY	10	30	60
INPATIENT PSYCHIATRIC FACILITY	15	45	75
OUTPATIENT DIALYSIS	10	30	50
OUTPATIENT INFUSION/CHEMO.	10	30	60
PHARMACY	5	10	30
SKILLED NURSING FACILITIES	10	30	60
SURGICAL SERVICES (OUTPATIENT OR AMBULATORY SURGICAL CENTER)	10	30	60
OTHER BH/SUD FACILITIES	10	25	60
ALL OTHERS	15	40	90

GROUP MODEL HMO PLANS: TRAVEL DISTANCE STANDARDS BY PROVIDER TYPE

PROVIDER TYPE	URBAN AREA MAX. DISTANCE (MI)	SUBURB. AREA MAX. DISTANCE (MI)	RURAL AREA MAX. DISTANCE (MI)
ALLERGY AND IMMUNOLOGY	20	30	75
APPLIED BEHAVIOR ANALYST	15	20	60
CARDIO. DISEASE	15	25	60
CHIROPRACTIC	20	30	75
DERMATOLOGY	20	30	60
ENDOCRIN.	20	40	90
ENT/OTOLARYNGOLOGY	20	30	75
GASTROENTEROLOGY	20	30	60
GENERAL SURGERY	20	30	60
OB/GYN	15	20	45
GYN ONLY	15	30	60
LCSW	15	30	75
NEPHROLOGY	15	30	75
NEUROLOGY	15	30	60
ONCOLOGY-MED. AND SURG.	15	30	60
ONC.-RAD.	15	40	90
OPHTHA.	15	20	60
PEDIATRICS-ROUTINE/PC	15	20	45
PHYSIATRY, REHAB. MED.	15	30	75
PLASTIC SURGERY	15	40	90
PODIATRY	15	30	90
PCP	15	20	45
PSYCHIATRY	15	30	60
PSYCHOLOGY	15	30	60
PULMONOLOGY	15	30	60
RHEUMATOLOGY	15	40	90
UROLOGY	15	30	60
OTHERS	20	40	90

FACILITY TYPE

FACILITY TYPE	URBAN AREA MAX. DISTANCE (MI)	SUBURB. AREA MAX. DISTANCE (MI)	RURAL AREA MAX. DISTANCE (MI)
ACUTE INPATIENT HOSPITALS	15	30	60
CRIT. CARE SERVICES - ICU	15	30	120
DIAGNOSTIC RADIOLOGY	15	30	60
INPATIENT PSYCHIATRIC FACILITY	15	45	75
OUTPATIENT DIALYSIS	15	30	60
OUTPATIENT INFUSION/CHEMO.	15	30	60
PHARMACY	5	10	30
SKILLED NURSING FACILITIES	15	30	60
SURGICAL SERVICES (OUTPATIENT OR AMBULATORY SURGICAL CENTER)	10	30	60
OTHER BH/SUD FACILITIES	15	30	60
ALL OTHERS	15	40	120

Appendix 1(B): Travel Distance Standards By Provider/Service Type For HMO Plans Offering MCPs (Missouri)

PROVIDER/SERVICE TYPE	URBAN COUNTY MAX. DISTANCE (MI)	BASIC COUNTY MAX. DISTANCE (MI)	RURAL AREA MAX. DISTANCE (MI)
PCPS	10	20	30
OB/GYN	15	30	60
NEUROLOGY	25	50	100
DERMATOLOGY	25	50	100
PHYSICAL MED/REHAB	25	50	100
PODIATRY	25	50	100
VISION CARE/PRIMARY EYE	15	30	60
ALLERGY	25	50	100
CARDIOLOGY	25	50	100
ENDOCRINOLOGY	25	50	100
GASTROENTEROLOGY	25	50	100
HEMATOLOTY/ONCOLOGY	25	50	100
INFECTIOUS DISEASE	25	50	100
NEPHROLOGY	25	50	100
OPTHAMOLOGY	25	50	100
ORTHOPEDICS	25	50	100
OTOLARYNOLOGY	25	50	100
PEDIATRIC	25	50	100
PULMONARY	25	50	100
RHEUMATOLOGY	25	50	100
UROLOGY	25	50	100
GENERAL SURGERY	15	30	60
PSYCHIATRIST (ADULT)	15	40	80
PSYCHIATRIST (CHILD)	22	45	90
PSYCHOLOGIST/OTHER THERAPIST	10	20	40
CHIROPRACTOR	15	30	60

PROVIDER/SERVICE TYPE	URBAN COUNTY MAX. DISTANCE (MI)	BASIC COUNTY MAX. DISTANCE (MI)	RURAL AREA MAX. DISTANCE (MI)
HOSPITAL (BASIC)	30	30	30
HOSPTIAL (SECONDARY)	50	50	50
INPATIENT MH FACILITY	25	40	75
MH TREATMENT PROVIDERS (AMBULATORY)	15	25	45
MH TREATMENT PROVIDERS (RESIDENTIAL)	20	30	50

Appendix 2(A): Specialties and Standards For Marketplace Plan Year 2018 Certification (Nevada)

SPECIALTY AREA	LARGE AREA MAX. TIME/DISTANCE (MIN/MILES)	METRO AREA MAX. TIME/DISTANCE (MIN/MILES)	MICRO AREA MAX. TIME/DISTANCE (MIN/MILES)	RURAL AREA MAX. TIME/DISTANCE (MIN/MILES)	COUNTIES WITH EXTREME ACCESS CONSIDERATIONS (CEAC) MAX. TIME/DISTANCE (MIN/MILES)
PRIMARY CARE		15/10	30/20	40/30	70/60
ENDOCRINOLOGY		60/40	100/75	110/90	145/130
INFECTIOUS DISEASES		60/40	100/75	110/90	145/130
ONCOLOGY – MEDICAL/SURGICAL		45/30	60/45	75/60	110/100
ONCOLOGY – RADIATION/RADIOLOGY		60/40	100/75	110/90	145/130
MH (INCLUDING SUD TREATMENT)		45/30	60/45	75/60	110/100
PEDIATRICS		25/15	30/20	40/30	105/90
RHEUMATOLOGY		60/40	100/75	110/90	145/130
HOSPITALS		45/30	80/60	75/60	110/100
OUTPATIENT DIALYSIS		45/30	80/60	90/75	125/110

Exhibit B: Analysis Comparing Quantitative Standards for MH/SUD Providers/Facilities to Quantitative Standards for other Medical/Surgical Providers/Facilities

State	Type of Quantitative Standard (specific to MH/SUD providers)	Comparison*
California	Geographic Criteria Appointment Wait Time	Distance standards and appointment wait time standards for MH/SUD provides = PCP.
Colorado	Geographic Criteria Appointment Wait Time Provider/Enrollee Ratio	Appointment wait time and provider/enrollee ratio standards for MH/SUD providers = PCP. Distance standards for MH/SUD providers > PCPs but = certain types of specialists (other specialists have longer standards). Distance standards for inpatient psychiatric facilities > acute inpatient hospitals.
Delaware	Geographic Criteria Provider/Enrollee Ratio	Distance standards for MH/SUD providers > PCPs but = specialty care providers. Distance standards for psychiatric hospitals > acute care hospitals. The provider/enrollee ratio for MH/SUD providers = PCPs.
Illinois	Provider/Enrollee Ratio	Provider/enrollee ratio for BH providers > PCPs; = general surgery; < other specialists.
Maine	Appointment Wait Time	Appointment wait time standard established only for behavioral health services and regulations defer to plans to establish medical services standards.
Maryland	Geographic Criteria Appointment Wait Time Provider/Enrollee Ratio	The distance standards for BH/SUD providers > PCPs, but < or = most specialists. The distance standards for inpatient psychiatric facilities > acute inpatient hospitals; distance standards for other BH/SUD facilities = acute inpatient hospitals except for suburban areas where the distance standards are shorter for BH/SUD facilities. Appointment wait time standard for urgent BH/SUD care = medical care, and the standard for non-urgent BH/SUD care < routine primary care. The provider/enrollee ratio for BH/SUD care > primary care and = OB/GYN care.
Minnesota	Geographic Criteria	The distance standard for mental health providers = PCP and general hospital services and < other health services.
Missouri	Geographic Criteria Appointment Wait Time	The distance standards for psychologists in urban and basic counties = PCPs. The distance standard for psychologists in rural counties > PCPs. The distance standards for psychiatrists and ambulatory and residential MH treatment providers > PCPs but < other types of specialty types (with exceptions for certain provider and county types when compared to OB/GYN and vision care). The distance

State	Type of Quantitative Standard (specific to MH/SUD providers)	Comparison*
		standard for inpatient MH treatment facilities < basic hospitals in urban counties but > basic hospitals in basic and rural counties. The appointment wait time standard for MH/SUD care is 24/7 telephone access to a licensed therapist = emergency care.
Nevada	Geographic Criteria	The distance standards for MH/SUD treatment > PCPs, = oncology, and < other specialists.
New Hampshire	Geographic Criteria Appointment Wait Time	The distance standards are based on classification of MH/SUD services and other medical services as core, common or specialized. MH/SUD services appear in all three classifications, depending on type of service and are subject to the same distance standards as other medical services in that classification. The appointment wait time standard for urgent BH = urgent PCP care. The wait time for initial/evaluation visit for BH care is < routine PCP care.
New Jersey	Geographic Criteria	The distance/travel time standard for inpatient psychiatric and residential SUD treatment (45 miles/60 min) > acute hospitals. The travel time standard for emergency and outpatient mental health treatment = PCPs but the distance standard is >. The distance/travel time standards for emergency and outpatient mental health treatment are < medical specialists.
New York	Number of Providers	Number of behavioral health providers per county < PCP and = other specialists
Oregon	Geographic Criteria[13]	Travel time/distance standards for psychiatry > PCPs. Travel time/distance standards for inpatient psychiatric facility services > other specialty facilities.
Pennsylvania	Geographic Criteria	Travel time/distance standards for psychiatry = PCPs and specialists.
Texas	Appointment Wait Time	The appointment wait time standard for routine BH care < routine medical care.
Vermont	Geographic Criteria	The travel time standard for routine MH/SUD care = PCPs, and the travel time standard for specialty MH/SUD care = other outpatient specialists.

Key

< Quantitative value for MH/SUD services is less than medical services' value

= Quantitative value for MH/SUD services is equal to medical services' value

> Quantitative value for MH/SUD services is greater than medical services' value

[13] Oregon relies on Medicare Advantage's geographic standards.

Exhibit C: Summary of Network Adequacy Requirements by State

State	Network Adequacy Standard *(states with specific standards for MH/SUD are in bold font)*
Alabama	Geographic Standards (travel distance)
Alaska	N/A
Arizona	Geographic Standards (travel time and distance) Appointment Wait Time Standards
Arkansas	Geographic Standards (travel distance)
California	**Geographic Standards** (travel time and distance) **Appointment Wait Time Standards** Provider/Enrollee Ratios
Colorado	**Geographic Standards** (travel distance) **Appointment Wait Time Standards** **Provider/Enrollee Ratios**
Connecticut	Provider/Enrollee Ratios and Calculation to determine the minimum number of providers
Delaware	**Geographic Standards** (travel distance) **Provider/Enrollee Ratios**
Florida	Geographic Standards (travel time) Appointment Wait Time Standards
Georgia	N/A
Hawaii	N/A
Idaho	Network adequacy standards must meet NCQA, AAAHC, or URAC standards
Illinois	Geographic Standards (travel time and distance) Appointment Wait Time Standards **Provider/Enrollee Ratios and Minimum Number of Providers**
Indiana	Network adequacy standards must comply with standards developed by NCQA
Iowa	N/A
Kansas	N/A
Kentucky	Geographic Standards (travel time and distance)
Louisiana	Network adequacy standards must meet the standards for accreditation of NCQA, American Accreditation Health Commission, Inc., or URAC
Maine	**Appointment Wait Time Standards** Provider/Enrollee Ratios
Maryland	**Geographic Standards** (travel distance) **Appointment Wait Time Standards**

State	Network Adequacy Standard *(states with specific standards for MH/SUD are in bold font)*
	Provider/Enrollee Ratios
Massachusetts	N/A
Michigan	N/A
Minnesota	**Geographic Standards** (travel time and distance) Appointment Wait Time Standards
Mississippi	N/A
Missouri	**Geographic Standards** (travel distance) **Appointment Wait Time Standards**
Montana	Geographic Standards (travel distance) Appointment Wait Time Standards Provider/Enrollee Ratios
Nebraska	N/A
Nevada	**Geographic Standards** (travel time and distance)
New Hampshire	**Geographic Standards** (travel time and distance) **Appointment Wait Time Standards**
New Jersey	**Geographic Standards** (travel time and distance) Appointment Wait Time Standards Calculation for minimum number of providers
New Mexico	Geographic Standards (travel time and distance) Appointment Wait Time Standards Calculation for minimum number of providers
New York	Geographic Standards (travel time and distance) **Provider/Enrollee Ratios and Minimum Number of Providers**
North Carolina	N/A
North Dakota	N/A
Ohio	N/A
Oklahoma	Geographic Standards (travel time)
Oregon	Relies on Medicare Advantage standards for **Geographic Standards** (travel time and distance)
Pennsylvania	**Geographic Standards** (travel time and distance) Appointment Wait Time Standards
Rhode Island	N/A
South Carolina	Calculation to determine the minimum number of providers
South Dakota	N/A
Tennessee	Geographic Standards (travel time and distance)
Texas	Geographic Standards (travel distance) **Appointment Wait Time Standards**
Utah	N/A
Vermont	**Geographic Standards** (travel time) Appointment Wait Time Standards

State	Network Adequacy Standard *(states with specific standards for MH/SUD are in bold font)*
Virginia	N/A
Washington	Geographic Standards (travel distance) Appointment Wait Time Standards
West Virginia	Geographic Standards (travel time and distance) Provider/Enrollee Ratios
Wisconsin	N/A
Wyoming	N/A

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