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Wait Time Standards for Behavioral Health Network Adequacy: Final Report

Prepared for
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by
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WAIT TIME STANDARDS FOR BEHAVIORAL HEALTH NETWORK ADEQUACY: FINAL REPORT

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EXECUTIVE SUMMARY

Background

Insufficient access to behavioral health (BH) care and the inability to get timely care are significant problems in the United States. Concerns about BH network adequacy have been prompted by evidence of narrow networks for BH, variation in network adequacy across plans, and evidence that network adequacy impacts access to certain specialties [1-3]. Federal and state regulatory agencies have therefore prioritized efforts to ensure the adequacy of BH provider networks. Specific network adequacy requirements vary by regulator, insurer, and provider type, but typical metrics applied to BH provider networks include time and distance standards and provider-to-member ratios. Although these measures objectively measure network size and distribution, they do not capture other dimensions of network adequacy reflecting patients' experience. Input from a technical advisory panel facilitated by the U.S. Department of Health and Human Services (HHS) Office of the Assistant Secretary for Planning and Evaluation (ASPE) in 2020 identified appointment wait times (WTs) as a potential addition to network monitoring efforts because of their desirable properties [4]. However, one obstacle to developing WT standards is an absence of research to inform such standards [5,6]. This ASPE study, conducted in June of 2023, aims to inform efforts to measure and monitor BH provider networks through WT standards by addressing the following research questions:

1. What BH WT standards are in use by regulators, health systems, and insurers, and how are they determined?
2. What data sources are typically used, and how are WTs calculated?
3. For what types of visits do WT standards apply, and do they differ by provider type, service type, patient characteristics, or geographic region?
4. Is patient preference taken into account?
5. How is telehealth delivery incorporated into standards?
6. How frequently are WTs monitored, and how are standards enforced?
7. What other considerations do regulators, health systems, and insurers take into account when applying a WT standard for measuring network adequacy?

Data and Methods

RTI International (RTI) conducted an environmental scan, key informant interviews, and case studies to address the research questions. The environmental scan included peer-reviewed journal articles, government reports, and grey literature published between 2020 and 2022. Findings from the scan were explored with eight subject matter experts (SMEs). For the case studies, RTI selected six state-regulated insurance markets that currently apply BH WT standards, and subsequently conducted an additional nine interviews with state officials and health plans to understand how standards were developed and the challenges of measuring, monitoring, and enforcing standards.

Findings

WT Standards

This of this writing, the HHS Centers for Medicare & Medicaid Services (CMS) finalized rules that add BH WT standards for Medicare Advantage (MA) plans and qualified health plans (QHPs) in federally-facilitated exchanges (FFEs), and are scheduled to apply to policies beginning January 1, 2024 and 2025, respectively [7,8]. Also in 2023, CMS issued a proposed rule adding standards for outpatient BH appointments for Medicaid managed care plans [9]. At the time this report was developed, the Medicaid and Children's Health Insurance Program Managed Care Access, Finance, and Quality Rule adding standards for Medicaid managed care plans had not been finalized. As of April 2023, 17 states have adopted standards for behavioral WTs for one or more regulated insurance markets with seven adding standards since 2020. Regulators interviewed cited a desire to

align physical health care and BH care standards and with other insurance markets as the most important factors for choosing specific standards. State regulators interviewed faced three main challenges when setting standards: balancing the conflicting interests of members their markets serve and the health plans they oversee, pervasiveness of provider shortages which limit what health plans can do to recruit providers to their networks, and lack of research or data to inform their decisions.

Measurement and Reporting Requirements

Recent regulations clarify that WTs should begin on the date a consumer first requests services to better approximate patient experience. Generally, regulators choose data sources to measure WTs that achieve one of three goals: (1) to capture the availability of services at the provider-level, where interventions can occur; (2) capture consumers' experience navigating a network, which is a high priority to understand; or (3) to frequently monitor trends and fluctuations, which could signal an emerging, systemic access problem. No data source can achieve all three of these goals, and each presents trade-offs which regulators must weigh, including the cost of data collection and burden imposed on providers and plans. Since the use of telehealth increased during the COVID-19 pandemic, federal and state regulators have been engaging stakeholders in deliberations about the treatment of telehealth in WT measurement. So far, regulators are taking different approaches to account for telehealth access in WT calculations.

Enforcement of WT Standards

In the six state market case studies, state regulators monitor WTs as part of a wider system that includes periodic review of plan adherence to time and distance standards, customer complaints, use of out-of-network providers, and data from patient satisfaction surveys. Recently, regulators have enforced WT standards using monetary penalties, and contract revocation; however, regulators prefer to reserve penalties for extreme cases and tend to work cooperatively with health plans to resolve network adequacy violations through guidance to develop corrective action plans and with technical assistance.

Future Research

Further research is needed that will lead to the development of best practices for setting standards, measurement, monitoring, and enforcement strategies. Recent studies point to the potential for research to identify services and populations that warrant closer monitoring and more stringent standards relative to current regulatory practice. Recent studies also underscore the importance of observing timeframes consumers experience when searching for care that are not captured in existing data collection tools. Research about the trade-offs of adopting WT standards as a lever for improving timeliness of care could inform state action in the short term. An overarching principle of research in this area should be to balance the burden on providers from data collection with identifying regulatory strategies that improve the timeliness of care.

Study Limitations

The national scan of state standards relied on published reports and case studies and may have missed some recent changes in standards. State insurance markets selected for case studies had established WT standards for BH. We did not interview state regulators that choose not to use WT standards; their perspectives may differ from those presented in study findings. Apart from by the U.S. Department of Veterans Affairs (VA) measurement system, we did not review measurement systems in vertically integrated delivery systems. An in-depth review of current practice could uncover a wider range of data collection methodologies and WT calculations.

Conclusion

Regulators interviewed viewed WT standards as critical to include in network adequacy requirements because they reflect a dimension of patient experience not captured by other measures. Recent federal and state regulatory changes have added BH WT standards and further defined the services and urgency levels to which standards apply. Federal and state regulators cited parity between BH and physical health and alignment of standards adopted in other regulated markets as rationale for standards set. Regulators lack guidance from research to inform their decisions.

Regulators and health plans interviewed described WTs as difficult to measure with available data. Challenges key informants cited include the high variability in response rates from providers submitting data, a lack of sufficient guidance from regulators to ensure uniform collection of measures and calculation of WT metrics, and the high burden on providers and cost to collect data that best approximates patients experiences of WTs.

Regulators interviewed at times have imposed penalties on health plans found to be non-compliant with WT standards. However, they prefer to work with health plans to develop corrective action plans and find other strategies to address access gaps, viewing collaborative approaches as more productive than imposing penalties, which could exacerbate access problems for consumers. Regulators also recognize that provider shortages make it harder for health plans to recruit providers to their networks.

1. INTRODUCTION

Insufficient access to BH care and the inability to get timely care are significant problems in the United States. Only 46 percent of adults with any mental illness received mental health (MH) services in 2020, and only 6.5 percent of individuals aged 12 or older with a substance use disorder (SUD) received treatment [10]. These access issues are often worse for people from racial and ethnic minority groups and people living in rural areas. Although reasons for low treatment rates include a range of factors such as lack of insurance coverage, cost barriers and treatment stigma, network adequacy and the resulting availability of services play a role.

Network adequacy refers to the sufficiency with which a health plan's network of participating providers facilitate reasonable access to care without delay [2]. As managed care plans assume greater responsibility for the delivery of BH services, federal and state regulatory agencies have increased focus on the adequacy of BH provider networks. Concerns about BH network adequacy have been prompted by evidence of narrow networks for BH, variation in network adequacy across plans, and evidence that network adequacy impacts access to certain specialties [1-3]. To ensure plan capacity to provide appropriate and timely access to needed care, regulating agencies establish network adequacy requirements that health insurers must comply with as a condition for offering products in the market. Specific network adequacy requirements vary, but insurers commonly monitor the average time and distance to a provider and provider-to-enrollee ratios for various specialties. Although these measures objectively gauge network size and distribution, they do not capture other dimensions of a network's capacity that reflect patients' experience across levels of care and over time. At the time of this writing, the CMS issued final rules for MA (managed care) plans and QHPs in FFEs and issued proposed rules for Medicaid managed care plans [7-9]. In all three cases, CMS added BH WT standards as requirements for network adequacy.

Input from a technical advisory panel facilitated by ASPE in 2020 identified WTs as a potential addition to network adequacy requirements for BH provider networks because they have desirable properties as a measure of access [4]. WTs reflect consumer experience within a network and are potentially sensitive to multiple factors operating within and upon delivery systems. Monitored over time, a spike in WTs could serve as an early warning of a systemic problem. Moreover, WTs can be objectively defined, measured, and quantified, yielding measurement data to compare patient experience across geography and networks. WTs also can be expected to vary between populations with different characteristics, allowing regulators to assess the performance of a network for people with different needs and barriers to access. Literature review and regulatory scans to date have found little existing research that could inform what network adequacy standards, inclusive of WTs, are appropriate or whether standards should differ based on community characteristics [5,6]. Moreover, definitions of WTs, as applied in regulations and in research vary without explanations of evidence or the rationale informing these definitions [6].

This ASPE study aims to inform efforts to measure and monitor BH provider networks using WT standards. Were robust WT measures implemented, monitoring systems may support efforts to "Connect Americans to Care" as described in President Biden's Strategy to Address our National Mental Health Crisis, and could address challenges to reimbursement and financing described in the HHS Roadmap for Behavioral Health Integration [11,12].

To help ASPE better understand current use of WT measures, RTI conducted an environmental scan, key informant interviews, and case studies to address the following questions:

1. What BH WT standards are in use by regulators, health systems, and insurers and how are they determined?
2. For what types of visits do WT standards apply, and do they differ by provider type, service type, patient characteristics, or geographic region?

3. What exclusions apply? Are patients' and other consumers' perspectives incorporated in the development process of standards?
4. How is telehealth delivery incorporated into standards?
5. What data sources are typically used and how are WTs calculated?
6. How frequently are WTs monitored, and how are standards enforced?
7. What other considerations do regulators, health systems and insurers take into account when applying a WT standard for measuring network adequacy?

Components of Wait Time Standards

In our review of federal and state standards, we identified two main domains of a WT standard: definition of the standard and WT measurement. The definition of a standard includes two components necessary to establish a standard: (1) the service to which the applies; and (2) the amount of time designated as the maximum allowable time patients should wait. Regulators may apply a WT standard to an appointment type (e.g., outpatient service, follow-up after hospital discharge), a level of urgency of care needed (e.g., non-urgent, symptomatic), or a service required for a patient in a specific situation (e.g., intake assessment after crisis intervention).

The second domain, measurement, has the potential to increase confidence that regulated entities will report comparable measures and enforcement action will be fairly applied. Regulators may specify many requirements, or none, regarding: (1) use of specific data sources and data collection methodologies, the timeframe (e.g., the start and end points of the WT), methods for measuring WTs from data; and (2) methods used to determine the issuer's compliance with the standard.

We organize study results to correspond with the components regulators described as part of their regulations and guidance to issuers. ***Section 3*** compares definitions of the services and amount of time designated as the standard. ***Section 4*** presents WT measurement and reporting requirements that health plans and providers must follow. ***Section 5*** describes what we learned from state case studies about regulators' treatment of WTs within a wider monitoring approach, and recent enforcement strategies and challenges. ***Sections 6-8*** present study conclusions, study limitations, and future research needs.

2. DATA AND METHODS

Environmental Scan

We conducted a limited environmental scan to update compilations of existing WT standards for BH provider networks. We also used the scan to identify state insurance markets that have included BH WT standards in their network adequacy requirements to select candidates for case study. Standards in state markets were compiled from review of state network adequacy requirements published between 2020 and 2022 and supplemented by our review of regulations and interviews in six case studies of state health insurance markets (see ***Appendix B***). We reviewed proposed and final federal regulations published between January 2022 and June 2023, as well as the websites of Federal Government agencies, national associations, and accreditation bodies to locate guidance and accreditation requirements related to BH WT standards.

We searched peer-reviewed journals and grey literature published between 2020 and 2022 to identify studies on WTs for BH services that documented data sources, methodologies for collecting data and calculation of WTs to compare them to regulatory approaches. Online search of grey literature and peer-reviewed articles used Google search terms informed by a review of key government reports and article abstracts and then tailored based on terms identified in a preliminary search (see ***Appendix E***). Through abstract review, we identified 16 peer-reviewed articles that met the inclusion criteria and documented methods with sufficient detail to inform study questions. ***Appendix D*** presents information abstracted from the included articles.

Subject Matter Expert Interviews

In March of 2023, we interviewed eight SMEs who represented different stakeholder perspectives on measurement and application of WT standards: BH policy and academic experts, accreditation and national association representatives, state program administrators, and CMS officials. We interviewed SMEs to draw out a range of perspectives from stakeholders with experience measuring and monitoring WTs and enforcing WT standards as well as from researchers who study WTs. We also sought to identify state insurance markets suitable for case study that currently apply BH WT standards.

Interview questions focused on the strengths and limitations of data sources, information systems for measuring WTs, and challenges and considerations for implementing monitoring and enforcement strategies. We also asked SMEs to identify information gaps and priorities for future research that could lead to better health information systems for measuring WTs, more meaningful WT thresholds, or more effective application of WTs for regulatory or systems monitoring purposes. To incentivize participation, we offered a $200 payment to all candidates except current federal and state government employees.

State Insurance Market Case Studies

In June of 2023, we conducted six case studies of insurance markets in five states currently using WTs standards: Colorado, Kansas, Maryland, Massachusetts, and Washington. We chose markets which represent both private insurance markets and Medicaid managed care programs which have implemented BH WT standards (see ***Table 1***). We also looked for insurance markets where there was evidence of enforcement mechanisms to understand how regulators respond when plans do not meet WT standards. The Colorado Division of Insurance (DOI), the Maryland Insurance Administration (MIA), and the Washington Office of the Insurance Commissioner (OIC) all represent private insurance regulators. The Kansas Department of Health and Environment (KDHE) and Kansas Department for Aging and Disability Services (KDADS) oversee Kansas Medicaid KanCare plans, and the Washington Health Care Authority (HCA) oversees Washington Medicaid AppleCare plans. The sixth case study examines a unique pediatric provider network, the Massachusetts Children's Behavioral Health Initiative (CBHI), now part of the Office of Behavioral Health within MassHealth, which administers the state Medicaid program [13]. ***Appendix A*** provides case study overviews.

Table 1: State Insurance Market Case Studies		
State	**Regulated Insurance Market**	**Regulator**
Colorado	Commercial carriers offering Affordable Care Act (ACA)-compliant health benefit plans	Division of Insurance (DOI)
Kansas	KanCare--Medicaid managed care plans	Kansas Department of Health and Environment (KDHE) Kansas Department for Aging and Disability Services (KDADS)
Massachusetts	Children's Behavioral Health Initiative (CBHI)--BH providers	MassHealth (Medicaid) Massachusetts Behavioral Health Partnership Office of Behavioral Health Executive Office of Health and Human Services
Maryland	Commercial and ACA-compliant health benefit plans	Maryland Insurance Administration (MIA)
Washington	Commercial plans and QHPs	Washington Office of the Insurance Commissioner (OIC)
	AppleCare--Medicaid managed care	Washington Health Care Authority (HCA)

Case studies served as an opportunity to review documentation and speak directly with representatives in state agencies and health plans, when available, who are involved in the measurement and monitoring of WTs. We obtained details on approaches that state regulators use to assess WTs, monitor compliance, and enforce WT standards, as well as the experiences of health plans required to report data on WTs. We conducted nine interviews with stakeholders in five states. In some cases, SMEs also contributed information to case studies. We refer to individuals interviewed collectively as key informants. Although states describe the health plans they regulate using different terms (e.g., carrier, health plan, managed care organization), we use the term "health plan" or "managed care plan" throughout for the reader's convenience.

3. WAIT TIME STANDARDS

In this section, we first describe what we learned about the processes, contextual factors and rationale informing standard-setting based on explanations provided by federal regulators in response to public comments and through case study interviews. Interviews also revealed challenges state regulators face when deliberating their choices. We then catalogue BH WT standards in place or proposed as part of network adequacy requirements.

We include in this review the standards developed by HHS for Certified Community Behavioral Health Clinics (CCBHCs) and requirements that national accreditation entities set related to the timeliness of care. Although we include VA in this report, we limit our discussion to the VA WT monitoring system presented in ***Section 4***.[a]

Processes and Rationale Informing Standard-Setting

Federal and state regulators viewed the alignment of standards for physical health care and BH care as an important step to achieve parity in the accessibility of BH care with physical health care. This priority is the primary reason regulators cited when they chose to apply the same WT standard for BH services that already is applied in their market to primary care (or urgent and emergency physical health care). In their view, alignment of standards for physical and BH care supports the objective of the Mental Health Parity and Addiction Equity Act (MHPAEA) [16]. In addition, regulators viewed alignment between insurance markets as an important objective and set BH WT standards to align with WT standards in other markets. State regulators who were able to describe decision making processes reported that development included scanning the BH standards already in use; input from stakeholders during public comment periods; and engaging managed care plans, providers and consumer advocacy groups in ongoing dialogue for their perspectives. However, they lacked guidance from research that could inform standards set.

State Challenges Establishing Standards

State regulators interviewed in case studies described facing three main challenges when deliberating about adding WT standards in BH provider network adequacy requirements and choosing specific WT thresholds health plans must meet. First, regulators described balancing the conflicting interests of members their markets serve and the health plans they oversee. On one hand, regulators need to set standards that will attract enough health plans to a market to achieve healthy competition for members through delivery of higher provider accessibility and quality. On the other hand, setting standards that allow for longer wait times could lead to lower service accessibility for members and could potentially harm consumers. Ultimately, health plans have some leverage to push back on standards they perceive to be unreasonable because their participation in an insurance market is voluntary.

State regulators also factor into their deliberations the pervasiveness of provider shortages and willingness of providers to participate in provider networks. Both limit what health plans can do to recruit providers to their networks and address violations to network adequacy requirements when they arise. These dynamics in statewide delivery systems limit the utility of setting WT standards that are too aspirational, or higher than what health plans can realistically achieve.

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[a] The VA established both time and distance standards and appointment wait time standards, including standards for MH care, for the community care program, which was enacted as part of the 2018 VA Mission Act [14]. However, these standards are not implemented as network adequacy standards. Rather, the standards represent one set of criteria through which veterans may be eligible for community care [15]. If a VA facility is unable to schedule an appointment which meets the access standards, a veteran is eligible to seek care from a non-VA facility.

Finally, regulators described a lack of research or data that could inform them about the relative impact that different WTs might have on patients. For example, what risk does waiting longer pose to patients' symptoms and health risks? For whom does waiting longer pose greater risks? How does this inform the WT standards we should set?

State Variation in Standards

According to a review of state standards in place as of March 2020, seven states had adopted maximum WT standards for BH care in one or more state-regulated insurance markets: California, Colorado, Maine, Maryland, Missouri, New Hampshire, and Texas (see ***Appendix B***) [17]. Since March 2020, another seven states adopted WT standards for Medicaid managed care networks, private health plan networks, or both: Arizona, Florida, Georgia, Kansas, Massachusetts, New Mexico, North Carolina, Pennsylvania, Washington, and West Virginia [18-20].

Nearly all state markets set two or more WT standards, differentiating the service type based on the degree of urgency of care needed--regular/routine or non-urgent care, urgent care/needs, and emergency care. The widest variation occurs for care defined as "non-urgent" and "routine." The descriptors used and the timeframes assigned vary in ways that suggest regulators apply different meanings to these terms. In states assigning a standard to both appointment types, "non-urgent" is assigned a more stringent standard and in several cases is described as "non-urgent symptomatic." In states only assigning a standard to "routine" MH/SUD some impose a more stringent standard than other states assign to "non-urgent, symptomatic." Additionally, some states assign additional standards to specific service needs or care transitions, such as initial assessment and evaluation after a discharge, and urgent need for inpatient care.

We did not identify any state markets that apply different standards for rural and urban areas. Two states set standards for a high-risk population--pregnant women and children--that were more stringent than other populations. Only Kansas set a more stringent standard for urgent SUD services (24 hours) than urgent general MH services (72 hours). No states set less stringent standards for SUD than MH care.

Federal Standards

Table 2 presents federal standards proposed or finalized since mid-2020 as of June 2023.

Medicare Advantage Plans. In its Final Rule issued April 27, 2023, CMS revised WT standards related to BH care that as of June 2023, were scheduled to become effective for coverage beginning January 1, 2024. The Final Rule made two clarifications that: some BH care qualifies as emergency care and therefore cannot require prior authorization, and outpatient BH care includes both MH and SUD services [22,23]. The Final Rule also extends the appointment WT standard already in place for primary care to routine and preventive outpatient BH care and reminds MA organizations that outpatient SUD services include medications for opioid use disorder (MOUD) and opioid treatment programs [24]. CMS indicated that the decision to set equivalent standards for these two types of outpatient care aligned with goals described in the 2022 CMS Behavioral Health Strategy, which prioritize BH parity with physical health [23]. Finally, the Final Rule added Clinical Psychology, Clinical Social Work and Prescribers of Medication for Opioid Use Disorder as additional BH specialty types that plans need to evaluate but did not apply WT standards to any specialty type [23].

Table 2: Federal Regulatory Standards for BH WTs*		
Federally Regulated Markets/Programs	**Service**	**Standards**
Medicare Advantage Plans CMS Final Rule effective January 1, 2024 [1]	Emergency/urgent BH.	Immediate.
	Not emergent/urgent BH but requiring medical attention.	Within 7 business days†.
	Routine and preventive.	Within 30 business days†.
Qualified Health Plans FFEs CMS, CCIIO	No WT standard currently [2].	
Final Rule effective January 1, 2025 [3]	Outpatient BH appointments.	Within 7 business days‡.
Medicaid Managed Care Plans HHS, CMS	No WT standard currently.	
Proposed Rule published May 23, 2023 [4]	Routine outpatient MH and SUD.	No longer than 10 business days‡.

NOTES:

* = Effective dates are accurate as of June 2023.

† = 100% of the time; ‡ = 90% of the time.

1. Centers for Medicare & Medicaid Services. *2024 Medicare Advantage and Part D Final Rule (CMS-4201-F), p. 22174*. Centers for Medicare & Medicaid Services, Editor. 2023. https://www.cms.gov/newsroom/fact-sheets/2024-medicare-advantage-and-part-d-final-rule-cms-4201-f.
2. Pollitz, K. *Network Adequacy Standards and Enforcement*. 2022. https://www.kff.org/health-reform/issue-brief/network-adequacy-standards-and-enforcement/.
3. Centers for Medicare & Medicaid Services. *Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2024, Compliance with Appointment Wait Time Standards. 45 CFR Parts 153, 155, and 156 [CMS-9899-F]. RIN 0938-AU97. ACTION: Final Rule*. ***Federal Register***, 2023, 88(81): p.25879.
4. Centers for Medicare & Medicaid Services. *Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality (88 FR 28100)*. ***Federal Register***, 2023, RIN 0938-AU99.

Qualified Health Plans. In its Final Rule issued April 27, 2023, the CMS Center for Consumer Information and Insurance Oversight (CCIIO) delayed implementation of BH WT standards for QHPs offered on FFEs until Plan Year 2025 [7]. Previously in May 2022, CMS had delayed implementing the standard until Plan Year 2024 due to concerns expressed by commenters about implementing standards during the COVID-19 pandemic [26,27]. Additionally, based on comments, CMS modified the measure of WT for outpatient BH care appointments from 10 calendar days to 10 business days to align with the standard set by National Committee for Quality Assurance (NCQA) [7].

As explanation for its decision to further delay implementation of BH WT standards until Plan Year 2025, CCIIO cited concerns expressed by commentators about the standard itself, the lack of specificity in its definition and measurement, and requests for additional guidance about methodologies that could be used to assess compliance other than attestation [7]. Other concerns mentioned included states' lack of resources to conduct compliance reviews, the burden on providers to report data, and the risk of collecting inaccurate WT data from providers. CCIIO indicated an interest to assure standards for QHPs were coordinated with other forthcoming federal standards and indicated the intention to develop specific guidelines to collect data and interpret metrics in future rulemaking.

Medicaid Managed Care Plans. At the time of this writing, in the Proposed Rule published May 3, 2023, CMS continued to delegate to states the responsibility to implement WT standards for Medicaid managed care plans but added requirements that standards extend to BH care [28]. CMS would require states to develop

appointment WT standards for "routine" appointments for outpatient adult and pediatric MH and adult and pediatric SUD services. State standards for these services would be required to be no longer than 10 business days, which CMS defined as the maximum allowable WT. The 10-day maximum for MH and substance use appointments is shorter than the maximum of 15 days set for routine primary care appointments. These WTs were informed by standards for individual insurance Marketplaces. The Proposed Rule gives states the discretion to develop definitions for the terms "routine," "urgent," and "emergent" and encourages but does not require states to set standards for "emergent" and "urgent" appointments.

Federal Requirements for Certified Community Behavioral Health Clinics

The CCBHC initiative included WT standards in the original criteria for certification of Section 223 CCBHC Demonstrations in 2015 (see ***Table 3***). The original certification criteria were applicable to states, and clinics within the state, participating in the Section 223 CCBHC Demonstration. Criteria were informed by review of state Medicaid Plans, standards for Federally Qualified Health Centers and Medicaid Health Homes, and state quality measures, and refined and finalized through a public process that included national listening sessions, consultation with Tribal, state, and federal leadership, and written public comments [29]. Since 2015, SAMHSA has supported CCBHCs through other funding vehicles and state certification outside of Section 223 Demonstrations. CCBHCs may be subject to more stringent state, federal, or applicable accreditation standards, depending on whether the CCBHC is a federal grant recipient or the clinic’s state adds more stringent criteria for state licensure or Medicaid certification.

SAMHSA released updated criteria in February 2023 which extended the standards for WTs and related reporting requirements to CCBHC-Expansion (CCBHC-E) award recipients and state-certified CCBHCs, in addition to Section 223 Demonstrations [30]. Although CCBHCs across these categories are subject to somewhat different implementation deadlines, most will need to meet the new criteria by July 1, 2024 [31].

Table 3: Federal Requirements for CCBHCs

Federal Program	Service	Standard
CCBHCs SAMHSA Standard updated in 2023 will apply to all CCBHCs [1].	Emergency.	Immediate.
	Mobile crisis team availability.	Respond within 1 hour (2 hours in rural and frontier settings), not to exceed 3 hours.
	Routine.	Within 10 business days.
	Initial and comprehensive evaluation.	Within 60 calendar days of the first request for services.

NOTES:

1. Substance Abuse and Mental Health Services Administration. *CCBHC Certification Criteria Summary of Changes*. 2022. https://www.samhsa.gov/sites/default/files/ccbhc-certification-criteria-summary-of-changes.pdf.

In the 2023 certification criteria, SAMHSA amended WTs for mobile crisis services. The impetus for this amendment was the establishment of the national 988 Suicide and Lifeline [32,33]. Criteria 4.c adds an expectation that mobile crisis teams will respond within 1 hour from time of dispatch and up to 2 hours for response in rural and frontier settings but “not to exceed 3 hours”. The criteria were written to align with national guidelines “while recognizing the difference in state definitions and the varying accessibility of crisis teams.” Other standards for the timeliness of care were not modified [33].

CCBHC accreditation requirements, set forth in the original SAMHSA criteria and retained in the update, also emphasize establishing staffing capacity, clinic flow, policies and procedures that assure the clinic responds in a timely manner to patients’ needs based on a preliminary triage and risk assessment to determine urgency.

This emphasis recognizes that oversight of clinical capacity, structures and processes supports the same objectives as WT standards, the assurance of timely care.

National Accreditation Entities

Network adequacy requirements established by national accreditation entities have a significant bearing on WT standards set nationally for two reasons. First, states may require national accreditation of Medicaid managed care plans or private health plans, including QHPs, to be eligible to offer a health benefit plan in the market, or accept accreditation as sufficient to meet the network adequacy requirements [17,34]. Second, CMS relies on accreditation by HHS-recognized accrediting entities [35] in states where CMS reviews QHPs for network adequacy [36]. These entities are the NCQA, Utilization Review Accreditation Commission (URAC), and the Accreditation Association for Ambulatory Health Care (AAAHC). URAC, which sets standards for MH and substance use program accreditation to health plans, does not include WT standards in their requirements [37].

National Committee for Quality Assurance. NCQA describes its accreditation of provider networks as "a framework for organizations to provide efficient, accurate and consistent network management" [38]. This framework includes a set of requirements for health plans. Insurance carriers must establish a plan for ensuring the availability and timeliness of appointments using quantitative standards [4,39]. NCQA specifies maximum appointment WTs for three categories of BH needs (see ***Table 4***). NCQA also requires that the carrier's plan for ensuring availability should include standards for specific types of BH providers, such as prescribers and non-prescribing practitioners, but does not suggest WT standards by provider type.

Table 4: BH WT Standards Adopted by National Accreditation Entities

Accreditation Body	Service	Standard
National Committee for Quality Assurance [1,2] Accreditation of health plans	Emergencies.	Within 6 hours.
	(Non-life-threatening) Urgent BH.	Within 48 hours.
	Regular/Routine BH.	Within 10 business days

NOTES:

1. Bradley, K., et al. *Network Adequacy for Behavioral Health: Existing Standards and Considerations for Designing Standards*. Office of the Assistant Secretary for Planning and Evaluation. 2021. https://aspe.hhs.gov/reports/network-adequacy-behavioral-health.
2. PressGaney (SPH Analytics). *Improving Member Access to Care*. 2022. https://info.pressganey.com/on-demand-webinars/improving-member-access-to-care.

Accreditation Association for Ambulatory Health Care. The AAAHC, which accredits provider organizations, does not establish prescriptive standards for network adequacy nor support the use of WT standards by regulators because variation in WTs may result from changes in patient volume by season and other factors outside of the issuer's control [40]. Instead, AAAHC supports the establishment of processes and systems that will minimize risk to patients while waiting for services and policies that inform patients of their rights.

State Insurance Market Case Studies

Table 5 presents the WT standards in effect for the six health insurance markets examined in the case studies, with the exception of CBHI. MassHealth CBHI standards are extensive, covering initial contact, initial assessment, subsequent evaluation and initiation of service for each of six core services (see ***Appendix A-2***).

Table 5: BH WT Standards in State Insurance Market Case Studies†		
State Market Regulator	**Service**	**Standard**
Colorado Commercial DOI [1]	Emergency.	24 hours a day, 7 days a week (100% of the time).
	Urgent.	Within 24 hours (100% of time).
	Routine, non-urgent appointments, initial or follow-up.	Within 7 calendar days (90% of time).
Kansas Medicaid managed care KDHE [2]	Crisis services.	24 hours a day, 7 days a week, emergency treatment and first response, including, when appropriate, staff going to the member for personal intervention.
	Emergency needs.	Referred to services immediately.
	Emergency SUD--not admitted.	Within 72 hours of crisis resolution, determine need for further service or referral.
	Urgent, non-emergency SUD.	Assessment within 24 hours of request for services. Services delivered within 24 hours of assessment.
	Urgent general MH.	72 hours from request for services.
	Non-urgent SUD.	14 calendar days from request for assessment.
	Non-urgent general MH.	14 business days from request for services.
	Follow-up after inpatient discharge "offering and encouraging Member's attendance at follow-up appointment".	Contractor will monitor provider contact: 24-72 hours (85% of contact attempts). 1-7 days (90% of contact attempts). 1-10 days (95% of contact attempts).
	Pregnant women who are intravenous drug users and all other pregnant substance users.	Must receive treatment within 24 hours of assessment.
	Persons who inject drugs.	No later than 14 calendar days after a request for assessment, receive assessment and be admitted for treatment.
Maryland Commercial MIA [3]	Inpatient urgent MH and SUD	72 hours (90% of time)
	Non-urgent	10 calendar days (90% of time)
Washington Commercial OIC [4,5]	Urgent, symptomatic	Within 24 hours
	Non-urgent, symptomatic	10 days
Washington Medicaid managed care Washington State HCA [6]	Emergency services	24 hours a day, 7 days a week (telehealth included)
	Urgent care	24 hours
	Non-urgent, symptomatic	10 days
	Clinical assessment and care planning by the primary care physician for transitional services and home care BH professional if ordered	Within 7 calendar days of discharge from inpatient or institutional care for BH or SUD treatment program
	Second opinion	Within 30 days unless patient chooses a later appointment

NOTES:

† = For standards set by MassHealth CBHI, see ***Appendix A-2***.

1. State of Colorado. *Network Plan Standards and Reporting Requirements for ACA-Compliant Health Benefit Plans, in 3 CCR 702-4:4-2-53; 702-4:4-2-54*. Colorado Secretary of State. 2020, p.421-423.
2. Kansas Department of Health and Environment. *Kansas Medicaid Managed Care Request for Proposal for Kancare 2.0, Behavioral Health Provider Network Standards*. n.d., BID Event Number: EVT0005464.
3. Code of Maryland Regulations. *Network Adequacy Regulations for Health Benefit Plans*. 2023, COMAR 31.10.44.
4. *Revised Code of Washington [RCW] 48.43.790*. Amended 2021.
5. Washington State Legislature. *Behavioral Services--Next-Day Appointments*. 2021, RCW 48.43.790.
6. Washington State Health Care Authority. *Washington Apple Health Integrated Managed Care Contract*. Washington State Health Care Authority. 2022, p.139. https://www.hca.wa.gov/.

Colorado Commercial. The DOI amended provider network adequacy requirements for private health plans in 2020 to include WT standards for BH [41]. Colorado distinguishes between MH and SUD care and based their separation of standards on the MHPAEA requirements, which includes separate standards based on provider type [16]. Although current regulations include the same standard for initial and subsequent (routine) visits, the DOI is working to amend the standards to include more detailed standards for initial and subsequent visits, to go into effect in 2024 [47].

Kansas Medicaid Managed Care. The KDHE added WT standards for BH sometime after 2020 [42]. KDHE staff interviewed were hired after standards took effect and could not speak to the rationale for standards set but described a general process for reviewing standards each contract year that includes soliciting feedback from stakeholders, including patient advocacy groups, and reviewing public comments. In addition to the standards based on urgency of need, Kansas sets standards for the assessment and treatment of pregnant women who use substances and persons who inject drugs. The standard allows for a longer WT when no provider has capacity. For instance, for persons who inject drugs and who request an assessment, "if no program has the capacity to admit the Member within the required timeframe" after the assessment, then "interim services must be offered no later than forty-eight (48) hours after such request."

Maryland Commercial. In 2016, the MIA included WT standards when they first developed network adequacy standards for BH services [48]. The regulation, which became effective in 2017, applied to all private health insurers. The first iteration of the WT standards was developed based on standards in California, Colorado, and those set by the NQCA. Maryland also reviewed public comments from patient advocates, consumers, and health insurance companies to determine network adequacy standards. In April 2023, Maryland adopted revised standards that went into effect May 15, 2023 [43]. The timeframes set in 2016 did not change, but standards were explicitly divided into MH and SUD care as distinct service categories requiring assessment. Although the standards remain the same for MH and SUD care, future rulemaking could modify standards for one service category.

Massachusetts Children's Behavioral Health Initiative. The standards for the CBHI stemmed from a lawsuit in 2009 that required the state to develop standards and monitor WTs specifically for children with serious emotional disturbance [13]. MassHealth, which administers CBHI has not amended its standards since their initial development.

Washington Commercial. In 2021, the Washington OIC adopted WT standards for urgent and non-urgent care for symptomatic BH needs. According to interviewees, the Commissioner made the explicit decision to match the requirements for Medicaid plans already in place. Also in 2021, the state legislature amended the state law implementing the 988 Suicide hotline and Crisis Lifeline to add a requirement that all health plans "must make next-day appointments available to enrollees experiencing urgent, symptomatic behavioral health conditions to receive covered behavioral health services" [44]. Statutory language defines the needs for which this standard applies as "associated with the presentation of BH signs or symptoms that require immediate attention, but are not emergent" [45].

Washington Medicaid Managed Care. Until 2016, Washington State operated its BH system through Pre-Paid Inpatient Health Plans. When BH was integrated with physical health into Medicaid plan contracts in 2016. HCA aligned its BH and physical health network adequacy standards where possible, including WT standards [46]. Agency staff set aside considerations to apply more stringent standards because workforce shortages were impacting network adequacy in ways that were outside of the control of health plans, even before the COVID-19 pandemic. The HCA has focused instead on improving monitoring systems, as discussed in ***Section 4***.

Summary

Since 2020, a number of federal and state regulators have incorporated WTs standards into network adequacy requirements for BH services. Most frequently, regulators added standards corresponding to the urgency of the care needed and less frequently, corresponding to waits for transition between settings, and for initial assessment and subsequent evaluation after a need is first identified or requested. Standards that correspond to the triage level of patient needs also align with guidance from the National Association of Insurance Commissioners, which maintains a model statute to assist state regulators [49]. Federal and state regulators identified parity between physical health care and BH care and alignment with other insurance markets as the most important factors for choosing specific standards. State regulators interviewed identified three major challenges to standard-setting: balancing the conflicting interests of consumers and health plans; the pervasiveness of provider shortages; and a lack of research on the relationship between WTs, consumers' health, and their willingness to engage in treatment for MH and substance use conditions.

4. MEASUREMENT AND REPORTING REQUIREMENTS

Table 6 demonstrates the variation in the specificity and scope of requirements that regulators place on health plans (or providers) regarding measurement and reporting. All regulators designate a service or need (e.g., "urgent care") and a WT (e.g., 10 business days). A checkmark in the first column (Service or Need) means that regulators provide an operational definition that establishes the meaning and boundaries of the term "urgent care," for example. A checkmark in the second column (WT) means that regulators provide an operational definition of the WT by specifying the start and end points of the timeframe to be measured (i.e., a regulator might clarify that the WT to be calculated must start on the date the patient requested the service and end on the date the service is received). Checkmarks in columns under the heading Measurement of WTs means that the regulator stipulated data sources to be used, how often WTs must be reported, provides a template or portal with instructions for submitting data elements, stipulates which metrics and other information a carrier is required to report. Of the standards we reviewed, few provide enough specifications to assure that carriers or providers produce standardized metrics.

We use the term "WT metric" to refer to any value derived from underlying data that characterizes the distribution of WT data, which regulators may compare against a standard to determine if an issuer complies with the standard. A common metric is the percentage of WTs that are no more than the allowable maximum WT of, for example, 10 business days. The regulator would compare this percentage to the required percentage a carrier must meet to be in compliance--for example, 90 percent of WTs do not exceed 10 days. Some regulators require carriers to report other metrics that do not directly correspond to the standard (e.g., an average or median WT) but serve as contextual information for assessing compliance. We found that reporting templates and reporting guidance on program websites or in managed care contracts sometimes contain specifications for data elements that are equivalent to the operationalization of measures and metrics that other states set in regulation.

Table 6: WT Standards Operationalized and Measurement Specified by Regulators in Selected Markets

Regulated Market	Operational Definitions		Measurement of WTs				
	Service or Need	Wait Time	Data Sources	Reporting Frequency	Data Template/ Data Portal	Defined Metric	Specified Report Elements
Federally regulated markets							
MA	✓		✓	✓			
FFE QHPs	✓	✓		✓			
Medicaid managed care			✓	✓			
CCBHC	✓	✓		✓	✓	✓	✓
VA	✓	✓	✓	✓		✓	✓
State Case Studies							
Colorado commercial [1]	✓		✓	✓		✓	✓
Kansas Medicaid care	✓	✓	✓	✓			
Maryland commercial	✓		✓	✓		✓	
Massachusetts CBHI	✓	✓	✓	✓	✓	✓	
Washington commercial	✓		✓	✓	✓		
Washington Medicaid	✓	✓	✓	✓	✓		✓

SOURCE: RTI review of federal and state regulations and guidance; and key informant interviews.
NOTES:
1. National Association of Insurance Commissioners. *Health Benefit Plan Network Access and Adequacy Model Act*. 2015. https://www.naic.org/store/free/MDL-74.pdf.

Based on discussions with key informants, we found that the differences in measurement approaches appear to stem from the balance regulators decide to strike when weighing the importance of protecting consumers from inadequate networks, the value of information gained from monitoring WTs, challenges deriving metrics that are comparable across health plans, and concerns about the burden on providers to collect data. In addition, regulators also weigh the overall cost to health plans for data collection since these costs are passed on to consumers. Finally, because nearly all health insurance plans are regulated by states, federal regulators consider where they will give states discretion to implement requirements and where uniform minimum standards may serve the interests of consumers.

Trade-offs Associated with Data Sources and Measurement Strategies

Regulators interviewed for this study emphasized that WTs are one of a portfolio of measures they review to assess the adequacy of provider networks. All key informants considered WTs to be a crucial dimension of accessibility of services because, if measured well, they can closely approximate patients' experience navigating a provider network. In fact, some interviewees described WTs as the most crucial metric for assessing network accessibility, especially for patients needing BH services, because of the risk that people will forego treatment if they cannot access it in a timely way [50,51]. On the other hand, other dimensions of a network--namely time and distance to various providers and provider-to-member ratios--are easier to incorporate into reviews because they take little effort to operationalize, standardize, and measure. Moreover, other data sources (i.e., consumer complaints) can alert regulators to problems stemming from long WTs even if they cannot directly measure waits. All regulators interviewed described supplementing information about WTs with patient surveys about the timeliness of their care, reviews of member complaints and hotlines, and frequent use of out-of-network providers. In addition, some quality metrics capture related information, such as the percentage of patients initiating treatment and receiving follow-up after hospital discharge.

Recognizing that WTs are both crucial and difficult to measure well, interviewees described choosing data sources to measure WTs that achieve one of three goals: (1) capture the availability of services at the provider-level, where interventions can occur; (2) capture consumers' experience navigating a network, which is a high priority to understand; or (3) frequently monitor trends and fluctuations, which could signal an emerging, systemic access problem. No data source can achieve all three of these goals, and each presents trade-offs which regulators must weigh.

Audits of provider appointment availability or secret shopper surveys support the first goal, while enrollee satisfaction surveys support the second--yet both are costly to conduct and must rely on samples to minimize costs, limiting their utility for identifying access problems for small populations and rural areas. Health plans we interviewed expressed two concerns about data from provider surveys. They reported high variability in the response rates to both telephone surveys and written requests for information by practices of different size and system capabilities. Health plans attributed non-participation by providers in data collection to provider directories with inaccurate or outdated information, and to staff shortages. One health plan explained they did not know how to factor in calls to providers that result in non-response or how other health plans treated these calls in WT calculations. The second concern arose in states where regulators did not provide technical specifications for measurement. For example, where health plans lack guidance on the type of appointment for which they should be collecting WTs, some plans may ask about next available appointments for existing patients and others may ask about new patients, which would result in non-comparable metrics between competitors.

Claims and encounter data can support frequent monitoring because they are already processed for operational purposes and analysis can be automated. Moreover, claims data support analysis for small groups that cannot be studied in sampled data. However, they cannot capture certain WTs without investment in information systems and merged databases. For instance, claims are useful for calculating the time between

hospital discharge and initiation of treatment, initial assessment and subsequent evaluation, or between therapy visits, but not for measuring WTs for members initiating care. Claims data do not capture a starting point for a wait that would capture accessibility of services for new patients, namely a "date of first contact." State regulators interviewed were well aware of the limitations of their data collection strategies and were considering or implementing changes to improve the quality and comparability of data and measures they were receiving from health plans and seeking to reduce the burden of data collection on providers.

Challenges Accounting for Patient Preference

Regulators and health plans interviewed frequently described as a top priority that WTs should reflect waiting experiences as consumers perceive them. Federal and state regulators recognize that WTs will most closely approximate consumers' experience if WTs are measured to begin when a consumer first requests a service or first contacts a provider. Our review identified two data sources for capturing this date of initial contact or patient request: provider surveys (or audits) and provider scheduling data linked to patient encounters.

Both data sources present trade-offs. Using provider surveys, depending on what the state requires, health plans or a vendor make phone calls to a sample of providers or audit all in-network providers to ask for the date of the next available appointment, using the date of the phone call to simulate a patient's "first contact." The disadvantage of this strategy is that it yields one data point per provider (or per appointment type per provider), which does not help regulators identify seasonal fluctuations, sudden shocks to the system, or variation in patient experiences with the same provider. Another limitation of surveys is the low provider response carriers encounter.

Several state regulators capture a date of first contact by linking claims and encounter data, which capture appointment dates, to administrative records designed to capture the date the consumer called a provider or requested a service through a hotline or care coordinator. Processes to derive WTs in this manner are time-intensive but some regulators believe the value of the data outweighs the burden. To capture the date of a consumer's initial request for an appointment, providers must enter an additional data point into their administrative data systems or an encounter record at the time of the service request. Key informants explained that some providers asked to collect this information enter data into spreadsheets manually or cannot comply with such requests at all because they lack the data infrastructure or administrative support. Research studies also design data collection procedures that require additional work by providers to capture this service request date, such as having providers manually record the date of the patient's first call (see ***Appendix C***).

Incorporation of Telehealth in Wait Time Measurement

Between 2019 and 2021, MH and substance use outpatient care that was offered through telehealth rose from less than 1 percent of visits to 36 percent of visits [52]. Regulators and health plans interviewed recognized that telehealth now fills critical gaps in access to BH services, especially for MH services and crisis intervention [53]. They also agreed that telehealth services should be monitored and somehow factored into WT metrics yet stressed that telehealth should be a choice for consumers. Thus, new standards should protect consumer preference by assuring that visits credited to WT calculations reflect only telehealth visits where consumers opted for telehealth voluntarily. Most regulators are requesting more data from health plans about the availability of telehealth from providers and are requesting input from stakeholders to support future rulemaking.

Among those revising standards recently, regulators are choosing different strategies to incorporate the availability or use of telehealth services within WT metrics. For example, Washington Medicaid managed care and MassHealth CBHI expressly allow telehealth appointments to be counted in WT data derived from health records [53,54]. In contrast, the MIA expressly excludes telehealth appointments from the WT to the next

available appointment collected through provider surveys. Two regulators, CMS and MIA, allow MA plans and private health plans, respectively, to apply a credit for the availability of telehealth through a 10-percentage adjustment to the WT metric [24,55].

CCIIO considered a credit adjustment for telehealth utilization in its 2023 Final Letter to Issuers but declined to add the adjustment for QHP network adequacy requirements [56]. This proposed revision prompted several public comments. In its comment letter to CCIIO, AAAHC cautioned that allowing issuers to apply a credit for telehealth access could produce unintended consequences and perpetuate access disparities [57]. While incentivizing telehealth services can benefit some members, the AAAHC argued those benefits do not accrue equally to urban and rural members since access to broadband in rural areas is limited, among other factors. In their view, a credit for telehealth appointments would discourage issuers from focusing on capacity expansions and reducing WTs in rural areas.

Regulators also vary in defining acceptable telehealth appointments. For example, Maryland excludes audio-only calls from the statutory definition of telehealth [55]. In contrast, CBHI allows telehealth broadly and audio-only telehealth appointments for emergency triage, to conduct an initial assessment for new clients where appropriate, and for after-hour consultation [58]. SAMHSA standards require CCBHCs to use telehealth, defined broadly, "to the extent possible, in alignment with the preferences of the person receiving services to support access to all required services" [32].

Federal Requirements

As of this writing, in recent final and proposed rules, federal regulators define the BH services and appointment types for which WT data should be collected and set the minimum frequency for data collection and reporting. Federal regulators continue to give states discretion to decide if they will develop additional specifications for data collection, calculation of metrics or reporting. The exceptions to this pattern are the VA requirements for its facilities and SAMHSA requirements for CCBHCs. Both the VA and SAMHSA prescribe the data collection methodologies and metrics to be calculated. Recent changes in federal regulations demonstrate the range of choices regulators make in data, measures and reporting.

Medicare Advantage Plans. As of this writing, in its Final Rule to become effective for Plan Year 2024, CMS adds the requirement that MA plans offering coordinated care plans "establish written policies for the timeliness of access to care and member services so that MA organizations must have appointment WTs that meet or exceed the minimum standards we proposed" [24]. Moreover, access must be "continuously" monitored.

CMS will not require MA plans to submit WT data or metrics to demonstrate compliance with the new requirements but will require them to attest that they meet the new WT standards [24]. CMS considered requiring plans to meet the standard for routine and non-emergency appointments in only 95 percent of appointments [26]. However, CMS declined to make this revision, effectively requiring MA plans to meet the standards for 100 percent of appointments [24]. CMS also refrained from specifying a data collection methodology that health plans would need to follow to determine their compliance.

CMS also allowed for MA plans to receive a 10-percentage point credit towards telehealth to encourage increased access for telehealth providers [23]. This includes providers contracted in MA networks and certain specialties to cover "beneficiaries that reside within published time and distance standards when the plan includes one or more telehealth providers of that specialty type." CMS expanded the telehealth credit after Medicare claims analysis showed telehealth was widely used for the BH diagnosis in 2020, and additionally, because stakeholders identified telehealth as important for expanding access to BH services. In addition, BH

specialty types will receive the credit,“ if the organization’s contracted network of providers includes one or more telehealth providers of that specialty type that provide additional telehealth benefits.”

Qualified Health Plans. As of this writing, in its Final Rule issued in May 2023, CMS required QHPs to submit an access plan with their annual certification application which must detail how the issuer will collect WT data using provider surveys or secret shoppers [7]. CMS does not prescribe or recommend a methodology for WT calculations. Commenters on the Proposed Rule requested CMS issue uniform methods for collecting WT data [26]. CMS defines the metric against which plans must demonstrate compliance as 90 percent of WTs reported by in-network providers to the QHP are no more than the specified standard for appointment type. CMS delayed implementation of WT standards until 2025 in part to allow time to develop guidelines for data collection methodologies and interpretation of metrics.

Medicaid Managed Care. As of this writing, in its Proposed Rule issued in May 2023, CMS proposed states should require Medicaid managed care plans to meet the standard for outpatient MH and substance use services 90 percent of the time and use provider surveys to measure WTs [9]. States would have the discretion to apply a more stringent standard (e.g., 100 percent of the time). To ensure comparability of results through consistent and unbiased methodologies states would be required to contract with an independent entity to conduct secret shopper surveys using the electronic provider directories of managed care plans.

Certified Community Behavioral Health Clinics. In its updated 2023 criteria, SAMHSA required all CCBHCs to report the Time to Services measures, regardless of the funding source for their certification [29]. The requirement applies to CCBHCs in Section 223 Demonstrations, other state-certified CCBHCs, and the more recent cohort of recipients of CCBHC-E grants. SAMHSA provides technical specifications and data reporting templates for all measures which clinics submit. Time to Services measures include Time to Comprehensive Person and Family-Centered Diagnostic & Treatment Planning Evaluation (TX-EVAL) and Time to Initial Evaluation (I-EVAL) [29]. To construct WTs, clinics may use either administrative or medical record data or a hybrid of both sources to report performance metrics. For the I-EVAL, the metrics are the percentage of new consumers with a WT to initial evaluation within 10 business days and the mean number of days until the initial evaluation for new consumers (see ***Appendix C-2*** [63]). For TX-EVAL, the metric is the mean number of days after first contact until the treatment planning evaluation [64]. The metrics must be stratified to report the numerators, denominators and rates for the total population and two age groups (age 12-17 and age 18 years and older), and within each age group, for Medicaid, Medicare & Medicaid, other payors, and total population.

U.S. Department of Veterans Affairs. The VA has published the average WT for appointments at each medical center of the Department since at least 2014. WTs are posted on facility websites and in the Federal Register. In 2022, the VA made several changes to its methodology [65]. Each facility posts WTs for six service subcategories: MH group therapy, SUD group therapy, MH individual therapy, SUD individual therapy, primary care-MH integrated care, and post-traumatic stress disorder programs [66]. Most facilities continue to publish the average WTs for appointments. A new methodology adopted to measure the underlying WTs (***Table 7***, New Methodology #1) captures additional steps in the appointment process not captured in the prior method by pushing the start date back to the “earliest recorded date” in the scheduling system. This change was intended to reflect “the complete process of requesting and receiving care.”

A few medical facilities which transitioned to a new electronic health record (EHR) now have the capacity to link EHR data to the scheduling system, supporting a second, preferred methodology for calculating WTs (***Table 7***, New Methodology #2). For these facilities, the VA calculates WTs in real time for each clinic and for subcategories of appointment types. For automated real-time calculation of WTs, EHRs must be linked to a scheduling system. Using this preferred methodology, the “earliest recorded date” is defined differently for

new and established patients and patients with and without a referral to reflect differences in how appointments are scheduled [65].

Table 7: Start and End Date of WT Measure, VA Medical Facilities [1,2]		
Patient Type	**Start Date**	**End Date**
New Methodology #1 (as of 2022)		
New Patient	• with referral: date provider enters referral into medical record	• appointment is completed
	or	*or*
	• without referral: date the scheduler and veteran begin to find a future appointment	• if not yet completed: date appointment is scheduled to occur
Established Patient	• veteran and provider make agreement for future care	• date agreed upon between a veteran and provider for future care
New Methodology #2 (as of 2022)		
All patients	• current date (live)	• date of the third next appointment available in VA's scheduling system

NOTES:

1. U.S. Department of Veterans Affairs. *Calculation of Average Wait Time for New and Established Patients*. ***Federal Register***, 2022, p.44191-44192. https://www.federalregister.gov/.
2. U.S. Department of Veterans Affairs. *Average Wait Times at Individual Facilities*.

The new methodology calculates the number of days between the current date and the third next appointment available (TNAA) [65]. The TNAA is measured by finding the next available appointment in the scheduling system, the next appointment available after that ("second next" available appointment) and landing on the "third next" available appointment (TNAA). The number of days between the current date and the TNAA is the WT posted on the facility website.

The VA transitioned to using TNAA, in part because this measure "informs veterans of their likely experience when seeking care [65]." In its public notice, the VA cited a study that tested this claim [67]. The study examined the fluctuation over time in the variance of first, second, third and fourth-available appointment WTs for different types of clinicians and found that the second-available WT was more reliable than the first-available but found no improvement in reliability between the second and third-available WTs. The study authors posited that skipping to the third-available appointment accounts for the possibility that the first-available appointments are a result of last-minute cancelations, while the TNAA is more likely to reflect the true backlog to see a clinician. The measure also acknowledges that patients face challenges getting to appointments at the date and time offered to them and may need to choose a later appointment time that is not ideal for their health but is a time they can get to the clinic.

State Insurance Market Case Studies

Colorado Commercial. On an annual basis, carriers submit to the DOI a network access plan and a three-page network adequacy summary with an attestation form; both are public-facing documents [41]. Health plans attest to meeting each standard and requirement of network adequacy and provide supporting documentation, including descriptions of the measures constructed based on WT data. We did not find subregulatory guidance about the methodologies for data collection.

Kansas Medicaid Managed Care. Medicaid plans annually contract with vendors to conduct secret shopper surveys of their providers to collect data and report WT metrics to the state. KDHE leaves to the plan's discretion how to field the survey and does not specify whether appointments for new or established patients should be measured. During annual on-site audits, Kansas Medicaid and its external quality review organization manually reviews claims and notes from EHRs to calculate the time between a patient's first contact with the provider and when the initial assessment or appointment occurred. Under KDHE direction, the plans have collaborated to develop a uniform provider survey instrument that will collect a range of standardized data and measures from providers.

Maryland Commercial. The MIA requires private plans to "make available to enrollees on a semi-annual basis the median wait times" for each appointment type through a random sample of providers listed in their directory by making direct contact with provider offices [43]. From sampled providers, plans must compile WTs to the next available in-person appointment "as measured by the date of the initial request to the date of the earliest available in-person appointment." Health plans must calculate the median WT for each appointment type and determine the percentage of appointments that meet the applicable standard and report those results to the MIA.

MIA allows plans to apply a 10 percentage point telehealth adjustment in appointment categories where the plan does not meet the requirement for at least 90 percent of appointments to meet the applicable standard [43]. In part, this adjustment offsets the exclusion of telehealth appointments from WTs compiled from providers. For example, if 80 percent of a health plan's outpatient WTs are no more than the specified number of days, the 10-percentage point adjustment would result in 90 percent of WTs being no more than that number of days, and so would meet the standard. To offset any incentive the credit might give plans to rely too heavily on telehealth availability to achieve compliance, regulations include an extensive list of additional requirements the carrier must demonstrate and additional information that carriers must submit to be eligible to receive the telehealth credit, which is ultimately subject to approval by the MIA (see ***Appendix C-3***).

Massachusetts Children's Behavioral Health Initiative. CBHI providers are required to monitor and document access to appointments using statistically valid sampling and report findings to MassHealth through a web portal. On a monthly basis, providers submit aggregate data on the number of patients who waited for a service, how long they waited, and for what services they were waiting. CBHI defines WTs by the time a family requests services to the date offered for an initial appointment; the initial assessment does count as an initial appointment.

Washington Commercial. Prior to January 2023, the OIC required health plans to submit an access plan every year describing, among other things, "standards of accessibility expressed in terms of objectives and minimum levels below which corrective action will be taken," and "monitoring policies and procedures for compliance." In late 2022, the state legislature amended its statute establishing the 988 Crisis Hotline to add a reporting requirement for private health plans [44]. Under the amendment, plans are required to submit the 988 Crisis Hotline Appointment Form D report to OIC reflecting the outcome of every referral received in the reporting period for urgent, symptomatic BH care services [68]. The OIC chose to require the reports monthly. Entries in Form D represent individual requests for service, the date of the request, and whether the requested service was received within 24 hours. Health plans gather information from the enrollee, their provider, and any other available sources, including the crisis call center hub, claims, and the BH integrated client referral system. The Washington OIC reviews these monthly reports to determine compliance with its urgent care standard.

Washington Medicaid Managed Care. Medicaid managed care plans submit a quarterly Behavioral Health Capacity Report describing how plans monitor appointment WTs and mitigate WTs exceeding standards [46]. Providers are required to report each request for service as a separate data point from the provision of service on a uniform encounter form. On a monthly basis, providers upload encounters and plans upload service

claims to a web portal. HCA links the provider encounters to corresponding claims to capture the WT from the date of a request to the service date. HCA is developing a dashboard that will support more detailed and automated analysis, such as monthly monitoring of WTs and other network adequacy metrics within counties. The addition of demographic data will allow analysis of race/ethnicity and age subgroups. Once the dashboard is fully operational, HCA will share results with plans quarterly instead of annually. In addition, the health plans are near completion of an HCA-directed collaboration to develop a standard survey instrument to collect data from providers. HCA representatives perceived this standardization as important to reduce provider burden.

Summary

State regulators differ on whether they require health plans to submit the underlying WT data directly to the agency or whether the regulator relies on the plan to calculate its own metrics. Colorado, Maryland, and Washington commercial regulators rely on plans to collect the data and calculate metrics, but they diverge on the amount of data and documentation plans must submit along with the metrics. All three regulators require an access plan describing the policies and procedures put in place to assure network adequacy and data collection undertaken to monitor network adequacy, including WTs. In addition, health plans must submit an attestation of their compliance with standards.

Kansas Medicaid, MassHealth CBHI, and Washington Medicaid gather enough data for the agency to calculate the metrics. MassHealth CBHI calculates metrics based on aggregate counts the providers submit, while Washington HCA uses appointment-level data uploaded to a data portal. Both strategies give agencies the capacity to further aggregate data across health plans (or providers) to compare WT distributions by geographical area and analyses of subgroups.

As of this writing, in recently proposed and final regulations, new requirements for measuring WTs more precisely define the services to which standards should apply and the start and end points of the timeframe to be measured. However, we found few instances where federal or state regulators specify uniform data collection processes and measurement sufficient to ensure comparable WT measures across managed care plans or providers. In federal regulations, absence of greater specification can be attributed in part to the overall framework of insurance regulations, which give states the primary responsibility for regulatory oversight. Federal regulators are setting minimum standards for allowable WTs and broadly delegating to states the specification of methodologies and level of detail required in reporting. Two exceptions are the methodologies established by the VA for its facilities and SAMHSA for all CCBHCs nationwide.

Both federal and state regulators are collecting more data about telehealth availability and continuing to seek input from stakeholders to inform future rulemaking. Other than the allowance for a “credit adjustment” for telehealth in metric calculations for MA plans and Maryland private plans, regulators have focused on clarifying telehealth definitions and stressing the importance of patient preference in new policies incorporating telehealth in WT calculations.

Some state regulators are seeking uniformity in data collection. The decisions by the Maryland DOI and Washington HCA to consolidate secret shopper survey administration into one conducted by an independent vendor is expected to improve measure comparability and reduce provider burden. The KDHE uniform provider survey developed jointly by the managed care plans achieves the same objectives. The new uniform data submission process in Washington for private health plans will track follow-up for urgent and symptomatic BH care needs from all referral sources. All of these strategies have the potential to enhance the value of data regulators receive already, reduce the burden on providers from data collection or improve capacity to monitor WTs.

5. ENFORCEMENT OF WAIT TIME STANDARDS

Perspectives about Enforcement of Wait Time Standards

Regulators, health plans, and experts interviewed described a common viewpoint that monitoring WTs is important; however, many held concerns about giving too much weight to WT metrics when taking enforcement action because WT data is not uniformly measured and metrics of plan performance may not be comparable. In contrast, both regulators and health plans expressed confidence that time and distance measures and provider-to-member ratios are uniformly measured and viewed enforcement action based on non-compliance with these standards as a sound decision.

Key informants viewed WT monitoring as one important element within a wider framework for monitoring network adequacy. Compliance review should include periodic monitoring of plan adherence to time and distance standards, review of customer complaints and the frequency use of out-of-network providers, and administration of patient satisfaction surveys. Through this wider framework, regulators should holistically assess each plan's performance across all available data when determining the point at which non-compliance should lead to punitive enforcement strategies. Key informants also point out the importance of using an array of measures and tools to monitor access and provider availability because every measure has limitations and many measures are needed to monitor complex delivery systems.

Key informants shared two concerns about the quality of the WT data they collect. The first concern was the incompleteness of provider data collected through secret shopper surveys, calls by health plan staff, or through provider forms logging the availability of appointments. The second concern arose in states where the regulator did not provide technical specifications for data collection methodologies and measurement. Both quality concerns have led health plans and state regulators to assert that WT metrics may not be comparable between plans. Despite such concerns, some regulators have taken enforcement action to directly address WTs that exceeded the maximum allowable time.

Federal Approaches

Medicare Advantage. As of this writing, in the June 2023 Final Rule, CMS made no changes to existing monitoring approaches and will continue to use the Complaint Tracking Module to identify and investigate complaints related to access to care [8]. CMS retains a range of enforcement options to impose when a plan is found to be non-compliant in any contractual requirements. These options include issuing compliance actions, including non-compliance notices, warning letters, and requests for Corrective Action Plans.

Qualified Health Plans. As of this writing, in its 2023 Proposed Standards for QHPs, CCIIO proposed to conduct care compliance reviews during the QHP certification review season and plans to coordinate with state departments of insurance to conduct surveys of in-network providers or secret shopping surveys based on random samples throughout the year [56]. Additional compliance reviews could be conducted at any time when triggered by member complaints, which QHPs are required to report to CCIIO when they receive many in one area, such as BH. When the issuer is unable to meet the WT standards, CCIIO would allow the issuer to: "(1) add more contracted providers to the network to come into alignment with the standard; or (2) submit a completed Network Adequacy Justification Form". CCIIO will require provider networks to ensure 90 percent of their marketplace eligible customers in the county can access services.

Medicaid Managed Care. As of this writing, CMS has proposed requiring states to enforce WT standards for managed care plans by submitting a plan for non-compliant plans to remedy issues [9]. States would have to submit a remedy plan within 90 calendar days of identifying a plan's access issues, and the plan would have to detail what actions the state and the plan would take to improve access to care within 12 months. Additionally, states would then have to submit quarterly progress updates on implementation of the remedy plan to CMS.

Further, CMS clarifies that states would have the right to cease payments made under a state's managed care contract for failure to meet or enforce the standards.

Certified Community Behavioral Health Clinics. SAMHSA delegates enforcement of certification requirements to states. We did not review state-specific enforcement approaches for CCBHCs.

State Insurance Market Case Studies

Interviewees across state case studies identified workforce shortages as a major barrier to reducing WTs for BH care in recent years through any regulatory levers available, especially since the onset of the COVID-19 pandemic. Clinicians are taking on large caseloads to account for staff departures, and hiring administrative staff and filling vacancies has also been difficult, leaving clinicians to keep up with monthly reporting requirements.

Regulators in state case studies described a range of enforcement options at their disposal. Although nearly all of the regulators interviewed described imposing monetary penalties and contract revocation in extreme cases, they all preferred to work cooperatively with health plans to identify action that the plan can take. Moreover, regulators also consider action the state can take to facilitate improvements in access, such as increasing Medicaid reimbursement. In part, the cooperative approach acknowledges that external factors outside of the control of health plans may be contributing to non-compliance, and that state policies and actions should play a role in improving network adequacy wherever the state has levers to push.

Colorado Commercial. Through reports submitted to the DOI, commercial plans calculate their own WT metrics and where WT standards are not met, the plan must fill out Attachment B, indicating the specific standard not met and providing an explanation for why the standard is not met [41]. Additionally, for each standard not met, the plan must attach a corrective action plan. The DOI may request additional information, and regularly reviews consumer and provider complaints about WTs. In response to non-compliance, the DOI may impose financial penalties, issue cease-and-desist orders, or suspend or revoke a carrier's license. With respect to non-compliance with network adequacy standards, the DOI generally applies a cooperative approach with carriers; in extreme cases, the DOI has issued small financial penalties or revoked the insurance license. In those severe cases, the DOI investigates non-compliance before issuing a financial penalty or revoking the insurance license. The DOI is still assessing how to best determine compliance for rural versus urban counties, where rural counties have limited providers.

Kansas Medicaid Managed Care. The WT standards are one set of criteria used to determine a plan's compliance with overall standards. If the state finds that a plan is failing to comply with network access standards, including the standards for BH WTs, they will work with the health plan to form a corrective action plan. The state has the option to enforce fines or withhold payments if action plans are not followed. In cases where a plan has repeated issues with non-compliance, KDHE can leverage a bonus program for the plans by placing the bonus at risk. For Kansas CCBHCs, if the CCBHCs are not meeting their criteria, the agency will help them develop a quality improvement plan.

Maryland Commercial. Recent changes in monitoring and enforcement arose after many private health plans failed to meet WT standards during the 2019 inspection, in particular, failing the BH WT standard, which required 95 percent of WTs to be no more than the standard set for the appointment type. Prior to this, MIA had not penalized any private health plans. To address non-compliance in 2019, MIA sent consent orders indicating that they would impose penalties, but suspended payment contingent on the plans demonstrating compliance or significant improvement by 2021. All private health showed improvement in at least some of the deficient standards through expanding provider networks or other means. As a result, the 2019 penalties

were rescinded or reduced for all plans. In new regulations effective in 2023, MIA lowered the WT standard to 90 percent in recognition of the challenges plans faced in meeting the 95 percent standard [43].

Massachusetts Children's Behavioral Health Initiative. MassHealth evaluates the results of the measures to determine compliance with the CBHI standards. Actions to address any access deficiencies may include taking corrective action, which can be in the form of fines, ending referrals by health plans, no longer contracting with the non-compliant provider, and requiring the provider to re-credential as a CBHI provider. Since the implementation of the standards, however, MassHealth has not issued fines or other penalties, instead taking a cooperative approach to help CBHI providers come into compliance.

Washington Commercial. Private health plans began to submit monthly reports in January 2023 documenting success in connecting members who need urgent follow-up with next-day appointments. This is the first time the OIC or health plans have tracked this type of information, and they having no historical data that could serve as a comparison. At the time of interview, the OIC was reviewing reports to see what patterns would emerge and developing new review and enforcement mechanisms for the new standard.

Washington Medicaid Managed Care. Because the COVID-19 pandemic placed further strain on providers and exacerbated provider shortages, the HCA has placed high priority throughout the pandemic on monitoring the system and supporting managed care plans with technical assistance and corrective action plans to address non-compliance. The HCA reviews data and grievances on a quarterly basis. They are working to develop a more automated process for BH WT standards that can be reviewed at statewide and regional levels. They currently have the capacity to determine non-compliance with other accessibility standards, locating specific geographic regions or provider types where the standard is not met. The HCA may issue a variety of financial and contract-related sanctions if health plans are still non-compliant in the next quarter.

Summary

Improvements in WT monitoring systems could contribute to a more robust oversight of network adequacy. Regulators, health plans, and experts interviewed valued WT monitoring as an important element within a wider framework for monitoring and enforcing network adequacy. However, many expressed concerns about the quality of the WT data collected--namely the completeness of data collected from providers about appointment availability, and insufficient technical specifications for data collection and WT measurement. These concerns and other considerations inform state approaches to incorporating WT metrics into enforcement decisions.

With respect to enforcement of network adequacy requirements generally, nearly all regulators interviewed described imposing monetary penalties and contract revocation in extreme cases. However, state regulators are well aware that workforce shortages have been a major barrier to reducing WTs for BH care in recent years, especially since the onset of the COVID-19 pandemic. This context and other factors motivate regulators to work cooperatively with health plans to identify action that the plan can take to improve network adequacy, including assessing what levers the state can pull to facilitate improvements in access.

6. CONCLUSION

As of this writing, in 2023, CMS issued final rules for MA plans and QHPs in FFEs adding WT standards for BH provider networks which will apply to policies beginning in 2024 and 2025, respectively. Also in 2023, CMS issued a proposed rule for Medicaid managed care plans that would require states to develop appointment WT standards for routine outpatient appointments for MH and SUD services. Prior to 2023, federally regulated markets did not include BH WT standards as part of provider network adequacy requirements, delegating decisions to states. Regulators emphasized parity between BH and physical health service accessibility and alignment across insurance markets as the rationale for recent regulatory changes.

Although CMS clarified service definitions, timeframes corresponding to their standards, and added measurement requirements in recent regulatory changes, some areas of measurement, data collection and WT calculations remain unspecified. New federal regulations may prompt a greater number of states to adopt BH WT standards or align existing requirements with those of federal markets. However, some accreditation entities do not incorporate WT standards in accreditation requirements and AAAHC argued that requirements ensuring appropriate policies and practices are in place will do more to improve the timeliness of care than setting and enforcing standards.

As of June 2023, 14 states require either commercial or Medicaid managed care health plans to meet WT standards for BH provider networks, with seven states adopting WT standards for the first time. Regulators, health plans, and experts interviewed considered WTs to be a critical measure of the accessibility of services because they reflect a dimension of patient experience important to members. Also, they stressed that monitoring and addressing WTs--especially for BH services--needs to be a high priority for regulators because major gaps in service and provider shortages within BH delivery systems are a pervasive underlying cause of long WTs for MH and SUD services and treatment. Key informants consider WT monitoring to be an important complement to other monitoring strategies within a comprehensive access monitoring framework. In part, the importance of using an array of tools to monitor access and provider availability is attributable to widespread acknowledgement that every measure of access has limitations, and many measures are needed to monitor complex delivery systems.

Federal and state regulators are consulting stakeholders and seeking input about implementing strategies that would account for patient preferences in accessing services and widespread uptake of telehealth as a mode for delivering BH care. Primarily, regulators are incorporating patient preference into standards by defining the start point for WTs as the date on which the consumer requests service. However, regulators acknowledge that collecting data that captures this start point is challenging and requires more effort from providers in data collection. Most regulators interviewed have a policy in place for incorporating telehealth in WT standards or WT measurement, but strategies vary in how telehealth is counted or incorporated, and whether patient preference for telehealth is expressly addressed when identifying services eligible to be counted in WT calculations. Moreover, regulators set different policies about when telehealth and audio-only telehealth are a reimbursed service.

From six case studies of regulatory approaches, we found that most state regulators set BH WT standards by matching standards for primary care and urgent physical health care, or by matching BH WT standards adopted in other regulated markets or other states. Setting standards to correspond to urgency of need also was the approach taken by federal regulators and is recommended by national associations and accreditation bodies. However, CCBHC certification criteria and provider requirements in the MassHealth CBHI reflect an alternative strategy which bases standards on specific service types and the timeliness of care from initial assessment through initiation of each service. Notably, the implementation of 988 suicide hotlines is informing new standards related to crisis intervention and next-day appointment access for urgent MH needs.

Regulators, health plans, and experts described a range of concerns about WT measures and difficulty interpreting them, which limits the meaningful application of standards. Concerns included limitations in available data, lack of guidance on sound methodologies for data collection, and lack of uniformity in how health plans measure WTs. As a result of these concerns, regulators are not sure how to interpret WT measures. When considering improvements to WT measurement, regulators and health plans must balance the need to collect detailed and accurate data with the cost and challenges of obtaining the data and the burden that is placed on health plans and providers. Regulators must also balance their enforcement approaches with recognized external factors (such as provider shortages) that limit the ability of the health plan to quickly come into compliance. State regulators also reported that they need research that can inform standards and their implementation, which in part could stem from evaluation of the experimentation that is occurring.

Regulators interviewed described ongoing attention to improving monitoring systems. Specifically, states are investing in data infrastructure, consolidating data collection activities across health plans, and developing uniform protocols and survey instruments, which are expected to improve the quality of WT data and decisions based on monitoring. By taking steps to improve WT data and monitoring systems, regulators seek to address some of the greatest limitations of WT data currently collected.

State regulators prefer to work collaboratively with health plans to address service areas or regions where WT standards are not being met. Although the regulators we interviewed had imposed financial penalties on health plans that failed to meet standards, states tended to reserve such action for extreme or persistent violations of network adequacy requirements. For several reasons, state regulators prefer to work collaboratively with health plans to address access gaps when WT standards are not being met and to monitor the problem area closely. Mainly, the choice to collaborate on solutions reflects an acknowledgement that provider shortages in every market make it harder for health plans to meet network requirements, and such challenges are better addressed through partnership.

7. STUDY LIMITATIONS

The national scan of state standards relied on published reports and case studies, which may have missed some recent changes in standards. In case studies we focused on understanding the decisions and activities of regulators and the health plans subject to regulation. Key informants interviewed for this study represented state and federal agencies charged with monitoring network adequacy that also have established WT standards for BH; health plans operating in these markets, researchers and policy experts. We did not interview state regulators that choose not to include WT standards in network adequacy requirements and who may offer different perspectives than those presented in study findings. Apart from a review of the VA measurement systems, we did not conduct searches specifically for measurement systems established by accountable care entities or vertically integrated managed care. An in-depth review of current practice could uncover a wider range of data collection methodologies and WT calculations, and possibly research and lessons that could improve policy makers' understanding of what is possible to measure and what is useful to monitor.

8. FUTURE RESEARCH NEEDS

Further research is needed that will lead to the development of best practices for setting standards, measurement, monitoring, and enforcement strategies. Our recommendations for future research are based on our review of recent research as well as the data needs identified by key informants. An overarching principle of research should be to lessen the burden on providers while identifying strategies regulators can implement to improve the timeliness of care.

Research about the trade-offs of adopting WT standards as a lever for improving timeliness of care could inform state action in the short term. Most state regulatory authorities have not adopted WT standards for BH services as a provider network adequacy requirement. We did not explore the reasons for omission of such standards. Seeking the perspectives of these regulators would expand our understanding of the trade-offs involved in foregoing the adoption of standards. The regulators and health plans we interviewed expressed concerns about the quality of WT data being collected. Some accreditation entities and regulators place greater emphasis on ensuring appropriate policies and processes are in place to ensure accessibility and mitigate risks to patients from delayed care, and place less emphasis on WT standards, or do not include standards in their approach. Examples include AAAHC accreditation requirements, SAMHSA's certification requirements for CCHBCs and Massachusetts CBHI provider requirements, which emphasize transparency of access monitoring plans, and establishing policies that minimize WTs and inform patients of their rights. Other agencies, exemplified by the VA and Washington HCA, have invested in WT measurement, improving transparency about WTs for consumers, and analysis of WT data to address disparities in access and reduce WTs. Improving monitoring systems for WTs could be an alternative to setting standards.

Research on the relationship between incremental changes in WTs and patient outcomes could inform standards that impact consumer health. One-half of the 16 studies reviewed examined WTs for the initiation of medication assisted treatment (MAT) for opioid use disorder (OUD) in outpatient programs, a critical access point for addressing the opioid crisis. Only two examined the association between WT length and adverse outcomes. These studies found that WTs of 2 or more days increased the likelihood that a patient would cancel or not show up for an appointment to initiate MOUD [69,70]. With further research exemplified by these studies, regulators could set performance targets for carriers, that if met, could reduce poor outcomes from delayed care.

Recent research is contributing knowledge about subgroups at high risk for adverse outcomes from delayed care that could provide regulators with a rationale for monitoring WTs for subgroups. Research is needed to estimate the differential risk for adverse outcomes as WT increases given a patient's condition, comorbidities, and symptom acuity. Key informants identified this type of research as important for decision making. Six studies in our review examined WTs for MAT or MH treatment for high-risk subpopulations: pregnant and post-partum women [71-74], adults with co-occurring conditions [75], and veterans with serious mental illness (SMI) [76]. Fewer studies measured the association between longer WTs and adverse outcomes. One study found that each week spent waiting for an appointment for peripartum depression symptoms increased the odds of clinically meaningful worsening of depression symptoms and odds of new self-harm ideation [72]. Studies like these could help regulators define "urgent" needs and identify the subgroups at high risk of adverse outcomes from delays in care.

Future research is needed that observes consumers and their strategies for searching for care. Research on timeframes not typically measured but which contribute to the overall WT consumers experience could fill gaps in our understanding of the factors that contribute to longer waits. Recent studies draw attention to consumers' search for care as a timeframe we know little about. Search time is not captured by the instruments commonly used by regulators. Notably, provider-level measures of appointment availability do not account for the reality that consumers may need to call a list of providers to find an appointment they can

attend. Studies estimating WTs reveal the types of provider encounters which consumers can expect to face. For example, two studies estimating WTs to initiating buprenorphine reported significant percentages of total calls resulting in: no answer, no return call, wrong number, provider does not offer the service indicated in the directory, required a referral, is not accepting patients, or provider would only schedule an appointment if the caller agreed to pay cash [74,77]. In both studies, researchers called providers found in a plan directory. These studies drive home the need to understand consumers who stop looking for care, because they are not reflected in WT measures nor represented in analyses of individual-level WT data. Moreover, using real consumers as study subjects is essential for understanding consumer-level factors such as resilience and personal resources which contribute to the success of searches for care.

Comparing methods currently used to measure WTs in quasi-experimental testing could shed light on design factors that are contributing to variation. In some markets, regulators and health plans are developing uniform data collection methodologies. Implementing new methodologies in conjunction with quasi-experimental research designs could help to identify uniform designs that yield consistent, reliable and valid WT measures across plans and over time. Comparison of data collection methodologies should measure the relative costs of data collection, including costs to providers, so that regulators can assess the trade-offs of different data sources and data collection strategies.

REFERENCES

1. Zhu, J.M., Y. Zhang, & D. Polsky. *Networks in ACA marketplaces are narrower for mental health care than for primary care*. ***Health Affairs***, 2017, 36(9): p.1624-1631.
2. Zhu, J.M., et al. *Variation in network adequacy standards in Medicaid managed care*. ***American Journal of Managed Care***, 2022, 28(6): p.288.
3. Schleicher, S.M., S. Mullangi, & T.W. Feeley. *Effects of narrow networks on access to high-quality cancer care*. ***JAMA Oncology***, 2016, 2(4): p.427-428.
4. Bradley, K., et al. *Network Adequacy for Behavioral Health: Existing Standards and Considerations for Designing Standards*. Washington, DC: Office of the Assistant Secretary for Planning and Evaluation, 2021. https://aspe.hhs.gov/reports/network-adequacy-behavioral-health.
5. Cook, B.L., et al. *Trends in racial-ethnic disparities in access to mental health care, 2004-2012*. ***Psychiatry Services***, 2017, 68(1): p.9-16.
6. Busch, S.H., & K.A. Kyanko. *Incorrect provider directories associated with out-of-network mental health care and outpatient surprise bills*. ***Health Affairs*** (Millwood), 2020, 39(6): p.975-983.
7. Centers for Medicare & Medicaid Services. *Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2024, Compliance with Appointment Wait Time Standards. 45 CFR Parts 153, 155, and 156 [CMS-9899-F]. RIN 0938-AU97. ACTION: Final rule*. ***Federal Register***, 2023, 88(81): p.25879.
8. Centers for Medicare & Medicaid Services. *2024 Medicare Advantage and Part D Final Rule [CMS-4201-F]*. 2023, p.22174. https://www.cms.gov/newsroom/fact-sheets/2024-medicare-advantage-and-part-d-final-rule-cms-4201-f.
9. Centers for Medicare & Medicaid Services. *Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality (88 FR 28100)*. ***Federal Register***, 2023, RIN 0938-AU99.
10. Substance Abuse and Mental Health Services Administration. *Key Substance Use and Mental Health Indicators in the United States: Results from the 2020 National Survey on Drug Use and Health*. Rockville, MD: SAMHSA, 2021, HHS Publication No. PEP21-07-01-003.
11. U.S. White House. *FACT SHEET: President Biden to Announce Strategy to Address Our National Mental Health Crisis, As Part of Unity Agenda in his First State of the Union*. Washington, DC: White House, 2022. https://www.whitehouse.gov/briefing-room/statements-releases/2022/03/01/fact-sheet-president-biden-to-announce-strategy-to-address-our-national-mental-health-crisis-as-part-of-unity-agenda-in-his-first-state-of-the-union/.
12. Bagalman, E., J. Dey, L. Jacobus-Kantor, B. Stoller, K.D. West, et al. *HHS Roadmap for Behavioral Health Integration* (Issue Brief). Washington, DC: Office of the Assistant Secretary for Planning and Evaluation, 2022. https://www.aspe.hhs.gov/reports/hhs-roadmap-behavioral-health-integration.
13. Commonwealth of Massachusetts. *Learn about CBHI--MassHealth Children's Behavioral Health Initiative (CBHI)*. n.d. https://www.mass.gov/info-details/learn-about-cbhi.
14. U.S. Department of Veterans Affairs. *B-331122, Veterans Affairs: Veterans Community Care Program*. ***Federal Register***, 2019, 84: p.26278. https://www.gao.gov/assets/b-331122.pdf#:~:text=It%20was%20published%20in%20the%20Federal%20Register%20as,from%20non-VA%20entities%20or%20providers%20in%20the%20community.
15. U.S. Department of Veterans Affairs. Community Care: Eligibility. n.d. https://www.va.gov/resources/eligibility-for-community-care-outside-va/#Eligibility.

16. Centers for Medicare & Medicaid Services. *The Mental Health Parity and Addiction Equity Act (MHPAEA)*. 2020. https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/MHPAEA_Factsheet.
17. Weber, E. Spotlight on Network Adequacy Standards for Substance Use Disorder and Mental Health Services. 2020. https://www.lac.org/.
18. Corlette, S., A. Schneider, M. Kona, A. Corcoran, R. Schwab, & M. Houston. *Access to Services in Medicaid and the Marketplaces: Comparing Network Adequacy Rules*. Washington, DC: Georgetown University, 2022.
19. Horner, L., J. Kim, M. Dormond, K. Hardy, J. Libersky, D.J. Lipson, M. Hossain, & A. Lechner. *Promoting Access in Medicaid and CHIP Managed Care: Behavioral Health Provider Network Adequacy Toolkit*. 2021.
20. West Virginia Department of Health and Human Services. *State of West Virginia Fiscal Year 2020 Model Purchase of Service Provider Agreement*. 2020.
21. Pollitz, K. *Network Adequacy Standards and Enforcement*. 2022. https://www.kff.org/health-reform/issue-brief/network-adequacy-standards-and-enforcement/.
22. Centers for Medicare & Medicaid Services. *Medicare Program; Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly Summary of Major Provisions: 6. Behavioral Health in Medicare Advantage (MA) (§§ 422.112 and 422.116). 42 CFR Parts 417, 422, 423, 455, and 460, [CMS-4201-F]*. 2023, RIN 0938-AU96.
23. Centers for Medicare & Medicaid Services. *2024 Medicare Advantage and Part D Final Rule [CMS-4201-F], Behavioral Health Specialties in Medicare Advantage Networks SS422.112 and 422.16*. 2023, p.22174. https://www.cms.gov/newsroom/fact-sheets/2024-medicare-advantage-and-part-d-final-rule-cms-4201-f.
24. Centers for Medicare & Medicaid Services. *2024 Medicare Advantage and Part D Final Rule [CMS-4201-F], Medicare Advantage Access to Services: Appointment Wait Time Standards SS422.122 (SS)*. 2023, p.22174. https://www.cms.gov/newsroom/fact-sheets/2024-medicare-advantage-and-part-d-final-rule-cms-4201-f.
25. Centers for Medicare & Medicaid Services. CMS Behavioral Health Strategy. n.d., [cited 2023]. https://www.cms.gov/cms-behavioral-health-strategy.
26. Centers for Medicare & Medicaid Services. *Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2023*. ***Federal Register***, 2022.
27. Centers for Medicare & Medicaid Services. *Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2023. 45 CFR Parts 144, 147, 153, 155, 156, and 158 [CMS-9911-F]. ACTION: Final Rule*. ***Federal Register***, 2022, 87(88): p.27324, RIN 0938-AU65.
28. Centers for Medicare & Medicaid Services. *Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality, Appointment Wait Time Standards (§§ 438.68(e), 457.1218),(88 FR 28097). Proposed Rule*. ***Federal Register***, 2023, RIN 0938-AU99.
29. Substance Abuse and Mental Health Services Administration. *Certified Community Behavioral Health Center (CCBHC) Certification Criteria*. 2023. https://www.samhsa.gov/certified-community-behavioral-health-clinics.

30. Substance Abuse and Mental Health Services Administration. *Deadlines for Implementation of the Updated CCBHC Certification Criteria*. 2023. https://www.samhsa.gov/certified-community-behavioral-health-clinics/deadlines-for-implementation.
31. Substance Abuse and Mental Health Services Administration. *Certified Community Behavioral Health Center (CCBHC) Certification Criteria*. 2023 [cited 2023]. https://www.samhsa.gov/certified-community-behavioral-health-clinics.
32. Substance Abuse and Mental Health Services Administration. *CCBHC Certification Criteria Summary of Changes*. 2022. https://www.samhsa.gov/sites/default/files/ccbhc-certification-criteria-summary-of-changes.pdf.
33. Substance Abuse and Mental Health Services Administration. *Certified Community Behavioral Health Clinics (CCBHCs)*. 2023 [cited 2023]. https://www.samhsa.gov/certified-community-behavioral-health-clinics.
34. Centers for Medicare & Medicaid Services. *HHS, Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2019*. 2018, 33 83 FR 1693; 17025.
35. National Archives, Code of Federal Regulations. *§156.275 Accreditation of QHP Issuers. 34 45 C.F.R. §§156.275(a)(1)(viii); (c)(2)(iv)*. 2014. https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-B/part-156/subpart-C/section-156.275.
36. Accreditation of QHP Issuers. *34 45 C.F.R. §§156.275(a)(1)(viii); (c)(2)(iv)*. 2014.
37. Utilization Review Accreditation Commission. *URAC Mental Health/Substance Use Disorder Parity Accreditation*. 2022. https://www.urac.org/accreditation-cert/mental-health-parity-accreditation/.
38. National Committee for Quality Assurance. *Utilization Management/Credentialing/Provider Network (UM/CR/PN)*. n.d. https://store.ncqa.org/index.php/catalog/category/view/s/utilization-management-credentialing-um-cr/id/79/.
39. PressGaney (SPH Analytics). *Improving Member Access to Care*. 2022. https://info.pressganey.com/on-demand-webinars/improving-member-access-to-care.
40. Centers for Medicare & Medicaid Services. *Qualified Health Plan (QHP) Comment Letter*. 2023. https://www.aaahc.org/news/cms-cy2023-qualified-health-plan-qhp-comment-letter/.
41. State of Colorado. *Network Plan Standards and Reporting Requirements for ACA-Compliant Health Benefit Plans, in 3 CCR 702-4:4-2-53; 702-4:4-2-54*. Colorado Secretary of State, 2020, p.421-423.
42. Kansas Department of Health and Environment. *Kansas Medicaid Managed Care Request for Proposal for Kancare 2.0, Behavioral Health Provider Network Standards*. n.d., BID Event Number: EVT0005464.
43. Code of Maryland Regulations. *Network Adequacy Regulations for Health Benefit Plans*. 2023, COMAR 31.10.44.
44. Revised Code of Washington *[RCW] 48.43.790*. Amended 2021.
45. Washington State Legislature. *Behavioral Services--Next-Day Appointments*. 2021, RCW 48.43.790.
46. Washington State Health Care Authority. *Washington Apple Health Integrated Managed Care Contract*. 2022, p.139. https://www.hca.wa.gov/.

47. State of Colorado. *Requirements for Annual Network Adequacy Reporting for ACA-Compliant Individual, Small Group, and Large Group Health Benefit Plans, and Student Health Insurance Coverage Plans. (p 421-423). 3 CCR 702-4-2-53-11*. Colorado Secretary of State, Code of Colorado Regulations. 2023. https://sos.state.co.us/CCR/GenerateRulePdf.do?ruleVersionId=11051&fileName=3%20CCR%20702-4%20Series%204-2.
48. Maryland Insurance Administration. *Appointment Waiting Time Standards*. n.d. Maryland Code Regs. 31.10.44.06.
49. National Association of Insurance Commissioners. *Health Benefit Plan Network Access and Adequacy Model Act*. 2015. https://www.naic.org/store/free/MDL-74.pdf.
50. Ofonedu, M.E., et al. *Understanding barriers to initial treatment engagement among underserved families seeking mental health services*. ***Journal of Child & Family Studies***, 2017, 26: p.863-876.
51. Redko, C., R.C. Rapp, & R.G. Carlson. *Waiting time as a barrier to treatment entry: Perceptions of substance users*. ***Journal of Drug Issues***, 2006, 36(4): p.831-852.
52. McBain, R.K., et al. *Expansion of telehealth availability for mental health care after state-level policy changes from 2019 to 2022*. ***JAMA Network Open***, 2023, 6(6): p.e2318045-e2318045.
53. Washington State Health Care Authority. *Apple Health (Medicaid) Telemedicine & Telehealth Brief*. 2020. https://www.hca.wa.gov/assets/billers-and-providers/apple-health-telemedicine-telehealth-brief-COVID19-20200428.pdf.
54. Commonwealth of Massachusetts, Executive Office of Health and Human Services, Office of Medicaid. *MassHealth All Provider Bulletin 289*. 2020. https://www.mass.gov/.
55. Birrane, K.A. *Title 31. Maryland Insurance Administration, Subtitle 10 Health Insurance--General, 31.10.44 Network Adequacy*. ***Maryland Register***, 2023, 50(9).
56. Center for Consumer Information and Insurance Oversight. *2023 Final Letter to Issuers in the Federally-Facilitated Exchanges*. 2022. https://www.cms.gov/sites/default/files/2022-04/Final-2023-Letter-to-Issuers_0.pdf#:~:text=This%202023%20Final%20Letter%20provides%20updates%20on%20operational,the%20Facilitatedederally-f%20Small%20Business%20Health%20Options%20Programs%20%28FF-SHOPs%29.
57. Accreditation Association for Ambulatory Health Care. *CMS CY2024 Qualified Health Plan (QHP) Comment Letter*. 2023. https://www.aaahc.org/search/comment+letter.
58. Partnership, M.B.H. *Children's Behavioral Health Initiative--Performance Specifications, Medical Necessity Criteria, and Service Definitions*. Massachusetts Behavioral Health Partnership, n.d. [cited 2023]. https://www.masspartnership.com/provider/CBHIPerformanceSpecs.aspx.
59. Centers for Medicare & Medicaid Services. *Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality (88 FR 28100)*. ***Federal Register***, 2023, RIN 0938-AU99.
60. Centers for Medicare & Medicaid Services. *2024 Medicare Advantage and Part D Final Rule [CMS-4201-F], Medicare Advantage Access to Services: Appointment Wait Time Standards §§422.112*. 2023, p.22174. https://www.cms.gov/newsroom/fact-sheets/2024-medicare-advantage-and-part-d-final-rule-cms-4201-f.
61. Centers for Medicare & Medicaid Services. *2024 Medicare Advantage and Part D Final Rule [CMS-4201-F], Behavioral Health in Medicare Advantage (MA) (§§422.112 and 422.116)*. 2023, p.22174. https://www.cms.gov/newsroom/fact-sheets/2024-medicare-advantage-and-part-d-final-rule-cms-4201-f.

62. Centers for Medicare & Medicaid Services. *2024 Medicare Advantage and Part D Final Rule [CMS-4201-F], Behavioral Health in Medicare Advantage (MA) (§§422.112 and 422.116)*. 2023, p.22174. https://www.cms.gov/newsroom/fact-sheets/2024-medicare-advantage-and-part-d-final-rule-cms-4201-f.
63. Substance Abuse and Mental Health Services Administration. *Demonstration 223 Templates OMB*. 2016.
64. Substance Abuse and Mental Health Services Administration. *223 Demonstration Quality Measures: Time to Comprehensive Evaluations*. n.d.
65. U.S. Department of Veterans Affairs. *Calculation of Average Wait Time for New and Established Patients*. ***Federal Register***, 2022, p.44191-44192. https://www.federalregister.gov/.
66. U.S. Department of Veterans Affairs. *Average Wait Times at Individual Facilities*.
67. Brar, S., M. Hopkins, & D. Margolius. *Time to next available appointment as an access to care metric*. ***Jt Comm J Qual Patient Saf***, 2019, 45(11): p.779-780.
68. Washington State Legislature. *Network Reports--Format*. W.A. Code, 2023.
69. Roy, P.J., et al. *Appointment wait-times and arrival for patients at a low-barrier access addiction clinic*. ***J Subst Abuse Treat***, 2020, 114: p.108011.
70. Roy, P.J., et al. *Shorter outpatient wait-times for buprenorphine are associated with linkage to care post-hospital discharge*. ***Drug Alcohol Depend***, 2021, 224: p.108703.
71. Kelley, A.T., et al. *Treatment access for opioid use disorder in pregnancy among rural and American Indian communities*. ***J Subst Abuse Treat***, 2022, 136: p.108685.
72. Koire, A., et al. *Longer wait time after identification of peripartum depression symptoms is associated with increased symptom burden at psychiatric assessment*. ***J Psychiatr Res***, 2022, 152: p.360-365.
73. Morain, S.R., L.R. Fowler, & J.W. Boyd. *A pregnant pause: System-level barriers to perinatal mental health care*. ***Health Promot Pract***, 2022, p.15248399221101373.
74. Patrick, S.W., et al. *Association of pregnancy and insurance status with treatment access for opioid use disorder*. ***JAMA Netw Open***, 2020, 3(8): p.e2013456.
75. Ford, J.H. 2nd, et al. *Wait no longer: Reducing medication wait-times for individuals with co-occurring disorders*. ***J Dual Diagn***, 2022, 18(2): p.101-110.
76. Nelson, S.M., et al. *Access to timely mental health care treatment initiation among Veterans Health Administration patients with and without serious mental illness*. ***Psychol Serv***, 2022, 19(3): p.488-493.
77. Flavin, L., et al. *Availability of buprenorphine treatment in the 10 states with the highest drug overdose death rates in the United States*. ***J Psychiatr Pract***, 2020, 26(1): p.17-22.
78. Commonwealth of Massachusetts. *Performance Specifications Children's Behavioral Health Initiative Family Support and Training Components of Service*. n.d. [cited 2023]. https://www.masspartnership.com/pdf/PerfSpec-FS_T.pdf.
79. Commonwealth of Massachusetts, Executive Office of Health and Human Services. *Performance Specifications: Children's Behavioral Health Initiative In-Home Behavioral Services. Effective November 1, 2019, January 1, 2022; Updated December 2020, November 1, 2021*. 2021. https://www.masspartnership.com/pdf/PerfSpec-IHBS.pdf.
80. Commonwealth of Massachusetts. *Performance Specifications Children's Behavioral Health Initiative. In-Home Therapy Services*. n.d. [cited 2023]. https://www.masspartnership.com/pdf/PerfSpec-IHT.pdf.

81. Commonwealth of Massachusetts. *Performance Specifications Children's Behavioral Health Initiative Targeted Case Management Services. Intensive Care Coordination*. n.d. [cited 2023]. https://www.masspartnership.com/pdf/PerfSpec-ICC.pdf.
82. Commonwealth of Massachusetts. *Performance Specifications Children's Behavioral Health Initiative Therapeutic Mentoring Services*. n.d. [cited 2023]. https://www.masspartnership.com/pdf/PerfSpec-TM.pdf.
83. Commonwealth of Massachusetts. *Performance Specifications Children's Behavioral Health Initiative Intensive Hospital Diversion Program*. n.d. [cited 2023]. https://www.masspartnership.com/pdf/PerfSpec-IHD.pdf.
84. Winograd, R.P., et al. *Implementation and evaluation of Missouri's Medication First treatment approach for opioid use disorder in publicly-funded substance use treatment programs*. ***J Subst Abuse Treat***, 2020, 108: p.55-64.
85. Joudrey, P.J., et al. *Methadone access for opioid use disorder during the COVID-19 pandemic within the United States and Canada*. ***JAMA Netw Open***, 2021, 4(7): p.e2118223.
86. Kong, Y., et al. *Using machine learning to advance disparities research: Subgroup analyses of access to opioid treatment*. ***Health Serv Res***, 2022, 57(2): p.411-421.
87. Kovach, J.V., & M.N. Flores. *Streamlining admissions to outpatient substance use treatment using lean methods*. ***Journal of Substance Use***, 2020, 26(3): p.306-312.
88. Nam, E., E. Lee, & H. Kim. *10-year trends of emergency department visits, wait time, and length of stay among adults with mental health and substance use disorders in the United States*. ***Psychiatr Q***, 2021, 92(3): p.1159-1174.
89. Vaughn, S.X., et al. *Assessing public behavioral health services data: A mixed method analysis*. ***Subst Abuse Treat Prev Policy***, 2020, 15(1): p.85.

APPENDIX A: STATE CASE STUDY OVERVIEW

State Insurance Market	Case Study Overview
Colorado commercial Colorado Department of Insurance (DOI)	• The impetus for developing WT standards in 2014 in Colorado was the ACA/MHPAEA and issues with BH service access, particularly in rural areas. • Colorado is currently working on amending the standards to go into effect in 2024; they are further amending the standards to include more detailed standards for initial and subsequent visits. • On an annual basis, carriers must submit to the DOI a network access plan and a 3-page network adequacy summary with an attestation form; both are public-facing documents.
Kansas Medicaid managed care Kansas Department of Health and the Environment (KDHE)	• KDHE developed regulations for its Medicaid managed care program, KanCare, by soliciting feedback from stakeholders, including patient advocacy groups, and reviewing public comments. • Medicaid managed care plans annually contract with vendors to conduct secret shopper surveys of their providers to collect data and report WT metrics to the state. In addition, Kansas Medicaid reviews WT data during annual health plan on-site audits.
Massachusetts Children's Behavioral Health Initiative (CBHI) MassHealth	• The CBHI began as an interagency initiative in 2009 to carry out the remedy for the Rosie D class action lawsuit. CBHI offers an enhanced continuum of home and community-based BH services to children and youth with serious emotional disturbance who are uninsured, covered by Medicaid or covered by other insurance that require wrap-around services. • CBHI has established WT standards for each of six core services: Family Support and Training, In-Home Behavioral Services, In-Home Therapy Services, Intensive Care Coordination, Therapeutic Monitoring, and Intensive Hospital Diversion. • CBHI providers are required to monitor and document access to appointments using statistically valid sampling and report findings to MassHealth through a web portal.
Maryland Commercial Maryland Insurance Administration (MIA)	• MIA WT standards went into effect in 2017; standards were developed based on standards in California, Colorado, and those set by the NCQA. • MIA adopted revised standards for WTs which went into effect on May 15, 2023; the revised standards were explicitly divided into MH and SUD care as distinct service categories requiring assessment. • MIA requires private carriers to submit an access plan and to collect WT data annually through a random sample of providers.
Washington Commercial Washington Office of the Insurance Commissioner (OIC)	• In 2021, OIC adopted WT standards for urgent and non-urgent care for symptomatic BH needs to match requirements for Medicaid plans already in place; the new standard and reporting requirements became effective January 2023. • Carriers are required to submit an access plan every year describing, among other things, "standards of accessibility expressed in terms of objectives and minimum levels below which corrective action will be taken," and "monitoring policies and procedures for compliance." • In late 2022, an amendment was added that requires carriers to submit the 988 Crisis Hotline Appointment Form D report to OIC reflecting the outcome of every referral for urgent, symptomatic BH care services the carrier received in the reporting period. The OIC chose to require the reports monthly.
Washington Medicaid managed care (AppleCare) Washington Health Care Authority (HCA)	• The HCA aligned WT standards for managed care plans that contract with Medicaid when the state integrated MH and physical health financing and delivery through integrated managed care contracts in 2016. • Medicaid plans submit a quarterly Behavioral Health Capacity Report which describes how plans are monitoring appointment WTs and mitigating WTs exceeding standards. Providers report encounter data to plans, who then upload data to a web portal, which HCA then links to corresponding claims to capture the WT from the date of a request to the service date. • HCA is developing a dashboard that will support more detailed and automated analysis; the health plans are also near completion of an HCA-directed collaboration to develop a standard survey instrument to collect data from providers.

SOURCE: RTI review of state regulations, websites, and interviews with key informants.

APPENDIX B: WAIT TIME STANDARDS

Exhibit B-1: Massachusetts CBHI: WT Standards		
CBHI Service	**Service**	**Standard**
Family Support and Training (FST)	Telephone the parent/caregiver to offer a face-to-face interview.	Within 5 calendar days of referral.
Family Support and Training (masspartnership.com) [1]	Initiate FST services.	Within 14 days of contact with the family.
In-Home Behavioral Services (IHB) [2]	Telephone the parent/caregiver and offer a face-to-face interview.	Within 5 calendar days of referral, including self-referral.
	Initiate IHB services.	Within 14 days of the time the family was contacted.
	Maintain a waitlist.	If unable to initiate services within 5 calendar days.
In-Home Therapy Services [3]	Availability to take referrals.	24 hours a day, 7 days a week, 365 days a year.
	Contact family and offer a face-to-face interview time within the next 24 hours for at least 75% of the clients.	Within 1 calendar day of referral.
	Visit within 24 hours of the referral.	If referral from inpatient unit/community-based acute treatment/crisis stabilization.
	Complete initial assessment.	Within 7 calendar days of meeting.
Targeted Case Management Services Intensive Care Coordination (ICC) [4]	Availability of ICC provider and staff to assist with access to emergency/mobile crisis services.	24 hours a day, 365 days a year.
	Telephone the family and offer a face-to-face interview.	Within 24 hours of referral, including self-referral.
	Date of face-to-face interview offered, from date of offer.	Within 3 calendar days for at least 50% of clients, 10 days for 75% of clients, and no more than 14 days for 100% of the clients.
Therapeutic Mentoring Services [5]	Telephone caregiver to offer a face-to-face interview.	Within 5 calendar days of referral.
	Initiate services.	Within 14 days from the time the family is contacted.
	Maintain a waitlist.	If unable to initiate services within 5 calendar days.
Intensive Hospital Diversion Program [6]	Initiate therapy.	Within 24 hours of intake.

NOTES:

1. Commonwealth of Massachusetts, Executive Office of Health and Human Services. *Performance Specifications: Children's Behavioral Health Initiative In-Home Behavioral Services. Effective November 1, 2019, January 1, 2022; Updated December 2020, November 1, 2021*. 2021. https://www.masspartnership.com/pdf/PerfSpec-IHBS.pdf.
2. Commonwealth of Massachusetts. *Performance Specifications Children's Behavioral Health Initiative. In-Home Therapy Services*. n.d. [cited 2023]. https://www.masspartnership.com/pdf/PerfSpec-IHT.pdf.
3. Commonwealth of Massachusetts. *Performance Specifications Children's Behavioral Health Initiative Targeted Case Management Services. Intensive Care Coordination*. n.d. [cited 2023]. https://www.masspartnership.com/pdf/PerfSpec-ICC.pdf.
4. Commonwealth of Massachusetts. *Performance Specifications Children's Behavioral Health Initiative Therapeutic Mentoring Services*. n.d. [cited 2023]. https://www.masspartnership.com/pdf/PerfSpec-TM.pdf.
5. Commonwealth of Massachusetts. *Performance Specifications Children's Behavioral Health Initiative Intensive Hospital Diversion Program*. n.d. [cited 2023]. https://www.masspartnership.com/pdf/PerfSpec-IHD.pdf.
6. Winograd, R.P., et al. *Implementation and evaluation of Missouri's Medication First treatment approach for opioid use disorder in publicly-funded substance use treatment programs*. ***J Subst Abuse Treat***, 2020, 108: p.55-64.

Exhibit B-2: WT Standards for BH Care in State Insurance Markets		
State	**Service**	**Standard**
Arizona [1]	**Medicaid Managed Care:**	**Medicaid Managed Care:**
	Urgent need	Within 24 hours
	Initial assessment	Within 7 days of referral or request
	Non-urgent care	No later than 45 days, sooner if required by condition
California [2]	**Health Insurance Policies:**	**Health Insurance Policies:**
	Non-urgent appointments with a non-physician	Within 10 business days
Colorado [2]	**Health Benefit Plans:**	**Health Benefit Plans:**
	Emergency care (BH/SU)	24/7 (100% of the time)
	Urgent care (BH/SU)	Within 24 hours (100% of time)
	MH/SUD (routine)	Within 7 calendar days (90% of time)
Florida [1,3]	**Medicaid Managed Care:**	**Medicaid Managed Care:**
	Urgent care	48 hours
	Urgent care for services requiring PA	96 hours
	Post-discharge follow-up	7 days
	Initial assessment	14 calendar days
	Qualified Health Plans:	**Qualified Health Plans:**
	Urgent	24 hours
Georgia [3]	**Managed Care Organizations:**	**Managed Care Organizations:**
	Does not specify levels of service	14 calendar days
Kansas [4]	**Managed Care Organizations:**	**Managed Care Organizations:**
	Urgent SUD services	24 hours from request for services
	Urgent general MH services	72 hours from request for services
	Non-urgent SUD services	14 calendar days from request for assessment
	Non-urgent general MH services	14 business days from request for services
Maine [2]	**Health Maintenance Organizations (HMO), Managed Care Plans, and Health Plans:**	**Health Maintenance Organizations, Managed Care Plans, and Health Plans:**
	Non-life-threatening emergencies	Within 6 hours
	Urgent care	Within 48 hours
	Routine office visit	Within 10 business days
Maryland [5]	**Health Benefit Plans, including Qualified Health Plans:**	**Health Benefit Plans, including Qualified Health Plans:**
	Non-urgent	10 calendar days (90% of time)
	Inpatient urgent	72 hours (90% of time)
Massachusetts [1]	**Medicaid Managed Care:**	**Medicaid Managed Care:**
	Emergency services	Access 24/7
	Urgent care	48 hours
	Other BH services	14 days
	Post-discharge follow-up for outpatient services	Within 7 days and medication management within 14 days

Exhibit B-2 (*continued*)		
State	**Service**	**Standard**
Missouri [1,2]	**Health Maintenance Organizations offering Managed Care Plans:**	**Health Maintenance Organizations offering Managed Care Plans:**
	Licensed therapist	24/7 telephone access
	Medicaid Managed Care:	**Medicaid Managed Care:**
	Non-symptomatic routine care	30 days
	Non-urgent symptomatic care	Lessor of 1 week or 5 business days
	Urgent care services	24 hours
	Emergency services	24/7
North Carolina [1]	**Managed Care Organizations:**	**Managed Care Organizations:**
	After-hours access	24/7
	Community/mobile crisis services	30 minutes
	Urgent care	24 hours
	Routine care	14 days
New Hampshire [2]	**Medicaid Managed Care:**	**Medicaid Managed Care:**
	Initial/evaluation visit	10 business days
	Urgent care	48 hours
	Emergency, non-life-threatening	6 hours
New Mexico [3]	**Managed Care Organizations and Qualified Health Plans:**	**Managed Care Organizations and Qualified Health Plans:**
	Urgent crisis services	2 hours
	Urgent outpatient	24 hours
	Non-urgent	14 calendar days from request
Pennsylvania [3]	**Managed Care Organizations:**	**Managed Care Organizations:**
	Urgent	24 hours
	Routine requests and specialty referrals	7 days from request
Texas [2]	**Health Maintenance Organizations:**	**Health Maintenance Organizations:**
	Emergency care, general, special, and psychiatric hospital care	24 hours per day, 7 days per week within the HMO's service area
	Urgent care	Within 24 hours
	Routine BH conditions	Within 2 weeks
	Preferred Provider Organizations:	**Preferred Provider Organizations:**
	Urgent care	Within 24 hours within designated health service area
	Routine care BH conditions	Within 2 weeks

Exhibit B-2 (*continued*)		
State	**Service**	**Standard**
Washington [1,3]	**Managed Care Organizations:**	**Managed Care Organizations:**
	Urgent, symptomatic	24 hours
	Non-urgent symptomatic	10 calendar days
	Medicaid Managed Care:	**Medicaid Managed Care:**
	Non-symptomatic routine care	30 days
	Non-urgent symptomatic care	10 days
	Urgent care	24 hours
	Emergency services	24/7
	Commercial Health Plans:	**Commercial Health Plans:**
	Urgent care	24 hours
West Virginia [6]	**Managed Care Organizations:**	**Managed Care Organizations:**
	Routine	Within 21 days
	Urgent	Within 48 hours "of request"
	Emergency	24/7

NOTES:

1. Horner, L., J. Kim, M. Dormond, K. Hardy, J. Libersky, D.J. Lipson, M. Hossain, & A. Lechner. *Promoting Access in Medicaid and CHIP Managed Care: Behavioral Health Provider Network Adequacy Toolkit*. 2021.
2. Weber, E. Spotlight on Network Adequacy Standards for Substance Use Disorder and Mental Health Services. 2020. https://www.lac.org/.
3. Corlette, S., A. Schneider, M. Kona, A. Corcoran, R. Schwab, & M. Houston. *Access to Services in Medicaid and the Marketplaces: Comparing Network Adequacy Rules*. Washington, DC: Georgetown University, 2022.
4. Kansas Department of Health and Environment. *Kansas Medicaid Managed Care Request for Proposal for Kancare 2.0, Behavioral Health Provider Network Standards*. n.d., BID Event Number: EVT0005464.
5. Code of Maryland Regulations. *Network Adequacy Regulations for Health Benefit Plans*. 2023, COMAR 31.10.44.
6. West Virginia Department of Health and Human Services. *State of West Virginia Fiscal Year 2020 Model Purchase of Service Provider Agreement*. 2020.

APPENDIX C: WAIT TIME MEASUREMENT AND REPORTING

Exhibit C-1: WT Measures for BH Services in Peer-Reviewed Literature				
Author	**Patient Population**	**Types of Visits/ Setting**	**Start points (from)**	**End points (to)**
Health Care Claims Data				
Winograd, 2020 [1]	Patients with OUD	14 treatment programs	First billable service in SUD treatment program	First billable medication prescription
Electronic Health Records				
Koire, 2022 [2]	Peripartum women with depression	Psychiatry	Initial screening	Date "seen" (actual visit completed)
Roy, 2020 [3]	Patients scheduled for an assessment for MAT initiation	Addiction clinic	Date the patient schedules an outpatient clinic appointment	Date of service
Roy, 2021 [4]	Hospitalized patients with OUD evaluated for initiating MOUD	Inpatient addiction consult service	Date of hospital discharge	Date of follow-up appointment to initiate MOUD
Secret Shopper Surveys				
Morain, 2022 [5]	Women with perinatal mood and anxiety disorders	Reproductive psychiatry	Date the secret shopper contacted receptionist	Date of earliest appointment available
Flavin, 2020 [6]	Patients 18 and older with OUD	Buprenorphine treatment	Date shopper reaches the provider by phone	Date of initial available appointment
Joudrey, 2021 [7]	New patients seeking methadone treatment	Methadone treatment	Date the secret shopper contacted the clinic	"Next available appointment" to initiate methadone
Kelley, 2022 [8]	American Indian and White pregnant women with OUD	Buprenorphine prescribers	Date the secret shopper spoke with receptionist	Date of first appointment "offered"
Patrick, 2020 [9]	Pregnant women and non-pregnant women	Outpatient clinics providing methadone and buprenorphine	Date the secret shopper reached the outpatient clinic	“Initial appointment" for buprenorphine and methadone
Other Data Sources (Missouri SUD billing records; client-level diagnosis data; Treatment Episode Data Set; and Missouri Medicaid claims data)				
Ford, 2022 [10]	Patients with co-occurring disorders	Medication encounters	Date of admission	Date of client’s first medication encounter
Kong, 2022 [11]	Patients with OUD, 18 years or older	Publicly funded SUD treatment facilities	Date patient reported opioids as their primary drug use problem	Date of treatment initiation
Kovach, 2021 [12]	Patients admitting to SUD treatment program	Intensive outpatient SUD treatment program	Date of intake assessment	Date of admission to the intensive outpatient program
Nam, 2022 [13]	Patients with MH or SUD, 18 years or older	Emergency department visits	Arrival in the emergency department	Time seen by a physician
Nelson, 2022 [14]	Veterans with SMI	SMI visits	Date the appointment was scheduled	Date visit occurred
Vaughn, 2022 [15]	New patients	287 BH treatment facilities	Date the appointment was scheduled	Date visit occurred

Exhibit C-1 (*continued*)

NOTES:

1. Winograd, R.P., et al. *Implementation and evaluation of Missouri's Medication First treatment approach for opioid use disorder in publicly-funded substance use treatment programs*. ***J Subst Abuse Treat***, 2020, 108: p.55-64.
2. Koire, A., et al. *Longer wait time after identification of peripartum depression symptoms is associated with increased symptom burden at psychiatric assessment*. ***J Psychiatr Res***, 2022, 152: p.360-365.
3. Roy, P.J., et al. *Appointment wait-times and arrival for patients at a low-barrier access addiction clinic*. ***J Subst Abuse Treat***, 2020, 114: p.108011.
4. Roy, P.J., et al. *Shorter outpatient wait-times for buprenorphine are associated with linkage to care post-hospital discharge*. ***Drug Alcohol Depend***, 2021, 224: p.108703.
5. Morain, S.R., L.R. Fowler, & J.W. Boyd. *A pregnant pause: System-level barriers to perinatal mental health care*. ***Health Promot Pract***, 2022, p.15248399221101373.
6. Flavin, L., et al. *Availability of buprenorphine treatment in the 10 states with the highest drug overdose death rates in the United States*. ***J Psychiatr Pract***, 2020, 26(1): p.17-22.
7. Joudrey, P.J., et al. *Methadone access for opioid use disorder during the COVID-19 pandemic within the United States and Canada*. ***JAMA Netw Open***, 2021, 4(7): p.e2118223.
8. Kelley, A.T., et al. *Treatment access for opioid use disorder in pregnancy among rural and American Indian communities*. ***J Subst Abuse Treat***, 2022, 136: p.108685.
9. Patrick, S.W., et al. *Association of pregnancy and insurance status with treatment access for opioid use disorder*. ***JAMA Netw Open***, 2020, 3(8): p.e2013456.
10. Ford, J.H. 2nd, et al. *Wait no longer: Reducing medication wait-times for individuals with co-occurring disorders*. ***J Dual Diagn***, 2022, 18(2): p.101-110.
11. Kong, Y., et al. *Using machine learning to advance disparities research: Subgroup analyses of access to opioid treatment*. ***Health Serv Res***, 2022, 57(2): p.411-421.
12. Kovach, J.V., & M.N. Flores. *Streamlining admissions to outpatient substance use treatment using lean methods*. ***Journal of Substance Use***, 2020, 26(3): p.306-312.
13. Nam, E., E. Lee, & H. Kim. *10-year trends of emergency department visits, wait time, and length of stay among adults with mental health and substance use disorders in the United States*. ***Psychiatr Q***, 2021, 92(3): p.1159-1174.
14. Nelson, S.M., et al. *Access to timely mental health care treatment initiation among Veterans Health Administration patients with and without serious mental illness*. ***Psychol Serv***, 2022, 19(3): p.488-493.
15. Vaughn, S.X., et al. *Assessing public behavioral health services data: A mixed method analysis*. ***Subst Abuse Treat Prev Policy***, 2020, 15(1): p.85.

Exhibit C-2: Data Reporting Template for I-EVAL Performance Metric, SAMHSA 2023 Criteria for CCBHCs [1]

	A	B	C	D
1				
2	Time to Initial Evaluation (I-EVAL)			
3	A SAMHSA-Developed Metric			
4	**A. Measurement Year:**			
5	Insert measurement year based on CCBHC or non-CCBHC status. For CCBHCs, enter DY1 or DY2. For non-CCBHCs, enter year such as FY2017.			
6	**B. Data Source:**			
7	Select the data source type (Medical Records or Other):		If medical records data, select source (EHR, Paper Records, Both):	
8	If other data source selected, specify source:			
9	**C. Date Range:**			
10	Denominator Start Date (mm/dd/yyyy)			
11	Denominator End Date (mm/dd/yyyy)			
12	Numerator Start Date (mm/dd/yyyy)			
13	Numerator End Date (mm/dd/yyyy)			
14	**D. Performance Measure:**			
15	Metric 1. The percentage of new consumers with initial evaluation provided within 10 business days of first contact			
16	Metric 2. The mean number of days until initial evaluation for new consumers			
17	These metrics are stratified to report by age (12–17 years, 18 years and older) and are stratified to report by Medicaid, Medicare & Medicaid, other, and total population.			
18	**Metric #1: Percentage of New Clients with Initial Evaluation within 10 Business Days**			
19	**Measure**	**Numerator**	**Denominator**	**Rate**
20	**Age 12-17 years**	0	0	
21	**Medicaid**			
22	**Medicare & Medicaid**			
23	**Other**			
24	**Age 18+ years**	0	0	
25	**Medicaid**			
26	**Medicare & Medicaid**			
27	**Other**			
28	**Total (all Age Groups)**	0	0	
29	**Medicaid**	0	0	
30	**Medicare & Medicaid**	0	0	
31	**Other**	0	0	
32	**Metric #2: Mean Number of Days until Initial Evaluation**			
33	**Measure**	**Numerator**	**Denominator**	**Rate**
34	**Age 12-17 years**	0	0	
35	**Medicaid**			
36	**Medicare & Medicaid**			
37	**Other**			
38	**Age 18+ years**	0	0	

NOTE:

1. Substance Abuse and Mental Health Services Administration. *Demonstration 223 Templates OMB*. 2016.

Exhibit C-3: Telehealth Appointment WT Credit, Final Regulation Text, MIA [1]

08. Telehealth.

C. Appointment Waiting Time Credit.

(1) Subject to approval by the Commissioner as described in §C(3) of this regulation, when determining whether the carrier's provider panel meets the waiting time standards under Regulation .06E of this chapter for at least 90 percent of appointments in each category, a carrier may apply a telehealth credit of up to 10 [percent] percentage points for each appointment category where the standard is not met.

(2) A carrier seeking to apply the telehealth credit described in §C(1) of this regulation shall identify:

(a) Each appointment type to which the credit is being applied;

(b) The percentage of appointments for which the carrier met the waiting time standard before the credit was applied; and

(c) The percentage of appointments for which the carrier met the waiting time standard after the credit was applied.

(3) The Commissioner may approve the telehealth credit described in §C(1) of this regulation if a carrier sufficiently demonstrates, in accordance with the documentation requirements of §D of this regulation, that:

(a) The carrier provides coverage for and access to clinically appropriate telehealth services from participating providers for the appointment type to which the credit is being applied;

(b) The carrier provides coverage for a corresponding in-person service if the enrollee chooses not to elect utilization of a telehealth service; and

(c) The carrier establishes, maintains, and adheres to written policies and procedures to assist enrollees for whom a telehealth service is not clinically appropriate, not available, or not accessible with obtaining timely access to an in-person appointment within a reasonable travel distance with:

(i) A participating provider; or

(ii) A non-participating provider at no greater cost to the enrollee than if the service was obtained from a participating provider.

D. Required Documentation.

(1) A carrier seeking to apply the telehealth credit described in §B(1) or C(1) of the regulation shall submit the following documentation to demonstrate that it provides coverage for and access to clinically appropriate telehealth services as described in §§B(5) and C(3)(a) of this regulation:

(a) A description of any requirements imposed or incentives provided for participating providers to offer telehealth services;

(b) A detailed description of all telehealth services offered under the health benefit plans issued by the carrier in Maryland that use the provider panel including:

(i) Telehealth modalities covered;

(ii) Types of platforms through which participating providers may deliver telehealth;

(iii) Whether the carrier offers or provides services through a telehealth-only vendor or platform, and which types of services are provided on this basis;

(iv) Whether the carrier arranges for telehealth services to be available on a 24/7 basis, and which types of services are provided on this basis;

(v) Whether the carrier arranges for telehealth kiosks to be installed and maintained in convenient locations throughout Maryland; and

(vi) The specific services available through telehealth for each provider type and appointment type to which the telehealth credit is being applied;

Exhibit C-3 (*continued*)

(c) Evidence that telehealth is clinically appropriate and available for the services performed by each provider type and for each appointment type to which the telehealth credit is being applied, which may include:

(i) Actual telehealth utilization data comparing telehealth claims for the specific provider type or appointment type to telehealth claims for all provider types or appointment types;

(ii) Actual telehealth utilization data comparing telehealth claims for the specific provider type or appointment type to all claims for the same provider type or appointment type;

(iii) Survey results or attestations from participating providers indicating that telehealth is offered for the services performed by the specific provider type or for the specific appointment type;

(iv) Enrollee survey results indicating that enrollees have the willingness and ability to use telehealth services for the specific provider type or appointment type; and

(v) Other documentation that, in the discretion of the Commissioner, demonstrates the clinical appropriateness and availability of telehealth services for the provider type or appointment type to which the credit is being applied;

Note: In the Final Rule published May 5, 2023, Maryland changed the wording from "10 percent" to "10 percentage points." This change is reflected in brackets in the final regulation text for the reader's convenience.

NOTE:

1. Code of Maryland Regulations. *Network Adequacy Regulations for Health Benefit Plans*. 2023, COMAR 31.10.44.

APPENDIX D: ENVIRONMENTAL SCAN METHODOLOGY

Exhibit D-1: Key Search Terms for Environmental Scan	
BH WTs	**Medical Subject Heading Terms/Subject/Topic**
WT	BH
Appointment availability	MH
Provider availability	Substance use
Timely access	Addiction
Secret shopper	

Exhibit D-2: Inclusion and Exclusion Criteria for Environmental Scan	
Inclusion Criteria	**Exclusion Criteria**
Published between 2020-2022	Published prior to 2020
English	Non-English or published in another language
Published and population is ins United States only	Anything published outside of the United States or populations outside of the United States
United States only	Focuses only on network adequacy
All ages, including 18 and under/over	Not related to BH or focuses on other types of care (i.e., primary, oncology)
All populations, including special groups (e.g., pregnant and post-partum women)	Does not explicitly discuss WT calculation or standards
Discusses or examines standards for behavioral WTs	Discusses provider to patient ratio in geographic regions
Provides overview of how behavioral WTs are calculated	Focuses only on time/distance to provide and/or clinical setting and does not discuss WTs
Includes both the Medical Subject Headings term and BH WTs terms	Dissertations
Inclusion criteria	Examines access to prescriptions for MH/substance use only
	Calculates the percentage of providers that call back from the initial contact and does not include the WT calculation for scheduling the appointment

ACRONYMS

AAAHC	Accreditation Association for Ambulatory Health Care
ACA	Affordable Care Act
ASPE	HHS Office of the Assistant Secretary for Planning and Evaluation
BH	Behavioral Health
CBHI	Massachusetts Children's Behavioral Health Initiative
CCBHC	Certified Community Behavioral Health Clinic
CCBHC-E	CCBHC-Expansion
CCIIO	CMS Center for Consumer Information and Insurance Oversight
CMS	HHS Centers for Medicare & Medicaid Services
COVID-19	Novel Coronavirus
DOI	Colorado Division of Insurance
EHR	Electronic Health Record
FFE	Federally-Facilitated Exchange
FST	Massachusetts Family Support and Training
HCA	Health Care Authority
HHS	U.S. Department of Health and Human Services
HMO	Health Maintenance Organization
I-EVAL	Time to Initial Evaluation
ICC	Intensive Care Coordination
IHB	In-Home Behavioral Services
KDADS	Kansas Department for Aging and Disability Services
KDHE	Kansas Department of Health and Environment
MA	Medicare Advantage
MAT	Medication Assisted Treatment
MH	Mental Health
MHPAEA	Mental Health Parity and Addiction Equity Act
MIA	Maryland Insurance Administration
MOUD	Medications for Opioid Use Disorder
NCQA	National Committee for Quality Assurance
OIC	Washington Office of the Insurance Commissioner
OUD	Opioid Use Disorder
QHP	Qualified Health Plan
RTI	RTI International

SME	Subject Matter Expert
SMI	Serious Mental Illness
SUD	Substance Use Disorder
TNAA	Third Next Appointment Available
TX-EVAL	Time to Comprehensive Person and Family-Centered Diagnostic & Treatment Planning Evaluation
URAC	Utilization Review Accreditation Commission
VA	U.S. Department of Veterans Affairs
WT	Wait Time

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