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AMA telehealth issue brief: Network adequacy

Background and considerations

Network adequacy refers to a health plan's ability to provide access to sufficient in-network physicians and other clinicians in order to meet patient care needs. Establishing network adequacy standards is an important regulatory tool that federal and state governments use to ensure health plans contract with an appropriately sized and distributed physician population.

As the use of telehealth services has increased, state and federal lawmakers and regulators are evaluating if and how the availability of telehealth services and telehealth-only physicians should contribute to the adequacy of a health plan's network.

The most common measures of network adequacy are "time and distance standards," which outline the maximum lengths of time and distance a patient should have to travel in order to see an in-network physician (e.g., a patient in an urban center seeking a primary care appointment should have to travel no more than 15 minutes or 15 miles). However, alternative network adequacy models are emerging that attempt to more accurately reflect the experience of a patient seeking in-person services (e.g., states requiring that plans use secret shopper surveys[1] to evaluate provider availability and service offerings, or leveraging "time to next appointment"[2] measures to ensure appointment availability). In April, the Centers for Medicare & Medicaid Services (CMS) published a Notice Of Proposed Rulemaking (NPRM) for Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality, which aligns with these newer models; the NPRM outlines a multiyear approach to strengthening timely and equitable access to providers and services, including secret shopper surveys, maximum appointment wait time standards, and new enforcement mechanisms and policies to promote transparency.

Regulation and oversight of network adequacy standards vary by insurance type. Medicare Advantage plans are regulated by the federal government. Medicaid managed care plans must follow federal standards and are also subject to state laws and regulations. Commercial insurance plans offered in individual and small group markets are regulated by the states, however, federal minimums may apply, particularly in states that rely on the Federally Facilitated Marketplace (FFM), rather than a state-based marketplace. Finally, self-insured plans are exempt from most state insurance laws, but must comply with a limited set of federal laws and regulations.

The recent increase in telehealth use has sparked discussion amongst policymakers on whether telehealth services and telehealth providers should be counted toward network adequacy standards. On the one hand, telehealth can increase access to care. On the other hand, allowing telehealth and telehealth-only providers to count toward network adequacy standards may result in fewer in-person physicians in a network and thus limit patient access to in-person care.

1. A "secret shopper" survey describes when a regulatory agency conducts primary research of a plan's network (e.g., presenting as a patient seeking an appointment and evaluating the time to next appointment).
2. "Time to next appointment" measures outline a maximum amount of time that a plan must have an in-network and applicable provider able to see a patient.

Federal landscape

The federal government continues to evolve its approach to regulating telehealth and network adequacy. In Medicare, since 2020, CMS has allowed Medicare Advantage plans to use telehealth providers in a defined set of specialties to account for a 10% credit toward meeting network adequacy time and distance requirements.[3] Most recently, CMS' April 2023 Medicaid managed care NPRM proposes that appointments via telehealth be counted toward network adequacy calculations only if the provider also offers in-person appointments, noting that "States need to balance the use of telehealth with the availability of providers that can provide in-person care and enrollees' preferences for receiving care."[4]

State landscape

At the state level, legislation or regulation generally disallows health plans from using telehealth to count toward network adequacy standards:

- For both Medicaid managed care and commercial plans, Maine prohibits plans from using telehealth to demonstrate network adequacy and Arizona prohibits telehealth providers from counting toward network adequacy standards, unless those providers also offer in-person services in-state or within 50 miles of the state's border. Massachusetts notes that plans are barred from meeting network adequacy standards through "significant reliance[5] on telehealth providers and shall not be considered to have an adequate network if patients are not able to access appropriate in-person services in a timely manner upon request." Minnesota and New Hampshire only permit consideration of telehealth service availability in a request to waive network adequacy standards based on the unavailability of providers of in-person services.
- Although final policy is still under development, California has approached the matter differently, proposing that Medicaid managed care plans be allowed to use "clinically appropriate video" telehealth to demonstrate compliance with time or distance standards.
- For commercial plans, Oregon prohibits plans from using telehealth to demonstrate network adequacy in their networks. West Virginia is less restrictive; instead of prohibiting plans from using telehealth to meet network adequacy standards, the state requires plans to submit access reports that include how plans intend to use telemedicine or telehealth, as applicable, to meet network adequacy access standards.

AMA perspective

The American Medical Association affirms that in-network physicians who provide both in-person and telehealth services may count toward health plan network adequacy requirements on a limited basis when their physical practice does not meet time and distance standards, based on regulator discretion, such as when there is a shortage of physicians in the needed specialty or subspecialty within the community served by the health plan. The AMA does not support counting physicians who only offer telehealth services toward network adequacy requirements.

See AMA's Managed Care Legal Database, which includes information on state network adequacy laws.

3. 42 CFR 422.116(d)(5)
4. CMS Notice of Proposed Rulemaking (NPRM) for Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality. Accessed on Nov. 28, 2023.
5. As of May 2023, the Department does not appear to define "significant reliance." June 2021 comments from the Massachusetts Medical Society indicate that the Department of Insurance had not defined the term.