REPORT 3 OF THE COUNCIL ON MEDICAL SERVICE (I-23)
Strengthening Network Adequacy
(Reference Committee J)

EXECUTIVE SUMMARY

Almost a decade after presenting Council on Medical Service Report 4-A-14, the Council self-initiated this report to strengthen and supplant existing American Medical Association (AMA) policy on the adequacy of health plan networks and the accuracy of provider directories. Although network adequacy must be monitored across all types of health plans, the use of limited networks has become increasingly common in Medicare Advantage, Medicaid managed care, and Affordable Care Act marketplace plans. This report provides an overview of federal and state network adequacy requirements and oversight; addresses the role of telehealth in network adequacy; describes efforts to use network adequacy requirements to improve health equity; summarizes AMA policy and advocacy; and presents policy recommendations.

Network adequacy refers to a health plan's ability to provide access to in-network physicians and hospitals to meet enrollees' health care needs. While acknowledging the challenges involved to ensuring network adequacy without adding substantially to the cost of insurance, the Council believes that regulators should take a multilayered approach that includes meaningful standards, transparency of network breadth and in-network physicians and hospitals, parameters around out-of-network care, and effective monitoring and enforcement. Among the large number of AMA policies addressing network adequacy, out-of-network care, and provider directory accuracy, four are recommended for reaffirmation: Policies H-285.908, H-285.904, H-285.902, and H-285.911, which are appended to this report.

Seven recommendations for new AMA policy ask our AMA to encourage and/or support: 1) a minimum federal network adequacy standard; 2) the use of multiple criteria to evaluate the sufficiency of provider networks; 3) the development and promulgation of assessment tools that allow consumers to compare insurance plans; 4) requirements for reporting to regulators and prominently displaying important network adequacy information, including the breadth of a plan's network and instructions for filing complaints; 5) the use of claims data, audits, secret shopper programs, and complaints to monitor network adequacy, and appointment wait times; 6) counting in-network physicians who provide both in-person and telehealth services towards network adequacy requirements on a very limited bases when their physical practice does not meet time and distance standards (while affirming the AMA does not support counting telehealth-only physicians towards network adequacy requirements); and 7) regulation to hold health plans accountable for network inadequacies, including through the use of corrective action plans and substantial financial penalties.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 3-I-23

Subject: Strengthening Network Adequacy

Presented by: Sheila Rege, MD, Chair

Referred to: Reference Committee J

During the development of Council on Medical Service Report 6-A-23, Health Care Marketplace Plan Selection, the Council identified provider network adequacy as a key factor in maintaining healthy competition and choice in Affordable Care Act (ACA) marketplace plans. In that report, the Council highlighted concerns about the ability of patients to see certain physicians who are listed in provider directories as in-network but for whom access is limited because they are not accepting new patients or do not have timely appointments available. Because similar critiques have plagued other types of plans—most notably Medicare Advantage (MA) and Medicaid managed care organization (MCO) plans—the Council developed this self-initiated report on strengthening network adequacy, which provides overviews of federal and state network adequacy requirements, summarizes AMA policy and advocacy, and presents policy recommendations.

BACKGROUND

Access to physicians, hospitals, and other health care providers to obtain evidence-based, high-quality health care depends on a range of factors, including the breadth, size, and distribution of a plan's provider network. Health insurers manage the quantity and quality of providers and facilities in their networks and may limit the number of those in-network, or contract with less expensive providers and facilities, to manage utilization and contain costs. Although network adequacy should be monitored across all health plans, the use of narrow networks has become increasingly common in MA, Medicaid, and ACA marketplace plans as insurers compete for customers by offering lower-cost plans with limited networks.

According to a recent Kaiser Family Foundation survey, more than a quarter (26 percent) of insured adults reported that an in-network physician they wanted to see in the last year did not have appointments available and 14 percent of respondents said their insurance did not cover a particular physician or hospital they needed.[1] Additionally, nearly a quarter (23 percent) of survey respondents indicated that it was at least somewhat difficult to understand where to find out which physicians and hospitals are covered in their plan's network.[2] Provider directory inaccuracies also remain problematic for patients and physicians as some plans' networks may appear more robust by including physicians who are not in-network or who are unavailable or unwilling to provide services. While directory inaccuracies and network inadequacy are two different problems, directory inaccuracy may complicate efforts to address network inadequacy and is often considered along with network adequacy efforts.

Network adequacy generally refers to a health plan's ability to provide access to in-network physicians, other clinicians, and facilities to meet enrollees' health care needs. Establishing network adequacy standards is an important regulatory tool used to ensure that health plans

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contract with an appropriately sized and distributed provider population. Federal and state qualitative standards generally require health plans to attest that networks include sufficient physicians and facilities to enable enrollees to access care within reasonable distances and timeframes. Notably, no national standard exists for network adequacy or network size, or what constitutes a sufficient network, and standards—and their enforcement—can vary significantly across states and plan types. The most common measures are time and distance standards outlining the maximum length of time and distance a patient should have to travel in order to see an in-network physician. Alternative network adequacy measures attempting to more accurately reflect the experience of a patient seeking in-network services include requirements that plans use secret shopper surveys to evaluate provider availability or employ maximum appointment wait times to ensure that appointments are available in a timely manner. Although midlevel providers may be in a provider network if permitted under state law, health plans must meet network adequacy requirements for physicians and measurement should be limited to physicians for physician services.

As described in the following sections, regulation and oversight of network adequacy vary by insurance type. Although MA plans are federally regulated, states are primarily responsible for regulating commercial plans offered in individual and small group markets; federal minimum requirements may apply, including in states relying on the federally facilitated marketplace rather than a state-based marketplace. States also regulate network adequacy in Medicaid in accordance with federal standards and generally have broad discretion to oversee Medicaid MCOs. Self-insured plans are exempt from most state insurance laws but must comply with a limited set of federal regulations.

The AMA maintains that although state regulators should have flexibility to regulate health plan provider networks, minimum federal standards are also needed, especially in light of inaction in many states to update and/or enforce network adequacy requirements. A state's network adequacy standards affect patients' access to care and also health insurance markets, and regulators overseeing insurer networks must try to balance access to care concerns and premium costs without interfering in local market dynamics.[3,4]

Medicare Advantage (Part C) Plans

Although traditional Medicare generally allows seniors to visit any physician or hospital that accepts Medicare patients, access for MA (Part C) beneficiaries is limited to physicians and hospitals within a plan's network. A 2017 analysis found that one in three MA enrollees were in a narrow physician network, defined as participation of less than 30 percent of physicians in the county, with access most restricted for psychiatrists.[5] A 2023 study found that almost two-thirds of psychiatrist networks in MA plans were narrow in 2019, and significantly narrower than in Medicaid MCO and marketplace plans. Further, more than half of the counties that had data available had no MA network psychiatrists.[6] Inadequate MA networks across all specialty and facility types are concerning since more than 30 million people were enrolled in MA plans this year, representing half of the total Medicare population.[7]

Network Adequacy Requirements: While it is accepted practice for MA plans to establish provider networks, federal regulations require these plans to demonstrate that a network is sufficient to provide access to covered services.[8] If patients need services that are not available within the plan's network, the Centers for Medicare & Medicaid Services (CMS) requires plans to arrange for patients to obtain services outside of the plan's network at in-network cost-sharing.

MA network adequacy criteria include 29 provider specialty types and 13 facility types that must be available to enrollees consistent with federal minimum number, time, and distance standards. MA network adequacy is assessed at the county level, and standards vary by county type (large metro, metro, micro, rural or counties with extreme access issues) based on population and density thresholds. Minimum physician and other health provider ratios, or the number of providers required per 1,000 enrollees, are determined annually for each specialty type based on Medicare utilization patterns.[9] In large metro and metro counties, for example, plans must contract with at least 1.67 primary care physicians per 1,000 enrollees and 1.42 primary care physicians per 1,000 enrollees in all other counties.[10] Beginning in 2024, plans must include an adequate supply of clinical psychologists, licensed clinical social workers, and prescribers of medication for opioid use disorder in their networks subject to time, distance, and minimum provider standards.

Maximum time (in minutes) and distance (in miles) standards require MA plans to ensure that at least 85 percent of enrollees in micro, rural, or counties with extreme access issues, and 90 percent of enrollees in large metro, metro, and micro counties, have access to at least one provider/facility of each specialty type within the published time and distance standards. Maximum time and distance standards (Table 1) and minimum provider ratios (Table 2) can be found in the Code of Federal Regulations, Title 42, Chapter IV, Subpart B, Part 422, Subpart C § 422.116.[11]

AMA Advocacy: The AMA has consistently advocated that CMS adopt a suite of policy proposals to enhance network adequacy, provider directory accuracy, network stability, and communication with patients about MA plans' physician networks. In recent communications with CMS, the AMA has urged the agency to:

- Require plans to report the percentage of physicians in the network, broken down by specialty and subspecialty, who actually provided services to plan members during the prior year;
- Publish the research supporting the adequacy of minimum provider ratios and maximum time and distance standards;
- Measure the stability of networks by calculating the percentage change in the physicians in each specialty in an MA plan's network compared to the previous year and over several years;
- Ban no-cause terminations of MA network physicians during the initial term or any subsequent renewal term of a physician's participation contract within an MA plan; and
- Update the Health Plan Consumer Assessment of Healthcare Providers & Systems (CAHPS) survey to include questions assessing patients' actual access to care, including whether they are able to find in-network physicians accepting new patients and maintain utilization of physicians who have longitudinally provided them treatment; the distance needed to travel to obtain care; the average time to get an appointment; and the ability to obtain care at an in-network hospital where the patient's physician has staffing privileges.

The AMA has also recommended that CMS create a network adequacy task force that would allow CMS to engage with patients, physicians (including those in-network), and other stakeholders to review and strengthen MA network adequacy policies. Finally, the AMA has recommended that CMS adopt several policy changes to improve communications with consumers about MA plans so that people shopping for plans can more easily discern differences among provider networks and understand what they are purchasing.

Medicaid Managed Care Plans

Medicaid MCOs, which manage the care of more than 70 percent of Medicaid patients,[12] have also faced ongoing criticisms regarding network adequacy and true access to care. For example, a recent

Health Affairs study found that care was highly concentrated in Medicaid managed care networks, with a small number of primary care and specialty physicians providing most of the care to enrollees in the four states that were studied. The authors concluded that current network adequacy standards might not reflect actual access and that new methods are needed to account for physicians' willingness to serve Medicaid patients.[13] Additionally, a meta-analysis of 34 audit studies showed that Medicaid is associated with a 1.6-fold lower likelihood in successfully scheduling a primary care appointment and a 3.3-fold lower likelihood in successfully scheduling a specialty appointment when compared with private plans.[14] As the AMA has consistently noted in communications to CMS, access to primary and specialty care is a perennial issue faced by Medicaid enrollees which can be especially problematic in rural and underserved areas.

Network Adequacy Requirements: Network adequacy standards for Medicaid MCOs differ by state, but must meet standards set forth in federal regulations specifying that state Medicaid agencies must develop and publish a quantitative network adequacy standard for different provider types (adult and pediatric), including primary care, OB/GYN, mental health and substance use disorder (SUD), specialists as designated by the state, hospital, and pharmacy. In developing network adequacy standards, states are supposed to consider numerous elements related to network adequacy, including anticipated Medicaid enrollment; the expected utilization of services; characteristics and health care needs of specific Medicaid populations; the numbers and types of network providers required to furnish the contracted Medicaid services; numbers of network providers who are not accepting new Medicaid patients; and the geographic location of network providers and Medicaid enrollees, considering distance, travel time, and the means of transportation ordinarily used by Medicaid patients.[15]

Most states have time and distance standards in place along with a range of other network adequacy requirements that vary by state. In recent rulemaking for Medicaid and Children's Health Insurance Program managed care plans, CMS proposed requiring states to implement maximum appointment wait times for primary care (15 business days), outpatient mental health/SUD (10 days), and OB/GYN care (15 days); use secret shopper surveys to evaluate whether wait times and provider directory requirements are being met; conduct payment analyses that compare Medicaid MCO payment rates for certain services as a percentage of Medicare rates; implement a remedy plan for any MCO that has an access issue; and enhance existing state website requirements for content and ease of use.

Federal regulations currently require state Medicaid agencies to monitor MCO compliance with network adequacy standards, including through an annual validation of the adequacy of each network (by the external quality review organization engaged by the state agency) and annual submission of documentation of the adequacy of its MCO networks to CMS. CMS does not require minimum provider ratios for Medicaid managed care plans, as it does for MA plans, although some states have established such ratios that apply to Medicaid plans.

AMA Advocacy: The AMA has advocated for strong network adequacy standards at the federal level, and in states, at the request of state medical associations. Among other things, the AMA has advocated for active approval of networks prior to insurance products going to market; state enforcement of network adequacy requirements; transparency of network standards; and the use of quantitative standards, including time and distance standards, minimum provider-to-enrollee ratios, wait time maximums, and access to alternative office hour (e.g., evening and weekend) requirements. The AMA has also encouraged CMS to require that time and distance standards incorporate travel on public transportation to access services and has noted that additional quantitative and qualitative standards would help enable regulators to also assess the adequacy of a network and whether there is sufficient diversity among providers to meet the needs and

preferences of enrollees. The AMA has encouraged CMS to closely monitor state implementation of network adequacy standards and consider federal minimum requirements in the future.

ACA Marketplace Plans

CMS has previously acknowledged the proliferation of narrow networks among exchange plans, and the U.S. Government Accountability Office (GAO) has cited several studies demonstrating varying degrees of challenges facing enrollees attempting to access in-network providers, most commonly mental health specialists.[16] While marketplace plans with restricted networks may be popular with some consumers because their premium prices are lower, purchasers of these plans may not be aware that the provider network is narrow and that they may have trouble getting needed care from in-network physicians, hospitals, and other providers.

Network Adequacy Requirements: The ACA requires that health plans certified as Qualified Health Plans (QHPs) in ACA marketplaces maintain provider networks that are sufficient in number and types of providers to assure that all services, including mental health and SUD services, are accessible to enrollees without unreasonable delay.[17] Provider networks of marketplace plans also must include "essential community providers" (ECPs) to serve predominately lower-income and medically underserved individuals. Additionally, QHPs participating in the federally facilitated exchange must comply with time and distance standards and, beginning in 2025, they must meet maximum appointment wait time standards.[18]

Similar to MA network adequacy regulations, time and distance standards for plans on the federally-facilitated exchange are based on county type and are outlined for provider and facility types in Tables 3.1 and 3.2, on pages 12-14, of CMS' guidance for plan year 2023.[19] The AMA has supported the time and distance standards, suggested additional provider types, and further urged CMS to separate outpatient clinical behavioral health into outpatient clinical mental health and outpatient treatment for SUD to ensure patient access to appropriate providers. For plan year 2023, CMS also proposed assessing network adequacy using appointment wait time standards (15 days for routine primary care; 30 days for specialty care; and 10 days for behavioral health at least 90 percent of the time), although implementation of this requirement has been delayed until 2025.[20]

QHPs participating in the federally facilitated marketplace had in earlier years been required to submit provider networks to CMS for review; however, 2018 rulemaking by CMS ended this practice, effectively deferring most oversight to states, accreditation bodies, and the issuers themselves. After a federal court ruled against this change, CMS resumed its reviews and currently oversees the network adequacy of QHPs on the federally facilitated marketplace through annual certification and compliance reviews, targeted reviews stemming from complaints, and provider directory reviews.[21]

In 2016, CMS began implementing a network breadth pilot for QHPs in four states (Maine, Ohio, Tennessee, and Texas) intended to help CMS understand how consumers use network breadth information in making plan choices. During open enrollment, consumers in the four states see information classifying the relative breadth of the plans' provider networks, as compared to other exchange plans in the county, for adult primary care providers, pediatricians, and hospitals. Network breadth is classified as either "basic" (less than 30 percent of available providers), "standard" (between 30 and 70 percent of providers), or "broad" (70 percent or more of providers).[22] Data from this pilot would be useful to policymakers and regulators across all plan types; however, it had not yet been made publicly available at the time this report was written.

AMA Advocacy: Although CMS stated earlier this year that additional time was needed to develop guidance for appointment wait time standards, the AMA has strongly supported wait time requirements and urged CMS to implement them as soon as possible. The AMA maintains that maximum wait time standards are critical because they address access problems related to in-network physicians and other clinicians who are not accepting new patients or do not have appointments available in the timeframe needed. Importantly, the AMA has also urged CMS to consider additional tools to measure sufficiency of networks that move beyond insurer attestation including audits, secret shopper programs, and patient interviews and surveys.

The AMA also strongly supported CMS rulemaking for plan year 2024 that added two new ECP categories—mental health facilities and SUD treatment centers—so that all communities, including those that are lower income or medically underserved, have affordable, convenient, and timely access to mental health and SUD treatment. The AMA further urged CMS to consider additional ways to expand access to mental health and SUD services in underserved communities, including through network adequacy and mental health and SUD parity enforcement. The AMA also supported rulemaking by CMS for 2024 and beyond to extend the 35 percent provider participation threshold to two major ECP categories: Federally Qualified Health Centers and family planning providers. These changes will increase provider choice and access to care for low-income and medically underserved consumers, and with regard to family planning providers, are especially important in states that have banned abortion services.

Finally, the AMA has supported CMS' proposals to strengthen network adequacy standards for QHPs and has repeatedly advocated for the establishment of a federal minimum standard for QHPs. The AMA has urged CMS not to limit network adequacy requirements to QHPs in federally facilitated exchanges but to apply them to all marketplace plans.

State Network Adequacy Standards

In addition to federal standards, many states have established network adequacy standards for various types of health plans. Historically, most states monitored the network adequacy of health maintenance organization plans more closely than plans with broader networks, such as preferred provider organizations, although some states have put strong standards in place to supplement the aforementioned federal requirements. In part because of state variability in network adequacy oversight, the National Association of Insurance Commissioners (NAIC) revised its network adequacy model law in 2015 and urged states to adopt it; however, few states have done so and efforts to establish and enforce substantive network adequacy standards has been somewhat limited. The NAIC model law includes a general qualitative standard that requires networks to be sufficient in numbers and appropriate types of providers to assure that all covered services are accessible without unreasonable travel or delay, as well as several positive provisions. The AMA has offered a redlined version to state medical associations as a model bill, under which regulators would be required to review and approve networks before they go to market; network adequacy would be measured using multiple, measurable standards; and telehealth would not be used to meet network adequacy requirements.

State implementation of quantitative network adequacy standards has increased over the years and, as of 2021, 30 states had established at least one such standard, most commonly time and distance standards (in 29 states) while at least 15 states had established maximum wait times.[23] A handful of states now require a minimum ratio of certain types of providers to enrollees, although these requirements vary depending on the state. For example, West Virginia requires one primary care provider per 500 enrollees; Colorado and Illinois require a primary care provider to enrollee ratio of 1:1,000; New Mexico requires a ratio of one primary care provider for every 1,500 people; and a

minimum ratio of 1:2,000 is required in California, Connecticut, Delaware, Maine, and South Carolina.[24] A table summarizing state network adequacy laws can be found on the National Association of State Legislatures' website.

Importantly, the content and strength of state network adequacy standards, and state monitoring and compliance efforts, vary significantly across states, as do the tools used to enforce the standards. Some states require plans in violation of standards to take corrective action but typically do not take more punitive action, even if authorized to do so. The Illinois Department of Insurance stands out as an exception, as recent enforcement efforts included assessing fines against a major insurer for excluding a large clinic from its network.[25]

Although states have often relied on patient complaints and insurer attestation to comply with state standards, interest in the use of data to assess network adequacy is increasing. For example, some states require plans to submit certain data elements annually and whenever the composition of a plan substantively changes to help regulators identify network access problems. Additionally, regulators in some states review claims data, such as from an all-payer claims database (APCD), to assess utilization norms, patterns of out-of-network care, who is (and is not) providing care to enrollees, and the network's overall stability and adequacy. New Hampshire was the first state to use APCD data to determine the network breadth of private health plans by calculating the share of all available providers in a county that participate in a plan's network.[26] The New Hampshire Insurance Department also reviews APCD data to identify the services being provided in order to assess utilization and categorize providers. When APCD data are available, the use of claims-based metrics can play an important role in improving the accuracy of network adequacy assessments.

Mental Health and Substance Use Disorder and Network Adequacy

There are many complexities as to why individuals with a mental illness or SUD do not receive care, but network inadequacy and the high cost of out-of-network care are among the key reasons[27] and, notably, inadequate networks are even more pervasive for children seeking behavioral health care.[28] Networks for mental health and substance use disorders present unique issues given that patients with a mental illness or substance use disorder may be at increased risk of acute harm without evidence-based care. Although treatment for mental health conditions and substance use disorder may begin in the emergency department, it is essential that in-network care is available in the patient's community.

In Colorado, regulators require plans to report multiple quantitative elements to help analyze network adequacy for substance use disorder providers, including the number of substance use disorder and opioid treatment programs in the network and the type of medications for opioid use disorder (MOUD) provided.[29] The Colorado regulation requires plans to submit this information for each county, which may not guarantee network adequacy but is essential data for regulators—and health plans—to understand where gaps may exist, and how regulators, the medical community and plans can work together to fill those gaps.

Telehealth and Network Adequacy

Increases in telehealth use since the Covid-19 pandemic have prompted ongoing policy discussions of the role telehealth plays in network adequacy and to what extent telehealth services and providers should count towards network adequacy standards. Although the AMA strongly supports integrating telehealth into the delivery of health care when clinically appropriate, integrating telehealth into network adequacy standards could potentially lead to fewer in-person physicians in a network and thereby limit access to in-person care. The AMA maintains that telehealth should be

a supplement to, and not a replacement for, in-person provider networks so that patients can always access in-person care if they choose. Moreover, telehealth is not appropriate for all services or patients, and it is often impossible for a physician to know whether a telehealth visit may necessitate in-person care. As such, the AMA has advocated that telehealth-only providers should generally not count towards network adequacy requirements.

State and federal regulators have taken a variety of approaches to account for the provision of telehealth in contracted networks and ensure that all care is clinically appropriate. Certain regulators have allowed plans some leniency to count telehealth towards network adequacy for specialties in short supply or if other conditions are met. In 2020, for example, CMS began allowing MA plans to use telehealth providers in several specialties (e.g., dermatology, psychiatry, endocrinology, otolaryngology, and others) to account for a 10 percent credit towards meeting network adequacy time and distance requirements. This year, CMS rulemaking for Medicaid MCOs proposed that telehealth appointments be counted towards network adequacy calculations only if the provider offers in-person appointments.

Depending on the state, insurers may be prohibited from using telehealth to demonstrate network adequacy or allowed to count telehealth towards time and distance standards, similar to MA plans. Still other states require only that plans report how they intend to use telehealth to meet network adequacy standards. Finally, some states may allow plans to use telehealth-only providers as an exception to network adequacy standards so that where in-person care is otherwise not available, telehealth-only providers can be used to support patients.

PROVIDER DIRECTORY ACCURACY

Provider directories are the most public-facing data that health plans provide and may be used by regulators to evaluate compliance with network adequacy standards. Patients obviously depend on accurate directories to successfully access care and, conversely, inaccurate or misleading provider information prevents patients from making informed decisions when selecting a plan. For physicians, directories are important resources for referrals and contracting and, as noted in the AMA's 2023 statement to the Senate Finance Committee, are plagued by high rates of inaccuracies that incorrectly state physicians' office locations and phone numbers, specialty, network status, and availability to see new patients. Substantial inaccuracies have been identified in provider directories across all types of insurance products, including employer-sponsored plans as well as MA, Medicaid, and marketplace plans. In the lead-up to a hearing on ghost networks and mental health care, Senate Finance Committee staff reviewed directories from 12 plans in 6 states and called 10 providers from each plan. Of the 120 providers contacted by phone, 33 percent were inaccurate, non-working numbers or unreturned calls and staff were only able to make appointments 18 percent of the time.

The AMA continues to advocate that policymakers and other stakeholders must take action to improve the data, reduce burden on physician practices, and protect patients from errors in real time. In response to a 2022 CMS Request for Information seeking public input on the concept of CMS establishing a National Directory of Healthcare Providers and Services, the AMA doubled down on its call for increased data standardization and highlighted a lack of data reporting standards as a barrier to accuracy. For example, each payer's directory requires that physicians provide different types of data, similar but named differently, or requires that physicians report their information using different data formats. The AMA advocates that CMS and state regulators should consider standardizing data elements as a means of improving accuracy. Because most enforcement of directory inaccuracies relies on patient reporting, which likely underestimates the problem, the AMA has also urged regulators to take a more active role in regularly reviewing and

assessing directory accuracy. As such, the AMA has advocated that regulators should: require plans to submit accurate network directories every year prior to the open enrollment period and whenever there is a significant change to the status of the physicians included in the network; audit directory accuracy more frequently for plans that have had deficiencies; take enforcement action against plans that fail to either maintain complete and accurate directories or have a sufficient number of in-network physician practices open and accepting new patients; encourage stakeholders to develop a common system to update physician information in their directories; and require plans to immediately remove from network directories physicians who no longer participate in their network.

The AMA also acknowledges that physicians and practices have a role to play in achieving accuracy but emphasizes that updating directories should not add to physicians' administrative burdens. In 2021, the AMA collaborated with CAQH to examine the pain points for both physicians and health plans in achieving directory accuracy and published Improving Health Plan Provider Directories: And the Need for Health Plan-Practice Alignment, Automation, and Streamlined Workflows, which identifies best practices and recommends practical approaches that both health plans and practices can implement. At a minimum for patients with mental illness or an SUD, health plans must ensure that provider directories provide accurate, timely information about whether a mental health or substance use disorder professional is accepting new patients. For substance use disorder providers, the directory also must state whether MOUD is offered, and if so, what type of MOUD is offered. Research indicates that 43 percent of people in substance use disorder treatment for nonmedical use of prescription painkillers have a diagnosis or symptoms of mental health disorders, particularly depression and anxiety, underscoring the importance of having available counseling and psychiatric care.[30]

IMPROVING HEALTH EQUITY

Patients and other health care stakeholders have expressed interest in including physician race and ethnicity data (REI) in provider directories and as a component of network adequacy requirements to advance health equity and ensure culturally competent care. The AMA recognizes that there are many reasons why patients may want to consider REI when choosing a physician, including connecting with physicians with whom they may relate and selecting plans that can help them accomplish their health goals. Although federal regulations do not require QHPs to have culturally diverse provider networks, Medicaid regulations require states developing MCO network adequacy standards to address the ability of network providers to communicate with limited English proficient enrollees in their preferred language and to accommodate enrollees with disabilities.[31] Federal regulations also require provider directories maintained by Medicaid MCOs to include information on the provider's cultural and linguistic capabilities, including languages offered, and this year CMS proposed similar requirements for MA plans. The AMA has supported such measures so that a patient can more easily determine in advance whether a provider can deliver care that will meet their cultural and linguistic needs.

The use of network adequacy standards to improve health equity has also been discussed by some states as well as the NAIC, whose special committee on race and insurance has been looking at access and affordability issues, including the use of network adequacy and provider directory information to promote equitable access to culturally competent health care.[32] As noted in an AMA letter to NAIC, designation of a physician's race was historically used as a tool to discriminate and exclude physicians and displaying REI and/or other personal information in provider directories has the potential to expose minoritized physicians to discrimination. The AMA has argued that guardrails be included in regulatory guidance so that the use of REI data by an insurer is limited,

transparent to the physician, evaluated for potential benefits and harms, and quickly discontinued if it causes harm.[33]

Legislation passed by the Colorado General Assembly creating the "Colorado Option" program required insurers offering standardized "Colorado Option" plans to have provider networks that are culturally responsive and reflect the diversity of the communities they serve.[34] Regulations implementing this provision require plans to collect demographic information—on race and ethnicity, sexual orientation, gender identity, and ability status—voluntarily submitted by network providers and their front office staff as well as plan enrollees who voluntarily provide such data.[35] Insurers are required to report that demographic data—in aggregate—to the state and describe their efforts to build a diverse and culturally responsive provider network. State regulations further require network provider directories to identify providers who are multilingual or employ multilingual front office staff and the languages spoken; whether a provider offers extended and weekend hours; and the accessibility of a provider's office and examination rooms for people with disabilities.[36]

Some network directories also provide REI information and/or proximity to public transportation, experience with specific patient populations, languages offered, and the ability to provide specific services. Although the AMA has generally supported the ability of physicians to voluntarily specify information that they want included in a provider directory, caution has been advised regarding the use of REI and other data in directories so that data collection is voluntary and appropriate safeguards are in place. The AMA has further advocated that insurers consider other ways to support diversification and health equity, such as investing in pathway programs from elementary schools to residency/fellowship programs.[37]

RELEVANT AMA POLICY

Network adequacy is addressed in Policy H-285.908, established via Council on Medical Service Report 4-I-14, which supports state regulators as the primary enforcer of network adequacy requirements, sets parameters for out-of-network care and insurer termination of in-network providers, and advocates that plans be required to document to regulators that they have met requisite network adequacy standards and that in-network adequacy is timely and geographically accessible. Policy H-285.911 similarly states that health insurance provider networks should be sufficient to provide meaningful access to all medically necessary and emergency care at the preferred, in-network level on a timely and geographically accessible basis.

Policy H-285.984 states that plans or networks that use criteria to determine the number, geographic distribution, and specialties of physicians be required to regularly report to the public on the impact that the use of such criteria has on the quality, access, cost, and choice of health care services. Policy D-285.972 supports monitoring the development of tiered, narrow, or restricted networks to ensure they are not inappropriately driven by economic criteria by the plans and that patients are not caused health care access problems based on the potential for a limited number of specialists in the resulting networks. Policy H-450.941 strongly opposes the use of tiered and narrow physician networks that deny patient access to, or attempt to steer patients towards, certain physicians based on cost of care factors. Under Policy D-180.984, the AMA will work with state medical associations and other groups to evaluate on an annual basis and recommend measures for payers that should be publicly reported by payers including the number of primary and specialty physicians and consumer complaints.

Policy H-285.904 adopts principles related to unanticipated out-of-network care, including minimum coverage standards and payment parameters that insurers must meet, and also affirms

that state regulators should enforce such standards through active regulation of health plans. Policy H-180.952 opposes penalties implemented by insurers against physicians when patients independently choose to obtain out-of-network services.

Policy H-285.924 states that health plans should provide patients with a current directory of participating physicians through multiple media and continue to cover services provided by physicians who involuntarily leave a plan until an updated directory is available. Among several provisions regarding MA plans' provider directories, Policy H-285.902 urges CMS to conduct accuracy reviews and publicly report accuracy scores. Policy H-330.878 advocates for better enforcement of MA network regulations and maintenance by CMS of a publicly available database of physicians in network that states whether these physicians are accepting new patients.

Under Policy H-290.985, the AMA advocates that certain criteria be used in federal and state oversight of Medicaid managed care plans, including geographic dispersion and accessibility of participating physicians and other providers, and the ability of plan participating physicians to determine how many patients and which medical problems they will care for. Policy H-345.975 supports state responsibility to develop programs that rapidly identify and refer individuals with significant mental illness for treatment as well as enforcement of the Mental Health Parity Act. H-160.949 addresses scope of practice and advocates for appropriate physician supervision of non-physician clinical staff. Policy H-480.937 opposes efforts by health plans to use cost-sharing as a means to incentivize or require the use of telehealth or in-person care or incentivize care from a separate or preferred telehealth network over the patient's current physicians.

DISCUSSION

Network adequacy refers to a health plan's ability to provide access to in-network physicians and hospitals to meet enrollees' health care needs. Because inadequate networks create obstacles for patients seeking new or continued care and limit their choice of physicians and facilities, network adequacy standards and other requirements are used by regulators to ensure that health plan subscribers are able to access in-network care within reasonable distances and timeframes. Physicians and other providers are also impacted by the adequacy of a network and, although strong network adequacy standards should incentivize health plans to negotiate fairly, inadequate networks can negatively impact physicians' bargaining power. Furthermore, network inadequacies often lead to excessive appointment wait times and overburden many in-network physicians, contributing to increased burden and potential liability for delayed care. While acknowledging the challenges involved to ensuring network adequacy without adding substantially to the cost of insurance, the Council believes that regulators should take a multilayered approach to network adequacy that includes meaningful standards, transparency of network breadth and in-network physicians, hospitals, and other providers, parameters around out-of-network care, and effective monitoring and enforcement efforts.

The Council recommends seven new AMA policies to supplant and strengthen our existing network adequacy policies, and reaffirmation of four existing policies. Although state regulators are the primary enforcer of network adequacy requirements (Policy H-285.908), the Council recommends that our AMA support establishment and enforcement of a minimum federal network adequacy standard requiring health plans to contract with sufficient numbers and types of physicians and other providers, including for mental health and substance use disorders, such that both scheduled and unscheduled care may be provided without unreasonable travel or delay. The Council also recommends encouraging the use of multiple criteria to evaluate the sufficiency of health plan provider networks, including minimum physician-to-enrollee ratios and a clear standard for network appointment wait times. To facilitate informed decision-making among consumers

shopping for plans, the Council recommends encouraging the development and promulgation of network adequacy assessment tools that allow patients and employers to compare insurance plans.

Although transparency of health plan network adequacy is addressed in part by Policies H-285.908, D-285.972, and H-330.878, the Council seeks to strengthen AMA policy in this area by recommending that our AMA support requiring health plans to report annually and prominently display important information so it is accessible by enrollees as well as consumers shopping for plans, including the breadth of a plan's provider network; average wait times for primary care appointments and common specialty referrals; numbers of physicians treating mental health and substance use disorders who are accepting new patients; and instructions for enrollees to contact regulators to report access problems and other network adequacy complaints. Even with robust quantitative standards in place, the Council understands that some physicians may be booked or not accepting new patients and that additional tools are needed to measure true patient access to timely and quality in-network care. Accordingly, we recommend encouraging the use of claims data, audits, secret shopper programs, complaints, and enrollee surveys/interviews to monitor and validate in-network provider availability and wait times, network stability, and provider directory accuracy and to identify other access or quality problems.

State and federal regulators have taken a variety of approaches to addressing the role of telehealth in network adequacy, and the policy landscape across many states is evolving. The Council recommends new policy affirming that in-network physicians who provide both in-person and telehealth services may count towards health plan network adequacy requirements on a very limited basis when their physical practice does not meet time and distance standards, such as when there is a shortage of physicians in the needed specialty within the community. The AMA does not support counting physicians who only offer telehealth services towards network adequacy requirements.

It is also important to highlight that even vigorous standards and requirements will fail to strengthen network adequacy unless regulators take a more active role to ensure health plan compliance and patient access to care. Policy H-285.904, which advocates that state regulators should enforce network adequacy standards through active regulation of health plans, is recommended for reaffirmation. The Council further recommends supporting regulation to hold health plans accountable for network inadequacies through the use of corrective action plans and substantial financial penalties.

Several AMA policies (Policies H-285.902, H-285.924, and H-330.878) call for health plans to provide patients with accurate, complete, and up-to-date provider directories and AMA advocacy on this topic has been strong. Because outdated and inaccurate directories are an ongoing pain point that is burdensome for physicians and patients, we recommend reaffirmation of Policy H-285.902, which urges the CMS to take several steps to enhance provider directory accuracy and effectively communicate network information to patients. Similarly, several AMA policies address out-of-network care (Policies H-180.952, H-285.904, and H-285.908); Policy H-285.904, which outlines principles related to coverage and payment for out-of-network care and Policy H-285.908, which addresses out-of-network care as well as other elements of network adequacy, are recommended for reaffirmation. On this topic, the Council notes that the AMA continues its focus on the *No Surprises Act* and remains concerned that implementation of the statute does not support physicians' ability to meaningfully engage in dispute resolution, as Congress intended, because of the Administration's problematic reliance on the qualified payment amount (QPA) in arbitration, among other issues. As a result, health plans may feel emboldened to disengage from fair contract negotiations with physicians and network adequacy may suffer. While there have been successful

legal challenges to the Administration's flawed positions on the QPA among other aspects, the situation continues to be closely monitored.

Policy H-285.911, which advocates that provider networks be sufficient to provide meaningful access to subscribers for all medically necessary and emergency care, at the in-network benefit level, is also recommended for reaffirmation. Additional relevant AMA policies affirm that health plans should be required to inform physicians of criteria used to evaluate a physician for network inclusion (Policy H-285.984), prohibited from forming networks based only on economic criteria (Policy D-285.972), and required to notify providers at least 90 days prior to termination from a network (Policy H-285.908). Among other provisions, Policy H-285.908 directs the AMA to provide assistance (upon request) to state medical associations and disseminate model state legislation; accordingly, the AMA's model state legislation will be updated and made available to the Federation once new network adequacy policy is adopted. The Council also acknowledges that physician shortages across many specialties may impact the adequacy of some networks, especially in, but not limited to, rural areas. As stated previously, although midlevel providers may be in a provider network if permitted under state law, health plans must meet network adequacy requirements for physicians and measurement should be limited to physicians for physician services. Finally, the Council encourages physicians to report network adequacy violations to state departments of insurance, which may track complaints as part of their network adequacy assessments. Contact information for state departments of insurance can be found on the NAIC's website.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted and the remainder of the report be filed:

1. That our American Medical Association (AMA) support establishment and enforcement of a minimum network adequacy standard requiring all health plans to contract with sufficient numbers and types of physicians and other providers, including for mental health and substance use disorder, such that both scheduled and unscheduled care may be provided without unreasonable travel or delay. (New HOD Policy)

2. That our AMA encourage the use of multiple criteria to evaluate the sufficiency of health plan physician networks, including but not limited to:
    a. Minimum physician-to-enrollee ratios across specialties and subspecialties, including mental health and substance use disorder providers who are accepting new patients;
    b. Minimum percentages of non-emergency physicians available on nights and weekends;
    c. Maximum time and distance standards, including for enrollees who rely on public transportation;
    d. Clear standard for network appointment wait times across specialties and subspecialties, developed in consultation with appropriate specialty societies, for both new patients and continuing care, that are appropriate to a patient's urgent and non-urgent health care needs; and
    e. Sufficient physicians to meet the care needs of people experiencing economic or social marginalization, chronic or complex health conditions, disability, or limited English proficiency. (New HOD Policy)

3. That our AMA encourage the development and promulgation of network adequacy assessment tools that allow patients and employers to compare insurance plans and make informed decisions when enrolling in a plan. (New HOD Policy)

4. That our AMA support requiring health plans to report to regulators annually and prominently display network adequacy information so that it is available to enrollees and consumers shopping for plans, including:
    a. The breadth of a plan's provider network, by county and geographic region or Metropolitan Statistical Area (MSA);
    b. Average wait times for primary and behavioral health care appointments as well as common specialty and subspecialty referrals;
    c. The number of in-network physicians treating substance use disorder who are accepting new patients in a timely manner, and the type of substance use disorder medications offered;
    d. The number of in-network psychiatrists and other mental health providers accepting new patients in a timely manner; and
    e. Instructions for consumers and physicians to easily contact regulators to report complaints about inadequate provider networks and other access problems;
    f. The number of physicians versus non-physician providers in the network overall and by specialty/practice focus; and
    g. The number, geographic location, and medical specialty of any physician contracts terminated or added during the prior calendar year. (Modify HOD Policy)

5. That our AMA encourage the use of claims data, audits, secret shopper programs, complaints, and enrollee surveys or interviews to monitor and validate in-network provider availability and wait times, network stability, and provider directory accuracy, and to identify other access or quality problems. (New HOD Policy)

6. That our AMA affirm that in-network physicians who provide both in-person and telehealth services may count towards 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 towards network adequacy requirements. (New HOD Policy)

7. That our AMA support regulation to hold health plans accountable for network inadequacies, including through use of corrective action plans and substantial financial penalties. (New HOD Policy)

8. That our AMA reaffirm Policy H-285.908, which supports state regulators as the primary enforcer of network adequacy requirements, sets parameters for out-of-network care and insurer termination of in-network providers, and advocates that plans be required to document to regulators that they have met requisite network adequacy standards including hospital-based physician specialties. (Reaffirm HOD Policy)

9. That our AMA reaffirm Policy H-285.904, which supports principles related to unanticipated out-of-network care and advocates that state regulators should enforce network adequacy standards through active regulation of health plans. (Reaffirm HOD Policy)

10. That our AMA reaffirm Policy H-285.902, which urges the Centers for Medicare & Medicaid Services to take several steps to ensure network adequacy, enhance provider directory accuracy, measure network stability, and effectively communicate provider network information to patients. (Reaffirm HOD Policy)

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2 11. That our AMA reaffirm Policy H-285.911, which advocates that health insurance provider
3 networks be sufficient to provide meaningful access to subscribers, for all medically necessary
4 and emergency care, at the preferred, in-network benefit level on a timely and geographically
5 accessible basis. (Reaffirm HOD Policy)
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Fiscal Note: Less than $500.

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APPENDIX

Policies Recommended for Reaffirmation

Network Adequacy H-285.908

1. Our AMA supports state regulators as the primary enforcer of network adequacy requirements.
2. Our AMA supports requiring that provider terminations without cause be done prior to the enrollment period, thereby allowing enrollees to have continued access throughout the coverage year to the network they reasonably relied upon when purchasing the product. Physicians may be added to the network at any time.
3. Our AMA supports requiring health insurers to submit and make publicly available, at least quarterly, reports to state regulators that provide data on several measures of network adequacy, including the number and type of providers that have joined or left the network; the number and type of specialists and subspecialists that have left or joined the network; the number and types of providers who have filed an in network claim within the calendar year; total number of claims by provider type made on an out-of-network basis; data that indicate the provision of Essential Health Benefits; and consumer complaints received.
4. Our AMA supports requiring health insurers to indemnify patients for any covered medical expenses provided by out-of-network providers incurred over the co-payments and deductibles that would apply to in-network providers, in the case that a provider network is deemed inadequate by the health plan or appropriate regulatory authorities.
5. Our AMA advocates for regulation and legislation to require that out-of-network expenses count toward a participant’s annual deductibles and out-of-pocket maximums when a patient is enrolled in a plan with out-of-network benefits, or forced to go out-of-network due to network inadequacies.
6. Our AMA supports fair and equitable compensation to out-of-network providers in the event that a provider network is deemed inadequate by the health plan or appropriate regulatory authorities.
7. Our AMA supports health insurers paying out-of-network physicians fairly and equitably for emergency and out-of-network bills in a hospital. AMA policy is that any legislation which addresses this issue should assure that insurer payment for such care be based upon a number of factors, including the physicians' usual charge, the usual and customary charge for such service, the circumstances of the care and the expertise of the particular physician.
8. Our AMA provides assistance upon request to state medical associations in support of state legislative and regulatory efforts, and disseminate relevant model state legislation, to ensure physicians and patients have access to adequate and fair appeals processes in the event that they are harmed by inadequate networks.
9. Our AMA supports the development of a mechanism by which health insurance enrollees are able to file formal complaints about network adequacy with appropriate regulatory authorities.
10. Our AMA advocates for legislation that prohibits health insurers from falsely advertising that enrollees in their plans have access to physicians of their choosing if the health insurer's network is limited.
11. Our AMA advocates that health plans should be required to document to regulators that they have met requisite standards of network adequacy including hospital-based physician specialties (i.e. radiology, pathology, emergency medicine, anesthesiologists and hospitalists) at in-network facilities, and ensure in-network adequacy is both timely and geographically accessible.
12. Our AMA supports requiring that health insurers that terminate in-network providers: (a) notify providers of pending termination at least 90 days prior to removal from network; (b) give to providers, at least 60 days prior to distribution, a copy of the health insurer’s letter notifying patients of the provider’s change in network status; and (c) allow the provider 30 days to respond to

and contest if necessary the letter prior to its distribution. (CMS Rep. 4, I-14; Reaffirmation I-15; Reaffirmed in lieu of Res. 808, I-15; Modified: Sub. Res. 811, I-15; Reaffirmed: CMS Rep. 03, A-17; Reaffirmed: Res. 108, A-17; Appended: Res. 809, I-17; Reaffirmed: Res. 116, A-18; Reaffirmation: A-19)

Out-of-Network Care H-285.904
1. Our AMA adopts the following principles related to unanticipated out-of-network care:
A. Patients must not be financially penalized for receiving unanticipated care from an out-of-network provider.
B. Insurers must meet appropriate network adequacy standards that include adequate patient access to care, including access to hospital-based physician specialties. State regulators should enforce such standards through active regulation of health insurance company plans.
C. Insurers must be transparent and proactive in informing enrollees about all deductibles, copayments and other out-of-pocket costs that enrollees may incur.
D. Prior to scheduled procedures, insurers must provide enrollees with reasonable and timely access to in-network physicians.
E. Patients who are seeking emergency care should be protected under the "prudent layperson" legal standard as established in state and federal law, without regard to prior authorization or retrospective denial for services after emergency care is rendered.
F. Out-of-network payments must not be based on a contrived percentage of the Medicare rate or rates determined by the insurance company.
G. Minimum coverage standards for unanticipated out-of-network services should be identified. Minimum coverage standards should pay out-of-network providers at the usual and customary out-of-network charges for services, with the definition of usual and customary based upon a percentile of all out-of-network charges for the particular health care service performed by a provider in the same or similar specialty and provided in the same geographical area as reported by a benchmarking database. Such a benchmarking database must be independently recognized and verifiable, completely transparent, independent of the control of either payers or providers and maintained by a non-profit organization. The non-profit organization shall not be affiliated with an insurer, a municipal cooperative health benefit plan or health management organization.
H. Independent Dispute Resolution (IDR) should be allowed in all circumstances as an option or alternative to come to payment resolution between insurers and physicians.
2. Our AMA will advocate for the principles delineated in Policy H-285.904 for all health plans, including ERISA plans.
3. Our AMA will advocate that any legislation addressing surprise out of network medical bills use an independent, non-conflicted database of commercial charges. (Res. 108, A-17; Reaffirmation: A-18; Appended: Res. 104, A-18; Reaffirmed in lieu of: Res. 225, I-18; Reaffirmation: A-19; Reaffirmed: Res. 210, A-19; Appended: Res. 211, A-19; Reaffirmed: CMS Rep. 5, A-21; Modified: Res. 236, A-22)

Ban on Medicare Advantage "No Cause" Network Terminations H-285.902
1. Our AMA urges the Centers for Medicare & Medicaid Services (CMS) to further enhance the agency's efforts to ensure directory accuracy by: a. Requiring Medicare Advantage (MA) plans to submit accurate provider directories to CMS every year prior to the Medicare open enrollment period and whenever there is a significant change in the physicians included in the network; b. Conducting accuracy reviews on provider directories more frequently for plans that have had deficiencies; c. Publicly reporting the most recent accuracy score for each plan on Medicare Plan Finder; d. Indicating to plans that failure to maintain complete and accurate directories, as well as failure to have a sufficient number of physician practices open and accepting new patients, may

subject the MA plans to one of the following: (i) civil monetary penalties; (ii) enrollment sanctions; or (iii) incorporating the accuracy score into the Stars rating for each plan; e. Requiring MA plans immediately remove from provider directories providers who no longer participate in their network.
2. Our AMA urges CMS to ensure that network adequacy standards provide adequate access for beneficiaries and support coordinated care delivery by: a. Requiring plans to report the percentage of the physicians, broken down by specialty and subspecialty, in the network who actually provided services to plan members during the prior year; b. Publishing the research supporting the adequacy of the ratios and distance requirements CMS currently uses to determine network adequacy; c. Conducting a study of the extent to which networks maintain or disrupt teams of physicians and hospitals that work together; d. Evaluating alternative/additional measures of adequacy.
3. Our AMA urges CMS to ensure lists of contracted physicians are made more easily accessible by: a. Requiring that MA plans submit their contracted provider list to CMS annually and whenever changes occur, and post the lists on the Medicare Plan Finder website in both a web-friendly and downloadable spreadsheet form; b. Linking the provider lists to Physician Compare so that a patient can first find a physician and then find which health plans contract with that physician. Our AMA urges CMS to simplify the process for beneficiaries to compare network size and accessibility by expanding the information for each MA plan on Medicare Plan Finder to include: (i) the number of contracted physicians in each specialty and county; (ii) the extent to which a plan's network exceeds minimum standards in each specialty, subspecialty, and county; and (iii) the percentage of the physicians in each specialty and county participating in Medicare who are included in the plan's network.
4. Our AMA urges CMS to measure the stability of networks by calculating the percentage change in the physicians in each specialty and subspecialty in an MA plan's network compared to the previous year and over several years and post that information on Plan Finder.
5. Our AMA urges CMS to develop a marketing/communication plan to effectively communicate with patients about network access and any changes to the network that may directly or indirectly impact patients; including updating the Medicare Plan Finder website.
6. Our AMA urges CMS to develop process improvements for recurring input from in-network physicians regarding network policies by creating a network adequacy task force that includes multiple stakeholders including patients.
7. Our AMA urges CMS to ban "no cause" terminations of MA network physicians during the initial term or any subsequent renewal term of a physician's participation contract with a MA plan. (BOT Rep. 17, A-19; Reaffirmation: I-19; Modified: Speakers Rep. 1, A-21)

Health Insurance Safeguards H-285.911
Our AMA will advocate that health insurance provider networks should be sufficient to provide meaningful access to subscribers, for all medically necessary and emergency care, at the preferred, in-network benefit level on a timely and geographically accessible basis. (CMS Rep. 8, A-10; Reaffirmed in lieu of Res. 815, I-13; Reaffirmation I-15; Reaffirmed: CMS Rep. 03, A-17; Reaffirmed: Res. 108, A-17)