November 16, 2016

Nancy Grodin
Deputy Insurance Commissioner
Maryland Insurance Administration

Dear Ms. Grodin:

Consumer Health First (CHF) appreciates the collaborative process that you have led for the Maryland Insurance Administration (MIA) to develop regulations specifying quantitative standards for health insurance carrier (carrier) networks as required by HB 1318. As part of that process, we and our colleagues at the University of Maryland Carey School of Law Drug Policy Clinic and the Mental Health Association of Maryland wish to provide you with recommendations that go beyond what we have previously provided to you. These are based upon our own expertise in this area as well as our extensive research into network adequacy standards being developed in other states, as well as at the federal level through Medicare Advantage and the Federally Facilitated Marketplaces (FFM). In addition to our three organizations, the 47 entities and two individuals listed at the bottom have endorsed our recommendations. We believe that our recommendations will result in substantive quantitative standards that will ensure that Maryland consumers have access to high quality, affordable health care.

Introduction

We have provided specific recommendations for the following categories called for in HB 1318: (1) appointment wait times; (2) geographic time and distance standards; (3) essential community providers; (4) language interpretation services; (5) confidentiality of access plans; (6) telehealth and other technology; and (7) enforcement and annual reporting. We have attached to this letter the comprehensive analysis and research that informed and supports our recommendations, including the Drug Policy Clinic's Fifty-State Survey: Network Adequacy Quantitative Standards.

We suggest that special consideration be applied to two areas:

- The development of quantitative network adequacy standards will require the MIA to articulate the types of providers and settings of care (i.e., facilities) that should be tracked in the network standards. We urge the MIA to adopt a comprehensive list that takes into consideration consumer's health care needs and Maryland's provider system. The attached geographic time/distance chart outlines the providers and facilities that we recommend be tracked based on our assessment of consumer health care needs. The list combines the providers and facilities identified by the Colorado insurance commissioner, the Department of Health and Human Services (HHS) Medicare Advantage Program and the behavioral health providers from the Maryland Health Care

Commission's report *2015 Comprehensive Quality Report: Comparing Performance Trends of Maryland's Commercial Health Benefit Plans*.

- As the MIA considers the specific standards to be implemented, we urge you to pay particular attention to those impacting individuals with mental health and substance use disorders. Robust and verifiable network standards are needed more than ever to ensure that plans help address the State's opioid overdose crisis and meet the requirements of the federal Mental Health Parity and Addiction Equity Act. In addition, ensuring that these individuals have timely access to services will likely reduce unnecessary utilization of emergency departments and inpatient hospitalizations, a key goal of Maryland's All-Payer Model.

Appointment Wait Times

Appointment wait time standards are the most important metric for the MIA to develop, as these are the most meaningful to consumers. In fact, Maryland's current standards on provider network adequacy, Ins. § 15-830(d-g), recognize the importance of a consumer's ability to access care without unreasonable delay or travel as the most important measure of network adequacy. The development of specific appointment wait time standards is the only way to ensure that access to care without unreasonable delay is enforceable. We believe the following wait time standards will provide Maryland's consumers with the access they need to the full range of providers in a timely manner.

Recommended Wait Time Standards for Maryland	
Urgent Care (including medical, mental health, and substance use disorder)	24 hours
Routine Primary Care	7 calendar days
Preventive Visit / Well Visit	30 calendar days
Non-Urgent Specialty Care	30 calendar days
Non-Urgent Ancillary Services	30 calendar days
Non-urgent Mental Health / Substance Use Disorder provider	7 calendar days

Geographic Time/Distance Standards

We recommend that the MIA adopt geographic time/distance standards for a uniform list of providers and facility types.

- We recommend that the MIA adopt the geographic regions and definitions as specified by HHS for Medicare Advantage Plans and for the 2017 FFM plans.
- We recommend that the geographic standard address both distance and travel time from a member's residence, with the shorter of the two metrics governing.

- We recommend that specific standards be developed for mental health and substance use disorder providers by provider type and facility.

Attachment A provides our comprehensive recommendations for geographic time and distance standards for each provider and facility type.

Essential Community Providers

To ensure that lower-income individuals have access to medical and mental health and substance use disorder services in settings in which many currently receive care, we recommend that the MIA adopt the following essential community provider (ECP) standard for all health plans. These are consistent with, and expand upon, the requirements set forth by the Maryland Health Benefit Exchange (MHBE) for 2017 essential health benefit (EHB) based plans:

- Expand the definition of ECP to include local health departments, school-based programs and outpatient mental health and community-based substance use disorder programs.
- Require carriers to contract with at least 30% of available ECPs in each plan's service area as part of each plan's provider network.
- Require carriers to offer contracts in good faith to the following provider types: all available Indian Health Care Providers in the plan's service area; any willing local health department in the plan's service area; and, at least one ECP in each ECP category in each county in the carrier's service area.
- Adopt a separate requirement for carriers to contract with at least 30% of outpatient mental health and community-based outpatient substance use disorder providers.
- Adopt the FFM 2018 ECP calculation model as the methodology carriers must use to demonstrate compliance on an annual basis.

Language Interpretation Services

Providing access to language interpretation is essential to reducing health disparities, and has the potential to save costs to the health system by ensuring patients can communicate with their providers, arrive more quickly at a diagnosis and fully understand their treatment plan. Carriers should be required to disclose the steps they are taking to ensure that network providers provide access to language assistance services in accordance with the provisions of Section 1557 of the Affordable Care Act and all applicable regulations to ensure all Marylanders receive the right care. As HHS recognized in its 1557 regulations, carriers are encouraged to structure their plan payment structures to consider health plan providers' expenses in providing language assistance services.

Confidentiality of Access Plans

We believe that, as indicated in the National Association of Insurance Commissioner's Health Benefit Plan Network Access and Adequacy Model Act, Section 5.E.2, the carriers' access plans should be public documents. Carriers should not be permitted to deem any part of the plans pertaining to how they perform against the quantitative

standards, or the policies and procedures they use to comply with the statutory and regulatory requirements, as proprietary. The lack of transparency regarding network standards has prevented Maryland's consumers from comparing health plans and ensuring that their plan will provide access to targeted health services. The adoption of quantitative standards in all metrics is needed to provide consumers with the assurance that they can access the care they are paying for.

Telehealth and Other Technology

We support the use of telehealth and other technology as a way to enhance consumers' access to high quality, affordable health care, and we look forward to working with stakeholders as such methods of access continue to develop. We also support the recommendations of the American Telemedicine Association regarding the inclusion of telemedicine usage in provider directories and network access plans.

We caution, however, that telehealth should not be the only way for a consumer to access care. Rather, it should supplement access to in-person care and should be used for the convenience and benefit of the consumer, not the provider or the carrier. Consumers who prefer in-person care must have that option without undue travel or appointment wait times. In addition, to the extent telehealth standards are developed for providers, they must comply with the Mental Health Parity and Addiction Equity Act, insofar as the range of providers who are eligible to be reimbursed for those services as well as for the range of services to be reimbursed.

Enforcement and Annual Reporting Requirements

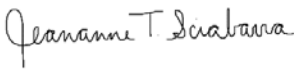
While the establishment of standards is a most important first step, the MIA must also determine how articulated standards will be enforced and how the results of network adequacy testing are communicated to consumers. This is critical if consumers are to have confidence in their ability to access care. We make the following recommendations regarding enforcement, reporting and consumer engagement:

1. The MIA should use the template developed by HHS for the FFM with modifications to include all the specialists and facilities identified for the geographic time/distance standards and ECPs to annually monitor compliance with these standards.
2. Regarding wait time standards, we recommend that the MIA adopt the testing and reporting requirements established by California. California has developed a common methodology that each carrier must use to measure its performance against the established standards. Carriers are required to demonstrate that their networks are adequate by performing periodic audits or provider surveys and reporting those results to the Department of Managed Health Care, which in turn reports the compliance scores for each carrier on their website.
3. The MIA should create a comprehensive resource page on its website that explains the network adequacy regulations, posts all compliance reporting documents, clearly states the rights of consumers and provides clear direction on where consumers can go for assistance. See, for example, California's Department of Managed Health Care website.

Conclusion

Adoption of these recommendations will be an important step forward in assuring Maryland's consumers that they have access to the health care providers they and their families need. Therefore, we strongly urge the MIA to adopt these as part of the network adequacy regulations being developed under HB1318. We are grateful to the MIA for the opportunity to provide input to this important process. We look forward to continuing to work with you as your regulatory process proceeds and to answering any questions you may have - now and in the future.

Sincerely,



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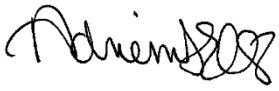

Adrienne Ellis
Director Healthcare Reform
Mental Health Association of MD

Signatory Organizations

Advocates for Children and Youth

American Association on Health & Disability

Anne Arundel County Department of Health

Baltimore City Substance Abuse Directorate

Behavioral Health System Baltimore

Center for Addiction Medicine

Center for Children, Inc.

Community Behavioral Health Association of Maryland

Disability Rights Maryland

FIRN

Greater Washington Society for Clinical Social Work

IBR/REACH Health Services

League of Women Voters of Maryland

Licensed Clinical Professional Counselors of Maryland

Maryland Addictions Directors Council

Maryland Affiliate of the American College of Nurse Midwives

Maryland Assembly on School-Based Health Care

Maryland Association of Behavioral Health Authorities, Inc.

Maryland Coalition of Families

Maryland Hospital Association

Maryland Nonprofits

Maryland Nurses Association

Maryland Occupational Therapy Association

Maryland Association for the Treatment of Opioid Dependence

Montgomery County Department of Health and Human Services

NAMI Maryland (and 12 County Chapters)

NARAL Pro-Choice Maryland

National Council on Alcoholism and Drug Dependence-Maryland Chapter

Open Society Institute-Baltimore

Planned Parenthood of Maryland

Powell Recovery Center

Primary Care Coalition

Progressive Cheverly Health Committee

Public Justice Center

Sisters Together And Reaching, Inc.

Individuals

Mike Davidson

Kerri Preul

Network Adequacy Quantitative Standards Report
Research and Explanation of Recommendations

This report, compiled by Consumer Health First (CHF) and its partner organizations, the University of Maryland Carey School of Law Drug Policy Clinic and the Mental Health Association of Maryland, summarizes the research done around network adequacy standards and explains the rationale for our recommendations to the Maryland Insurance Administration as it develops standards, as required by HB1318. Network adequacy standards are being developed by states around the country and at the federal level through Medicare Advantage and the Federally Facilitated Marketplace, and have long been in place for carriers accredited by NCQA, as all Maryland carriers are. We urge the State to use this opportunity to create robust and enforceable standards to ensure that Maryland consumers have access to the health care that they are purchasing with their premiums.

In this report, we lay out our specific recommendations for many of the categories of standards the MIA is developing under this regulatory process: appointment wait times; geographic time and distance standards; essential community providers; language interpretation services; confidentiality of access plans; telehealth and other technology; and, enforcement and annual reporting. We have attached to this report the Carey School of Law Drug Policy Clinic's Fifty-State Survey: Network Adequacy Quantitative Standards (Attachment B), which was used to inform our recommendations.

Throughout our research, we paid special attention to standards regarding access to mental health and substance use disorder services. One in four individuals has a behavioral health disorder, affecting children, adults and seniors at similar rates. The opioid overdose crisis continues to spiral out of control, and, the number of individuals who died from an opioid overdose in the first six months of 2016 is nearly equal to the total number of opioid-related deaths for all of 2015. Governor Hogan committed to addressing the crisis as one of his first acts in office, and the Lt. Governor's Heroin and Opioid Emergency Task Force heard from citizens across the state about the gaps in access to substance use treatment services under their private insurance plans. Most recently, Governor Hogan entered the National Governors Association compact that has committed the State to "ensure a pathway to recovery for individuals with addiction" by "reducing payment and administrative barriers in … health plans to promote access to a range of treatment options, including well-supervised medication assisted treatment and comprehensive recovery services."

Private insurance must fulfill its role in addressing this crisis – the most significant being ensuring that carriers have adequate numbers of substance use disorder providers in their networks. According to the Maryland Health Care Commission's report *2015 Comprehensive Quality Report: Comparing Performance Trends of Maryland's Commercial Health Benefit Plans*, most private insurance plan networks

have zero alcohol or drug counselors and few, if any, physicians certified in addiction medicine. At least weekly, MHAMD receives calls from consumers who aren't able to access timely, in-network, mental health care.

I. Appointment Wait Times: The Single Most Important Network Adequacy Metric

One of the most significant barriers to a consumer's ability to access timely, cost-effective, appropriate care is the amount of time they must wait for an appointment with an in-network provider. This is why establishing appointment wait time standards is the most important consumer protection measure. The length of time a consumer must wait for an appointment is directly dependent on whether the network is sufficient to meet the needs of its members. As the California Department of Managed Health Care noted in this year's *Timely Access Report* "the true test of whether a health plan is meeting its commitments is whether a health plan enrollee can get an appointment with their provider within a reasonable period of time."

Consistent with NCQA requirements of both geographic distribution and wait time metrics, we believe the best approach is to couple time and distance standards with wait time standards. This will provide the MIA with a metric for review while also enabling consumers to exercise their rights under Maryland Insurance § 15-830(d-g) to access in-network specialty appointments, including mental health and substance use disorder treatment, without unreasonable delay or travel. A wait time metric is essential to ensure that consumers know when they may access an out-of-network provider without paying additional non-network cost sharing. Particularly for consumers with mental health and substance use disorders, a geographic metric alone does not begin to address the real life-and-death consequences that some face when a carrier is not required to ensure timely access to care.

Maryland's carriers are currently assessing wait time access for regular and routine primary care appointments, urgent care appointments and after-hours care under NCQA requirements. In addition, NCQA imposes specific standards for behavioral health wait times: 6 hours for non-life threatening emergency, 48 hours for urgent care, and 10 business days for a routine office visit. These more stringent requirements appear to be in response to a known behavioral health network adequacy problem. NCQA noted that "wait times for first and follow-up appointments for mental health services continue to be a concern, particularly visits to psychiatrists." NCQA, Health Plan Accreditation 2016 and Additional Accreditation and Certification Product Updates, Overview at 5 (2015). We have demonstrated that these problems persist in Maryland in the Mental Health Association of Maryland's 2015 report, "Access to Psychiatrists in Qualified Health Plans."

The attached report by the University of Maryland Carey School of Law Drug Policy Clinic indicates that twelve states have established appointment wait time standards: Arizona, California, Colorado, Florida (HMO), Maine, Missouri (HMO), Montana, New Jersey, New Mexico, Texas (HMO and PPO), Vermont, and Washington. After reviewing these states' standards, we recommend the following appointment wait time standards for Maryland:

Recommended Wait Time Standards for Maryland	
Urgent Care (including medical, mental health, and substance use disorder)	24 hours
Routine Primary Care	7 calendar days
Preventive Visit / Well Visit	30 calendar days
Non-Urgent Specialty Care	30 calendar days
Non-Urgent Ancillary Services	30 calendar days
Non-urgent Mental Health / Substance Use Disorder provider	7 calendar days

Colorado also specifies a percentage of the time that carriers must meet the appointment wait time standards. Emergency and urgent care standards must be met 100% of the time, and all other standards must be met at least 90% of the time. We recommend that the MIA adopt the same structure.

Our proposed wait time standard for mental health and substance use disorder providers mirror those for primary health care to ensure prompt access to life-saving care. When individuals with a mental health condition are unable to get an appointment in a timely manner, a crisis situation often develops, resulting in the need for more intensive and expensive levels of care. Individuals with substance use disorders face unique health risks when they cannot find and enter treatment in a timely manner. Most will continue to use drugs or alcohol in harmful ways that pose an immediate threat to their lives. Five states have specific standard for mental health and substance use disorder providers: California, Colorado, Maine, Texas (HMO and PPO), and Vermont. California, Colorado, and Texas have shorter wait time standards for some substance use disorder and mental health providers than for medical conditions.

Questions have been raised about the enforceability of wait time standards. The twelve (12) states that have adopted wait time standards have proven that they are enforceable by regulators. Without more specific and uniform standards, consumer will never be able to enforce their rights under Maryland Insurance Article §15-830(d-g).

II. *Geographic Standards: An Important Supplement to Wait Time Standards but Must Include Both Distance and Travel Time*

We recommend that the MIA adopt geographic standards with requirements for three separate metrics using a uniform list of providers and facility types: geographic regions by county; distance from a member's residence; and, travel time from a member's residence.

A. Geographic Regions

First, we recommend that the MIA adopt the geographic regions and definitions as specified by CMS for Medicare Advantage Plans and for the 2017 Federally Facilitated Marketplace plans. Medicare divides each county into 5 geographic categories based on population density: large metro, metro, micro, rural, and counties with extreme access considerations (CEAC). This ensures that all areas of Maryland, not just rural, urban and suburban, are adequately addressed. Colorado and Nevada (FFM) have also adopted this geographic region framework. *See* CO BULLETIN NO. B-4.89, 4.90 and 4.91 (2016); CO PROPOSED REG. 4-2-53 Sec.8(C) (2017); and NEV. REV. STAT. § 57-687B.490 (2014); NEV. ADMIN. CODE § 687B.xxx(9) (2015). Medicare Advantage uses the category type to determine the number of specific primary care, specialty care, and behavioral health care providers that should be available in each region.

B. Distance and Travel Time

Second, we strongly recommend that the geographic standards address both distance and travel time from a member's residence, with the shorter of the two metrics governing. This is especially important for individuals who must use public transportation and will take into consideration that in a large urban area 5 miles could be a 45-minute travel time, as well as the limitations of public transportation outside of urban areas. Twelve (12) states have adopted both time and distance standards: Arizona, California, Kentucky, Minnesota, Nevada (FFM), New Hampshire, New Jersey, New Mexico, New York, Pennsylvania, Tennessee, and Washington (metric depends on service). Nine (9) other states with geographic standards have adopted either one or the other metric: Alabama (HMO) Arkansas, Colorado, Delaware, Missouri (HMO), Montana and Texas (HMO & PPO) have distance requirements, and Florida (HMO) and Vermont have travel time standards. See Attachment B.

C. Categorization of Providers

In order to ascertain compliance with both geographic and wait time standards, the MIA must articulate the types of providers and settings of care (i.e. facilities) that should be tracked in order to assess compliance with established standards. We recommend the adoption of specialty providers consistent with Colorado's recently adopted network standards with minor modifications in the mental health and substance use disorder provider list to conform to Maryland's health care delivery system.

As set out in the geographic standards chart, we recommend that the MIA adopt specific geographic standards for mental health and substance use disorder providers, rather than fold them into the "specialty" category. We have identified key provider categories that are reported in the Maryland Health Care Commission's Comprehensive Quality Report: psychiatrists, physicians certified in addiction medicine, psychologists, licensed social workers, therapists and counselors and alcohol and drug counselors. It is critically important that there are sufficient numbers of providers in each category to ensure reasonable wait and travel times. It is not enough to have one monolithic behavioral health category, because this could allow an insurer to have a network consisting of only non-prescribing mental health

providers to the detriment of members who need to see a psychiatrist or a provider specializing in substance use disorders. The NCQA, for example, identifies three different provider types for behavioral healthcare practitioners: MD/DO, doctoral non-MD/DO, and non-MD/DO practitioners.

In recommending distance and travel metrics, we have broken our recommendation into prescribing providers (physicians and advanced practice nurses) and non-prescribing providers (licensed social workers, therapists and counselors, and alcohol and drug counselors). For non-prescribing providers, we recommend standards that are no less protective than the requirements for primary care providers. Many individuals with a substance use disorder or mental health condition often see their behavioral health provider more frequently than their primary care provider or would consider their behavioral health provider to be their primary care provider. They should be able to access these providers without undue delay or travel. We have recommended a slightly less stringent geographic standard for prescribing providers and psychologists because patients may not need to see these practitioners as frequently and in recognition that there are fewer prescribing providers and psychologists.

In addition, consumers are able to access mental health and substance use disorder services in community-based facility or clinic settings, as well as from individual providers. We recommend that the MIA adopt standards for two specific facility types: federally licensed Opioid Treatment Programs (OTPs) and community based substance use disorder and mental health clinics. OTPs are the only entities in the state authorized by federal law to provide methadone treatment – an essential treatment for opioid use disorders. Outpatient clinics similarly provide significant levels of care for individuals and families and must be included and assessed in the pool of providers to create adequate networks. As we have also noted in our testimony, ensuring that consumers are able to access timely behavioral health care may require carriers to expand the reimbursable providers within facilities to include both the types of practitioners – licensed and certified – who are authorized by law to deliver care in Maryland.

Many states, including Colorado[1], Missouri (HMO)[2], New Hampshire[3], New Jersey[4], Vermont[5], and Washington[6], as well as Medicare Advantage establish specific behavioral health provider standards. Washington has the same distance standards for behavioral health as it has for primary care providers; Vermont, New Jersey and Missouri outpatient services have the same standard for behavioral health as primary care providers; and Medicare Advantage, Colorado and New Hampshire have shorter distance standards for behavioral health than for other specialties. Arkansas requires the submission of geographical access maps that provide data for three categories of

[1] Colorado provides enumerated standards for Licensed Clinical Social Workers, Psychiatry, and Psychology. The distance requirements provide for slightly longer distances than for primary care, OB/GYNs and routine pediatrics, but shorter distance requirements than most other specialty services. Co. Div. of Insurance, Bulletin No. B-4.90.

[2] Missouri provides enumerated standards for psychiatrists – adult, psychiatrists – child/adolescent, psychologist/other therapists, inpatient mental health treatment facilities, ambulatory mental health providers and residential mental health treatment providers. The distance standard for psychologists/other therapists is the same as that for primary care providers. The distance standard for all other outpatient services is either the same as the OB/GYN standard or a shorter distance than allowed for other specialties. The distance standard for inpatient behavioral health services is shorter than the distance standard for basic hospitals. 20 Mo. Code of State Reg. § 400.7095.

[3] New Hampshire provides enumerated standards for outpatient mental health providers, emergency mental health providers, inpatient psychiatry, and short term care facility for substance use treatment. The distance standard for outpatient mental health services, other than psychiatrists, is shorter than the distance for other specialists (which includes psychiatrists). The distance standard for inpatient mental health services and substance use treatment is the same as other inpatient services. Ins. § 2701.04.

[4] New Jersey provides enumerated standards for emergency mental health services, outpatient therapy for mental health and substance use conditions, inpatient psychiatric services for adults, adolescents and children and residential substance use treatment centers. The distance standards for outpatient mental health and substance use services are slightly longer than the distance standard for primary care services, but the travel time standards are the same as those for primary care services. N.J.A.C. § 11:24A-4.10.

[5] Vermont provides enumerated standards for outpatient mental health and substance use disorder services, intensive outpatient treatment, partial hospitalization and residential or inpatient mental health and substance use services. The time standard for routine, office-based services for mental health and substance use services is the same as the time standard for primary care services. The time standard for all other behavioral health services is the same as that for outpatient specialty services. Vt. Admin. Code § 4-5-3:10.500

[6] Washington provides enumerated standards for mental health and substance use disorder providers, including licensed psychiatrists, psychologists, social workers, and mental health nurse practitioners and also identifies the services that members must have access to through a provider or facility, including: evaluation and treatment, voluntary and involuntary inpatient mental health and substance use disorder treatment, outpatient mental health and substance use disorder treatment and behavioral therapy. The distance standards for the licensed practitioners is the same standard as that for primary care providers. 2016 WA Reg. Text 425217 (NS) amending WAC § 284-170-200

mental health and substance use disorder providers: psychiatric and state licensed clinical psychologists, substance use disorder providers, and "other mental health, behavioral health and substance use disorder providers with additional documentation describing the provider and facility types included in the other category." Ark. Admin. Code § 054.00.106-5(F)(3).

D. Compliance Metric

Finally, we recommend that the MIA require that at least 90% of a carrier's members meet the designated geographic time and distance standards. Six (6) states have implemented a similar requirement. These include Nevada (FFM), New Hampshire, New Jersey, New Mexico and Pennsylvania, which set a 90% target, and Washington, which sets an 80% target. While some of these targets apply generally to medical services, New Hampshire, New Jersey and Washington apply the targets to some or all mental health and substance use services.

The chart in Attachment A provides our comprehensive recommendations for geographic time and distance standards for each provider category and facility type.

III. Essential Community Providers: Changes are Required to Ensure Access

To ensure that lower-income individuals have access to health services in the settings in which many receive care, we recommend that the MIA adopt an essential community provider (ECP) standard for all health plans. We support and urge adoption of the requirements set forth by the Maryland Health Benefit Exchange for 2017 EHB-based plans, with the addition of standards discussed below for mental health and substance use disorder ECPs. These standards include:

- Expanding the definition of essential community provider to include local health departments, school-based programs and outpatient mental health and community-based substance use disorder programs.

- Requiring carriers to contract with at least 30% of available ECPs in each plan's service area as part of each plan's provider network.

- Requiring carriers to offer contracts in good faith to the following provider types: all available Indian Health Care Providers in the plan's service area; any willing local health department in the plan's service area; and, at least one ECP in each ECP category in each county in the carrier's service area.

In addition to the adoption of the expanded ECP category, we recommend that the MIA adopt a separate 30% contracting metric for mental health and substance use disorder providers as opposed to folding those providers into a single 30% ECP metric. Many individuals who seek treatment or are in long-term treatment, such as those with opioid use disorders or serious mental illness, have low incomes. This is often a result of their inability to work or work to their full capacity during periods of illness or active

alcohol or drug use. As individuals enter treatment and sustain recovery, many enter or reenter the workforce and find employment with health insurance benefits. Those individuals, however, may continue to participate in community-based treatment programs that have historically served persons in the public health system. For this reason, community-based programs, which deliver a significant portion of the SUD services in our state, must be included in private carrier networks.

We, therefore, recommend that the MIA adopt a separate requirement for carriers to contract with 30% of outpatient mental health and substance use disorder providers.[7] This standard improves upon the 2017 MHBE standard, which would only require carriers to offer a contract to one ECP in each county in the category in which substance use disorder programs are designated. This could result in the inclusion of no substance use disorder providers as they are in the expansion category that includes local health departments, outpatient mental health centers, and school-based health centers. Under the MHBE 2017 standards, any willing health department must be offered a contract, which would satisfy the carrier's obligation for this ECP category.

Finally, the MIA should adopt the FFE ECP calculation model for 2018 EHB-based plans as the standard for compliance demonstration. This model will count all individual providers at an ECP location as an ECP for purposes of calculating the 30% requirement. The MHBE has adopted this calculation methodology for its 2017 QHPs and that standards will likely be adopted by the FFE for 2018 plans. To the extent the FFE standard changes in the future, the State's metric will conform to that standard.

IV. Language Interpretation: Meeting the Needs of LEP Enrollees Will Help to Reduce Health Disparities

Providing access to language interpretation is essential to reducing health disparities, and has the potential to save costs to the health system by ensuring patients can communicate with their providers, arrive more quickly at a diagnosis and fully understand their treatment plan. Carriers should be required to disclose the steps they are taking to ensure that network providers provide access to language assistance services in accordance with the provisions of Section 1557 of the Affordable Care Act and all applicable regulations to ensure all Marylanders receive the right care. As HHS recognized in its 1557 regulations, carriers are encouraged to structure their plan payment structures to consider health plan providers' expenses in providing language assistance services.

[7] Using 2015 Medicaid provider data, the 30% requirement would result in the admission of approximately 110 substance and mental health providers, out of a total of 211 substance use disorder programs and 154 outpatient mental health centers.

V. Access Plans Must Be Public Documents

The accreditation organizations, NCQA and URAC, have been engaged in evaluating carriers' network adequacy for decades. NCQA notes "Determining whether a health plan provides adequate member access to care is a function of multiple indicators" and has long required carriers to establish: (1) provider-enrollee ratios for primary care, high-volume medical specialists and high-volume behavioral health specialists; (2) standards for geographic distribution of each type of primary care providers, high-volume medical specialists, and high-volume behavioral health specialists; and (3) appointment wait times for primary care and behavioral health.

We know from the Maryland Health Care Commission's report cards that all major carriers in the state have NCQA accreditation. Thus, it is reasonable to assume that each of these carriers has already established quantitative criteria for provider-enrollee ratios, geographic distribution, and appointment wait times and yet these criteria have not been shared publicly through the regulatory process.

In August, 2016, CHF submitted a PIA request seeking to review the access plans of the major carriers to determine whether the NCQA criteria are sufficient to assure consumers that every carrier has a network capable of delivering the care they need when they need it, and whether the criteria should form the basis for the MIA's quantitative criteria. To our great disappointment, the MIA denied the PIA request in its entirety. Accordingly, a clear disclosure requirement is essential.

We believe that, as indicated in the National Association of Insurance Commissioner's Health Benefit Plan Network Access and Adequacy Model Act, Section 5.E.2, the carriers' access plans should be public documents. Carriers should not be permitted to deem any part of the plans pertaining to how they perform against the quantitative standards, or the policies and procedures they use to comply with the statutory and regulatory requirements, as proprietary. The lack of transparency regarding network standards prevents Maryland's consumers from comparing health plans and ensuring that their plan will provide access to targeted health services. The adoption of quantitative standards in all metrics is needed to ensure consumers have the greatest opportunity to get access to the care they are paying for.

VI. Telehealth and Other Technology: A Promising Way to Supplement In-Person Access

We support the use of telehealth and other technology as a way to enhance consumers' access to high quality, affordable health care, and we look forward to working with stakeholders as such methods of access continue to develop. We also support the recommendations of the American Telemedicine Association regarding the inclusion of telemedicine usage in provider directories and network access plans.

We caution, however, that telehealth should not be the only way for a consumer to access care. Rather, it should supplement access to in-person care and should be used for the convenience and benefit of the consumer, not the provider or the carrier.

Consumers who prefer in-person care must have that option without undue travel or appointment wait times. In addition, to the extent telehealth standards are developed for providers, they must comply with the Mental Health Parity and Addiction Equity Act, insofar as the range of providers who are eligible to be reimbursed for those services as well as for the range of services to be reimbursed.

VII. Enforcement and Annual Reporting: Requirements Will Ensure Compliance and Transparency

While the establishment of standards is a most important first step, the MIA must also determine how articulated standards will be enforced and how the results of network adequacy testing are communicated to consumers. We make the following recommendations regarding enforcement, reporting and consumer engagement.

1. The MIA should use the template developed by CMS for the Federally Facilitated Exchange (FFE) to monitor compliance with time and distance standards. While the FFE does not require QHPs to demonstrate compliance with time and distance standards for all specialists, we feel that it is necessary to do so in Maryland, as Colorado has done, to fully protect consumers.
2. Regarding wait time standards, we recommend that the MIA adopt the testing and reporting requirements established by California. California has developed a common methodology that each carrier must use to measure its performance against the established standards. Carriers are required to demonstrate that their networks are adequate by performing periodic audits or provider surveys and reporting those results to the Department of Managed Health Care, which in turn reports the compliance scores for each carrier on their website.
3. The MIA should create a comprehensive website that explains the network adequacy regulations, posts all compliance reporting documents, clearly states the rights of consumers, and provides clear direction on where consumers can go for assistance.

Conclusion

The recommendations laid out in this report will ensure that Maryland's health care consumers have access to the health care providers they need to care for themselves and their families, and we strongly urge the MIA to adopt them as part of the network adequacy regulations being developed under HB1318. Only through robust network adequacy standards, coupled with strong reporting and enforcement requirements, can consumers be assured that the health insurance plans they are buying will provide adequate health care access.

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Drug Policy and Public Health Strategies Clinic

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Network Adequacy Quantitative Standards Report
Attachment A: Recommended Geographic Time and Distance Standards

Recommended Geographic Time & Distance Standards for Maryland										
	Geographic Type									
	Large Metro		Metro		Micro		Rural		CEAC	
Specialty	Max Time (mins)	Max Dist. (miles)	Max Time (mins)	Max Dist. (miles)	Max Time (mins)	Max Dist. (miles)	Max Time (mins)	Max Dist. (miles)	Max Time (mins)	Max Dist. (miles)
Primary Care	10	5	15	10	30	20	40	30	70	60
Gynecology, OB/GYN	10	5	15	10	30	20	40	30	70	60
Pediatrics - Routine/Primary	10	5	15	10	30	20	40	30	70	60
Advanced Practice Nurse	10	5	15	10	30	20	40	30	70	60
Alcohol and Drug Counselors	10	5	15	10	30	20	40	30	70	60
Allergy and Immunology	30	15	45	30	80	60	90	75	125	110
Cardiothoracic Surgery	30	15	60	40	100	75	110	90	145	130
Cardiovascular Disease	20	10	30	20	50	35	75	60	95	85
Chiropracty	30	15	45	30	80	60	90	75	125	110
Dermatology	20	10	45	30	60	45	75	60	110	100
Endocrinology	30	15	60	40	100	75	110	90	145	130
ENT/Otolaryngology	40	15	45	30	80	60	90	75	125	110
Gastroenterology	20	10	45	30	60	45	75	60	110	100
General Surgery	20	10	30	20	50	35	75	60	95	85
Gynecology only	30	15	45	30	80	60	90	75	125	110
Infectious Diseases	30	15	60	40	100	75	110	90	145	130
Licensed Clinical Social Worker	10	5	15	10	30	20	40	30	70	60
Licensed Therapists and Counselors	10	5	15	10	30	20	40	30	70	60
Nephrology	30	15	45	30	80	60	90	75	125	110
Neurology	20	10	45	30	60	45	75	60	110	100
Neurological Surgery	30	15	60	40	100	75	110	90	145	130
Oncology - Medical, Surgical	20	10	45	30	60	45	75	60	110	100
Oncology - Radiation/Radiation	30	15	60	40	100	75	110	90	145	130
Ophthalmology	20	10	30	20	50	35	75	60	95	85
Orthopedic Surgery	20	10	30	20	50	35	75	60	95	85
Physiatry, Rehabilitative	30	15	45	30	80	60	90	75	125	110

Recommended Geographic Time & Distance Standards for Maryland										
	Geographic Type									
	Large Metro		Metro		Micro		Rural		CEAC	
Specialty	Max Time (mins)	Max Dist. (miles)	Max Time (mins)	Max Dist. (miles)	Max Time (mins)	Max Dist. (miles)	Max Time (mins)	Max Dist. (miles)	Max Time (mins)	Max Dist. (miles)
Physicians certified in addiction medicine	20	10	30	20	50	35	75	60	95	85
Plastic Surgery	30	15	60	40	100	75	110	90	145	130
Podiatry	20	10	45	30	60	45	75	60	110	100
Psychiatry	20	10	30	20	50	35	75	60	95	85
Psychology	20	10	30	20	50	35	75	60	95	85
Pulmonology	20	10	45	30	60	45	75	60	110	100
Rheumatology	30	15	60	40	100	75	110	90	145	130
Urology	20	10	45	30	60	45	75	60	110	100
Vascular Surgery	30	15	60	40	100	75	110	90	145	130
OTHER MEDICAL PROVIDER	30	15	60	40	100	75	110	90	145	130
Dental	30	15	45	30	80	60	90	75	125	110
Pharmacy	10	5	15	10	30	20	40	30	70	60
Acute Inpatient Hospitals	20	10	45	30	80	60	75	60	110	100
Cardiac Surgery Program	30	15	60	40	160	120	145	120	155	140
Cardiac Catheterization	30	15	60	40	160	120	145	120	155	140
Critical Care Services – Intensive Care Units (ICU)	20	10	45	30	160	120	145	120	155	140
Outpatient Dialysis	20	10	45	30	65	50	55	50	100	90
Surgical Services (Outpatient)	20	10	45	30	80	60	75	60	110	100
Skilled Nursing Facilities	20	10	45	30	80	60	75	60	95	85
Diagnostic Radiology	20	10	45	30	80	60	75	60	110	100
Mammography	20	10	45	30	80	60	75	60	110	100
Physical Therapy	20	10	45	30	80	60	75	60	110	100
Occupational Therapy	20	10	45	30	80	60	75	60	110	100
Speech Therapy	20	10	45	30	80	60	75	60	110	100
Inpatient Psychiatric Facility	30	15	70	45	100	75	90	75	155	140
Orthotics and Prosthetics	30	15	45	30	160	120	145	120	155	140
Outpatient Infusion/Chemotherapy	20	10	45	30	80	60	75	60	110	100
Outpatient substance use and mental health clinics	20	10	45	30	65	50	65	50	100	90
Opioid Treatment Programs	20	10	45	30	65	50	65	50	100	90
OTHER FACILITIES	30	15	60	40	160	120	145	120	155	140

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Network Adequacy Quantitative Standards Report
Attachment B: Fifty-State Survey
Network Adequacy Quantitative Standards:
Geographic Criteria, Appointment Wait Times & Provider/Enrollee Ratios

Fifty-State Survey
Network Adequacy Quantitative Standards:
Geographic Criteria, Appointment Wait Times & Provider/Enrollee Ratios
Current through August 2016

Quantitative Standards in Commercial Insurance Plans:

- Twenty-three (23) states and Medicare Advantage have adopted one or more of the quantitative standards included in this survey to measure network adequacy in commercial insurance plans: Alabama (HMO), Arizona, Arkansas, California, Colorado, Delaware, Florida (HMO), Kentucky, Louisiana, Maine, Minnesota, Missouri (HMO), Montana, Nevada (FFM), New Hampshire, New Jersey, New Mexico, New York, Pennsylvania, Tennessee, Texas (HMO & PPO), Vermont, and Washington.
    - Nevada requires health plans to meet Federally-Facilitated Marketplaces (FFM) standards issued by CMS.
- Five (5) states require health plans to meet NCQA and/or other national accreditation standards:[1] Connecticut, Idaho, Indiana (HMO), Louisiana and New Hampshire (for wait time standards).
- An additional six (6) states have adopted quantitative standards to measure network adequacy for emergency services only: Michigan, Mississippi, Nebraska, North Dakota (HMO), South Dakota, and Virginia (HMO).

Appointment Wait Times:

- Twelve (12) states have established appointment wait time standards: Arizona, California, Colorado, Florida (HMO), Maine, Missouri (HMO), Montana, New Jersey, New Mexico, Texas (HMO & PPO), Vermont, and Washington.
    - Five (5) states have specific wait time standards for mental health and substance use disorder providers: California, Colorado, Maine, Texas (HMO and PPO), and Vermont.
    - An additional five (5) states require that plans satisfy NCQA appointment time standards for mental health and substance use disorder health visits: Connecticut, Idaho, Indiana (HMO), Louisiana, and New Hampshire.
- Eleven (11) states have adopted both wait time and geographic standards: Arizona, California, Colorado, Florida (HMO), Missouri (HMO), Montana, New Jersey, New Mexico, Texas (HMO & PPO), Vermont, and Washington.

Geographic Standards:

- Twenty-one (21) states have adopted or require geographic standards of network adequacy: Alabama (HMO), Arizona, Arkansas, California, Colorado, Delaware, Florida (HMO), Kentucky, Minnesota, Missouri (HMO), Montana, Nevada (FFM), New Hampshire, New Jersey, New Mexico, New York, Pennsylvania, Tennessee, Texas (HMO & PPO), Vermont, and Washington.

[1] NCQA requires carriers to establish quantitative standards to measure the availability and accessibility of primary care and specialty care. Carriers may also determine which medical specialties are subject to these quantitative standards. NCQA has established appointment wait time standards for behavioral health care.

- Eleven (11) states and Medicare Advantage have adopted or require geographic standards that account for population density: Arizona, Colorado, Delaware, Kentucky, Missouri (HMO), Nevada (FFM), New Mexico, New York, Pennsylvania, Texas (PPO), and Washington.
    - Colorado and Nevada (FFM) have adopted the population categories used by Medicare Advantage: Large Metro, Metro, Micro, Rural, and Counties with Extreme Access Considerations (CEAC).
- Twenty-one (21) states and Medicare Advantage have adopted or require time and/or distance criteria for their geographic standards.
    - Twelve (12) states have adopted or require both time and distance geographic requirements: Arizona, California, Kentucky, Minnesota, Nevada (FFM), New Hampshire, New Jersey, New Mexico, New York, Pennsylvania, Tennessee, and Washington.
    - Seven (7) states have adopted only distance requirements: Alabama (HMO), Arkansas, Colorado, Delaware, Missouri (HMO), Montana, and Texas (HMO & PPO).
    - Two (2) states have adopted only travel time requirements: Florida (HMO) and Vermont.
- Twenty (20) states and Medicare Advantage have adopted or require geographic criteria that vary by provider and/or facility-type: Alabama (HMO), Arizona, Arkansas, California, Colorado, Delaware, Florida (HMO), Kentucky, Minnesota, Missouri (HMO), Montana, Nevada (FFM), New Hampshire, New Jersey, New Mexico, New York, Tennessee, Texas (HMO & PPO), Vermont, and Washington.
    - Ten (10) states and Medicare Advantage have adopted or require geographic criteria specific to mental health and substance use disorder providers: California, Colorado, Delaware, Minnesota, Missouri (HMO), Nevada (FFM), New Hampshire, New Jersey, Vermont, and Washington.
- Six (6) states require a targeted percentage of members (90% unless otherwise designated) whose geographic access must meet the designated services: Nevada (FFM), New Hampshire, New Jersey, New Mexico, Pennsylvania, and Washington (80%).

Provider/Enrollee Ratio or Minimum Number of Providers:

- Nine (9) states and Medicare Advantage have adopted provider/enrollee ratios or a standard to determine the minimum number of providers available: California, Colorado, Delaware, Maine, Montana, New Jersey, New Mexico, New York, and Washington.
- Four (4) states require plans to meet the NCQA and/or other national accreditation requirement to measure the provider/enrollee ratio: Connecticut, Idaho, Indiana (HMO), and Louisiana.

This survey was prepared by Martha Marr, Drug Policy Clinic, University of Maryland Carey School of Law, under the supervision of Ellen Weber. For additional information, please contact Ellen Weber at eweber@law.umaryland.edu.

State[2]	Source	Geographic Criteria[3]	Appointment Wait Times	Provider/Enrollee Ratio
Alabama *(Standards apply to Health Maintenance Organizations)*	ALA. ADMIN. CODE R. 420-5-6-.06 (1999)	• The distance from the health maintenance organization's geographic service area boundary to the nearest primary care delivery site and the nearest institutional service site shall be a radius of no more than 30 miles. • Frequently utilized specialty services shall be within a radius of no more than 60 miles.	• Providers must have policies regarding emergency telephone consultation on a 24-hour per day, 7-day per week basis including qualified physician coverage for emergency services.	• No quantitative criteria provided.
Arizona *(Standards apply to Health Care Service Organizations)*	ARIZ. ADMIN. CODE § R20-6-1901 to 20-6-1921 (2005); Regulatory Bulletin 2006-07 (2006)[4]	• HCSO may require an enrollee to travel a greater distance in-area to obtain covered services from a contracted provider than the enrollee would have to travel to obtain equivalent services from a non-contracted provider, except where a network exception is medically necessary. • Urban areas: 1. Primary care services from a contracted PCP located within 10 miles or 30 minutes of the enrollee's home; 2. High profile specialty care services from a contracted SCP located within 15 miles or 45 minutes of the enrollee's home; and 3. Inpatient care in a contracted general hospital, or contracted special hospital, within	• Preventive care services from a contracted PCP, an appointment date within 60 days of the enrollee's request, or sooner if necessary, for the enrollee to be immunized on schedule. • Routine-care services from a contracted PCP, an appointment date within 15 days of the enrollee's request or sooner if medically necessary. • For specialty care services from a contracted SCP, an appointment date within 60 days of the enrollee's request or sooner if medically necessary. • In-area urgent care services from a contracted provider 7 days per week.	• No quantitative criteria provided.

[2] States not identified have no quantitative standards for the network adequacy metrics included in this survey.
[3] Note that 3 states (Arizona, Arkansas, and New Hampshire) provide standards regarding the type, format, or level of detail required of maps that must be submitted to show compliance with geographic criteria.
[4] https://insurance.az.gov/sites/default/files/documents/files/2006-07.pdf

		25 miles or 75 minutes of the enrollee's home. • Suburban areas: 1. Primary care from a contracted PCP located within 15 miles or 45 minutes of the enrollee's home; 2. High profile specialty care services from a contracted SPC within 20 miles or 60 minutes of the enrollee's home; and 3. Inpatient care in a contracted hospital, or a contracted special hospital within 30 miles or 90 minutes of the enrollee's home. • Rural areas: Primary care services from a contracted physician or practitioner within 30 miles or 90 minutes of the enrollee's home.	• Timely non-emergency inpatient care services from a contracted facility. • Timely services from a contracted physician or practitioner in a contracted facility including inpatient emergency care. Services from a contracted ancillary provider during normal business hours, or sooner if medically necessary.	
Arkansas *(Standards apply to health benefit plans)*	054-00 ARK. CODE R. §§ 077 (2014)	• Emergency services within a 30 mile radius of residence. • Primary care professional – at least one within 30 mile radius of residence. • Specialty care services within 60 mile radius of residence. • For QHPs: at least 1 essential community provider within a 30 mile radius of residence.	• Access to emergency services 24 hours per day, 7 days per week.	• No quantitative criteria provided.
California *(Standards apply to health insurance policies)*	CAL. CODE REGS. TIT. 10, § 2240.1 to 2240.15 (2016)	• Facilities used by providers to render health care services are located within reasonable proximity to the work places or the principal residences of the primary covered persons, are reasonably accessible by public transportation and are reasonably accessible, both	• Health care services available at least 40 hours per week, except for weeks including holidays. Such services shall be available until at least 10:00 p.m. at least one day per week or for at least four hours each Saturday, except for Saturdays falling on holidays.	• At least 1 full-time physician per 1,200 covered persons and at least the equivalent of 1 full-time primary care physician per 2,000 covered persons.

		physically and in terms of provision of service, to covered persons with disabilities. • Max travel time for PCP 30 minutes or max travel distance 15 miles from insured's residence or workplace. • Max travel time for specialists 60 minutes or max travel distance 30 miles from insured's residence or workplace. • Max travel time for MH/SUD professionals 30 minutes or max travel distance 15 miles from insured's residence or workplace. • Max travel time for hospital 30 minutes or max travel distance of 15 miles from insured's residence or workplace. • Networks for mountainous rural areas shall take into consideration typical patterns of winter road closures, so as to comply with access and timeliness standards throughout the calendar year.	• Emergency health care services are available and accessible within the service area at all times. • <u>Appointments meet the following timeframes</u>: ○ Urgent care appointments for services that do not require prior authorization: within 48 hours of the request for appointment, ○ Urgent care appointments for services that require prior authorization: within 96 hours of the request for appointment ○ Non-urgent appointments for primary care: within 10 business days of the request for appointment ○ Non-urgent appointments with specialist physicians: within 15 business days of the request for appointment ○ Non-urgent appointments with a non-physician mental health or substance use disorder provider: within 10 business days of the request for appointment • Non-urgent appointments for ancillary services for the diagnosis or treatment of injury, illness, or other health condition: within 15 business days of the request for appointment.	
Colorado	CO Bulletin No. B-4.89 (2016);	• <u>Primary Care, OB/GYN, Pediatric Primary Care</u> ○ Large Metro – within 5 miles	• Emergency Care (Medical, Behavioral, Substance Abuse) – 24 hours per day, 7 days per	• 1:1000 for large metro, metro, and micro areas (primary care,

(Standards apply to health benefit plans)	CO Bulletin No. B-4.90 (2016); CO Bulletin No. B-4.91 (2016); CO Proposed Reg. 4-2-53 (2017)	○ Metro – within 10 miles ○ Micro – within 20 miles ○ Rural – within 30 miles ○ CEAC - within 60 miles • <u>Mental Health and Substance Use Disorder (Licensed Clinical Social Worker, Psychiatrist, Psychologist)</u> ○ Large Metro –10 miles ○ Metro – 30 miles ○ Micro – 45 miles ○ Rural – 60 miles ○ CEAC – 100 miles • <u>Specialty Care (see specific specialty)</u> ○ Large Metro – ranges from 10 to 15 miles, based on specialty ○ Metro – ranges from 20 to 40 miles, based on specialty ○ Micro – ranges from 35 to 75 miles, based on specialty ○ Rural – ranges from 60 to 90 miles, depending on specialty ○ CEAC – ranges from 85 to 130 miles, depending on specialty • <u>Other Medical Providers (Includes other MH/SUD providers):</u> ○ Large Metro – within 15 miles ○ Metro – within 40 miles ○ Micro - within 75 miles ○ Rural – within 90 miles ○ CEAC – within 130 miles • Facilities (see specific facility type) ○ Large Metro – ranges from 5 to 15 miles, depending on facility type ○ Metro – ranges from 10 to 45 miles, depending on facility type	week, with time-frame met 100% of the time • Urgent Care (Medical, Behavioral, Mental Health and Substance Abuse) - Within 24 hours, with time-frame met 100% of the time • Behavioral Health, Mental Health and Substance Abuse Care (Routine, non-urgent, non-emergency) - Within 7 calendar days, with timeframe met ≥ 90% of the time. • PCP: Within 7 calendar days, with goal met ≥ 90% of the time; • Prenatal Care: Within 7 calendar days, with goal met ≥ 90% of the time; • Primary Care Access to after-hours care: Office number answered 24 hrs./ 7 days a week by answering service or instructions on how to reach a physician, with goal met ≥ 90% of the time; • Preventive visit/well visits: Within 30 calendar days, with goal met ≥ 90% of the time; • Specialty Care: Within 60 calendar days, with goal met ≥ 90% of the time	pediatrics, OB/GYN, Mental health, behavioral health and SUD care providers)

		○ Micro – ranges from 20 to 120 miles, depending on facility type ○ Rural – ranges from 30 to 120 miles, depending on facility type ○ CEAC – ranges from 60 to 140 miles, depending on facility type • Other Facilities (see specific facility type): ○ Large Metro – within 15 miles ○ Metro – within 40 miles ○ Micro - within 120 miles ○ Rural – within 120 miles ○ CEAC – within 140 miles • In some circumstances, access may require crossing of county or state lines.		
Connecticut *(Standards apply to health insurance policies)*	2016 CONN. LEGIS. SERV. P.A. 16-205 (S.B. 433) (WEST) (2016)	• Must maintain a network consistent with NCQA or URAC requirements.	• Must maintain a network consistent with NCQA or URAC requirements • Covered persons shall have access to emergency services 24 hours per day, 7 days per week.	• Must maintain a network consistent with NCQA or URAC requirements
Delaware *(Separate standards apply to Managed Care Organizations and Qualified Health Plans)*	MCO: 18-1400-1403 DEL. CODE REGS. § 1.0 (2007); QHP: Delaware QHP Guidance Document[5] (2014)	MCO: • No quantitative criteria provided. QHP: • PCP: 15 miles in Urban/Suburban area, 25 miles in rural area • OB/GYN: 15 miles in Urban/Suburban area, 25 miles in rural area • Pediatrician: 15 miles in Urban/Suburban area, 25 miles in rural area	MCO: • Health care services shall be available 24 hours per day and 7 days per week for urgent or emergency conditions. QHP: • No quantitative criteria provided.	MCO: • No quantitative criteria provided. QHP: • PCP: 1:2,000 patients. • Behavioral health practitioner or mid-level professional (licensed psychologists, psychiatric nurse specialists, Licensed

[5] http://dhss.delaware.gov/dhcc/files/ChooseDE.pdf

		• Specialty Care Providers: 35 miles in Urban/Suburban area, 45 miles in rural area • Behavioral Health/Mental Health/Substance Abuse Providers: 35 miles in Urban/Suburban area, 45 miles in rural area • Acute-care hospitals: 15 miles in Urban/Suburban area, 25 miles in rural area • Psychiatric hospitals: 35 miles in an Urban/Suburban area, 45 miles in a rural area • Dental: 35 miles in Urban/Suburban area; 45 miles in rural area		Clinical Social Workers, Licensed Professional Counselors of Mental Health, Licensed Marriage & Family Therapists) supervised by an advanced-degree behavioral health practitioner: 1:2,000
Florida *(Standards apply to Health Maintenance Organizations and Prepaid Health Clinics)*	FLA. ADMIN. CODE ANN. R. 59A-12.006 (2003)	• Average travel time from the HMO geographic services area boundary to the nearest primary care delivery site and to the nearest general hospital no longer than 30 minutes under normal circumstances. • Average travel time from the HMO geographic services area boundary to the nearest provider of specialty physician services, ancillary services, specialty inpatient hospital services and all other health services of no longer than 60 minutes under normal circumstances.	• Emergencies will be seen immediately • Urgent cases will be seen within 24 hours; • Routine symptomatic cases will be seen within 2 weeks; and • Routine non-symptomatic cases will be seen as soon as possible. • Patients with appointments should have a professional evaluation within one hour of scheduled appointment time. If a delay is unavoidable, patient shall be informed and provided an alternative	• No quantitative criteria provided.
Idaho *(Standards apply to*	IDAHO ADMIN. CODE R 41-3915 (2015); 2016 QHP Standards	• Carriers must meet NCQA, AAAHC or URAC standards.	• Carriers must meet NCQA, AAAHC or URAC standards.	• Carriers must meet NCQA, AAAHC or URAC standards.

Qualified Health Plans)	Guidance Document[6]			
Indiana *(Standards apply to Health Maintenance Organizations)*	IND. CODE ANN. § 27-13-36-2 to IC 27-13-36-12 (Burns) (1999)	• Must comply with standards developed by NCQA or a successor organization.	• Must comply with standards developed by NCQA or a successor organization.	• Must comply with standards developed by NCQA or a successor organization.
Kentucky *(Standards apply to Qualified Health Plans and Managed Care Plans)*	KY. REV. STAT. § 304.17A-515 (West 2016); 900 KY. ADMIN. REGS. 10:010 (2015)	• Urban areas: a provider network that is available to all persons enrolled in the plan within 30 miles or 30 minutes of each person's place of residence or work, to the extent that services are available; or • Non-urban areas: primary care physician services, hospital services, and pharmacy services within 30 minutes or 30 miles of each enrollee's place of residence or work, to the extent those services are available. • Non-urban areas: all other providers within 50 minutes or 50 miles of each enrollee's place of residence or work, to the extent those services are available.	• No quantitative criteria provided.	• No quantitative criteria provided.
Louisiana *(Standards apply to Health Benefit Plans)*	LA. REV. STAT. ANN. § 22:1019.2 (2013)	• Carriers must meet standards for NCQA, American Accreditation Health Commission, Inc., or URAC accreditation.	• Carriers must meet standards for NCQA, American Accreditation Health Commission, Inc., or URAC accreditation. • Emergency services and ancillary emergency health care services	• Carriers must meet standards for NCQA, American Accreditation Health Commission, Inc., or URAC accreditation.

[6] http://doi.idaho.gov/Consumer/HCReform/2016QHPStandardsforYHI215.pdf

			shall be available 24 hours per day and 7 days per week.	• PCP: minimum ratio of 1 full-time equivalent primary care provider to 2000 enrollees.
Maine *(Standards apply to Health Maintenance Organizations, Managed Care Plans, and health plans)*	850 ME. CODE R. §02-031 (2012	• Carriers must define high-volume specialty care and behavioral health practitioners and establish quantifiable and measurable standards for the geographic distribution of each type of practitioner	• Behavioral Health: ○ Care for non-life-threatening emergencies within 6 hours; ○ urgent care within 48 hours; and ○ an appointment for a routine office visit within 10 business days • Managed care plans must provide access to emergency services at all times.	• PCPs: 1:2000 • Carriers must define high-volume specialty care and behavioral health practitioners and establish quantifiable and measurable standards for the number of each type of practitioner
Michigan *(Standards apply to health insurance issuers, including Health Maintenance Organizations)*	MICH. COMP. LAWS SERV. § 500.221 (2016); Michigan Network Adequacy Guidance Document[7]	• No quantitative criteria provided.	• Services available and accessible to covered persons 24 hours a day and 7 days a week for the treatment of emergency episodes of illness or injury.	• No quantitative criteria provided.
Minnesota *(Standards apply to health carriers)*	MINN. STAT. ANN. § 62K.10 (2013); MINN. STAT. ANN. § 62Q.19 (2013)	• Primary care services, mental health services, and general hospital services: maximum travel distance or time shall be the lesser of 30 miles or 30 minutes to the nearest provider. • Specialty physician services, ancillary services, specialized hospital services, and all other health	• PCP services are available and accessible 24 hours per day, seven days per week, within the network area	• No quantitative criteria provided.

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

		services: maximum travel distance or time shall be the lesser of 60 miles or 60 minutes to the nearest provider.		
Mississippi *(Standards apply to Managed Care Plans)*	MISS. ADMIN. CODE R. 19-3:14.05 (2014); MS Bulletin No. 2015-4 (MS INS BUL) (2015)	• No quantitative criteria provided.	• Emergency facility services shall provide access 24 hours/day and 7 days/week.	• No quantitative criteria provided.
Missouri *(Standards apply to Health Maintenance Organizations offering Managed Care Plans)*	MO. REV. STAT. § 354.603 (2007); MO. CODE REGS. ANN. tit. 20, § 400-7.095 (2007)	• PCPs: within 10 miles in urban areas; 20 miles in basic areas; 30 miles in rural areas • OB/GYN: within 15 miles in urban areas; 30 miles in basic areas; 60 miles in rural areas • Specialists: within 25 miles in urban areas; 50 miles in basic areas; 100 miles in rural areas • Basic hospital, physical and speech therapy: 30 miles in urban, basic and rural areas • Psychiatrist-Adult/General: within 15 miles in urban areas; 40 miles in basic areas; 80 miles in rural areas • Psychiatrist-Child/Adolescent: within 22 miles in urban areas; 45 miles in basic areas; 90 miles in rural areas • Psychologists/Other Therapists: within 10 miles in urban areas; 20 miles in basic areas; 40 miles in rural areas	• Routine care, without symptoms— within 30 days from the time the enrollee contacts the provider; • Routine care, with symptoms—within 5 business days from the time the enrollee contacts the provider; • Urgent care for illnesses/injuries which require care immediately, but which do not constitute emergencies: within 24 hours from the time the enrollee contacts the provider; • Emergency care—a provider or emergency care facility shall be available 24 hours per day, 7 days per week for enrollees who require emergency care; • Obstetrical care—within 1 week for enrollees in the first or second trimester of pregnancy; within 3 days for enrollees in the third trimester. Emergency obstetrical	• No quantitative criteria provided.

		• Inpatient mental health treatment facility: within 25 miles in urban areas; 40 miles in basic areas; 75 miles in rural areas • Ambulatory mental health treatment providers: within 15 miles in urban areas; 25 miles in basic areas; 45 miles in rural areas • Residential mental health treatment providers: within 20 miles in urban areas; 30 miles in basic areas; 50 miles in rural areas (Not full list) Exhibit A[8]	care is subject to the same standards as emergency care, except that an obstetrician must be available 24 hours per day, 7 days per week for enrollees who require emergency obstetrical care; and • Mental health care – telephone access to licensed therapist shall be available 24 hours/day and 7 days/week.	
Montana *(Standards apply to Managed Care Plans)*	MONT. CODE ANN. § 33-36-201 (2003); MONT. ADMIN. R. 37.108.201 to 37.108.241 (2003)	• Carrier must have an adequate network of primary care providers; a hospital, critical access hospital, or medical assistance facility; and a pharmacy that is located within a 30 mile radius of each enrollee's residence or place of work, unless: ○ the usual and customary travel pattern of the general population within the service area to reach health care providers is further, and if the fact that the usual and customary travel pattern exists is documented by the health carrier; or ○ the provider is available but does not meet the health carrier's reasonable credentialing requirements; and	• Emergency services must be available and accessible at all times; • Urgent care appointments must be available within 24 hours; • Non-urgent care with symptoms appointments must be available within 10 calendar days; • Immunization appointments must be available within 21 calendar days; and • Routine or preventive care appointments for must be available within 45 calendar days.	• Must include 1 mid-level PCP per 1,500 projected enrollees or 1 physician PCP per 2,500 projected enrollees.

[8]https://1.next.westlaw.com/Document/N3CCEA04817E94397B6AFE13132B8D4AF/View/FullText.html?navigationPath=%2FRelatedInfo%2Fv1%2FkcCitingReferences%2Fnav%3FdocGuid%3DNCBA45B3049A111DB9A80B90E4B840C8B%26midlineIndex%3D24%26warningFlag%3DN%26planIcons%3DNO%26skipOutOfPlan%3DNO%26sort%3Ddatedesc%26category%3DkcCitingReferences%26origDocSource%3D45a534b8961245069c4697aa0cf40369&listSource=RelatedInfo&list=CitingReferences&rank=24&originationContext=citingreferences&transitionType=CitingReferencesItem&contextData=%28sc.Default%29

		○ if no qualified provider for a service covered by the plan exists within a 30 mile radius of an enrollee's residence or place of work, the health carrier must document how covered services will be provided at no additional charge to enrollees through referrals to qualified providers outside the 30 mile radius. • At the time of initial selection or the renewal of a managed care plan, the maximum number of eligible employees residing and working outside the 30 mile radius of the primary place of work may not exceed the following: ○ for groups with 2 to 5 employees, 1; ○ for groups with 6 to 15 employees, 2; ○ for groups with 16 to 30 employees, 3, and ○ for groups with 30 or more employees, 10% of the employees.		
Nebraska *(Standards apply to Managed Care Plans)*	NEB. REV. STAT. ANN § 44-7105 (1998)	• No quantitative criteria provided.	• Emergency facility services: access 24 hours per day, 7 days per week.	• No quantitative criteria provided.
Nevada *(Standards apply to Health Benefit Plans)*	NEV. REV. STAT. § 57-687B.490 (2014); NEV. ADMIN. CODE § 687B.xxx(9) (2015)	• Must meet the standards in the 2017 Letter to Issuers in the Federally-facilitated Marketplaces issued by CMS. That letter provides the following standards: • Primary Care	• Must meet the standards in the 2017 Letter to Issuers in the Federally-facilitated Marketplaces issued by CMS. That letter does not provide quantitative standards.	• Must meet the standards in the 2017 Letter to Issuers in the Federally-facilitated Marketplaces issued by CMS. That letter does not provide quantitative standards.

		○ Large Metro – within 10 minutes/5 miles ○ Metro – within 15 minutes/10 miles ○ Micro – within 30 minutes/20 miles ○ Rural – within 40 minutes/30 miles ○ CEAC - within 70 minutes/60 miles • <u>Mental Health (Including Substance Use Disorder)</u> ○ Large Metro – within 20 minutes/10 miles ○ Metro – within 45 minutes/30 miles ○ Micro – within 60 minutes/45 miles ○ Rural – within 75 minutes/60 miles ○ CEAC – within 110 minutes/100 miles • <u>Other Specialty Care</u> ○ Large Metro – ranges from 20 to 30 minutes or 10 to 15 miles, based on specialty ○ Metro – ranges from 45 to 60 minutes or 30 to 40 miles, based on specialty ○ Micro – ranges from 60 to 100 minutes or 45 to 75 miles, based on specialty ○ Rural – ranges from 75 to 110 minutes or 60 to 90 miles , depending on specialty ○ CEAC – ranges from 110 to 145 minutes or 100 to 130 minutes, depending on specialty • Plans must provide access to at least one provider in each of the above-listed provider types for at least 90% of enrollees.		

New Hampshire *(Standards apply to Managed Care Plans)*	N.H. CODE ADMIN. R. INS 2701.04 to 2701.10 (2010)	• PCPs: At least 2 open panel primary care providers within 15 miles or 40 minutes average driving time of at least 90 percent of the enrolled population within each county or hospital service area. • Key Specialists (list includes psychiatrists): Within 45 miles or 60 minutes travel time for at least 90 percent of the enrolled population within each county or hospital service area. • Pharmacy shall be 15 miles or 45 minutes travel time; • Provider of outpatient mental health services shall be 25 miles or 45 minutes travel time; • The travel time interval for the following list of services shall be 45 miles or 60 minutes o Licensed medical-surgical, pediatric, obstetrical and critical care services associated with acute care hospital services; o Surgical facilities associated with acute care hospital services; o General inpatient psychiatric; o Emergency mental health provider; o Short term care facility for involuntary psychiatric admissions; o Short term care facility for substance abuse treatment; and o Short term care facility for inpatient medical rehabilitation services.	• Standard waiting times for appointments shall be measured from the initial request for an appointment and shall meet NCQA requirements.	• No quantitative criteria provided.

New Jersey *(Standards apply to Managed Care Plans)*	N.J. ADMIN. CODE § 11:24A-4.10 (2011)	• PCPs – at least 2 within 10 miles or 30 minutes driving time or public transit time (if available), whichever is less, of 90 percent of the carrier's covered persons. Medical specialist access within 45 miles or one hour driving time, whichever is less, of 90 percent of covered persons within each county or approved sub-county service area. • Institutional providers - maintain geographic accessibility of the services subject to no less than the following: ○ At least one licensed acute care hospital with licensed medical-surgical, pediatric, obstetrical and critical care services in any county or service area that is no greater than 20 miles or 30 minutes driving time, whichever is less, from 90% covered persons within county/service area ○ Surgical facilities, including acute care hospitals, licensed ambulatory surgical facilities, and/or Medicare-certified physician surgical practices available in each county or service area that are no greater than 20 miles or 30 minutes driving time, whichever is less, from 90% covered persons ○ Specialized services available within 45 miles or 60 minutes average driving time, whichever is less, of 90 percent of covered persons within each county or service area:	• Emergencies shall be triaged immediately through the PCP or by a hospital emergency department through medical screening or evaluation; • Urgent care shall be provided within 24 hours of notification of the PCP or carrier; and • In both emergent and urgent care, PCPs shall be required to provide 24 hour per day, 7days per week access to triage services; • Routine appointments can be scheduled within at least 2 weeks; and • Routine physical exams can be scheduled within at least 4 months.	• The carrier shall demonstrate sufficiency of network PCPs to meet the adult, pediatric and primary ob/gyn needs of the current and/or projected number of covered persons by assuming:(1) 4 primary care visits per year per member, averaging one hour per year per member; and(2) 4 patient visits per hour per PCP. To demonstrate PCP availability, a carrier shall verify that the PCP has committed to providing a specific number of hours for new patients that cumulatively add up to projected clinic hour needs of the projected number of covered persons by county or service area.

		▪ Hospital providing regional perinatal services and tertiary pediatric services ▪ In-patient psychiatric services for adults, adolescents and children; ▪ Residential substance abuse treatment centers; ▪ Specialty out-patient centers for HIV/AIDS, sickle cell disease, hemophilia, and cranio-facial and congenital anomalies; and ▪ Comprehensive rehabilitation services. ○ Services will be available within 20 miles or 30 minutes average driving time, whichever is less, of 90 percent of covered persons within each county or service area: ▪ Emergency mental health service, including a short term care facility for involuntary psychiatric admissions; ▪ Outpatient therapy for mental health and substance abuse conditions; ▪ Licensed long-term care facility, therapeutic radiations, MRI, diagnostic radiology, renal dialysis ▪ In any county or approved service area in which 20 percent or more of a carrier's projected or actual number of covered persons must rely upon public transportation to access health care services, as documented by U.S. Census Data, the driving times set forth in the specifications above shall be based upon average transit		

		time using public transportation, and the carrier shall demonstrate how it will meet the requirements in its application.		
New Mexico *(Standards apply to Managed health care plans)*	N. M. STAT. ANN. § 59A-57-4 (1998); N.M. CODE § 13.10.22 (1998)	• In population areas of 50,000 or more residents, 2 PCPs are available within no more than 20 miles or 20 minutes average driving time for 90 percent of the enrolled population, or, in population areas of less than 50,000, 2 PCPs are available in any county or service area within no more than 60 miles or 60 minutes average driving time for 90 percent of the enrolled population. • For remote rural areas, the superintendent shall consider on a case by case basis whether the MHCP has made sufficient PCPs available given the number of residents in the county or service area and given the community's standard of care. • Attempt to provide at least one licensed medical specialist in those specialties that are generally available in the geographic area served, taking into consideration the urban or rural nature of the service area, the geographic location of each covered person, and the type of specialty care needed by the covered person population. • In population areas of 50,000 or more residents, at least one licensed acute care hospital providing, at a	• Emergency care is immediately available without prior authorization requirements. The medical needs of covered persons are met 24 hours per day, seven days per week. • Urgent care shall be available within 48 hours of notification to the PCP or MHCP, or sooner as required by the medical exigencies of the case; • For emergent and urgent care, triage services by PCP 7 days per week and 24 hours per day • Routine appointments scheduled as soon as is practicable given the medical needs of the covered person and the nature of the health care professional's medical practice; • Routine physical exams shall be scheduled within 4 months; • All appointments shall be scheduled either during normal business hours or after hours (if applicable), depending upon the individual patient's needs and in accordance with the individual physician's scheduling practice.	• Must have a sufficient number of PCPs to meet the primary care needs of the enrolled population, using, as guidelines for calculation, the following criteria: 1) that each covered person will have four primary care visits annually, averaging a total of one hour; 2) that each PCP will see an average of four patients per hour; and 3) that one full-time equivalent PCP will be available for every 1,500 covered persons.

		minimum, licensed medical-surgical, emergency medical, pediatric, obstetrical, and critical care services is available no greater than 30 miles or 30 minutes average driving time for 90 percent of the enrolled population within the service area, and, in population areas of less than 50,000, that the acute care hospital is available no greater than 60 miles or 60 minutes average driving time for 90 percent of the enrolled population within the service area. • For remote rural areas, the superintendent shall consider on a case by case basis whether the MHCP has made at least one licensed acute care hospital available given the number of residents in the county or service area and given the community's standard of care.		
New York *(Standards apply to issuers of health insurance contracts or policies)*	N.Y. INS. LAW § 3241 (2015); Standards Guidance Document[9]	• Must be geographically accessible (i.e., meeting time/distance standards) and be accessiblefor people with disabilities. • PCPs: ○ Metropolitan Areas: 30 minutes by public transportation. ○ Non-Metropolitan Areas: 30 minutes or 30 miles by public transportation or by car. ○ In rural areas, transportation may exceed these standards if justified.	• No quantitative criteria provided.	• A choice of 3 PCPs in each county, and potentially more based on enrollment and geographic accessibility; and • At least 2 of each specialist provider type, and potentially more based on enrollment and geographic accessibility. • Carrier must offer insureds a choice of 2

[9] http://www.dfs.ny.gov/insurance/health/Network_Adeq_standards_guidance.pdf

		• Providers other than PCPs: It is preferred that an insurer meet the 30 minute or 30 mile standard. • At least one hospital in each county and at least 3 hospitals for Erie, Monroe, Nassau, Suffolk,Westchester, Bronx, Kings, New York and Queens Counties.		primary dentists in their service area and achieve a ratio of at least 1 primary care dentist for each 2,000 insureds. • Networks must include at least 2 orthodontists, 1 pedodontist and 1 oral surgeon.
North Dakota *(Standards apply to Health Maintenance Organizations)*	N.D. ADMIN. CODE 45-06-07-06 (1994)	• No quantitative criteria provided.	• Emergency Services available and accessible 24 hours/day and 7 days/week.	• No quantitative criteria provided.
Pennsylvania *(Standards apply to Managed Care Plans)*	28 PA. CODE § 9.679 (2001)	• Plan shall provide for at least 90% of its enrollees in each county in its service area, access to covered services that are within 20 miles or 30 minutes travel from an enrollee's residence or work in a county designated as a metropolitan statistical area (MSA) and within 45 miles or 60 minutes travel from an enrollee's residence or work in any other county. Standard applies to primary care, specialty care and other health care facilities and services necessary to provide covered benefits. Standards also apply to prescription drugs, vision, dental and DME, to extent provided.	• No quantitative criteria provided.	• No quantitative criteria provided.

South Dakota *(Standards apply to Managed Care Plans)*	S.D. CODIFIED LAWS § 58-17F-5 to 58-17F-9 (2011); S.D. ADMIN. R. 20:06:33:04 (2011)	• No quantitative criteria provided.	• Emergency services available twenty-four hours a day, seven days a week.	• No quantitative criteria provided.
Tennessee *(Standards apply to Health Maintenance Organizations and Managed Care Plans)*	TENN. CODE ANN. § 56-7-2356 (1998); TENN. COMP. R. & REGS. 1200-8-33-.06 (2003)	• Managed health insurance issuer and HMOs shall demonstrate the following: ○ An adequate number of acute care hospital services, within a reasonable distance or travel time; ○ An adequate number of primary care providers and hospitals within not more than 30 miles distance or 30 minutes travel time at a reasonable speed; ○ An adequate number of specialists and subspecialists, within a reasonable distance or travel time. • Point of service providers shall see patients on a timely basis.	• Access to emergency services 24 hours per day, 7 days per week. • For HMOs, the hours of operation and service availability for behavioral health care must reflect the needs of members needing behavioral health care.	• No quantitative criteria provided.
Texas *(Separate standards apply to Health Maintenance Organizations and Preferred Provider Organizations)*	HMO: 28 TEX. ADMIN. CODE § 11.1607 (2006); PPO: 28 TEX. ADMIN. CODE § 3.3704 (2013)	HMO: • 30 miles for primary care and general hospital care; and 75 miles for specialty care, specialty hospitals, and single healthcare service plan physicians or providers. PPO: • Provide for preferred benefit services sufficiently accessible and available as necessary to ensure that the distance from any point in the	HMO: • Emergency care, general, special, and psychiatric hospital care available and accessible 24 hours per day, 7 days per week, within the HMO's service area. • Urgent care shall be available: ○ medical, dental and behavioral health conditions within 24 hours; • Routine care shall be available: ○ medical conditions within 3 weeks ;	HMO: • No quantitative criteria provided. PPO: • No quantitative criteria provided

		insurer's designated service area to a point of service is not greater than: ○ Primary care and general hospital care - 30 miles in non-rural areas and 60 miles in rural areas ; and ○ Specialty care and specialty hospitals - 75 miles.	○ behavioral health conditions within 2 weeks ○ dental conditions within 8 weeks ; and • Preventive health services shall be available: ○ within 2 months for a child; ○ within 3 months for an adult; and ○ within 4 months for dental services. PPO: • Emergency care available 24 hours/day and 7 days/week • Urgent care for medical and behavioral health conditions available and accessible within designated service area within 24 hours • Routine care: ○ within 3 weeks for medical conditions; and ○ within 2 weeks for behavioral health conditions; • Preventive health services: • within 2 months for a child, or earlier if necessary for compliance with recommendations for specific preventive care services; and within 3 months for an adult.	
Vermont *(Standards apply to*	21-040-010 VT. CODE R. § 1 (2009)	• Travel times from residence or place of business, generally should not exceed: ○ Primary care provider - 30 minutes ;	• Immediate access to emergency care • Urgent care - 24 hours or a time frame consistent with the medical	• No quantitative criteria provided

Managed Care Organizations)		○ Mental health and substance abuse services routine, office-based services - 30 minutes ; ○ Outpatient physician specialty care; intensive outpatient, partial hospital, residential or inpatient mental health and substance abuse services; laboratory; pharmacy; general optometry; inpatient; imaging; and inpatient medical rehabilitation services - 60 minutes; ○ Kidney transplantation; major trauma treatment; neonatal intensive care; and tertiary-level cardiac services, including procedures such as cardiac catheterization and cardiac surgery -- 90 minutes; and ○ Reasonable accessibility for other specialty services, including major burn care, organ transplantation (other than kidneys), and specialty pediatric care.	exigencies of the case for urgent care • Outpatient mental health and substance abuse care designated by the member or provider as non-urgent is not considered to be urgent care; • Non-emergency, non-urgent care - 2 weeks ; • Preventive care, including routine physical examinations, - 90 days; and ○ Routine laboratory, imaging, general optometry, and all other routine services - 30 days.	
Virginia *(Standards apply to Health Maintenance Organizations)*	VA. CODE ANN. § 38.2-4312.3 (2011)	○ No quantitative criteria provided.	• Emergency medical care available on a 24-hour basis: ○ access to medical care or • access by telephone to a physician or licensed health care professional with appropriate medical training.	• No quantitative criteria provided.
Washington *(Standards apply to Essential Health Benefit Services)*	WASH. ADMIN. CODE § 284-170-200 (2016)	• Hospitals and Emergency Services: Each enrollee access within 30 minutes in urban area and 60 minutes in a rural area from either residence or workplace	• Emergency services are accessible 24 hours per day, 7 days per week. • EHB services: Urgent appointments without prior authorization within 48 hours, or	• PCP: the ratio of primary care providers to enrollees within the issuer's service area as a whole must meet or exceed the average ratio

		• PCP: 80% of enrollees within the service area are within 30 miles of a sufficient number of primary care providers in an urban area and within 60 miles of a sufficient number of primary care providers in a rural area from either their residence or work. • Mental health and substance use disorder providers, such as licensed psychiatrists, psychologists, social workers, and mental health nurse practitioners, 80% of the enrollees in the service area have access to a mental health provider within 30 miles in an urban area and 60 miles in a rural area from either their residence or workplace. • For specialty mental health providers and substance use disorder providers, 80% of the enrollees must access to the following types of service provider or facility: evaluation and treatment, voluntary and involuntary inpatient mental health and substance use disorder treatment, outpatient mental health and substance use disorder treatment, and behavioral therapy.	with prior authorization, within 96 hours of the provider's referral. • PCP: Non- preventive services within 10 business days of request. • Specialists: Non-urgent services - within 15 business days of referral. ○ Preventive care services, and periodic follow-up care including, but not limited to, standing referrals to specialists for chronic conditions, periodic office visits to monitor and treat pregnancy, cardiac or mental health conditions, and laboratory and radiological or imaging monitoring for recurrence of disease, scheduling in advance, consistent with professionally recognized standards of practice.	for Washington State for the prior plan year.
Medicare Advantage *(Standards apply to Medicare*	Centers for Medicare & Medicaid Services 2017 Letter to Issuers in the Federally-	• <u>Primary Care</u> ○ Large Metro – within 10 minutes/5 miles ○ Metro – within 15 minutes/10 miles ○ Micro – within 30 minutes/20 miles ○ Rural – within 40 minutes/30 miles ○ CEAC – within 70 minutes/60 miles	• No quantitative criteria provided.	• <u>Primary Care</u> ○ Large Metro – 1.67 ratio ○ Metro – 1.67 ratio ○ Micro – 1.42 ratio ○ Rural – 1.42 ratio ○ CEAC – 1.42 ratio

Advantage Organizations)	facilitated Marketplaces; [10] CMS 2017 HSD Reference File[11]	• <u>Specialty Care (see specific specialty)</u> ○ Large Metro – ranges from 20 to 30 minutes or 10 to 15 miles, based on specialty ○ Metro – ranges from 30 to 60 minutes or 20 to 40 miles, based on specialty ○ Micro – ranges from 50 to 100 minutes or 35 to 75 miles, based on specialty ○ Rural – ranges from75 to 110 minutes or 60 to 90 miles, depending on specialty ○ CEAC – ranges from 95 to 145 minutes or 85 to 130 miles, depending on specialty • <u>Facilities (see specific facility type)</u> ○ Large Metro – ranges from 20 to 30 minutes or 10 to 15 miles, depending on facility type ○ Metro – ranges from 45 to 70 minutes or 30 to 45 miles, depending on facility type ○ Micro – ranges from 80 to 160 minutes or 60 to 120 miles, depending on facility type ○ Rural – ranges from 75 to 145 minutes or 60 to 120 miles, depending on facility type • CEAC – ranges from 110 to 155 minutes or 100 to 140 miles, depending on facility type		• <u>Specialty Care (see specific specialty)</u> ○ Large Metro – ranges from 0.01 to 0.27 ratio, based on specialty ○ Metro – ranges from 0.01 to 0.28 ratio, based on specialty ○ Micro – ranges from 0.01 to 0.24 ratio, based on specialty ○ Rural – ranges from 0.01 to 0.24 ratio, depending on specialty • CEAC – ranges from 0.01 to 0.24 ratio, depending on specialty • MAOs must have at least one of each HSD facility type. • Must have a minimum of 12.2 inpatient hospital beds per 1,000 beneficiaries required to cover for that county. • Provider/enrollee and facility ratios vary based on type of provider or facility and on the geographic category.

[10] https://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/Downloads/CY2017_MA_HSD_Network_Criteria_Guidance.PDF

[11] https://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/Downloads/CY2017_MA_HSD_Reference_File.zip

		• At least 90% of have access to at least one provider/facility, for each specialty type, within established time and distance requirements for that county. • Specialized, long-term care, and pediatric/children's hospitals as well as providers/facilities contracted with the MAO only for its commercial, Medicaid, or other products do not count toward meeting HSD criteria.		
National Committee for Quality Assurance (NCQA) *(Standards apply to NCQA Accredited Health Plans)*	Health Plan Accreditation 2016 and Additional Accreditation and Certification Product Updates Overview[12]; 2016 NCQA Health Plan Accreditation Requirements[13]	• Organizations must analyze access, availability and member experience to ensure that all services are accessible without an unreasonable delay. • Carriers must set quantitative standards for availability and accessibility of primary care providers and specialty care. The carrier determines which specialties these standards must apply to based on claim volume.	• NCQA has set appointment time standards for behavioral health and requires carriers to measure these for each type of behavioral health professional meeting NCQA's credentialing standards (e.g., psychologists, psychiatrists, licensed clinical social workers...). • Organizations must currently assess access for "routine" behavioral health visits within 10 business days.	• Plans must have enough in-network hospitals and doctors available to members so that all services will be accessible without an unreasonable delay. • Organizations currently must identify specialties considered high volume, which at a minimum must include obstetrics/gynecology.
Federally-Facilitated Marketplaces	2017 Letter to Issuers in the Federally-facilitated Marketplaces[14]	• <u>Primary Care</u> ○ Large Metro – within 10 minutes/5 miles ○ Metro – within 15 minutes/10 miles ○ Micro – within 30 minutes/20 miles	• No quantitative criteria provided.	• No quantitative criteria provided.

[12]https://www.ncqa.org/Portals/0/PublicComment/HPA2016/Health%20Plan%20Accreditation%202016%20and%20Additional%20Accreditation%20%26%20Certification%20Product%20Updates%20Overview.pdf

[13] https://www.ncqa.org/Portals/0/Programs/Accreditation/2016_HPA_SGs.pdf

[14] https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2017-Letter-to-Issuers-2-29-16.pdf

(Standards apply to Qualified Health Plans in Federally-Facilitated Marketplaces)		○ Rural – within 40 minutes/30 miles ○ CEAC - within 70 minutes/60 miles • <u>Mental Health (Including Substance Use Disorder)</u> ○ Large Metro – within 20 minutes/10 miles ○ Metro – within 45 minutes/30 miles ○ Micro – within 60 minutes/45 miles ○ Rural – within 75 minutes/60 miles ○ CEAC – within 110 minutes/100 miles • <u>Other Specialty Care</u> ○ Large Metro – ranges from 20 to 30 minutes or 10 to 15 miles, based on specialty ○ Metro – ranges from 45 to 60 minutes or 30 to 40 miles, based on specialty ○ Micro – ranges from 60 to 100 minutes or 45 to 75 miles, based on specialty ○ Rural – ranges from 75 to 110 minutes or 60 to 90 miles , depending on specialty ○ CEAC – ranges from 110 to 145 minutes or 100 to 130 minutes, depending on specialty • Plans must provide access to at least one provider in each of the above-listed provider types for at least 90% of enrollees.		