

# Title 31 MARYLAND INSURANCE ADMINISTRATION

## Subtitle 10 HEALTH INSURANCE — GENERAL

### Chapter 44 Network Adequacy

Authority: Insurance Article, §§2-109(a)(1) and 15-112(a)—(d), Annotated Code of Maryland

#### .02 Definitions.

A. (text unchanged)

B. Terms Defined.

(1) (text unchanged)

(2) *“Ambulatory infusion therapy center” means any location authorized to administer chemotherapy or infusion services on an outpatient basis.*

[(2)] (3) – [(4)] (5) (text unchanged)

(6) *“Drug and alcohol treatment program” means any organization or individual certified by the Maryland Department of Health in accordance with Title 10, Subtitle 47 of COMAR.*

[(5)] (7) *“Enrollee” means a person entitled to health care benefits from a carrier under a policy or contract subject to Maryland law.*

[(6)] (8) *“Essential community provider” means a provider that serves predominantly low-income or medically underserved individuals. “Essential community provider” includes:*

(a) (text unchanged)

(b) Outpatient [behavioral] *mental* health and community based substance use disorder programs;[and]

(c) Any entity listed in 45 CFR §156.235(c); and [.]

(d) *School-based health centers.*

[(7)] (9) – [(12)] (14) (text unchanged)

(15) *“Hospital-based physician” has the meaning stated in Insurance Article, §14-201, Annotated Code of Maryland.*

[(13)] (16) – [(14)] (17) (text unchanged)

[(15)] (18) *“Network adequacy waiver [request]” means [a written request from a carrier to the Commissioner wherein the carrier seeks] the Commissioner’s [approval to be relieved] decision to relieve a carrier of the obligation to comply with certain network adequacy standards in this chapter for 1 year.*

(19) *“On-call physician” has the meaning stated in Insurance Article, §14-201, Annotated Code of Maryland.*

[(16)] (20) – [(21)] (25) (text unchanged)

(26) *“School-based health center” means a community health resource described in Health-General Article, § 19-2101, Annotated Code of Maryland that is located within an elementary, middle, or high school and approved by the Maryland State Department of Education.*

[(22)] (27) – [(23)] (28) (text unchanged)

[(24)] (29) *“Telehealth” [means:*

(a) As it relates to the delivery of health care services, the use of interactive audio, video, or other telecommunications or electronic technology by a provider to deliver a health care service within the scope of practice of the provider at a location other than the location of the patient.

(b) *“Telehealth” does not include:*

(i) An audio-only telephone conversation between a provider and a patient;

(ii) An electronic mail message between a provider and a patient; or

(iii) A facsimile transmission between a provider and a patient.] *has the meaning stated in Insurance Article §15-139,*

*Annotated Code of Maryland.,*

[(25)] (30) – [(26)] (31) (text unchanged)

[(27)] (32) *“Waiting time” means the time from the initial request for health care services by an enrollee or by the enrollee’s treating provider to the earliest date offered for the appointment for services with a provider possessing the appropriate skill and expertise to treat the condition.*

#### .03 Network Adequacy Standards.

A. *Sufficiency Standards.*

(1) *A carrier shall develop and maintain a complete network of adult and pediatric primary care, mental and behavioral health, substance use disorder, specialty care, ancillary service, vision, pharmacy, home health, and any other providers adequate to deliver the full scope of covered benefits.*

(2) *A carrier shall clearly define and specify referral requirements to specialty and other providers.*

(3) *A carrier shall ensure that network providers provide physical access, reasonable accommodations, and accessible equipment for members with physical or mental disabilities.*

(4) *A carrier’s written policies and procedures to monitor availability of services shall include how the carrier will monitor the availability of services for:*

(a) *Continuity of care;*

- (b) *Individuals with physical or mental disabilities, including physical access issues; and*
- (c) *Individuals with limited English proficiency, including diverse cultural and ethnic backgrounds.*
- (5) *A carrier shall ensure services are delivered in a culturally competent manner to all enrollees, including enrollees:*
  - (a) *With limited English proficiency;*
  - (b) *With diverse cultural and ethnic backgrounds; and*
  - (c) *Of all genders, sexual orientations, and gender identities.*
- (6) *A carrier shall include in its annual plan under Regulation .04 of this chapter, by zip code, the number of providers by Board specialty, including but not limited to:*
  - (a) *The American Board of Medical Specialties;*
  - (b) *The American Board of Pharmacy Specialties;*
  - (c) *The American Board of Physical Therapy Specialties;*
  - (d) *The American Board of Professional Psychology;*
  - (e) *The Accreditation Board for Specialty Nursing Certification; and*
  - (f) *The American Academy of Nurse Practitioners Certification Board.*
- B. Monitoring Sufficiency Standards.**
  - (1) *A carrier shall monitor its provider network for compliance with this chapter on at least a monthly basis; and*
  - (2) *A carrier shall monitor out of network costs to members when network providers are not available and report this information on a form provided by the Administration on a quarterly basis.*

**[.03] .04 Filing of Access Plan.**

A. Using the instructions on the Maryland Insurance Administration's website *for submission method and* to determine rural, suburban, and urban zip code areas, each carrier subject to this chapter shall file an annual access plan with the Commissioner [through the System for Electronic Rate and Form Filing (SERFF)] on or before July 1 of each year for each provider panel used by the carrier, with the first access plan filing due on or before July 1, 2018.

B. (text unchanged)

C. Each annual access plan filed with the Commissioner shall include *the following information in the standardized format described on the Maryland Insurance Administration's website:*

- (1) *An executive summary in the form set forth in Regulation [.09] .10 of this chapter;*
- (2) (text unchanged)
- (3) *The description required by Insurance Article, §15-112(c)(4)(iv) shall include:*
  - (a) *The number of primary care physicians, including pediatricians, family practitioners, and internists, who report to the carrier that they use any of the following languages in their practices:*
    - (i) *American Sign Language;*
    - (ii) *Spanish;*
    - (iii) *Korean;*
    - (iv) *Chinese (Mandarin or Cantonese);*
    - (v) *Tagalog; or*
    - (vi) *French;*
  - (b) *A description of outreach efforts to recruit and retain providers from diverse cultural or ethnic backgrounds;*
  - (c) *A copy of the most recent enrollees' language needs assessment made by or on behalf of the carrier, if one was made;*
  - (d) *A copy of the most recent demographic profile of the enrollee population made by or on behalf of the carrier, if one was made;*
  - (e) *A copy of any analysis or assessment made of provider network requirements based on an assessment of language needs or demographic profile of the enrollee population;*
  - (f) *A copy of any provider manual provisions that describe requirements for access to individuals with physical or mental disabilities; and*
  - (g) *Copies of policies and procedures documents designed to ensure that the provider network is sufficient to address the needs of both adult and child enrollees, including adults and children with:*
    - (i) *Limited English proficiency or illiteracy;*
    - (ii) *Diverse cultural or ethnic backgrounds;*
    - (iii) *Physical or mental disabilities; and*
    - (iv) *Serious, chronic, or complex health conditions.*
- [(3)] (4) *Documentation justifying to the Commissioner how the access plan meets each network sufficiency standard set forth in Regulations [.04] (.05) — [.06] (.07) of this chapter; [and]*
- (5) *A description of the network access to hospital-based providers, which shall include:*
  - (a) *A list of all the hospitals included on the provider panel; and*
  - (b) *For each hospital included on the provider panel:*
    - (i) *The percentage of on-call physicians practicing in the hospital who are participating providers;*
    - (ii) *The percentage of hospital-based physicians practicing in the hospital who are participating providers;*
    - (iii) *The percentage of anesthesiologists practicing in the hospital who are participating providers;*

- (iv) *The percentage of radiologists practicing in the hospital who are participating providers; and*
  - (v) *A report of whether any non-physician providers, including laboratories or radiology facilities, within the hospital that routinely provide services to patients are not participating providers; and*
- [(4)] (6) (text unchanged)

**[.04] .05 Travel Distance Standards.**

**A. Sufficiency Standards.**

*(1) Standard and Methodology*

[(1)] (a) Except as stated in §B of this regulation, each provider panel of a carrier shall have within the geographic area served by the carrier’s network or networks, sufficient primary care physicians, specialty providers, [behavioral] *mental* health and substance use disorder providers, hospitals, and health care facilities to meet the maximum travel distance standards listed in the chart in §A(5) of this regulation for each type of geographic area.

(b) The distances listed in §A(5) of this regulation shall be:

(i) [measured] *Measured from the practicing location of the provider or facility to the enrollee’s place of residence[.]; and*

(ii) *Calculated based on road travel distance.*

(c) *Except for those provider types excluded under §A(3) of this regulation, for each provider type and facility type included on the carrier’s provider panel, the carrier shall:*

(i) *Map the practicing locations of every network provided within the geographic area served by the carrier’s network or networks;*

(ii) *Identify any geographic areas within each Maryland zip code that fall outside of the applicable distance standard based on road travel distance from the provider location;*

(iii) *For each zip code identify the total number of enrollees residing in the zip code and the number of enrollees residing within an area where the applicable distance standard is not met;*

(iv) *For each zip code calculate the percentage of enrollees residing within an area where the applicable distance standard is met;*

(v) *For each of the urban, rural, and suburban areas identify the total number of enrollees residing in the geographic area;*

(vi) *For each of the urban, rural, and suburban areas identify the total number of enrollees residing within an area where the applicable distance standard is not met; and*

(vii) *For each of the urban, rural, and suburban areas identify the percentage of enrollees residing within an area where the applicable distance standard is met.*

(d) *A carrier shall submit, as part of its documentation justifying to the Commissioner how the access plan meets the network sufficient standards in this regulation:*

(i) *Geo-access maps for each provider type and facility type except for those excluded under §A(3) of this regulation showing the practicing locations of network providers and identifying any geographic areas within each zip code where the applicable distance standards is not met;*

(ii) *For zip codes whether a significant portion of the population does not own a personal automobile, a description of any analysis or assessment of how public transportation is taken into account when considering enrollees’ access to care under the travel distance standards; and*

(iii) *For any facility types listed in §A(5) of this regulation the provider services for substance use disorders, the percentage of facilities on the carrier’s provider panel that provide services for alcohol treatment only, drug abuse treatment only, and alcohol and drug abuse treatment.*

(e) *A carrier shall report each number and percentage described in §A(1)(c)(iii)-(viii) of this regulation as part of the annual access plan filing.*

(2) – (3) (text unchanged)

(4) All other providers and facility types included on the carrier’s provider panel but not listed in the chart in §A(5) of this regulation, including physical therapists, nutritionists, and dietitians, shall individually be required to meet maximum distances standards of 15 miles for Urban Areas, 40 miles for Suburban Areas, and 90 miles for Rural Areas.

(5) Chart of Travel Distance Standards.

	Urban Area Maximum Distance (miles)	Suburban Area Maximum Distance (miles)	Rural Area Maximum Distance (miles)
<b>Provider Type:</b>			
Allergy and Immunology	15	30	75
Applied Behavioral Analyst	15	30	60
Cardiovascular Disease	10	20	60
Child Psychiatry	10	25	60

Chiropractic	15	30	75
Dermatology	10	30	60
Endocrinology	15	40	90
ENT/Otolaryngology	15	30	75
Gastroenterology	10	30	60
General Surgery	10	20	60
<i>Geriatric Psychiatry</i>	<i>10</i>	<i>25</i>	<i>60</i>
Gynecology, OB/GYN	5	10	30
Gynecology Only	15	30	75
Licensed Clinical Social Worker	10	25	60
<i>Licensed Professional Counselor</i>	<i>10</i>	<i>25</i>	<i>60</i>
Nephrology	15	25	75
Neurology	10	30	60
Oncology-Medical and Surgical	10	20	60
Oncology-Radiation/Radiation Oncology	15	40	90
Ophthalmology	10	20	60
Pediatrics-Routine/Primary Care	5	10	30
Physiatry, Rehabilitative Medicine	15	30	75
<i>Physician Certified in Addiction Medicine</i>	<i>10</i>	<i>25</i>	<i>60</i>
Plastic Surgery	15	40	90
Podiatry	10	30	60
Primary Care Physician ( <i>non-pediatric</i> )	5	10	30
Psychiatry	10	25	60
Psychology	10	25	60
Pulmonology	10	30	60
Rheumatology	15	40	90
Urology	10	30	60
All Other licensed or certified providers under contract with a carrier not listed	15	40	90
<b>Facility Type:</b>			
Acute Inpatient Hospitals	10	30	60
<i>Ambulatory Infusion Therapy Centers</i>	<i>10</i>	<i>30</i>	<i>60</i>
Critical Care Services — Intensive Care Units	10	30	100
Diagnostic Radiology	10	30	60
<i>Drug and Alcohol Treatment Program</i>	<i>10</i>	<i>25</i>	<i>60</i>
Inpatient Psychiatric Facility	15	45	75
Outpatient Dialysis	10	30	50
[Outpatient Infusion/Chemotherapy	10	30	60]
<i>Outpatient Mental Health Clinic</i>	<i>15</i>	<i>30</i>	<i>60</i>
<i>Outpatient Substance Use Disorder Facility</i>	<i>15</i>	<i>30</i>	<i>60</i>
Pharmacy	5	10	30
Skilled Nursing Facilities	10	30	60
<i>Substance Use Disorder Residential Treatment Facility</i>	<i>10</i>	<i>25</i>	<i>60</i>
Surgical Services (Outpatient or Ambulatory Surgical Center)	10	30	60

[Other Behavioral Health/Substance Abuse Facilities	10	25	60]
All other licensed or certified facilities under contract with a carrier not listed	15	40	90

**B. Group Model HMO Plans Sufficiency Standards.**

*(1) Standard and Methodology*

[(1)] (a) Each group model HMO’s health benefit plan’s provider panel shall have within the geographic area served by the group model HMO’s network or networks, sufficient primary care physicians, specialty providers, [behavioral] mental health and substance use disorder providers, hospitals, and health care facilities to meet the maximum travel distance standards listed in the chart in §B(5) of this regulation for each type geographic area.

(b) The distances listed in §B(5) of this regulation shall be:

(i)[measured] *Measured* from the practicing location of the provider or facility to the enrollee’s place of residence or place of employment from which the enrollee gains eligibility for participation in the group model HMO’s health benefit plan[.]; and

(ii) *Calculated based on road travel distance.*

(c) *Except for those provider types excluded §B(3) of this regulation, for each provider type and facility type included on the group model HMO’s provider panel, the carrier shall:*

(i) *Map the practicing locations of every network provider within the geographic area served by the group model HMO’s network or networks;*

(ii) *Identify any geographic areas within each Maryland zip code that fall outside of the applicable distance standard based on road travel distance from the provider locations;*

(iii) *For each zip code identify the total number of enrollees with a residence or place of employment in the zip code and the number of enrollees with a residence or a place of employment within an area where the applicable distance standard is not met;*

(iv) *For each zip code calculate the percentage of enrollees with a residence or place of employment within an area where the applicable distance standard is met;*

(v) *For each of the urban, rural, and suburban areas identify the total number of enrollees with a residence or place of employment in the geographic area;*

(vi) *For each of the urban, rural, and suburban areas identify the number of enrollees with a residence or place of employment within an area where the applicable distance standard is not met; and*

(vii) *For each of the urban, rural, and suburban areas identify the percentage of enrollees with a residence or place of employment within an area where the applicable distance standard is met.*

(d) *When calculating the number or percentage of enrollees with a place of employment within an area or zip code under §B(1)(c)(iii)-(viii) of this regulation, the carrier shall include only those enrollees who gain eligibility for participation in the group model HMO’s health benefit plan from their place of employment.*

(e) *A carrier shall submit, as part of its documentation justifying to the Commissioner how the access plan meets the network sufficiency standards in this regulation:*

(i) *Geo-access maps for each provider type and facility type except for those excluded under §B(3) of this regulation showing the practicing locations of network providers and identifying any geographic areas within each zip code where the applicable distance standard is not met;*

(ii) *For zip codes where a significant portion of the population does not own a personal automobile, a description of any analysis or assessment of how public transportation is taken into account when considering enrollees’ access to care under the travel distance standards; and*

(iii) *For any facility types listed in §B(5) of this regulation that provide services for substance use disorders, the percentage of facilities on the carrier’s provider panel that provide services for alcohol treatment only, drug abuse treatment only, and alcohol and drug abuse treatment.*

(f) *A carrier shall report each number and percentage described in §B(1)(c)(iii)-(viii) of this regulation as part of the annual access plan filing.*

(2) – (3) (text unchanged)

(4) All other provider and facility types included on the carrier’s provider panel, but not listed in the chart at §B(5) of this regulation, including physical therapists, nutritionists, and dietitians, shall individually be required to meet maximum distances standards of 15 miles for Urban Areas, 40 miles for Suburban Areas, and 90 miles for Rural Areas.

(5) Chart of Travel Distance Standards.

	Urban Area Maximum Distance (miles)	Suburban Area Maximum Distance (miles)	Rural Area Maximum Distance (miles)
<b>Provider Type:</b>			
Allergy and Immunology	20	30	75
Applied Behavioral Analyst	15	20	60

Cardiovascular Disease	15	25	60
<i>Child Psychiatry</i>	<i>15</i>	<i>30</i>	<i>75</i>
Chiropractic	20	30	75
Dermatology	20	30	60
Endocrinology	20	40	90
ENT/Otolaryngology	20	30	75
Gastroenterology	20	30	60
General Surgery	20	30	60
<i>Geriatric Psychiatry</i>	<i>15</i>	<i>30</i>	<i>75</i>
Gynecology, OB/GYN	15	20	45
Gynecology Only	15	30	60
Licensed Clinical Social Worker	15	30	75
<i>Licensed Professional Counselor</i>	<i>15</i>	<i>30</i>	<i>75</i>
Nephrology	15	30	75
Neurology	15	30	60
Oncology-Medical, Surgical	15	30	60
Oncology-Radiation/Radiation Oncology	15	40	90
Ophthalmology	15	20	60
Pediatrics-Routine/Primary Care	15	20	45
Physiatry, Rehabilitative Medicine	15	30	75
<i>Physician Certified in Addiction Medicine</i>	<i>15</i>	<i>30</i>	<i>75</i>
Plastic Surgery	15	40	90
Podiatry	15	30	90
Primary Care Physician ( <i>non-pediatric</i> )	15	20	45
Psychiatry	15	30	60
Psychology	15	30	60
Pulmonology	15	30	60
Rheumatology	15	40	90
Urology	15	30	60
All Other licensed or certified providers under contract with a carrier not listed	20	40	90
<b>Facility Type:</b>			
Acute Inpatient Hospitals	15	30	60
<i>Ambulatory Infusion Therapy Center</i>	<i>15</i>	<i>30</i>	<i>60</i>
Critical Care Services-Intensive Care Units	15	30	120
Diagnostic Radiology	15	30	60
<i>Drug and Alcohol Treatment Program</i>	<i>15</i>	<i>30</i>	<i>60</i>
Inpatient Psychiatric Facility	15	45	75
Outpatient Dialysis	15	30	60
[Outpatient Infusion/Chemotherapy	15	30	60]
<i>Outpatient Mental Health Clinic</i>	<i>15</i>	<i>30</i>	<i>60</i>
<i>Outpatient Substance Use Disorder Facility</i>	<i>15</i>	<i>30</i>	<i>60</i>
Pharmacy	5	10	30
Skilled Nursing Facilities	15	30	60

Substance Use Disorder Residential Treatment Facility	15	30	60
Surgical Services (Outpatient or Ambulatory Surgical Center)	10	30	60
[Other Behavioral Health/Substance Abuse Facilities	15	30	60]
All other licensed or certified facilities under contract with a carrier not listed	15	40	120

C. Essential Community Providers.

(1) Each provider panel of a carrier, that is not a group model HMO provider panel, shall include:

(a) [at] At least 30 percent of the available essential community providers *providing medical services* in each of the urban, rural, and suburban areas[.];

(b) *At least 30 percent of the available essential community providers providing mental health services in each of the urban, rural, and suburban areas; and*

(c) *At least 30 percent of the available essential community providers providing substance use disorder services in each of the urban, rural, and suburban areas.*

(2) *Methodology for calculating essential community provider inclusion standard.*

(a) *Except as provided in §§C(2)(b) and (c) of this regulation, a carrier shall use the MHBE ECP Network Inclusion Calculation Methodology that is described in the Instructions on Meeting the Essential Community Provider Plan Certification Standard guidance provided by the Maryland Health Benefit Exchange, which is current as of the date three months prior to the due date of the annual access plan.*

(b) *The calculation described in §C(2)(a) of this regulation shall be performed separately for essential community providers providing medical services, mental health services, and substance use disorder services in each of the urban, rural, and suburban areas.*

(c) *If the Maryland Health Benefit Exchange changes the MHBE ECP Network Inclusion Calculation Methodology after the effective date of this regulation, a carrier may not use the revised methodology to calculate the essential community provider inclusion standard in §C(1) of this regulation unless the Commissioner has approved the revised methodology for this purpose.*

[(2)] (3) – [(3)] (4) (text unchanged)

**[.05] .06 Appointment Waiting Time Standards.**

A. Network capacity.

(1) Each carrier shall create and utilize written policies and procedures to monitor the availability of services.

(2) On a quarterly basis, each carrier shall make available to its members the median wait times to obtain the following appointments with a participating provider within the applicable maximum travel distance standards described in Regulation .05 of this chapter as measured from the date of the initial request to the date of the earliest available appointment:

- (a) Urgent care for medical services;
- (b) Inpatient urgent care for mental health services;
- (c) Inpatient urgent care for substance use disorder services;
- (d) Outpatient urgent care for mental health services;
- (e) Outpatient urgent care for substance use disorder services;
- (f) Routine primary care;
- (g) Preventive care/well visits;
- (h) Non-urgent specialty care;
- (i) Non-urgent mental health care; and
- (j) Non-urgent substance use disorder care.

(3) To monitor availability of providers, a carrier shall:

- (a) Ensure the accuracy of its provider directory;
- (b) Utilize a survey tool with members;
- (c) Make direct contact with a random selection of provider offices qualified to provide the services for each of the appointment types listed in §A(2) of this regulation to ask for next available appointments; and
- (d) Retain documentation of the efforts described in §A(3)(a) – (c) of this regulation.

(4) The survey toll described in §A(3)(b) of this regulation shall:

(a) Utilize a statistically valid method to ensure that survey respondents are selected in a random manner;

(b) Ask members to provide the time period from the date of the initial request for each appointment type listed in §A(2) of this regulation to the earliest date offered for an appointment with a participating provider possessing the appropriate skill and expertise to treat the condition; and

(c) Ensure a minimum sample size of responsive answers for each appointment type listed in §A(2) of this regulation that is equivalent to the lesser of:

- (i) Ten percent of claims received by the carrier for that appointment type in the same quarter of the preceding calendar year; or
- (ii) One hundred answers.

(5) The minimum sample size for the random selection of provider offices described in §A(3)(c) of this regulation shall be equivalent to the lesser of:

(a) Ten percent of the participate providers qualified to provide the services for each of the appointment types listed in §A(2) of this regulation; or

(b) One hundred provider offices.

(6) The median wait times described in §A(2) of this regulation shall be calculated by:

(a) Determining the median wait time based on the results of the member surveys described in §A(3)(b) of this regulation and multiplying that number by 0.25;

(b) Determining the median wait time based on the direct contacts with provider offices described in §A(3)(c) of this regulation and multiplying that number by 0.75; and

(c) Adding the results in §A(6)(a) and §A(6)(b) of this regulation.

[A.] B. Sufficiency Standards.

(1) On a quarterly basis, a carrier shall determine whether the provider panel meets the waiting time standards listed in §E of this regulation based on the member surveys and the direct contacts with provider offices described in §A(3)(b)-(c) of this regulation.

[(1)] (2) Subject to the exceptions in [§B] §§C and D of this regulation, [each carrier’s provider panel shall meet the waiting time standards listed in §C of this regulation for at least 95 percent of the enrollees covered under health benefit plans that use that provider panel] if a carrier’s provider panel fails to meet the waiting time standards listed in §E of this regulation for at least 90% of appointments in each category, the carrier shall notify the Administration within 10 business days identifying the deficiency in the provider network and the efforts that have been taken or will be taken to correct the deficiency.

[(2)] (3) When [it] a telehealth appointment is clinically appropriate, available, and accessible to [and] an enrollee [elects to utilize a telehealth appointment], a carrier may consider [that utilization] the offer of that appointment as a part of its meeting the standards listed in [§C] §E of this regulation.

[B.] C. Preventive care services and periodic follow-up care, including but not limited to, standing referrals to specialty providers for chronic conditions, periodic office visits to monitor and treat pregnancy, cardiac or [behavioral] mental health or substance use disorder conditions, and laboratory and radiological monitoring for recurrence of disease, may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating provider acting within the scope of the provider’s license, certification, or other authorization.

D. A visit scheduled in advance in accordance with §C of this regulation may be disregarded when determining compliance with the waiting time standards listed in §E of this regulation.

[C.] E. Chart of Waiting Time Standards.

Waiting Time Standards	
Urgent care for medical services [ (including) medical, behavioral health, and substance use disorder services)]	72 hours
Inpatient urgent care for mental health services	72 hours
Inpatient urgent care for substance use disorder services	72 hours
Outpatient urgent care for mental health services	72 hours
Outpatient urgent care for substance use disorder services	72 hours
Routine primary care	15 calendar days
Preventive [visit] care/well visit	30 calendar days
Non-urgent specialty care	30 calendar days
Non-urgent mental health care	10 calendar days
Non-urgent [behavioral health/]substance use disorder [services] care	10 calendar days

F. On a quarterly basis, each carrier shall forward to the Administration a list of complaints it receives relating to the unavailability of a provider.

[.06] .07 Provider-to-Enrollee Ratio Standards.

A. (text unchanged)

B. The provider-to-enrollee ratios shall be equivalent to at least 1 full-time physician, or as appropriate, another full-time provider for:



- (1) – (3) (text unchanged)
- (4) 2,000 enrollees for [behavioral] *mental* health care or services; and
- (5) (text unchanged)

C. *The ratios described in §B of this regulation shall be calculated based on:*

- (1) *The number of enrollees covered under all health benefit plans issues by the carrier in Maryland that use that provider panel; and*
- (2) *The number of providers in that provider panel with practicing locations:*
  - (a) *In Maryland; or*
  - (b) *Within the applicable maximum travel distance standard specified in Regulation .04 of this chapter outside the geographic boundaries of Maryland.*

**[.07] .08 Network Adequacy Waiver [Request] Standards.**

A. [A carrier may apply for a network adequacy waiver, for up to 1 year, of a network adequacy requirement listed in this chapter.] *If a carrier's provider panel fails to meet one or more of the standards specified in Regulations .05-.07 of this chapter, the carrier shall provide the following information to the Commissioner as part of the annual access plan:*

- (1) *A description of any network adequacy waiver previously granted by the Commissioner;*
- (2) *An explanation of how many providers in each specialty or health care facility type that the carrier reasonably estimates it would need to contract with to satisfy each unmet standard;*
- (3) *A description of the methodology used to calculate the estimated number of providers in §A(2);*
- (4) *A list of physicians, other providers, or health care facilities related to each unmet standard and within the relevant service area that the carrier attempted to contract with, identified by name and specialty, if any, or health care facility type;*
- (5) *A description of how and when the carrier last contacted the physicians, other providers, or health care facilities;*
- (6) *A description of any reason each physician, other provider, or health care facility gave for refusing to contract with the carrier;*
- (7) *Identification of all incentives the carrier offers to providers to join the network;*
- (8) *If applicable, a statement that there are no physicians, other providers, or health care facilities available within the relevant service area for a covered service or services for which the carrier failed to meet a standard;*
- (9) *A detailed description of other efforts and initiatives undertaken by the carrier in the past year to enhance its network and address the deficiencies that contributed to each unmet standard;*
- (10) *A description of steps the carrier will take to attempt to improve its network to avoid a future failure to meet a standard; and*
- (11) *An attestation to the accuracy of the information provided in relation to each unmet standard.*

B. The Commissioner may find good cause to grant [the] a network adequacy waiver [request] of one or more of the standards specified in Regulations .05-.07 of this chapter, if the information provided by the carrier under §A of this regulation demonstrates that the physicians, other providers, or health care facilities necessary for an adequate network:

- (1) – (4) (text unchanged)

C. [A carrier seeking a network adequacy waiver shall submit a written request to the Commissioner that includes the following information:

- (1) A description of any waiver previously granted by the Commissioner;
- (2) A list of physicians, other providers, or health care facilities within the relevant service area that the carrier attempted to contract with, identified by name and specialty, if any, or health care facility type;
- (3) A description of how and when the carrier last contacted the physicians, other providers, or health care facilities;
- (4) A description of any reason each physician, other provider, or health care facility gave for refusing to contract with the carrier;
- (5) Steps the carrier will take to attempt to improve its network to avoid future network adequacy waiver requests;
- (6) If applicable, a statement that there are no physicians, other providers, or health care facilities available within the relevant service area for a covered service or services for which the carrier requests the waiver; and
- (7) An attestation to the accuracy of the information contained in the network adequacy waiver request.] *The Commissioner shall post a list of all network adequacy waivers that are granted for each annual access plan on the Maryland Insurance Administration's website.*

**[.08] .09 Confidential Information in Access Plans.**

A. Subject to §15-802 of the Insurance Article, Annotated Code of Maryland, the following information that is included in a carrier's access plan shall be considered confidential by the Commissioner:

- (1) [Methodology] *Proprietary methodology* used to annually assess the carrier's performance in meeting the standards established under this chapter;
- (2) [Methodology] *Proprietary methodology* used to annually measure timely access to health care services; and
- (3) (text unchanged)

B. A carrier submitting an access plan or [a] *supplemental information required for the network adequacy waiver [request] standards* may submit a written request to the Commissioner that specific information included in the plan [or request] not be disclosed under the Public Information Act and shall:

- (1) – (2) (text unchanged)

C. – D. (text unchanged)

**[.09] .10 Network Adequacy Access Plan Executive Summary Form.**

A. For each provider panel used by a carrier for a health benefit plan, the carrier shall provide the *following* network sufficiency results for the health benefit plan service area [as follows] *in the standardized format described on the Maryland Insurance Administration’s website:*

(1) Travel Distance Standards.

(a) For each provider type *and facility type* listed in Regulation [.04] .05, list the percentage of enrollees for which the carrier met the travel distance standards, in the following format:

	Urban Area	Suburban Area	Rural Area
Primary Care Provider			
Specialty Provider			

(b) All provider and facility types described in §§ A(4) and B(4) of Regulation .05 of this chapter and included on the carrier’s provider panel shall be listed individually in the chart described in §A(1)(a) of this regulation with the corresponding data for that specific type of provider or facility.

[(b)] (c) – [(c)] (d) (text unchanged)

[(d)] (e) List the total number of essential community providers in the carrier’s network *in each of the urban, rural, and suburban areas providing:*

- (i) Medical services;
- (ii) Mental health services; and
- (iii) Substance use disorder services.

[(e)] (f) List the total percentage of essential community providers available in the health benefit plan’s service area that are participating providers *for each of the nine categories described in §A(1)(e) of this regulation.*

(g) List the total number and percentage of local health departments in the carrier’s network providing:

- (i) Medical services;
- (ii) Mental health services; and
- (iii) Substance use disorder services.

(2) Appointment Waiting Time Standards.

(a) For each appointment type listed in Regulation [.05] .06, list the [percentage of enrollees for which the carrier met the appointment wait time standards] *calculated median wait time to obtain an appointment with a participating provider within the applicable maximum travel distance standards described in Regulation .05 of this chapter,* in the following format:

Appointment Waiting Time Standard Results	
Urgent care for medical services [ — within 72 hours]	
Inpatient urgent care for mental health services	
Inpatient urgent care for substance use disorder services	
Outpatient urgent care for mental health services	
Outpatient urgent care for substance use disorder services	
Routine primary care [— within 15 calendar days]	
[Preventative Visit] Preventive care/Well Visit[ — within 30 calendar days]	
Non-urgent specialty care [— within 30 calendar days]	
[Non-urgent ancillary services — within 30 calendar days]	
Non-urgent [behavioral] mental health[/substance use disorder services — within 10 calendar days] care	
Non-urgent substance use disorder care	

(b) List the total [percentage] *number* of telehealth appointments counted as part of the appointment waiting time standard results *for each type of visit.*

(c) List the percentage of appointments counted as part of the appointment waiting time standard results *for each type of visit that were telehealth appointments.*

(3) Provider-to-Enrollee Ratio Standards.

(a) (text unchanged)

(b) For all other carriers, [list whether the percentage of provider-to-enrollee ratios meet the] *summarize the network performance for each provider-to-enrollee ratio [standards] standard* listed in Regulation [.06] .07 of this chapter *by listing the calculated number of providers in the provider panel, rounded to the nearest whole number,* for each of the following categories of enrollees:

- (i) – (iii) (text unchanged)
- (iv) 2,000 enrollees for [behavioral] mental health care or service; and

(v) (text unchanged)

B. (text unchanged)