NETWORK ADEQUACY

ANNUAL FILING INSTRUCTIONS

Pursuant to Section 15-112 of the Insurance Article, Annotated Code of Maryland

I. HEALTH BENEFIT PLAN ACCESS PLAN FILINGS PER COMAR 31.10.44.03(A)

The Access Plan shall be filed:

- on an annual basis on or before July 1st of each year;
- with the Insurance Commissioner through the System for Electronic Rate and Form Filing (SERFF); and
- along with the completed Executive Summary Form required by Regulation .09.

II. DENTAL PLAN NETWORK SUFFICIENCY EXECUTIVE SUMMARY FORMS PER COMAR 31.10.45.06(A)

The Executive Summary Form shall be filed:

- on an annual basis on or before December 1st of each year; and
- with the Insurance Commissioner through the System for Electronic Rate and Form Filing (SERFF).

III. GUIDANCE FOR FILING IN SERFF

- Submit the filing through the MarylandH Instance, using the Filing Type ***Access Plan*** and the state-specific Type of Insurance (TOI) ***Network Access Plan*****,** specifying either sub-TOI ***Health Benefit Plans*** or ***Dental Plans*** as appropriate for the plan. Note that the MIA does not require a filing fee for access plan submission.
- A separate filing must be submitted for each distinct provider panel or network when the same carrier uses multiple networks for health benefit plans in Maryland.
- Confidential information for specific parts of the filing should be designated as such using the available functionality in SERFF.
- Please provide a brief explanation and overview of the filing in the Filing Description field on the General Information tab.
- Please upload all other materials to the appropriate submission requirements on the Supporting Documentation tab. These requirements should not be Bypassed if they are applicable to the filing. It is only permissible to add one or more User Added items of Supporting Documentation as separate Schedule Items if the carrier wishes to include additional supplemental information that is not contemplated by the list of submission requirements provided.
- A list of questions is included in the description of each submission requirement to elicit the level of details typically needed to complete plan reviews. Please respond to each or use the optional template forms provided to reduce the amount of follow-up correspondence required in previous years. Copies of these questions for both Health Benefit and Dental Plans are

included at the end of this file for reference; an editable document format is available upon request by emailing networkadequacy.mia@maryland.gov.

- Please note that files submitted using the incorrect Filing Type, TOI, or Sub-TOI, or that fail to separately attach the Supporting Documentation to the appropriate submission requirements will be rejected, and the carrier will be required to resubmit the filing in the manner required by these instructions.
- Use the **updated Population Density classification file** found on the MIA Network Adequacy webpage to **determine rural, suburban, and urban** areas when measuring travel distance compliance. Note that some of the classifications have changed based on more recent population data.[1] These changes are highlighted in the new file.

[1] The file comprises estimates provided by the Maryland State Department of Planning based on 2016-2020 ACS data from the US Census Bureau for Maryland ZIP Code Tabulation Areas (ZCTAs). ZCTAs are generalized areal representations of United States Postal Service (USPS) ZIP Code service areas. USPS ZIP Codes are not areal features but a collection of mail delivery routes; they identify the individual post office or metropolitan area delivery station associated with mailing addresses.

Reference Attachment 1:

Submission Requirement Questions- Health

SERFF Instance: MarylandH

TOI: Network Access Plan

Sub-TOI: Health Benefit Access Plan

Filing Type: Network Access

Network access filings for Health Benefit Plans in Maryland are due July 1, 2022 and should be submitted via SERFF using the information above. The submission requirements and optional templates are listed below for reference and as a pre-filing preparation convenience.

The optional templates referenced are available in pdf form on SERFF under the relevant requirement. Contact networkadequacy.mia@maryland.gov if an editable document format is preferred for the submission requirements below or their optional templates.

Requirement Name: Executive Summary (Public)
Description: Attach a summary of the elements specified in COMAR 31.10.44.09 in pdf format. Please see the optional template for guidance. NOTE: EXECUTIVE SUMMARIES ARE PUBLIC DOCUMENTS and will be posted on the MIA Network Adequacy webpage. All other plan files submitted should be marked confidential if they contain sensitive information.
Attachments: -- Executive Summary optional template

Requirement Name: Waiver Request
Description: A carrier may apply for a network adequacy waiver, for up to 1 year, of a network adequacy requirement. A waiver request will not be considered by the Commissioner unless it includes each required element specified in COMAR 31.10.44.07 or on the optional template here. Attach a separate waiver request for each requirement outside the standard.
Attachments: -- Waiver Request optional template

Requirement Name: Description of Network
Description: Attach an overall description of the carrier's network. Include:

a. the number of enrollees (i.e., all those covered under the plans that utilize the network), provider counts by specialty, and facility counts by type.
b. an explanation of how telemedicine and other technologies are used to satisfy the network access standards.

c. the number of providers and facilities who have specific licenses or certifications for substance use disorders as well as licensed behavioral health providers who self-report a focus on substance use disorders.
d. a clear description of the factors used to build the provider network, including the criteria used to select providers for participation in the network and, if applicable, to place providers in network tiers.

Please see § 15-112(c)(4)(i) and (iii) of the Insurance Article; COMAR 31.10.44.03C(2) and the optional template for guidance in level of description needed.
Attachments: -- Description of Network and Technology optional template

Requirement Name: Processes and Methods for Monitoring and Assessing Capacity of Network to Meet Enrollee Needs
Description: Attach a description of the process and the methods used to comply with each monitoring and assessment requirement specified in COMAR 31.10.44.03C(2) and § 15-112(c)(4)(ii), (iv), (vii), and (5) of the Insurance Article. This should include each of the items below or items in the attached template:

a. the process for monitoring and ensuring, on an ongoing basis, the sufficiency of the network to meet the health care needs of enrollees.
b. the efforts to address the needs of both adult and child enrollees, including enrollees with limited English proficiency or illiteracy; diverse cultural or ethnic backgrounds; physical or mental disabilities; and serious, chronic, or complex health conditions.
c. the methods for assessing the health care needs of enrollees and enrollee satisfaction with health care services provided to them.
d. the method for monitoring, on an ongoing basis, the clinical capacity of its participating providers to provide covered services to its enrollees.

Please see optional template for guidance in level of description needed.
Attachments: -- Processes and Methods optional template

Requirement Name: Documentation Justifying Travel Distance Metrics
Description: Attach a description of the methodology used to measure compliance with travel distance standards. It should include:

a. GeoAccess distance reports and maps to support ***travel*** distance metrics listed on the Executive Summary. Distance should be measured from the enrollee's residence (or, for a group model HMO, either the enrollee's place of residence or place of employment).
b. the numbers of enrollees within and outside each required standard in every Maryland zip code where there is anyone covered under the plan(s).

c. For zip codes with enrollees outside the standard, reports should identify the average distance of enrollees to the nearest provider as well as the maximum distance, i.e. the distance for the enrollee furthest away.
d. Urban/suburban/rural classifications should be consistent with the standards posted on the MIA Network Adequacy web page.
e. GeoAccess reports and maps should be clearly labeled with the methodology (e.g. Driving Distance) used for calculation.

Separate maps for each provider/facility type are preferred as is distance calculation based on road or driving distance mileage (rather than straight-line) to reflect how far an enrollee would likely need to travel to reach the provider/destination. Refer to COMAR 31.10.44.03C(3) and .04.

Requirement Name: Essential Community Provider Documentation
Description: Refer to COMAR 31.10.44.04C and § 15-112(c)(4) (v), (vi), or the optional template for guidance as to level of details preferred.

For carriers other than Group Model HMOs:

a. describe the efforts to address the needs of low–income, medically underserved individuals.
b. describe the efforts to include essential community providers and local health departments in the network.
c. provide the percent of available essential community providers (ECPs) included in the network in each of the urban, rural, and suburban areas.
d. identify the source of the ECP listings used to calculate the percentage contracted.
e. include a description (such as a GeoAccess map) of the geographic dispersion or concentration of contracted ECPs across the entire Maryland service area of the carrier.

For group model HMOs:

- provide a demonstration that the alternative standard has been satisfied.

Attachments: -- ECP Optional template

Requirement Name: Wait Time Measurement Methodology
Description: Attach a description of the methodology used to measure compliance with wait time standards. Data should cover service appointments for Maryland enrollees only. Include a detailed explanation of:

a. how wait time data is collected, including sources such as surveys, secret shopper, routine provider reports, claims data, scheduling software, etc, and the timeframe they were surveyed.

b. how appointment types are classified into the different categories of COMAR 31.10.44.05, e.g. urgent care, routine primary care, etc.

c. whether and how telehealth appointments were included in the in the calculation of wait time performance, along with a description of the calculation methodology, including formulas and numeric values.

d. if and how 3rd party telehealth services were included in the calculation, especially if they were offered separately from those who provided both in-person and telehealth services.

e. how surveys are conducted, who conducts them, how often are they done, how representative the survey sample is, what the response rate is, and how the response rate compares to previous years.

f. whether the surveys are prospective (and ask for the next available appointment) or retrospective (and ask how long the patient waited between requesting an appointment and being seen)

g. what the current average wait time is for any provider type that is deficient and how the company is assisting enrollees who are not being seen timely.

h. how and how often the company educates their enrollees about possible options if they cannot get an appointment timely.

See COMAR 31.10.44.03C(3) and 05 and the optional template for guidance as to level of details preferred.

Attachments: -- Wait Times Methodology Optional template

Requirement Name: Documentation Justifying Provider-to-Enrollee Ratio Metrics
Description: For carriers other than Group Model HMOs, attach a description of the methodology used to measure compliance with provider-to-enrollee standards. Explain how the provider-to-enrollee ratios reported on the executive summary were derived, or show the mathematical operations. Include an explanation of how the providers within each category were defined/identified. See COMAR 31.10.44.03C(3) and .06 and optional template for guidance as to level of details preferred.

Attachments: -- Provider-Enrollee Optional template

Requirement Name: Changes from Previous Plan
Description: Attach a listing of any changes from the previous year's access plan filing including:

a. reporting and calculation methods
b. service areas and scope
c. year over year comparisons in appointment wait times and any deficient metric from either year
d. significant changes in provider numbers, enrollee numbers, or provider-to-enrollee ratios
e. anything else that might impact network adequacy.

If there were no significant changes, include a statement affirming this. See COMAR 31.10.44.03C(4).

Requirement Name: Supplementary Information
Description: This optional section may be bypassed. Any supporting information that does not fit in the items above may be included here.

Reference Attachment 2:

Submission Requirement Questions – Dental Plans

Instance: MarylandH

TOI: Network Access Plan

Sub-TOI: Dental Plan

Filing Type: Network Access

Please file Maryland dental network access plans due December 1, 2022 on SERFF using the information above. The submission requirements and optional templates are listed here for reference and as a pre-filing preparation convenience.

The optional templates referenced are available in pdf form on SERFF under the relevant requirement. Contact networkadequacy.mia@maryland.gov if an editable document format is preferred for the submission requirements below or their optional templates.

Requirement Name: Dental Executive Summary (Public)
Description: Attach a summary of the elements specified in COMAR 31.10.45.06 in pdf format. Please see the optional template for guidance. NOTE: EXECUTIVE SUMMARIES ARE PUBLIC DOCUMENTS.
Attachments: -- Dental ExecSummary Optional template

Requirement Name: Waiver Request
Description: A carrier may apply for a network adequacy waiver, for up to 1 year, of a network adequacy requirement. A waiver request will not be considered by the Commissioner, unless it includes each required element specified in COMAR 31.10.45.05 or the optional template. Attach a separate waiver request for each requirement outside the standard. Please mark as confidential if sensitive information is included.
Attachments: -- Dental Waiver Request template