Title 31 MARYLAND INSURANCE ADMINISTRATION

Subtitle 10 HEALTH INSURANCE — GENERAL

Chapter 44 Network Adequacy

Authority: Insurance Article, §§ 2-109 and 15-112, Annotated Code of Maryland

.01 Scope.

This chapter applies to carriers that issue or renew health benefit plans in Maryland that use a provider panel.

.02 Definitions.

A. In this chapter, the following terms have the meanings indicated.

B. Terms Defined.

(1) "Access plan" means the materials that each carrier is required to file annually with the Commissioner to demonstrate that each of the carrier's provider panels is adequate to meet the needs of its enrollees.

(2) "Behavioral health care" means care for mental health services or for substance use disorder services.

(3) "Carrier" means:

(a) An insurer authorized to sell health insurance;

(b) A nonprofit health service plan; or

(c) A health maintenance organization.

(4) "Emergency Medical Condition" means a medical condition or behavioral health care condition manifesting itself by acute symptoms of sufficient severity, including severe pain, so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

(a) Placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;

(b) Serious impairment to bodily functions; or

(c) Serious dysfunction of any bodily organ or part.

(5) "Enrollee" means a person entitled to health care benefits from a carrier.

(6) "Essential Community Provider" means a provider that serves predominantly low-income or medically underserved individuals, local health departments, outpatient mental health and community based substance use disorder programs, and a health care provider defined in 42 U.S.C. § 300gg-13.

(7) "Health benefit plan" has the meaning stated in Insurance Article, § 15-112, Annotated Code of Maryland.

(8) "Health care facility" has the meaning stated in Insurance Article, § 15-112, Annotated Code of Maryland.

(9) "Health care practitioner" means a person who is licensed, certified, or otherwise authorized to provide health care services in the jurisdiction in which the health care services are provided.

(10) "Hospital" has the meaning stated in Health General Article, § 19-301, Annotated Code of Maryland.

(11) "Large metro area" means a county, as defined by U.S. Centers for Medicare and Medicaid Services, or an independent city, with a:

(a) Population equal to or greater than 1,000,000 and a population density equal to or greater than 1,000 per square mile;

(b) Population equal to or greater than 500,000, but less than 1,000,000, and a population density equal to or greater than 1,500 per square mile; or

(c) Population density equal to or greater than 5,000 per square mile, regardless of the population.

(12) "Material change to an access plan" means a change to an access plan that affects a carrier's ability to comply with the requirements of this chapter.

(13) "Maximum distance" means the distance from a provider to the enrollee's residence or workplace.

(14) "Metro area" means a county, as defined by U.S. Centers for Medicare and Medicaid Services, or an independent city, with a human population equal to or greater than:

(a) 1,000,000, and a population density that is at least 10 per square mile, but less than 1,000 per square mile;

(b) 500,000, but less than 1,000,000, and a population density that is at least 10 per square mile, but less than 1,500 per square mile;

(c) 200,000, but less than 500,000, and a population density that is at least 10 per square mile, but less than 5,000 per square mile;

(d) 50,000, but less than 200,000, and a population density that is at least 100 per square mile, but less than 5,000 per square mile; or

(e) 10,000, but less than 50,000, and a population density that is at least 1000 per square mile, but less than 5,000 per square mile.

(15) "Micro area" means a county, as defined by U.S. Centers for Medicare and Medicaid Services, or an independent city, with a human population:

(a) 50,000, but less than 200,000, and a population density that is at least 10 per square mile, but less than 100 per square mile; or

(b) 10,000, but less than 50,000, and a population density that is at least 50 per square mile, but less than 1,000 per square mile.

(16) "Network" means:

(a) A carrier's participating providers and the health care facilities with which a carrier contracts to provide health care services to the carrier's enrollees under the carrier's health benefit plan; or

(b) If a carrier uses a provider panel developed by a subcontracting entity, "network" includes providers and health care facilities that contract with the subcontracting entity to provide health care services to the carrier's enrollees under the carrier's health benefit plan.

(17) "Network Adequacy Waiver Request" means a written request from a carrier on a Network Adequacy Waiver Request form required by the Commissioner wherein the carrier seeks the Commissioner's approval to be relieved of certain network adequacy requirements under this Chapter for one year.

(18) "Participating Provider" means a provider on a carrier's provider panel.

(19) "Preventive Care" means health care provided for prevention and early detection of disease, illness, injury or other health condition. Preventive care includes all of the services required by 42 U.S.C. § 300gg-13.

(20) "Primary Care Physician" means a physician who is responsible for providing initial and primary care to patients, for maintaining the continuity of patient care or for initiating referrals for specialist care. A primary care physician may be either a physician whose practice of medicine is limited to general practice or who is a board-certified or board-eligible internist, pediatrician, obstetrician-gynecologist or family practitioner.

(21) "Provider" means a health care practitioner or group of health care practitioners licensed, certified, or otherwise authorized by law to provide health care services.

(22) "Provider Panel" means the providers that contract either directly or through a subcontracting entity with a carrier to provide health care services to the carrier's enrollees under the carrier's health benefit plan.

(23) "Rural area" means a county, as defined by U.S. Centers for Medicare and Medicaid Services, or an independent city, with a human population:

(a) Equal to or greater than 10,000, but less than 50,000, and a population density that is at least 10 per square mile, but less than 50 per square mile; or

(b) Less than 10,000, and a population density that is at least 10 per square mile, but less than 5,000 per square mile.

(24) "Specialty Provider" means a health care practitioner who:

(a) Focuses on a specific area of physical, mental, or behavioral health for a group of patients; and

(b) Has successfully completed required training and is recognized by the state in which the health care practitioner practices to provide specialty care.

(25) "Staff Model HMO" means a type of health maintenance organization that employs its own physicians and health care practitioners on a salaried basis in health maintenance organization buildings to provide care to enrollees of the health maintenance organization.

(26) "Telemedicine" means as it relates to the delivery of health care services, the use of interactive audio, video, or other telecommunications or electronic technology by a licensed health care provider to deliver a health care service within the scope of practice of the health care provider at a site other than the site at which the patient is located. Telemedicine does not mean an audio-only telephone conversation, electronic mail message, or facsimile transmission between a health care provider and a patient.

(27) "Tiered network" means a network of participating providers that has been divided into sub-groupings differentiated by the carrier according to cost-sharing levels, provider payment, performance ratings, quality scores, or any combination of these or other factors established as a means of influencing the enrollee's choice of provider.

(28) "Urgent care" means health care for a condition that requires prompt attention, but the condition does not satisfy the definition of emergency medical condition as set forth in § B(4) of this regulation.

(29) "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. Waiting time includes the time for obtaining authorization from the carrier or the carrier's participating providers for the appointment.

.03 Filing of Access Plan.

A. Each carrier that issues or renews a health benefit plan in Maryland that uses participating providers 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. If a carrier makes a material change to an access plan, the carrier shall:

(1) Notify the Commissioner of the change in writing within 15 business days after the material change to the access plan occurs; and

(2) Include in the notice required under § B(1) of this regulation a reasonable timeframe within which the carrier will file with the Commissioner an update to the existing access plan for review by the Commissioner.

C. Each annual access plan filed with the Commissioner shall include:

(1) An executive summary on a form required by the Commissioner;

(2) The information and process required by Insurance Article, § 15-112(c)(4), Annotated Code of Maryland, and the methods used for monitoring pursuant to § 15-112(c)(5); and

(3) Documentation of how the access plan meets each network sufficiency requirement set forth in Regulations .04-.06 of this chapter.

.04 Geographic Accessibility of Providers.

A. Sufficiency Standards.

(1) Except as stated in § B of this regulation, each provider panel shall have sufficient primary care physicians, specialty providers, mental health and substance use disorder providers, hospitals, and health care facilities to accept each enrollee within the maximum travel distance standards listed in the chart in § A(2) of this regulation for each type of specialty and geographic area.

(2) Chart of Specialty and Geographic Area Distance Requirements.

Specialty	*Large Metro Area Maximum Distance (miles)*	*Metro Area Maximum Distance (miles)*	*Micro Area Maximum Distance (miles)*	*Rural Area Maximum Distance (miles)*
Primary Care Physician	*5*	*10*	*20*	*30*
Gynecology, OB/GYN	*5*	*10*	*20*	*30*
Pediatrics—Routine/Primary Care	*5*	*10*	*20*	*30*
Allergy and Immunology	*15*	*30*	*60*	*75*
Cardiothoracic Surgery	*15*	*30*	*75*	*90*
Cardiovascular Disease	*10*	*20*	*35*	*60*
Chiropractic	*15*	*30*	*60*	*75*
Dermatology	*10*	*30*	*45*	*60*
Endocrinology	*15*	*40*	*75*	*90*
ENT/Otolaryngology	*15*	*30*	*60*	*75*
Gastroenterology	*10*	*30*	*45*	*60*
General Surgery	*10*	*20*	*35*	*60*
Gynecology Only	*15*	*30*	*60*	*75*
Licensed Clinical Social Worker	*10*	*30*	*45*	*60*
Nephrology	*15*	*25*	*60*	*75*
Neurology	*10*	*30*	*45*	*60*
Neurological Surgery	*15*	*40*	*75*	*90*
Oncology—Medical and Surgical	*10*	*20*	*45*	*60*
Oncology—Radiation/Radiation Oncology	*15*	*40*	*75*	*90*
Ophthalmology	*10*	*20*	*35*	*60*
Orthopedic Surgery	*10*	*20*	*35*	*60*
Physiatry, Rehabilitative Medicine	*15*	*30*	*60*	*75*
Plastic Surgery	*15*	*40*	*75*	*90*
Podiatry	*10*	*30*	*45*	*60*
Psychiatry	*10*	*25*	*45*	*60*
Psychology	*10*	*25*	*45*	*60*
Pulmonology	*10*	*30*	*45*	*60*
Rheumatology	*15*	*40*	*75*	*90*
Urology	*10*	*30*	*45*	*60*
Vascular Surgery	*15*	*40*	*75*	*90*
Other Medical Provider Not Listed	*15*	*40*	*75*	*90*
Pharmacy	*5*	*10*	*20*	*30*
Acute Inpatient Hospitals	*10*	*30*	*60*	*60*
Cardiac Surgery Program	*15*	*40*	*60*	*100*

Specialty	*Large Metro Area Maximum Distance (miles)*	*Metro Area Maximum Distance (miles)*	*Micro Area Maximum Distance (miles)*	*Rural Area Maximum Distance (miles)*
Cardiac Catherization Services	*15*	*40*	*60*	*100*
Critical Care Services—Intensive Care Units	*10*	*30*	*120*	*100*
Outpatient Dialysis	*10*	*30*	*50*	*50*
Surgical Services (Outpatient or Ambulatory Surgical Center)	*10*	*30*	*60*	*60*
Skilled Nursing Facilities	*10*	*30*	*60*	*60*
Diagnostic Radiology	*10*	*30*	*60*	*60*
Mammography	*10*	*30*	*60*	*60*
Physical Therapy	*10*	*30*	*60*	*60*
Occupational Therapy	*10*	*30*	*60*	*60*
Speech Therapy	*15*	*30*	*60*	*60*
Applied Behavioral Analysis	*15*	*30*	*60*	*60*
Inpatient Psychiatric Facility	*15*	*45*	*75*	*75*
Outpatient Infusion/Chemotherapy	*10*	*30*	*60*	*60*
Other Facilities	*15*	*40*	*90*	*120*

B. Staff Model HMO Plans.

(1) Each Staff Model HMO plan's provider panel shall have sufficient primary care physicians, specialty providers, mental health and substance use disorder providers, hospitals, and health care facilities to accept each enrollee within the maximum travel distance standards listed in the chart in § B(2) of this regulation for each type of specialty and geographic area. The distances stated in § B(2) shall be measured from the enrollee's location, home or place of employment, from which the enrollee gains eligibility for participation in the staff model HMO plan.

(2) Chart of Specialty and Geographic Area Distance Requirements.

Specialty	*Large Metro Area Maximum Distance (miles)*	*Metro Area Maximum Distance (miles)*	*Micro Area Maximum Distance (miles)*	*Rural Area Maximum Distance (miles)*
Primary Care Physician	*15*	*20*	*30*	*45*
Gynecology, OB/GYN	*15*	*20*	*30*	*45*
Pediatrics—Routine/Primary Care	*15*	*20*	*30*	*45*
Allergy and Immunology	*20*	*30*	*60*	*75*
Cardiothoracic Surgery	*15*	*40*	*75*	*90*
Cardiovascular Disease	*15*	*25*	*35*	*60*
Chiropractic	*20*	*30*	*60*	*75*
Dermatology	*20*	*30*	*45*	*60*
Endocrinology	*20*	*40*	*75*	*90*
ENT/Otolaryngology	*20*	*30*	*60*	*75*
Gastroenterology	*20*	*30*	*45*	*60*
General Surgery	*20*	*30*	*35*	*60*
Gynecology Only	*15*	*30*	*60*	*75*
Licensed Clinical Social Worker	*15*	*30*	*45*	*60*
Nephrology	*15*	*30*	*60*	*75*
Neurology	*15*	*30*	*45*	*60*
Oncology—Medical, Surgical	*15*	*30*	*45*	*60*
Oncology—Radiation/Radiation Oncology	*15*	*40*	*75*	*90*
Ophthalmology	*15*	*20*	*35*	*60*
Orthopedic Surgery	*15*	*20*	*35*	*60*
Physiatry, Rehabilitative Medicine	*15*	*30*	*60*	*75*

Specialty	*Large Metro Area Maximum Distance (miles)*	*Metro Area Maximum Distance (miles)*	*Micro Area Maximum Distance (miles)*	*Rural Area Maximum Distance (miles)*
Plastic Surgery	*15*	*40*	*75*	*90*
Podiatry	*15*	*30*	*60*	*90*
Psychiatry	*15*	*30*	*45*	*60*
Psychology	*15*	*30*	*45*	*60*
Pulmonology	*15*	*30*	*45*	*60*
Rheumatology	*15*	*40*	*75*	*90*
Urology	*15*	*30*	*45*	*60*
Vascular Surgery	*15*	*40*	*75*	*90*
Other Medical Provider	*20*	*40*	*75*	*90*
Pharmacy	*5*	*10*	*20*	*30*
Acute Inpatient Hospitals	*15*	*30*	*60*	*60*
Cardiac Surgery Program	*15*	*40*	*90*	*120*
Cardiac Catherization Services	*15*	*40*	*90*	*120*
Critical Care Services—Intensive Care Units	*15*	*30*	*90*	*120*
Outpatient Dialysis	*15*	*30*	*60*	*60*
Surgical Services (Outpatient or Ambulatory Surgical Center)	*10*	*30*	*60*	*60*
Skilled Nursing Facilities	*15*	*30*	*60*	*60*
Diagnostic Radiology	*15*	*30*	*60*	*60*
Mammography	*15*	*30*	*60*	*60*
Physical Therapy	*15*	*30*	*60*	*60*
Occupational Therapy	*15*	*30*	*60*	*60*
Inpatient Psychiatric Facility	*15*	*45*	*75*	*75*
Outpatient Infusion/Chemotherapy	*15*	*30*	*60*	*60*
Other Facilities	*15*	*40*	*90*	*120*

C. Each plan shall have 30 percent of the available essential community providers as part of its provider panel in each of the defined rating areas.

D. If a carrier uses a tiered network, the carrier's provider panel shall meet the standards of this regulation for the lowest cost-sharing tier.

E. A carrier may include a Maryland Certified Registered Nurse Practitioner in its access plan to help meet the requirements stated in § .04(A) and § .04(B) of this regulation.

.05 Waiting Times for Appointments with Providers.

A. Except as provided in § B of this regulation and Regulation .07 of this chapter, each carrier's provider panel shall meet the waiting time standards set forth in § C of this regulation for at least 90 percent of the enrollees covered under health benefit plans that use that provider panel.

B. 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 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 health care practitioner acting within the scope of the health care practitioner's license.

C. Appointment Wait Time Standards

Wait Time Standards	
Urgent Care (including medical, mental health, and substance use disorder)	*48 hours (If prior authorization required)* *96 hours (If prior authorization is not required)*
Routine Primary Care	*15 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	*10 calendar days*

.06 Provider-to-Enrollee Ratios.

A. Except for a Staff Model HMO plan, the provider panel for each carrier shall meet the provider-to-enrollee ratios listed in § B of this regulation.

B. The provider-to-enrollee ratios shall be the equivalent to at least 1 full-time physician for:

(1) 1,200 Enrollees for primary care;

(2) 2,000 Enrollees for pediatric care;

(3) 2,000 Enrollees for obstetrical/gynecological care;

(4) 2,000 Enrollees for mental health services; and

(5) 2,000 Enrollees for substance use disorder services.

.07 Waiver Request Requirements.

A. A carrier may apply for a network adequacy waiver, for up to one year, of one or more of the network adequacy requirements in this Chapter.

B. The Commissioner may find good cause to grant the network adequacy waiver request if the carrier demonstrates that providers or physicians necessary for an adequate local market network are:

(1) Not available to contract;

(2) Not available in sufficient numbers;

(3) Available, but have refused to contract with the carrier on any terms or on terms that are reasonable; or

(4) Unable to reach agreement with the carrier.

C. A carrier seeking a network adequacy waiver shall:

(1) Submit its request to the Commissioner on the network adequacy waiver request form required by the Commissioner; and

(2) Submit a copy of the network adequacy waiver request form to any provider or physician named in the network adequacy waiver request at the same time the carrier submits the network adequacy waiver request form to the Commissioner, provided, however, that the carrier:

(a) May redact information from the copy of the network adequacy waiver request submitted to the provider or physician where providing the information to the provider or physician would violate State or federal law; and

(b) Shall retain proof that the waiver request form was submitted to each provider and physician named in the network adequacy waiver request.

.08 Confidential Information in Access Plans.

A. The following information that is included in a carrier's access plan shall be considered confidential by the Commissioner:

(1) Methodology used to annually assess the carrier's performance;

(2) Methodology used to annually measure timely access to health care services; and

(3) Factors used by the carrier to build its provider network.