mhamd
MENTAL HEALTH ASSOCIATION OF MARYLAND

UNIVERSITY of MARYLAND
FRANCIS KING CAREY
SCHOOL OF LAW
Clinical Law Program
Drug Policy and Public Health Strategies Clinic

August 25, 2016

Nancy Grodin
Deputy Insurance Commissioner
Maryland Insurance Administration
2000 St. Paul Place
Suite 2700
Baltimore, MD 21202

Dear Ms. Grodin:

The Mental Health Association of Maryland and the University of Maryland Carey School of Law Drug Policy Clinic appreciate the opportunity to provide general recommendations on the development of quantitative standards for insurer network adequacy. We look forward to continuing to work with the Maryland Insurance Administration as it implements the requirements of HB1318. We are providing these preliminary comments as a summary of our oral recommendations to date as the MIA begins its drafting process. We are continuing to research best practices on network adequacy standards for individuals with mental health and substance use disorders. As noted in hearing testimony, the Drug Policy Clinic has conducted a 50-state survey of network adequacy standards, which is referenced in our comments and attached as Attachment A. We will submit additional substantive recommendations as the process moves forward.

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, claiming the lives of more than 1000 Marylanders annually. 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 a compact that has committed the State to:

> tak[e] actions to ensure a pathway to recovery for individuals with addiction, which may include reducing payment and administrative barriers in Medicaid and other health plans to promote access to a range of treatment options, including well-supervised medication assisted treatment and comprehensive recovery services.

National Governor's Association, A Compact to Fight Opioid Addiction, July 13, 2016. The adoption of quantitative network standards, as required under H.B. 1318, is a necessary step to address administrative barriers that limit access to substance use and mental health treatment.

Private insurance must fulfill its role in addressing this crisis – the most significant being ensuring that their members can access substance use disorder treatment through their network of providers in a timely manner. Maryland's public insurance system does a far better job ensuring that individuals who are eligible for Medical Assistance have access to treatment providers than private insurance carriers do for persons who pay substantial premiums for coverage. According to the Maryland Health Care Commission's 2015 Comprehensive Quality Report, 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 from individuals who aren't able to access timely, in-network, mental health care.

We appreciate the thoughtful and open process the MIA has undertaken in order to develop regulations with quantitative standards. We also believe that the next step in this process is to promote a constructive discussion between carriers and advocates about proposed standards. We suggest a two-step process to accomplish this. First, we urge the MIA to require all carriers to submit written recommendations for quantitative network standards. Upon submission of carrier recommendations and those of consumer advocates, we request that the MIA then convene one or more facilitated sessions to discuss recommendations and seek to reach consensus on appropriate standards. These discussion sessions can be in lieu of one or more of the previously scheduled meetings so that the process is not extended. The MIA followed this approach in the development of other recent and successful insurer standards, and we believe it can work here as well.

A. Existing Accreditation Requirements Related to Network Adequacy

We know from the Maryland Health Care Commission report card that all carriers in Maryland have NCQA certification. Our understanding of NCQA certification requirements is that carriers must establish quantitative standards for geographic distribution and appointment wait times for specialty care and must meet NCQA standards for primary and behavioral health care. The carrier-established standards may be an appropriate place for the MIA to begin its analysis of regulatory standards. We urge the MIA to release the carriers' network access plans, so that consumer advocates may comment on their current network adequacy standards and help assess sufficiency.

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 access or 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. 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.

B. Categorization of Providers

The development of quantitative network adequacy standards will require the MIA to articulate the types of mental health and substance use disorder providers that should be counted in the network standards, including both the types of providers and settings of care; i.e. facilities. It may also require carriers to expand the reimbursable providers to include both the types of practitioners – licensed and certified – and the settings of care – individual practitioner and certified and licensed community-based programs – in which substance use disorder services are authorized by statute to be delivered in Maryland. We request that the MIA, consistent with other accreditation and state standards, further define behavioral health providers into subspecialties for assessing network adequacy. It is not enough to have one monolithic behavioral health category, because this could mean an insurer would have a network consisting of non prescribing mental health providers alone to the detriment of members who need to see a psychiatrist or a provider specializing in substance use disorders.

Several options merit consideration for adoption. The NCQA identifies three different provider types for behavioral healthcare practitioners: MD/DO, doctoral non-MD/DO, and non-MD/DO practitioners. Arkansas requires the submission of geographical access maps that provide data for three categories of 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). Six (6) other states have enumerated mental health and substance use disorder practitioners in connection with their geographic standards. *See* Section C and footnotes 1-6 and Attachment A. We also note that the Maryland Healthcare Commission identifies both mental health providers and substance use disorder providers, including psychiatrists, physicians certified in addiction medicine, psychologists, social workers, licensed social worker associates, nurse psycho-therapists, nurse practitioners, registered nurses, licensed therapists and counselors and alcohol and drug counselors.in its Quality Report: Comparing the Performance of Maryland's Commercial Health Benefit Plans - Consumer Edition (2015).

Our future comments will provide additional recommendations on the most appropriate designations of provider and facility types, consistent with Maryland's health care delivery standards.

C. Geographic Time and Distance Standards

We recommend that the MIA adopt geographic standards and, in doing so, develop requirements for four separate metrics: geographic regions by county, distance, travel time, and, as noted above, a uniform list of provider and facility types.

First, we recommend that the MIA adopt the geographic regions and definitions as specified by CMS for Medicare Advantage 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 has also adopted this geographic region framework. *See* 4.90 and Div. of Insurance,

Prop. New Reg 4-2-53 Sec.8(C). Medicare Advantage uses the category type to determine the number of specific primary care, specialty care, and behavioral health care should be provided in each region.

Second, we strongly recommend that the geographic standard 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. Eleven (11) states have adopted both time and distance standards for non-HMO plans: Arizona, California, Kentucky, Maine, Minnesota, New Hampshire, New Jersey, New Mexico, New York, Pennsylvania, and Tennessee. Nine (9) other states with geographic standards have adopted either one or the other metric: Arkansas, Colorado, Delaware, Missouri (HMO plans), Montana, Texas, and Washington have distance requirements, and Florida (HMO) and Vermont have travel time standards. *See* Attachment A.

Finally, we strongly recommend that specific standards be developed for mental health and substance use disorder providers by provider type and facility. (See above for discussion of the development of these provider designations). These providers should have their own geographic standards, rather than being folded into the "specialty" category, and the standards should be no less protective than the requirements for primary care providers. For many individuals with a substance use disorder or mental health condition, they often see their behavioral health provider more frequently than their primary care provider. In fact, many would consider their behavioral health provider to be their primary care provider and should be able to access these providers without undue delay or travel. Many states, including Colorado[1], Missouri (HMO)[2],

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[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.

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.

Finally, five (5) states identify a targeted percentage of members whose geographic access must meet the designated services. These include 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. Future recommendations will address this standard.

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[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

D. Appointment Wait Times

This standard is the most critical metric to ensure that enrollees have the ability to access critical and timely mental health and substance use disorder care when and where they need it. Appointment wait times are used by accreditation organizations and a number of states. The federal government is also considering using wait time standards in the federal marketplaces.

NCQA requires carriers to establish their own wait time standards for certain specialties, but has specific requirements for primary care and behavioral health: 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 Addition Accreditation and Certification Product Updates, Overview at 5 ((2105). We have demonstrated that these problems persists in Maryland in MHAMD's 2015 report, "Access to Psychiatrists in Qualified Health Plans."

Ten (10) states (with non-HMO standards) have established geographic metrics and uniform wait-time standards: Arizona, California, Colorado, Maine, Montana, New Jersey, New Mexico, Texas, Vermont and Washington. Four (4) states have specific standard for mental health and substance use disorder providers: California, Colorado, Texas, and Vermont. California, Colorado, and Texas have shorter wait time standards for some substance use disorder and mental health providers than for medical conditions.

We believe that Colorado, the state with the most recently established standards, has the strongest and most appropriate behavioral health wait time standard. Colorado requires carriers to ensure that they consumers are able to secure an appointment with a behavioral health provider within 7 days. The standards also require that this wait time be met 90% of the time. We urge the MIA to adopt the Colorado approach for wait times for mental health and substance use disorder services.

Questions have been raised about the enforceability of wait time standards. The ten states that have adopted wait time standards have proven that they are enforceable by regulators. An established appointment wait time standard does not mean that the carrier must ensure that the consumer can get a timely appointment with the specialty provider of his or her choice. This would be unreasonable. What is reasonable and appropriate is that carriers ensure that their networks have adequate numbers of behavioral health providers to ensure that there is at least one available mental health and at least one available substance use disorder provider available within a reasonable travel time and within 7 calendar days. Without more specific and uniform standards, consumer will never be able to enforce their rights under Maryland Insurance Article §15-830(d-g).

This standard is especially important for new patients who do not have a relationship with a particular provider, but are in need of critical mental health or substance use disorder 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.

E. Enforcement and Reporting Requirements

While the establishment of standards is a most important first step, the MIA must take into account how articulated standards will be enforced and how the results of network adequacy testing are communicated to consumers. We recommend that the MIA adopt the testing and reporting requirements established by California in order to fully enforce access standards. California has developed a common methodology that each carrier must use to measure its performance against the established standards. California puts the onus on carriers to demonstrate that their networks are adequate by performing periodic audits or provider surveys and reporting those results to the Department of Managed Healthcare, which in turn reports the compliance scores for each carrier on their website.

Thank you for your consideration of our preliminary comments as you undertake the process of developing quantitative network adequacy standards. Please do not hesitate to contact Adrienne Ellis aellis@mhamd.org or Ellen Weber eweber@law.umaryland.edu if you have any questions.

Sincerely,

Adrienne Ellis
Director Healthcare Reform

Ellen Weber
Professor of Law

Attachment A
Network Adequacy Quantitative Standards: Fifty-State Survey
Current through August 2016

State[1]	Source	Geographic Criteria[2]	Hours of Operation/ Wait Times/ Appointment Times	Provider/Enrollee Ratio & Other Provider Requirements
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)[3]	• 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	• 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.	• No quantitative criteria provided.

[1] States not identified have no quantitative standards for the network adequacy metrics included in this survey.
[2] 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.
[3] https://insurance.az.gov/sites/default/files/documents/files/2006-07.pdf

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State[1]	Source	Geographic Criteria[2]	Hours of Operation/ Wait Times/ Appointment Times	Provider/Enrollee Ratio & Other Provider Requirements
		home; and 3. Inpatient care in a contracted general hospital, or contracted special hospital, within 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.	• In-area urgent care services from a contracted provider 7 days per week. • 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.

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State[1]	Source	Geographic Criteria[2]	Hours of Operation/ Wait Times/ Appointment Times	Provider/Enrollee Ratio & Other Provider Requirements
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 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	• 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. • Emergency health care services are available and accessible within the service area at all times. • Appointments meet the following timeframes: ○ 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	• 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.

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State[1]	Source	Geographic Criteria[2]	Hours of Operation/ Wait Times/ Appointment Times	Provider/Enrollee Ratio & Other Provider Requirements
		standards throughout the calendar year.	○ 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 *(Standards apply to health benefit plans)*	CO Bulletin No. B-4.89 (2016); CO Bulletin No. B-4.90 (2016); CO Bulletin No. B-4.91 (2016); CO Proposed Reg. 4-2-53 (2017)	• Primary Care, OB/GYN, Pediatric Primary Care ○ Large Metro – within 5 miles ○ Metro – within 10 miles ○ Micro – within 20 miles ○ Rural – within 30 miles ○ CEAC - within 60 miles • Speciality Care (see specific speciality) ○ Large Metro – ranges from 10 to 15 miles, based on speciality ○ Metro – ranges from 20 to 40 miles, based on speciality ○ Micro – ranges from 35 to 75 miles, based on speciality ○ Rural – ranges from 60 to 90 miles, depending on speciality ○ CEAC – ranges from 85 to 130 miles, depending on speciality	• Emergency Care (Medical, Behavioral, Substance Abuse) – 24 hours per day, 7 days per 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;	• 1:1000 for large metro, metro, and micro areas (primary care, pediatrics, OB/GYN, Mental health, behavioral health and SUD care providers)

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State[1]	Source	Geographic Criteria[2]	Hours of Operation/ Wait Times/ Appointment Times	Provider/Enrollee Ratio & Other Provider Requirements
		• Other Medical Providers (see specific provider type): o Large Metro – within 15 miles o Metro – within 40 miles o Micro - within 75 miles o Rural – within 90 miles o CEAC – within 130 miles • Facilities (see specific facility type) o Large Metro – ranges from 5 to 15 miles, depending on facility type o Metro – ranges from 10 to 45 miles, depending on facility type o Micro – ranges from 20 to 120 miles, depending on facility type o Rural – ranges from 30 to 120 miles, depending on facility type o CEAC – ranges from 60 to 140 miles, depending on facility type • Other Facilities (see specific facility type): o Large Metro – within 15 miles o Metro – within 40 miles o Micro - within 120 miles o Rural – within 120 miles o CEAC – within 140 miles • In some circumstances, access may require crossing of county or state lines.	• 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	

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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[4] (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 • 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	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 Clinical Social Workers, Licensed Professional Counselors of Mental Health, Licensed Marriage & Family Therapists) supervised by an advanced-degree behavioral health practitioner: 1:2,000

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

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State[1]	Source	Geographic Criteria[2]	Hours of Operation/ Wait Times/ Appointment Times	Provider/Enrollee Ratio & Other Provider Requirements
		• 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		
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 Qualified Health Plans)*	IDAHO ADMIN. CODE R 41-3915 (2015); 2016 QHP Standards Guidance Document[5]	• Carriers must meet NCQA, AAAHC or URAC standards.	• Carriers must meet NCQA, AAAHC or URAC standards.	• Carriers must meet NCQA, AAAHC or URAC standards.

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

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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.

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			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: o Care for non-life-threatening emergencies within 6 hours; o urgent care within 48 hours; and o 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[6]	• 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	MINN. STAT. ANN. § 62K.10	• Primary care services, mental health services, and general hospital services:	• PCP services are available and accessible 24 hours per day, seven	• No quantitative criteria provided.

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

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State[1]	Source	Geographic Criteria[2]	Hours of Operation/ Wait Times/ Appointment Times	Provider/Enrollee Ratio & Other Provider Requirements
(Standards apply to health carriers)	(2013); MINN. STAT. ANN. § 62Q.19 (2013)	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 services: maximum travel distance or time shall be the lesser of 60 miles or 60 minutes to the nearest provider.	days per week, within the network area	
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	• 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	• No quantitative criteria provided.

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		• 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 • 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[7]	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 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.	

[7]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

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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 ○ 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	• Emergency services must be available and accessible at all times; • Urgent care appointments must be available within 24 hours; • Appointments for non-urgent care with symptoms must be available within 10 calendar days; • Appointments for immunizations must be available within 21 calendar days; and • Appointments for routine or preventive care 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.

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		outside the 30 mile radius of the primary place of work may not exceed the following: o for groups with 2 to 5 employees, 1; o for groups with 6 to 15 employees, 2; o for groups with 16 to 30 employees, 3, and o 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.	• Must meet the standards in the 2017 Letter to Issuers in the Federally-facilitated Marketplaces issued by CMS.	• Must meet the standards in the 2017 Letter to Issuers in the Federally-facilitated Marketplaces issued by CMS.
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	• Standard waiting times for appointments shall be measured from the initial request for an appointment and shall meet NCQA requirements.	• No quantitative criteria provided.

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		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 ○ Licensed medical-surgical, pediatric, obstetrical and critical care services associated with acute care hospital services; ○ Surgical facilities associated with acute care hospital services; ○ General inpatient psychiatric; ○ Emergency mental health provider; ○ Short term care facility for involuntary psychiatric admissions; ○ Short term care facility for substance abuse treatment; and ○ Short term care facility for inpatient medical rehabilitation services.		
New Jersey *(Standards apply to*	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	• Emergencies shall be triaged immediately through the PCP or by a hospital emergency	• The carrier shall demonstrate sufficiency of network PCPs to meet the

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Managed Care Plans)		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: o 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 o 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 o 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:	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.	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.

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		▪ 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. o 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.		

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		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	• 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;	• 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.

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		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 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.	• 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.	
New York	N.Y. INS. LAW § 3241 (2015);	• Must be geographically accessible (i.e., meeting time/distance standards)	• No quantitative criteria provided	• A choice of 3 PCPs in each county, and

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(Standards apply to issuers of health insurance contracts or policies)	Standards Guidance Document[8]	and be accessiblefor people with disabilities. • PCPs: o Metropolitan Areas: 30 minutes by public transportation. o Non-Metropolitan Areas: 30 minutes or 30 miles by public transportation or by car. o In rural areas, transportation may exceed these standards if justified. • 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.		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 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*	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.

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

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Maintenance Organizations)				
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.
Rhode Island *(Standards apply to Qualified Health Plans)*	Rhode Island Network Adequacy Guidance Document[9] (2013)	• No quantitative criteria provided.	• PCPs: at least 25% shall be either open at least one day per week for 3 hours beyond normal business hours for routine, wellness and sick visits, or have an agreement with another PCP to provide for those extended hours.	• PCPs: at least 10% shall offer integrated behavioral health or MH/SUD services.

[9] http://www.ohic.ri.gov/documents/3_LTR%20Network%20Adequacy%2011113.pdf

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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: o An adequate number of acute care hospital services, within a reasonable distance or travel time; o 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; o An adequate number of specialists and subspecialists, within a reasonable distance or travel time. o 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*	HMO: 28 TEX. ADMIN. CODE § 11.1607 (2006); PPO: 28 TEX. ADMIN. CODE	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:	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:	HMO: • No quantitative criteria provided. PPO: • No quantitative criteria provided

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and Preferred Provider Organizations)	§ 3.3704 (2013)	• Provide for preferred benefit services sufficiently accessible and available as necessary to ensure that the distance from any point in the insurer's designated service area to a point of service is not greater than: ○ Primary care and general hospital care - 30 miles in nonrural areas and 60 miles in rural areas ; and ○ Specialty care and specialty hospitals - 75 miles.	○ medical, dental and behavioral health conditions within 24 hours; • Routine care shall be available: ○ medical conditions within 3 weeks ; ○ 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:	

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			○ 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 Managed Care Organizations)*	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 ; ○ Mental health and substance abuse services routine, office-based services - 0 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	• Immediate access to emergency care • Urgent care - 24 hours or a time frame consistent with the medical 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.	• No quantitative criteria provided

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		than kidneys), and specialty pediatric care.		
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 • 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	• Emergency services are accessible 24 hours per day, 7 days per week. • EHB services: Urgent appointments without prior authorization within 48 hours, or 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	• 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 for Washington State for the prior plan year.

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		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.	conditions, and laboratory and radiological or imaging monitoring for recurrence of disease, scheduling in advance, consistent with professionally recognized standards of practice.	

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.