Title 31
MARYLAND INSURANCE ADMINISTRATION

Subtitle 10 HEALTH INSURANCE — GENERAL

31.10.44 Network Adequacy

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

Notice of Proposed Action

[17-199-P]

The Insurance Commissioner proposes to adopt new Regulations **.01—.09** under a new chapter, **COMAR 31.10.44 Network Adequacy**.

Statement of Purpose

The purpose of this action is to adopt new regulations pursuant to updates to Insurance Article, §15-112, Annotated Code of Maryland, that occurred as a result of changes made during the 2016 legislative session.

Comparison to Federal Standards

There is no corresponding federal standard to this proposed action.

Estimate of Economic Impact

I. Summary of Economic Impact. The cost to insurance carriers may increase in order to meet these new requirements. While the definite cost cannot be determined at this point, the increase is expected to be minimal.

II. Types of Economic Impact.	Revenue (R+/R-) Expenditure (E+/E-)	Magnitude
A. On issuing agency:	NONE	
B. On other State agencies:	NONE	
C. On local governments:	NONE	
	Benefit (+) Cost (-)	**Magnitude**
D. On regulated industries or trade groups:	NONE	
(1) Administrative Expense	(+)	Minimal
(2) Expense	(+)	Minimal
E. On other industries or trade groups:	NONE	
F. Direct and indirect effects on public:	NONE	

III. Assumptions. (Identified by Impact Letter and Number from Section II.)

D(1). Assuming that insurance carriers are now required to submit additional forms to the Maryland Insurance Administration, their administrative expenses may go up.

D(2). Assuming that insurance carriers may have to expend some time and resources to work with additional providers to contract with them, this might increase their cost slightly.

Economic Impact on Small Businesses

The proposed action has minimal or no economic impact on small businesses.

Impact on Individuals with Disabilities

The proposed action has no impact on individuals with disabilities.

Opportunity for Public Comment

Comments may be sent to Lisa Larson, Regulations Manager, Maryland Insurance Administration, 200 St. Paul Place, Suite 2700, Baltimore, MD 21202, or call 410-468-2007, or email to networkadequacy.mia@maryland.gov, or fax to 410-468-2020. Comments will be accepted through August 21, 2017. A public hearing has not been scheduled.

.01 Scope.

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

.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 or a substance use disorder.

(3) "Carrier" means:

(a) An insurer authorized to sell health insurance;

(b) A nonprofit health service plan; or

(c) A health maintenance organization.

(4) "Certified registered nurse practitioner" means an individual who is licensed as a certified nurse practitioner under Health Occupations Article, Title 8, Subtitle 3, Annotated Code of Maryland.

(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. "Essential community provider" includes:

(a) Local health departments;

(b) Outpatient mental health and community based substance use disorder programs; and

(c) Any entity listed in 45 CFR 156.235(c)

(7) "Group model HMO" means a type of health maintenance organization that:

(a) Contracts with one multispecialty group of physicians who are employed by and shareholders of the multispecialty group; and

(b) Provides or arranges for the provision of physician and other health care services to patients at medical facilities operated by the HMO or employs its own physicians and other providers on a salaried basis in health maintenance organization buildings to provide care to enrollees of the health maintenance organization.

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

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

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

(11) "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.

(12) "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.

(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.

(13) "Network adequacy waiver request" means a written request from a carrier to the Commissioner wherein the carrier seeks the Commissioner's approval to be relieved of certain network adequacy standards in this chapter for 1 year.

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

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

(16) "Primary care physician" means:

(a) A physician who is responsible for:

(i) Providing initial and primary care to patients;

(ii) Maintaining the continuity of patient care; or

(iii) Initiating referrals for specialist care.

(b) "Primary care physician" includes:

(i) A physician whose practice of medicine is limited to general practice; and

(ii) A board-certified or board-eligible internist, pediatrician, obstetrician-gynecologist or family practitioner.

(17) "Provider" means a person or group of persons licensed, certified, or otherwise authorized by law to provide health care services.

(18) "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. "Provider panel" does not include an arrangement in which any provider may participate solely by contracting with the carrier to provide health care services at a discounted fee–for–service rate.

(19) "Rural area" means a region that, according to the Maryland Department of Planning, has a human population of less than 1,000 per square mile.

(20) "Specialty provider" means a provider who:

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

(b) Has successfully completed required professional training; and

(c) For a physician, has obtained Board certification through the American Board of Medical Specialties.

(21) "Suburban area" means a region that, according to the Maryland Department of Planning, has a human population equal to or more than 1,000 per square mile, but less than 3,000 per square mile.

(22) "Telehealth" means:

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

(b) "Telehealth" does not include:

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

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

(iii) A facsimile transmission between a provider and a patient.

(23) "Tiered network" means a network of participating providers that has been divided into sub-groupings differentiated by the carrier according to:

(a) Cost-sharing levels;

(b) Provider payment;

(c) Performance ratings;

(d) Quality scores; or

(e) Any combination of these or other factors established as a means of influencing an enrollee's choice of provider.

(24) "Urban area" means a region that, according to the Maryland Department of Planning, has a human population equal to or greater than 3,000 per square mile.

(25) "Urgent care" means the treatment for a condition of an enrollee that satisfies either of the following:

(a) A medical condition, including a physical condition or a mental health condition, that, in the absence of medical care or treatment within 72 hours, could reasonably be expected by an individual, acting on behalf of a carrier and applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine, would result in:

(i) Placing the enrollee's life or health in serious jeopardy;

(ii) The inability of the enrollee to regain maximum function;

(iii) Serious impairment to the enrollee's bodily function;

(iv) Serious dysfunction of any bodily organ or part of the enrollee; or

(v) The enrollee remaining seriously mentally ill with symptoms that cause the enrollee to be a danger to self or others; or

(b) A medical condition of an enrollee, including a physical condition or a mental health condition, that, in the absence of medical care or treatment within 72 hours, would, in the opinion of a provider with knowledge of the enrollee's medical condition, subject the enrollee to severe pain that cannot be adequately managed without the care or treatment.

(26) "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.

.03 Filing of Access Plan.

A. Each carrier subject to this chapter shall file an annual access plan with the Commissioner through the System for Electronic Rate and Form Filing (SERFF) on or before July 1 of each year for each provider panel used by the carrier, with the first access plan filing due on or before July 1, 2018.

B. 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 in the form set forth in Regulation .09 of this chapter;

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

(3) Documentation justifying to the Commissioner how the access plan meets each network sufficiency standard set forth in Regulations .04—.06 of this chapter; and

(4) A list of all changes made to the access plan filed the previous year.

.04 Travel Distance Standards.

A. Sufficiency Standards.

(1) Except as stated in §B of this regulation, each provider panel of a carrier shall have within the geographic area served by the carrier's network or networks, sufficient primary care physicians, specialty providers, mental health and substance use disorder providers, hospitals, and health care facilities to meet the maximum travel distance standards listed in the chart in §A(4) of this regulation for each type of geographic area. The distances listed in §A(4) of this regulation shall be measured from the enrollee's place of residence.

(2) When an enrollee elects to utilize a gynecologist, pediatrician, or certified registered nurse practitioner for primary care, a carrier may consider that utilization as a part of its meeting the standards listed in §A(4) of this regulation.

(3) The travel distance standards listed in §A(4) of this regulation do not apply to the following:

(a) Home health care;
(b) Durable medical equipment;
(c) Heart transplant programs;
(d) Heart or lung transplant programs;
(e) Kidney transplant programs;
(f) Liver transplant programs;
(g) Lung transplant programs; or
(h) Pancreas transplant programs.

(4) Chart of Travel Distance Standards.

	Urban Area Maximum Distance (miles)	Suburban Area Maximum Distance (miles)	Rural Area Maximum Distance (miles)
Provider Type:			
Primary Care Physician	5	10	30
Gynecology, OB/GYN	5	10	30
Pediatrics—Routine/Primary Care	5	10	30
Allergy and Immunology	15	30	75
Cardiovascular Disease	10	20	60
Chiropractic	15	30	75
Dermatology	10	30	60
Endocrinology	15	40	90
ENT/Otolaryngology	15	30	75
Gastroenterology	10	30	60
General Surgery	10	20	60
Gynecology Only	15	30	75
Licensed Clinical Social Worker	10	25	60
Nephrology	15	25	75
Neurology	10	30	60
Oncology—Medical and Surgical	10	20	60
Oncology—Radiation/Radiation Oncology	15	40	90
Ophthalmology	10	20	60
Physiatry, Rehabilitative Medicine	15	30	75
Plastic Surgery	15	40	90
Podiatry	10	30	60
Psychiatry	10	25	60
Psychology	10	25	60
Pulmonology	10	30	60
Rheumatology	15	40	90
Urology	10	30	60
Other Provider Not Listed	15	40	90
Facility Type:			
Pharmacy	5	10	30
Acute Inpatient Hospitals	10	30	60
Applied Behavioral Analysis	15	30	60
Critical Care Services—Intensive Care Units	10	30	100
Diagnostic Radiology	10	30	60
Inpatient Psychiatric Facility	15	45	75
Outpatient Dialysis	10	30	50
Outpatient Infusion/Chemotherapy	10	30	60
Skilled Nursing Facilities	10	30	60
Surgical Services (Outpatient or Ambulatory Surgical Center)	10	30	60
Other Facilities	15	40	90

B. Group Model HMO Plans Sufficiency Standards.

(1) Each group model HMO's health benefit plan's provider panel shall have within the geographic area served by the group model HMO's network or networks, sufficient primary care physicians, specialty providers, mental health and substance use disorder providers, hospitals, and health care facilities to meet the maximum travel distance standards listed in the chart in §B(4) of this regulation for each type geographic area. The distances listed in §B(4) of this regulation shall be measured from the enrollee's place of residence or place of employment from which the enrollee gains eligibility for participation in the group model HMO's health benefit plan.

(2) When an enrollee elects to utilize a gynecologist, pediatrician, or certified registered nurse practitioner for primary care, a carrier may consider that utilization as a part of its meeting the standards listed in §B(4) of this regulation.

(3) The travel distance standards listed in §B(4) of this regulation do not apply to the following:

(a) Home health care;
(b) Durable medical equipment;
(c) Heart transplant programs;
(d) Heart or lung transplant programs;
(e) Kidney transplant programs;
(f) Liver transplant programs;
(g) Lung transplant programs; or
(h) Pancreas transplant programs.

(4) Chart of Travel Distance Standards.

	Urban Area Maximum Distance (miles)	Suburban Area Maximum Distance (miles)	Rural Area Maximum Distance (miles)
Provider Type:			
Primary Care Physician	15	20	45
Gynecology, OB/GYN	15	20	45
Pediatrics—Routine/Primary Care	15	20	45
Allergy and Immunology	20	30	75
Cardiovascular Disease	15	25	60
Chiropractic	20	30	75
Dermatology	20	30	60
Endocrinology	20	40	90
ENT/Otolaryngology	20	30	75
Gastroenterology	20	30	60
General Surgery	20	30	60
Gynecology Only	15	30	60
Licensed Clinical Social Worker	15	30	75
Nephrology	15	30	75
Neurology	15	30	60
Oncology—Medical, Surgical	15	30	60
Oncology—Radiation/Radiation Oncology	15	40	90
Ophthalmology	15	20	60
Physiatry, Rehabilitative Medicine	15	30	75
Plastic Surgery	15	40	90
Podiatry	15	30	90
Psychiatry	15	30	60
Psychology	15	30	60
Pulmonology	15	30	60
Rheumatology	15	40	90
Urology	15	30	60
Other Provider Not Listed	20	40	90
Facility Type:			
Pharmacy	5	10	30
Acute Inpatient Hospitals	15	30	60
Applied Behavioral Analysis	15	30	60
Critical Care Services—Intensive Care Units	15	30	120
Diagnostic Radiology	15	30	60
Inpatient Psychiatric Facility	15	45	75
Outpatient Dialysis	15	30	60
Outpatient Infusion/Chemotherapy	15	30	60
Skilled Nursing Facilities	15	30	60
Surgical Services (Outpatient or Ambulatory Surgical Center)	10	30	60
Other Facilities	15	40	120

C. Each provider panel of a carrier shall include at least 30 percent of the available essential community providers in each of the urban, rural, and suburban 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.

.05 Appointment Waiting Time Standards.

A. Sufficiency Standards.

(1) Subject to §B of this regulation, each carrier's provider panel shall meet the waiting time standards listed in §C of this regulation for at least 95 percent of the enrollees covered under health benefit plans that use that provider panel.

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

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

C. Chart of Waiting Time Standards.

Waiting Time Standards	
Urgent care (including medical, mental health, and substance use disorder services)	72 hours
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 services	10 calendar days

.06 Provider-to-Enrollee Ratio Standards.

A. Except for a Group Model HMO's health benefit plan, the provider panel for each carrier shall meet the provider-to-enrollee ratio standards listed in §B of this regulation.

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

(1) 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 care or services; and

(5) 2,000 enrollees for substance use disorder care or services.

.07 Waiver Request Standards.

A. A carrier may apply for a network adequacy waiver, for up to 1 year, of a network adequacy requirement listed in this chapter.

B. The Commissioner may find good cause to grant the network adequacy waiver request if the carrier demonstrates that the physicians, other providers, or health care facilities necessary for an adequate network:

(1) Are not available to contract with the carrier;

(2) Are not available in sufficient numbers;

(3) Have refused to contract with the carrier; or

(4) Are unable to reach agreement with the carrier.

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

(1) A description of any waiver previously granted by the Commissioner;

(2) A list of physicians, other providers, or health care facilities within the relevant service area that the carrier attempted to contract with, identified by name and specialty, if any, or health care facility type;

(3) A description of how and when the carrier last contacted the physicians, other providers, or health care facilities;

(4) A description of any reason each physician, other provider, or health care facility gave for refusing to contract with the carrier;

(5) Steps the carrier will take to attempt to improve its network to avoid future network adequacy waiver requests;

(6) If applicable, a statement that there are no physicians, other providers, or health care facilities available within the relevant service area for a covered service or services for which the carrier requests the waiver; and

(7) An attestation to the accuracy of the information contained in the network adequacy waiver request.

.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 in meeting the standards established under this chapter;

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

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

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

(1) Identify the particular information that the carrier requests not be disclosed; and

(2) Cite the statutory authority that permits denial of access to the information.

C. The Commissioner may review a request made under §B of this regulation upon receipt of a request for access pursuant to the Public Information Act.

D. The Commissioner may notify the carrier that made a request under §B of this regulation before granting access to information that was the subject of the request.

.09 Network Adequacy Access Plan Executive Summary Form.

A. For each provider panel used by a carrier for a health benefit plan, the carrier shall provide the network sufficiency results for the health benefit plan service area as follows:

(1) Travel Distance Standards.

(a) List the percentage of the participating providers, by primary care provider and specialty provider type, for which the carrier met the travel distance standards listed in Regulation .04 of this chapter, in the following format:

	Urban Area	*Suburban Area*	*Rural Area*
Primary Care Provider			
Specialty Provider			

(b) List the total number of certified registered nurse practitioners counted as a primary care provider.

(c) List the total percentage of primary care providers who are certified registered nurse practitioners.

(d) List the total number of essential community providers in the carrier's network.

(e) List the total percentage of essential community providers available in the health benefit plan's service area that are participating providers.

(2) Appointment Waiting Time Standards.

(a) List the percentage of appointments, by type of care, visits, or services, for which the carrier met the appointment waiting time standards listed in Regulation .05 of this chapter, in the following format:

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

(b) List the total percentage of telehealth appointments counted as part of the appointment waiting time standard results.

(3) Provider-to-Enrollee Ratio Standards.

(a) This subsection does not apply to Group Model HMO health benefit plans.

(b) For all other carriers, list the percentage of provider-to-enrollee ratios that met the provider-to-enrollee ratio standards listed in Regulation .06 of this chapter for each of the following categories:

(i) 1,200 enrollees for primary care;

(ii) 2,000 enrollees for pediatric care;

(iii) 2,000 enrollees for obstetrical/gynecological care;

(iv) 2,000 enrollees for mental health care or service; and

(v) 2,000 enrollees for substance use disorder care and services.

B. The network adequacy access plan executive summary form filed by a carrier pursuant to §A of this regulation is not confidential information.

ALFRED W. REDMER, JR.
Insurance Commissioner