LEGAL ACTION CENTER

August 19, 2020

Kathleen Birrane
Commissioner
Maryland Insurance Administration
200 St. Paul Place, Suite 2700
Baltimore, MD 21202.

Dear Commissioner Birrane:

Thank you for the opportunity to submit supplemental comments on revisions to the Maryland Network Adequacy regulations, COMAR § 31.10.44. The Legal Action Center (Center) submitted comments on December 19, 2019, and we urge the Maryland Insurance Administration (MIA) to adopt those recommendations. We have gathered additional information that supplements our initial comments and have reviewed the carriers' 2020 Network Adequacy reports, which we believe further support the Center's recommendations. Our comments address the following issues:

- **Retaining All Three Quantitative Metrics**: The Center's updated 50-state survey of quantitative network adequacy standards demonstrates that, since 2016, 7 additional states, including Maryland, have adopted quantitative network adequacy metrics; 5 states have adopted geographical distance standards, and 5 states have adopted appointment wait time metrics. (*See* Attachment A). Maryland is one of only 7 states to adopt all three of the most common quantitative metrics: geographical distance, appointment wait time and provider: patient ratio. (*See* Attachment B). No state has retracted metrics since our 2016 analysis. **We urge the MIA to retain all three metrics with modifications to ensure better tracking of substance use disorder (SUD) and mental health (MH) services.**

- **Uniform Methodology for Metric Calculations**: The California Department of Managed Health Care has implemented a standardized methodology for calculating appointment wait time. The Department has also proposed rules that offer standardized instructions and templates to ensure uniform collection across carriers. **We urge the MIA to evaluate reporting methodologies that other states have adopted and adopt a single reporting standard for all three metrics.**

- **Better Tracking of Substance Use Disorder and Mental Health Providers**: The carriers' third annual reports on network adequacy compliance reinforce the need for more granular data on the availability of substance use disorder and mental health providers. **We urge the MIA to adopt the recommendations the Center submitted in December for these purposes**.

- **Waiver Requirements**: As in previous years, no carrier has satisfied all metrics, yet only two carriers have requested a waiver for one or more of the metrics, according to the MIA. **We urge the MIA to require every carrier that does not satisfy a metric or fails to submit information for every required metric to submit the information required under COMAR § 31.10.44.07, including additional information outlined in our December letter and as supplemented below.**

- **Telehealth Standard**: Pending a full discussion of statutory standards governing telehealth services in Maryland and necessary modifications to ensure full access to health services via all modes of communication, **we urge the MIA to retain the current standard for utilizing telehealth to satisfy the appointment wait time metric.**

I. Retention of Existing Quantitative Metrics

The Center has updated its 50-state survey of quantitative metrics for network adequacy – examining measures for geographical distance, appointment wait time and provider-patient ratios – to help respond to several questions posed by the MIA. (*See* Attachment A). In general, since 2016, states have continued to adopt quantitative metrics to measure availability of and access to network services, and no state has retracted a metric previously adopted.

- 7 additional states have adopted quantitative network adequacy metrics, including Connecticut, Illinois, Maryland, Oklahoma, Oregon, South Carolina and West Virginia.
- 5 additional states – Illinois, Maryland, Minnesota, New Hampshire and Pennsylvania – have adopted appointment wait time metrics.
- 5 additional states – Illinois, Maryland, Oklahoma, Oregon and West Virginia – have adopted geographical distance metrics.
- 4 additional states – Illinois, Maryland, Oregon and Pennsylvania – have adopted specific metrics for mental health and substance use disorder services for a total of 17 states (California, Colorado, Delaware, Maine, Minnesota, Missouri, Nevada, New Hampshire (adopted new wait time metrics for MH and SUD), New Jersey, New York, Texas, Vermont and West Virginia had previously adopted metrics for MH and SUD providers). (*See* Attachments A and B).
- 2 additional states – Illinois and Maryland – have adopted all 3 metrics for a total of 7 states (California, Colorado, Montana, New Jersey and New Mexico had previously adopted all three metrics). (*See* Attachment B).

A. Retention of Wait Time Metric

Questions have been raised regarding the retention of the wait time metric; **the Center continues to fully support Maryland's existing wait time metrics.** (*See* Dec. 19th Letter). As noted above, States continue to adopt this metric for one or more service. Since 2016, New Hampshire adopted wait time metrics for behavioral health and primary care practitioners, and the metric for behavioral health services is more rigorous that Maryland's standards. (*See* Attachment A).

The failure of all Maryland carriers to satisfy this metric for one or more medical service and/or mental health/substance use disorder service, three years after the adoption of network metrics, reflects the need for greater oversight, not less. Compliance rates remain most

problematic for mental health and substance use disorder services. (*See* Attachment C). As noted in our December letter, the MIA must gain a full understanding of the reasons carriers are not able to meet this metric before revising this standard. The adoption of a uniform methodology for calculating appointment wait times and enforcement of the waiver requirement are essential to understand the magnitude and source of non-compliance.

The Center supports measures that would help carriers gain more information about the universe of providers in Maryland to improve outreach and contracting opportunities and the adoption of measures that mitigate any provider shortages, as proposed by Community Behavioral Health Association. **At the same time, we know that existing mental health and substance use disorder providers are available and interested in joining carrier networks if reimbursement rates and contracting practices are equitable.** The carriers have not provided sufficient information to support their assertion that the lack of provider availability is the source of network gaps for mental health and substance use disorder providers. The waiver process (see below) adequately addresses that issue if, in fact, carriers can demonstrate that they have exhausted their search and contracting efforts.

B. Threshold for Satisfying Geographical Distance Standards

The MIA has requested guidance on whether the threshold for compliance with the geographical distance metric should be 100% or a lower threshold. Our review of state standards revealed that 21 out of the 26 states with geographical distance standards set a threshold of 100%. Four states, Nevada, New Jersey, New Mexico and Pennsylvania, set a threshold of 90% or greater, and Washington sets a threshold of 80% or greater. (*See* Attachment A). Four of these 5 states, however, set both travel time and travel distance standards, which are arguably more precise than Maryland's geographical distance standard. Medicare Advantage also sets a threshold of 90% or greater for both travel time and travel distance. The 2020 carrier reports demonstrated that all carriers met the geographical distance metric for virtually all services in all geographical regions for over 95% of members. **Based on that data and the need to ensure access to care for the remaining residents, the Center recommends that the threshold be retained at 100%.**

II. Establishment of a Uniform Methodology for Metric Calculations

As set out in our December letter, the Center urges the MIA to establish a uniform methodology for calculating and reporting each quantitative metric so that consumers can rely on the data to evaluate availability of and access to care and compare access across all carriers. Based on our review of the 2020 carrier reports and a comparison of the data from previous reports, particularly with regard to appointment wait time, we know that carriers use different methodologies and that a carrier's methodology likely differs from one year to the next.

- In its 2020 report, Cigna, for example, stated that its calculations for urgent care and non-urgent behavioral health (BH) and SUD care are determined by a third-party assessment as opposed to first-hand data from providers. While asserting a 96% compliance rate for non-urgent BH/SUD care, Cigna also stated that this data "***are at best an approximation of what patients experience but are not a complete picture***." (emphasis added). Cigna does not make the same representation for medical services and, therefore, must use a different methodology for calculating those appointment wait times.

- Kaiser Permanente Insurance Co. stated that its calculation of appointment wait time is based on the number of locations reporting data, the number meeting the standard and the percentage meeting the standard. The public has no way of knowing whether other carriers use this approach.
- Across the three years of reporting, each carrier has presented dramatically different compliance rates for MH/SUD non-urgent services, which raises significant questions about methodology and validity of the data. (*See* Attachment C).

These discrepancies would be resolved through the adoption of a uniform methodology for calculating geographical distance, appointment wait time and provider-patient ratios. In addition to these three key metrics, the standards for calculating network coverage of essential community providers (ECP), certified registered nurse practitioners (CRNP) counted as primary care practitioners, and local health departments should also be set out with standardized definitions and instructions for calculations. We note, based on our review of the 2020 carrier reports, that Aetna and Cigna have not reported CRNP data, and CareFirst and Cigna have not reported ECP data. A standardized methodology for calculating these metrics would assist these carriers in reporting this required data.

We note that the MIA is in the best position to identify the most appropriate methodology for reporting the metrics, having access to the various methodologies used by Maryland's carriers and the ability to obtain information from other state departments of insurance. Clearly, the public is unable to evaluate various methodologies without access to such information. Since submission of our December letter, however, the Center has obtained additional information from the California Department of Managed Health Care (DMHC) regarding its methodology for calculating timely access (appointment wait time) standards. 28 CA ADC § 1300.67.2.2

The DMHC's current practice for measuring timely access standards is described generally on its website with reference to a Timely Access Reporting Web Portal, which contains instructions, methodology, survey tools and reporting templates. **The portal is not publicly available, and the Center has a pending public records request to obtains those documents.** DMHC describes the process as a "standardized methodology [that] requires health plans to survey network providers to assess the timeframe for the provider's next available appointment. The results of this survey are used to calculate a rate of compliance with the time-elapsed standards for each of the health plan's networks." DMHC has also issued guidance on the filing of the timely access reports that reinforces the requirement that each health plan must use an external vendor to review its timely access data and conduct a quality assurance review of the health plan's report prior to submission.

The DMHC is also in the process of revising the timely access reporting regulations, methodology, instructions and templates. The proposed rule and all materials are publicly available and highly detailed. In brief, the rule would require carriers to collect a wide range of data for 5 provider types – primary care providers, non-physician mental health care providers, specialist physicians, psychiatrists and ancillary service providers. For each provider type, the plan is required to submit a contact list of network providers from which unique providers in each county are to be selected for a survey of appointment availability for "the next" urgent and non-urgent service. Detailed instructions are provided for completing the survey in a uniform manner. The plan is required to enter raw data it collects on standardized templates for each provider type, and additional forms auto-calculate the required information. As under the current DMHC rules, an external vendor is required to review the plan's data for quality assurance.

We urge the MIA to evaluate the CA DMHC materials and adopt a similar process for calculating appointment wait times. The report forms include the collection of important information related to the provider's listing in a carrier's network directories that would also allow for the confirmation and updating of provider data on a regular basis.

III. Implementation of More Granular Tracking of MH and SUD Providers

As noted in the Center's December letter, we urge the MIA to track MH and SUD network providers with greater granularity by:

- Tracking additional MH and SUD providers under the distance metric, using the ASAM levels of care to select additional SUD provider types; and
- Disaggregating MH, SUD, and medical providers under the urgent care appointment wait time metric and disaggregating MH and SUD providers for the non-urgent care wait time metric.

A review of the carriers' 2020 reports provides additional support for this recommendation. We note that United Healthcare's compliance rate for urgent care wait time dropped dramatically between 2019 and 2020 and is far worse than other carriers. (*See* Attachment D). Reporting the compliance rate for MH and SUD services will likely reveal even greater limitations in accessing these services and will offer guidance on critical areas for network expansion, including residential crisis services – a mandated benefit under Ins. § 15-840. Similarly, for non-urgent MH/SUD services, it is important to understand whether the wider availability of MH services masks gaps in SUD services. The provider-patient ratios reported for 2020 again demonstrated that all carriers had far fewer SUD network providers than MH network providers.

IV. Mandating Submission of Waiver Requirement Information

The 2020 carrier reports reveal for ***the third consecutive year*** that no carrier complies with all network adequacy metrics and, as in past years, most carriers have not sought a waiver of standards to avoid penalties, notwithstanding non-compliance. As noted in our December letter, ***this creates an untenable stalemate for problem-solving***: stakeholders have no information regarding the carriers' efforts to contract with MH and SUD providers or the real barriers to building an adequate network. Carriers contend that they fail to meet the required metrics because there are insufficient providers with whom to contact and patients choose to wait longer for appointments with preferred practitioners. By seeking a waiver and submitting the requested information, carriers will have an opportunity to substantiate their efforts.

The MIA has monitored carrier compliance and encouraged improved compliance for three years and should now require carriers that do not meet a compliance metric to submit all information set out in COMAR § 31.10.44.07 and to make that information publicly available. This requirement would invariably open up networks to providers that seek to contract with carriers, reveal deficiencies in carrier contracting and reimbursement practices, and force carriers to live up to their legal obligation to offer covered services through network providers. A review of carrier practices will likely also reveal network admission, contracting and reimbursement practices that violate the Mental Health Parity and Addiction Equity Act (Parity Act).

The Center's December letter sets out additional information that should be included in the waiver disclosures to ensure that carriers are taking steps to remedy deficiencies in the MH and SUD provider networks and in a manner that complies with the Parity Act. We urge the MIA to adopt those additional requirements, and we request that three additional requirements be included, based on our additional research:

- Identification of all incentives that a carrier offers to medical, MH and SUD providers to join a network.
- Steps that the carrier will take to ensure that members have access to covered services and will pay no more than the network rate when network metrics are not satisfied.
- Submission of a separate network report at the mid-year point when a carrier fails to meet a metric.

In researching what other states have done to address network gaps, we have identified several important measures. First, in conversations with the Pennsylvania Department of Insurance, we learned that some carriers offer monetary incentives to specific provider types to join a network and address network gaps. **To the extent Maryland carriers adopt similar practices, those practices should be explicitly set out in the waiver request and reviewed for comparable application for mental health and substance use disorder providers.**

Second, the Washington Department of Insurance requires carriers that do not meet quantitative network access standards to articulate how the plan will ensure access to covered services and ensure that members obtain covered services at no greater cost than if the service were obtained from a network provider. WA ADC §§ 284-170-200; 284-170-210; 284-170-280. Based on discussions with state insurance officials responsible for network access, we learned that state officials conduct individual carrier negotiations to address gaps and access to covered services. Carriers are required to submit Alternative Access Delivery Request Form C that identifies, among other items, "data describing how the proposed plan ensures enrollees will have reasonable access to sufficient providers, by number and type for covered services." (p. 2). *See also* Analyst Checklist Access Plan and Access Plan – AADR. It is also important to note, that carriers are required to submit Provider Network Form A to inform state insurance regulators "about [the carrier's] network as it is marketed." (p. 31). *See* WA ADC §§ 284-170-280 for all form requirements.

We urge the MIA to require carriers to submit these same types of standardized forms, articulate how they are ensuring access to covered services, and demonstrate that those measures comply with the Parity Act. In connection with the MIA's second market conduct survey of parity compliance, carriers have adopted measures to address network gaps that, in our view, do not comply with the Parity Act. (p. 4). In its report on the third market conduct survey of parity compliance, the MIA noted that all carriers reported greater utilization of out-of-network services for MH and SUD services than for medical/surgical services between 2015 and 2017. (p. 7). The MIA stated that it:

> is hopeful that [the final network adequacy regulations] for behavioral health providers and facilities will address the concerns about inadequate networks for behavioral health services. The Administration plans to continue working on this issue through its enforcement of the Network Adequacy regulations.

(p. 7). **We urge the MIA to use this regulatory revision process to better enforce the regulations through the adoption of stronger carrier reporting and compliance measures.**

Finally, we urge the MIA to protect consumers from the high costs associated with inadequate networks by requiring carriers to provide non-network services at no greater cost to the member. Washington, like at least 10 other states,[1] requires carriers that have an insufficient number of participating providers or facilities for a particular health service to "ensure…that the enrollee obtains the covered service from a provider or facility within responsible proximity of the enrollee ***at no greater cost to the enrollee than if the service were obtained from network providers and facilities***. (emphasis added). WA ADC 284-170-200(5). In 2016, the Hogan Administration offered the first bill, HB 800, to ensure that consumers of substance use disorder and other services would not shoulder the costs of inadequate networks. Since then, MH and SUD stakeholders have sought, unsuccessfully, to enact similar protections in the 2019 and 2020 legislative sessions. (*See* SB 484/HB 1165 (2020); SB761/HB 837 (2019)).

With the third consecutive year of carrier non-compliance with network metrics, it is abundantly clear that regulatory action is needed to protect consumers from the unfair cost shift that results from inadequate networks. **We urge the MIA to: (1) require carriers to articulate, in their waiver requests, how they will cover non-network provider services at no greater cost to members; and (2) adopt a new regulatory standard that would require a carrier to make non-network services available at no great cost to the member when it cannot deliver services in compliance with the network adequacy metrics.**

V. Retention of Telehealth Standards for Appointment Wait Time Metrics

The Center urges the MIA to retain the current standards for the utilization of telehealth services to meet the appointment wait time metrics. The current standard appropriately conditions the use of telehealth services on being both clinically appropriate and elected by the enrollee for the appointment. COMAR § 31.10.44.05.A(2). We strongly oppose any proposal to allow a carrier to meet the appointment wait time metric via telehealth without the informed and affirmative election by the enrollee.

As confirmed by the 2020 carrier reports, carriers have not used telehealth to meet network adequacy requirements pre-pandemic. (*See* Attachment E). Significant revisions to state law would be needed to ensure access to health services via telehealth ***before*** carriers could rely on this service delivery platform to satisfy network adequacy standards. The current definition of telehealth (COMAR § 31.10.44.02.B(24)) omits services delivered by audio-only telephone, which is essential to meet the needs of Marylanders who have no access to broadband, internet services or computer or smart phone devices. While Maryland has operated during the pandemic under a uniform set of standards in Medicaid for the delivery of telehealth services, commercial carriers have adopted their own practices without uniform guidance from regulators. While carriers have likely revised their policies to allow for the expansion of telehealth, they have not demonstrated that they will retain these flexibilities post-pandemic. Additionally, stakeholders have no understanding of the full range of those practices and substantial standardization would be needed to ensure that consumers have access to the same services and platforms, regardless of their health plan. We look forward to further stakeholder conversations on this important issue.

[1] Arkansas, Colorado, Illinois, Maine, Mississippi, Missouri, Nebraska, New Hampshire, South Dakota and West Virginia have similar protections.

Thank you for considering our views. Please contact me at eweber@lac.org if you have any questions or need additional information.

Sincerely,

Ellen M. Weber, J.D.
Vice President for Health Initiatives

Attachment A

Attachment A: Network Adequacy Quantitative Standards – Fifty-State Survey: Geographic Criteria, Appointment Wait Times & Providers/ Enrollee Ratios (Updated March 2020)

Quantitative Standards in Commercial Insurance Plans:

- Twenty-nine (29) states and Medicare Advantage have adopted one or more of the quantitative standards included in this survey to measure network adequacy in commercial insurance plans: Alabama (HMO), Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Florida (HMO), Illinois, Kentucky, Maine, Maryland, Minnesota, Missouri, Montana, Nevada, New Hampshire, New Jersey, New Mexico, New York, Oklahoma (HMO), Oregon, Pennsylvania, South Carolina, Tennessee, Texas, Vermont, Washington and West Virginia (HMO).
- Sixteen (16) states have specific quantitative standards for Mental Health /Substance Use Disorder (MH/SUD) services: California, Colorado, Delaware, Illinois, Maine, Maryland, Minnesota, Missouri, Nevada, New Hampshire, New Jersey, New York, Oregon, Pennsylvania, Texas and Vermont.
- Nine (9) states have adopted quantitative standards to measure network adequacy for emergency services only: Hawaii, Louisiana, Michigan, Mississippi, Nebraska, North Carolina, North Dakota, South Dakota and Virginia.
- Three (3) of these states require health plans to meet NCQA and/or other national accreditation standards: Idaho, Indiana and Louisiana

Geographic Standards:

- Twenty-six (26) states have adopted or require geographic standards of network adequacy: Alabama (HMO), Arizona, Arkansas, California, Colorado, Delaware, Florida (HMO), Illinois, Kentucky, Maryland, Minnesota, Missouri (HMO), Montana, Nevada, New

Hampshire, New Jersey, New Mexico, New York, Oklahoma (HMO), Oregon, Pennsylvania, Tennessee, Texas, Vermont, Washington and West Virginia (HMO).

- Twelve (12) states have specific geographic standards for MH/SUD services: California, Colorado, Delaware, Maryland, Minnesota, Missouri, Nevada, New Hampshire, New Jersey, Oregon, Pennsylvania and Vermont.

Appointment Wait Times:

- Seventeen (17) states have established appointment wait time standards (excluding emergency services only): Arizona, California, Colorado, Florida, Illinois, Maine, Maryland, Minnesota, Missouri, Montana, New Hampshire, New Jersey, New Mexico, Pennsylvania, Texas, Vermont and Washington.

- Seven (7) states have specific appointment wait time standards for MH/SUD services: California, Colorado, Maine, Maryland, Missouri (telephone access), New Hampshire and Texas.

Provider/Enrollee Ratio or Minimum Number of Providers:

- Thirteen (13) states and Medicare Advantage have adopted provider/enrollee ratios or a standard to determine the minimum number of providers available: California, Colorado, Connecticut, Delaware, Illinois, Maine, Maryland, Montana, New Jersey, New Mexico, New York, South Carolina and West Virginia.

- Four (4) states have specific provider/enrollee ratios for MH/SUD services: Colorado, Delaware, Illinois and Maryland.

State	Source	Geographic Criteria	Appointment Wait Times	Provider/Enrollee Ratio
Alabama (*Standards apply to Health Maintenance Organizations*)	Ala. Admin. Code r. 420-5-6-.06 (1999) Current through Nov. 29, 2019	• The distance from the HMO's geographic service area boundary to the nearest primary care delivery site and to 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	• Emergency telephone consultation on a 24-hour a day, 7-day a week basis including qualified physician coverage for emergency service	• No quantitative criteria provided
Alaska	N/A	• No quantitative criteria provided	• No quantitative criteria provided	• No quantitative criteria provided
Arizona (*Standards apply to Health Care Service Organizations*)	A.A.C. R20-6-1901 to A.A.C. R20-6-1921 (2005); Regulatory Bulletin 2006-7 (2006) Current through Feb. 28, 2020	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 If the HCSO prior-authorizes services that require an enrollee to travel outside the	• **Preventative care services from a contracted PCP**: 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**: Appointment date within 15 days of the enrollee's request to the PCP or	• No quantitative criteria provided

State	Source	Geographic Criteria	Appointment Wait Times	Provider/Enrollee Ratio
		HCSO service area because the services are not available in the area, the HCSO shall reimburse the enrollee for travel expenses • **Urban areas**: Primary care services from a contracted PCP located within 10 miles or 30 minutes of the enrollee's home; High profile specialty care services from a contracted SCP located within 15 miles or 45 minutes of the enrollee's home; Inpatient care in a contracted general hospital, or contracted special hospital, within 25 miles or 75 minutes of the enrollee's home • **Suburban areas**: Primary care from a contracted PCP located with 15 miles or 45 minutes of the enrollee's home; High profile specialty care services from a contracted SPC within 20 miles or 60 minutes of the enrollee's home; Inpatient	sooner if medically necessary • **Specialty care services from a contracted SCP**: Appointment date within 60 days of the enrollee's request or sooner if medically necessary • In-area urgent care services from a contracted provider seven 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	

State	Source	Geographic Criteria	Appointment Wait Times	Provider/Enrollee Ratio
		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.		
Arkansas (*Standards apply to health benefit plans*)	Ark. Admin. Code 054.00.106-5 (2014) Current through Dec. 15, 2019	• **Emergency Services**: Within a 30-mile radius between the location of the emergency services and the residence of the covered person • **Primary Care**: At least one Primary Care Professional within a 30-mile radius between the location of the Primary Care Professional and the residence of the covered person • **Specialty Care Services**: within a 60-mile radius between the location of the Specialty Care	• **Emergency Services**: Covered person will have access to emergency services, twenty-four (24) hours per day, seven (7) days per week	• No quantitative criteria provided

State	Source	Geographic Criteria	Appointment Wait Times	Provider/Enrollee Ratio
		Professional and the residence of the Covered Person • **For QHPs**: At least one Essential Community Provider within a 30-mile radius between the location of the Essential Community Provider and the residence of the covered person		
California (*Standards apply to health insurance policies*)	10 CCR § 2240.1 to 2240.15 (2016) Current through March 6, 2020	• 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. Insurers shall establish written standards for their providers that ensure that provider facilities are	• Health care services (excluding emergency health care services) are 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	• Equivalent of at least one full-time physician per 1,200 covered persons • Equivalent of at least one full-time primary care physician per 2,000 covered persons.

State	Source	Geographic Criteria	Appointment Wait Times	Provider/Enrollee Ratio
		accessible to people with disabilities and compliant with all applicable state and federal laws regarding access for people with disabilities. • **Primary Care**: Primary care network providers with sufficient capacity to accept covered persons within a maximum travel time of 30 minutes or a maximum travel distance of 15 miles of each covered person's residence or workplace • **Specialists**: There are medically required network specialists who are certified or eligible for certification by the appropriate specialty board with sufficient capacity to accept covered persons within a maximum travel time of 60 minutes or a maximum travel distance of 30 miles of each covered person's residence or workplace	• **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 • **Non-urgent appointments with a non-physician mental health care 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**	

State	Source	Geographic Criteria	Appointment Wait Times	Provider/Enrollee Ratio
		• **MH/SUD Providers**: There are mental health and substance use disorder professionals with skills appropriate to care for the mental health and substance use disorder needs of covered persons and with sufficient capacity to accept covered persons within a maximum travel time of 30 minutes or a maximum travel distance of 15 miles of each covered person's residence or workplace. • **Hospitals:** There is a network hospital with sufficient capacity to accept covered persons for covered services within a maximum travel time of 30 minutes or a maximum travel distance of 15 miles of each covered person's residence or workplace.	**health condition**: within 15 business days of the request for appointment • Insurers shall provide or arrange for the provision, 24 hours per day, 7 days per week, of triage or screening services by telephone • Insurers shall ensure that telephone triage or screening services are provided in a timely manner appropriate for the insured's condition, and that the triage or screening waiting time does not exceed 30 minutes • Insurers shall ensure that, during normal business hours, the waiting time for a covered person to speak by telephone with an insurer customer service representative knowledgeable and competent regarding the covered person's questions and concerns shall not exceed ten (10) minutes, or	

State	Source	Geographic Criteria	Appointment Wait Times	Provider/Enrollee Ratio
			that the covered person will receive a scheduled call-back within 30 minutes	
Colorado *(Standards apply to health benefit plans)*	Network Plan Standards and Reporting Requirements for ACA Compliant Health Benefit Plans 3 CCR 702-4:4-2-53; 702-4:4-2-54 Current through Feb. 25, 2020	***See***: Section 8, Geographic Access Standards (3 CCR 702-4:4-2-53) for complete list: • **PCP/OB-GYN**: Large Metro, 5 miles; Metro, 10 miles; Micro, 20 miles, Rural, 30 miles; CEAC 60 miles; • **Psychiatry/Psychology/Licensed Social Worker**: Large metro, 10 miles; Metro, 30 miles; Micro, 45 miles; Rural, 60 miles; CEAC, 100 miles. • **Acute Inpatient Hospitals**: Large metro, 10 miles; Metro, 30 miles; Micro, 60 miles; Rural, 60 miles; CEAC 100 miles. • **Inpatient Psychiatric Facility**: Large metro, 15 miles; Metro, 45 miles, Micro, 75 miles; Rural 75 miles, CEAC 145 miles.	• **Emergency care** (Medical, Behavioral, Substance Use): 24/7 (100% of the time) • **Urgent care** (Medical, Behavioral, Substance Use): within 24 hours (100% of time) • **Primary care** (routine): within 7 calendar days (90% of time) • **MH/SUD (routine**): within 7 calendar days (90% of time) • **Prenatal care**: within 7 calendar days (90% of time) • **Primary care access to after-hours care**: office number answered 24/7 by answering service or instructions on how to reach physician (90% of time)	Large Metro, Metro, Micro: • Primary care – 1:1000 • Pediatrics – 1:000 • OBGYN – 1:1000 • MH/SUD – 1:1000

State	Source	Geographic Criteria	Appointment Wait Times	Provider/Enrollee Ratio
			• **Preventative visits/well visits**: within 30 days (90% of time) • **Specialty care/non-urgent**: within 60 calendar days (90% of time)	
Connecticut (*Standards apply to health insurance policies*)	Regs. Conn. State Agencies § 38a-472f-3 (2018) CT. ST. § 38a-472f Current through March 10, 2020	• No quantitative criteria provided	• Covered persons have access to emergency services twenty-four (24) hours a day, seven (7) days a week.	• One primary care physician per two thousand (2,000) covered persons • Percentage of providers accepting new patients at least 70%.
Delaware (*Separate standards apply to MCOs and QHPs*)	MCO: 18 DE ADC 1403-11.0 (2007) Current through March 1, 2020 QHP: Delaware UHP Standards for Plan Year 2019[1]	**MCOs**: No quantitative criteria provided **QHPs**: • **PCP**: 15 miles for urban/suburban, 25 miles for rural • **OBGYN**: 15 miles for urban/suburban, 25 miles for rural • **Pediatrician**: 15 miles for urban/suburban, 25 miles for rural	**MCOs**: • Enrollees shall have access to emergency care 24 hours per day,7 days per week **QHPs**: No quantitative criteria provided	**MCOs**: No quantitative criteria provided **QHPs**: • **PCPs**: One full time equivalent PCP for every 2,000 patients • **BH Practitioner or Mid-Level Professional Supervised by a BH Practitioner**: One for every 2,000 patients

[1] **http://dhss.delaware.gov/dhcc/files/qualifiedstandards.pdf**

State	Source	Geographic Criteria	Appointment Wait Times	Provider/Enrollee Ratio
		• **Specialty Care**: 35 miles for urban/suburban, 45 miles for rural • **MH/SUD**: 35 miles for urban/suburban, 45 miles for rural • **Acute-Care Hospitals**: 15 miles for urban/suburban, 25 miles for rural • **Psychiatric Hospitals**: 35 miles for urban/suburban, 45 for rural • **Dental**: 35 miles for urban/suburban, 45 miles for rural		
Florida (*Standards apply to Health Maintenance Organizations and Prepaid Health Clinics)*	Fla. Admin. Code r. 59A-12.006 (2003) Current through March 9, 2020	• **Travel Time to PC and General Hospital**: Average travel time from the HMO geographic services area boundary to the nearest primary care delivery site and to the nearest general hospital under arrangement with the HMO to provide health care services no longer than 30 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 • Routine non-symptomatic cases will be seen as soon as possible • Patients with appointments should have a professional evaluation within (1) hour of scheduled appointment	• No quantitative criteria provided

State	Source	Geographic Criteria	Appointment Wait Times	Provider/Enrollee Ratio
		• **Travel Time to Specialty/Ancillary/Other**: 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 no longer than 60 minutes under normal circumstances	time; if a delay is unavoidable, patient shall be informed and provided an alternative	
Georgia NA advocacy efforts by Georgians for a Healthy Future[2]	N/A	• No quantitative criteria provided	• No quantitative criteria provided	• No quantitative criteria provided
Hawaii *(Standards apply to network plans/health benefit plans)*	HRS § 431:26-103 Current through 2019 Regular Session	• No quantitative criteria provided	• **Emergency Services**: Covered persons shall have access to emergency services 24/7	• No quantitative criteria provided

[2] http://healthyfuturega.org/our-priorities/increasing-access-to-care/network-adequacy/

State	Source	Geographic Criteria	Appointment Wait Times	Provider/Enrollee Ratio
Idaho (*Standards apply to health benefit plans*)	2020 Idaho Standards for ACA Compliant Individual and Small Group Health Benefit Plans and QDPs Document[3]	• Carriers must meet NCQA, AAAHC, or URAC standards	• Carriers must meet NCQA, AAAHC, or URAC standards	• Carriers must meet NCQA, AAAHC, or URAC standards
Illinois *(Standards apply to network plans)*	Illinois Department of Insurance Network Adequacy Checklist[4] 215 ILCS 124/10 (eff. 6-29-18) authorizing legislation Current through P.A. 101-629	• **Primary Urban**: 30 minutes or 30 miles for primary care, OB-GYN and general hospital care for urban areas • **Primary Rural**: 60 minutes or 60 miles for primary care, OB-GYN and general hospital care for rural areas • **Specialist Urban**: 45 minutes or 60 miles for specialist in urban areas • **Specialist Rural**: 75 minutes or 100 miles for specialist in rural	• Access to primary care, emergency services and woman's principal health care providers 24/7.	• 1 per county -- Hospital Facility, and Mental Health Facility • 1 per 1,000 – PCP/Pediatrician • 1 per 2,500 – OB/GYN • 1 per 5,000 – General Surgery, and Behavioral Health • 1 per 10,000 – Cardiology, Chiropractor, Dermatology, Endocrinology, Gastroenterology, Nephrology, Ophthalmology, Orthopedic Surgery, Pulmonary, Rheumatology, and Urology • 1 per 15,000 – Infectious Disease, Allergy/Immunology, ENT/Otolaryngology, Oncology/Radiation, and Physiatry/Rehabilitative

[3] https://doi.idaho.gov/DisplayPDF?Cat=company&ID=2020%20Idaho%20ACA%20HBP%20and%20QDP%20Standards
[4] http://insurance.illinois.gov/HealthInsurance/NetworkAdequacyTransparencyChecklist.pdf

State	Source	Geographic Criteria	Appointment Wait Times	Provider/Enrollee Ratio
				• 1 per 20,000 – Plastic Surgery, and Neurology • Insurers who are not able to comply with the provider ratios and time and distance standards established by the Department may request an exception to these requirements.
Indiana (*Standards apply to Health Maintenance Organizations*)	IC 27-13-36-2 to IC 27-13-36-4; and 13-36-8 (1999) Current through 2020 Second Regular Session of 121st General Assembly	• Must comply with standards developed by NCQA	• Must comply with standards developed by NCQA	• Must comply with standards developed by NCQA
Iowa	N/A	• No quantitative criteria provided	• No quantitative criteria provided	• No quantitative criteria provided
Kansas	N/A	• No quantitative criteria provided	• No quantitative criteria provided	• No quantitative criteria provided
Kentucky (*Standards apply to Qualified Health Benefit Plans and Managed Care and Non-Managed Care Plans*)	KRS § 304.17A-515 Effective January 1, 2019 900 Ky. Admin. Regs. 10:200 Sec. 4	• **Urban areas**: 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	• No quantitative criteria provided	• No quantitative criteria provided

State	Source	Geographic Criteria	Appointment Wait Times	Provider/Enrollee Ratio
	Current through Chapter 5 of 2020 Regular Session	• **Non-urban areas**: Provider network that makes available 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. All other providers shall be available to all persons enrolled in the plan within 50 minutes or 50 miles of each enrollee's place of residence or work, to the extent those services are available		
Louisiana (*Standards apply to Health Benefit Plans*)	LA. REV. STAT. ANN. § 22:1019.2 (2013) Current through 2019 Regular Session	• Carriers must meet the standards for accreditation of NCQA, American Accreditation Health Commission, Inc., or URAC	• Carriers must meet the standards for accreditation of NCQA, American Accreditation Health Commission, Inc., or URAC • In the case of emergency services/any ancillary emergency health care services, covered persons shall have access 24/7	• Carriers must meet the standards for accreditation of NCQA, American Accreditation Health Commission, Inc., or URAC

State	Source	Geographic Criteria	Appointment Wait Times	Provider/Enrollee Ratio
Maine (*Standards apply to Health Maintenance Organizations, Managed Care Plans, and health plans*)	02-031 CMR Ch. 850, § 7 (2012) Current through Feb. 26, 2020	• No quantitative criteria provided	• **Emergency Services**: MCPs must provide access to emergency services at all times • **Behavioral Health – Non-life-threatening emergencies**: within 6 hours • **Behavioral Health – Urgent care**: within 48 hours • **Behavioral Health – Routine office visit**: within 10 business days	• **PCPs**: To the extent possible, carriers that offer MCPs utilizing PCPs shall maintain a minimum of one full-time PCP to 2000 enrollees
Maryland *(Standards apply to health benefit plans)*	COMAR 31.10.44.04-06 Current through Feb. 25, 2020	*See Appendix 1(A) for complete list.* • **PCP/OBGYN**: 5 miles (urban), 10 miles (suburban), 30 miles (rural) • **Psychiatry, Psychology, LCSW:** 10 miles (urban), 25 miles (suburban), 60 miles (rural) • **Applied Behavior Analyst:** 15 miles (urban), 30 miles (suburban), 60 miles (rural) • **Specialists Range:** 10-15 miles (urban), 10-40 miles (suburban), 60-90 miles (rural)	• **Urgent care** (including medical, BH/SUD services): 72 hours • **Routine Primary Care:** 15 calendar days • **Preventative Visit/Well Visit**: 30 calendar days • **Non-Urgent Specialty Care**: 30 calendar days • **Non-Urgent BH/SUD Services**: 10 calendar days	Provider-to-enrollee ratios shall be equivalent to at least 1 full-time physician, or as appropriate, another full-time provider to enrollees: • 1:1,200 primary care • 1: 2,000 pediatric care • 1:2,000 OB/GYN care • 1: 2,000 BH services • 1: 2,000 SUD services

State	Source	Geographic Criteria	Appointment Wait Times	Provider/Enrollee Ratio
		• **Behavioral Health Facilities:** 10 miles (urban), 25 miles (suburban), 60 miles (rural)		
Massachusetts	N/A	• No quantitative criteria provided	• No quantitative criteria provided	• No quantitative criteria provided
Michigan	Michigan Network Adequacy Guidance Document (Revised June 2019)[5] MCLA 500.3513 (HMO)	• No quantitative criteria provided. • Identifies a 30-minute travel time as guidance for adequacy but not applied to any provider/service.	• **Emergency episodes of illness or injury**: Services available and accessible to covered persons 24 hours a day and 7 days a week.	• No quantitative criteria provided
Minnesota (*Standards apply to health carriers*)	M.S.A. § 62K.10 Current through Jan. 1, 2020	• **Primary Care, Mental Health, General Hospital Services**: Maximum travel distance or time shall be the lesser of 30 miles or 30 minutes to the nearest provider • **Other Health Services**: Maximum travel distance or time shall be the lesser of 60 miles or 60 minutes to the nearest provider of specialty physician services, ancillary services,	• **Primary Care Physician Services**: Must be available and accessible 24/7 within the network's area	• No quantitative criteria provided

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

State	Source	Geographic Criteria	Appointment Wait Times	Provider/Enrollee Ratio
		specialty hospital services, and all other health services		
Mississippi	Miss. Admin. Code 19-3:14.05 Current through Nov. 2019	• No quantitative criteria provided	• **Emergency Facility Services**: Covered persons shall have access 24/7	• No quantitative criteria provided
Missouri (*Standards apply to Health Maintenance Organizations Offering Managed Care Plans*)	20 Mo. Code of State Regulations 400-7.095 (2007) Current through Dec. 15, 2019 MO. ST. § 354.603	*See* Appendix 1 (B), Distance Standards for complete list.[6] • **PCP:** 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 • **Psychiatry – Adult/General**: within 15 miles in urban areas; 40 miles in basic areas; 80 miles in rural areas. • **Psychiatry – Child/Adolescent:** within	• **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 from the time the enrollee contacts the provider; • **Emergency care**: A provider or emergency care facility shall be	• No quantitative criteria provided

[6] **https://www.sos.mo.gov/cmsimages/adrules/csr/current/20csr/20c400-7.pdf**

State	Source	Geographic Criteria	Appointment Wait Times	Provider/Enrollee Ratio
		22 miles in urban areas; 45 miles in basic areas; 90 miles in rural areas • **Psychologist/Other Therapist**: within 10 miles in urban areas; 20 miles in basic areas; 40 miles in rural areas • **Basic Hospital:** 30 miles in urban, basic and 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 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.	available 24 hours per day, 7 days per week • **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 • **Mental health care**: Telephone access to a licensed therapist shall be available 24 hours per day, 7 days per week.	
Montana	MCA 33-36-201 Current through 2019 Session	• To the extent that services are covered, the health carrier must have an	• **Emergency services**: available and accessible at all times;	• In order to be deemed adequate, a health carrier's network must include one

State	Source	Geographic Criteria	Appointment Wait Times	Provider/Enrollee Ratio
(Standards apply to Managed Care Plans)	Mont. Admin. R. 37.108.215-227 Current through Feb. 28, 2020	adequate network of primary care providers, a hospital, critical access hospital, or medical assistance facility, and a pharmacy within a 30-mile radius of each enrollee's residence or place of work	• **Urgent care appointments**: available within 24 hours; • **Non-urgent care with symptoms appointments**: available within 10 calendar days; • **Immunization appointments**: available within 21 calendar days; and • **Routine or preventive care appointments**: available within 45 calendar days.	mid-level PCP per 1,500 projected enrollees or one physician PCP per 2,500 projected enrollees.
Nebraska	Neb. Rev. St. § 44-7105 (1998) Current through Feb. 13, 2020 of 3nd Regular Session, 106th Legislature	• No quantitative criteria provided	• **Emergency services**: Covered persons shall have access twenty-four hours per day, seven days per week	• No quantitative criteria provided
Nevada	N.R.S. 687B.490 Nev. Admin. Code 687B.768 Current through Feb. 29, 2020	• Network plan must provide reasonable access to 1 provider in each specialty area for at least 90% of enrollees s based on maximum time/distance standards. • For Mental Health and Substance Use Disorder providers (psychiatrists,	• No quantitative criteria provided	• No quantitative criteria provided

State	Source	Geographic Criteria	Appointment Wait Times	Provider/Enrollee Ratio
		psychologists and licensed clinical social workers) standards are: Metro 45 minutes/30 miles; Micro 60 minutes/45 miles; Rural 75 minutes/60 miles and CEAC 110 minutes/100 miles. *See Appendix 2(A) for all specialties.*		
New Hampshire (*Standards apply to Managed Care Plans*)	N.H. Code Admin. R. Ins 2701.04-.10 (2010) Current through March. 1, 2020	• **Service Designation**: Core, common and specialized. ***Core services*** include: alcohol or drug treatment in ambulatory setting for crisis intervention, detoxification or medical or somatic treatment; assessment, case management, group counseling, IOP, methadone or equivalent treatment, subacute detox, medication training and support, BH or SUD comprehensive community support services, BH or SUD comprehensive medication services, BH counseling or therapy, BH	• **Behavioral Health**: 6 hours for non-life-threatening emergency; 48 hours for urgent care; 10 business days for initial or evaluation visit. • **PCP**: 48 hours for urgent care; 30 days for other routine care	• No quantitative criteria provided

State	Source	Geographic Criteria	Appointment Wait Times	Provider/Enrollee Ratio
		partial hospitalization, BH short-term residential. ***Common services*** include general psychiatric care on inpatient basis, psychiatric diagnostic evaluation with medical services; ***Specialized services*** include alcohol or drug acute detox • **Urban Counties**: For core services, 10 miles or 15 minutes driving time; for common services, 20 miles or 30 minutes driving time; for specialized services 40 miles or 1 hour driving time. • **Middle Counties**: Core services, 20 miles or 40 minutes driving time; common services, 40 miles or 80 minutes driving time; specialized services 70 miles or 2 hours driving time. • **Rural Counties**: Core services, 30 miles or one hour driving time; common services, 80 miles or 2 hours driving time;		

State	Source	Geographic Criteria	Appointment Wait Times	Provider/Enrollee Ratio
		specialized services 125 miles or 2.5 hours driving time.		
New Jersey (*Standards apply to Managed Care Plans*)	NJ ADC 11:24A-4.10 Current through March 16, 2020	• **PCPs**: Sufficient number of physicians to assure that at least 2 physicians eligible as PCPs are 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 persons • **Specialists**: Sufficient number of the medical specialists, as applicable to the services covered in-network, to assure access within 45 miles or 60 minute driving time, whichever is less, of 90 percent of covered persons within each county or approved sub-county service area • **Acute Care Hospital/Surgical Facilities**: At least 1 licensed acute care hospital with licensed medical-surgical, pediatric,	If the carrier provides benefits for emergency services: • **Urgent care:** provided within 24 hours of notification of the PCP or carrier • **Emergent and urgent care:** PCPs shall be required to provide 7-day, 24-hour access to triage services • **Routine appointments:** scheduled within at least 2 weeks • **Routine physical exams:** scheduled within at least 4 months	• The carrier shall demonstrate sufficiency of network PCPs to meet the adult, pediatric and primary OB/GYN needs of the current and/or projected number of covered persons by assuming: (1) Four primary care visits per year per member, averaging one hour per year per member; and (2) Four patient visits per hour per PCP • The carrier shall have a contract or arrangement with at least one home health agency licensed by the Department of Health and Senior Services to serve each county where 1,000 or more covered persons reside • The carrier shall have a contract or arrangement with at least one hospice program certified by

State	Source	Geographic Criteria	Appointment Wait Times	Provider/Enrollee Ratio
		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 percent of covered persons within the county or service area; The carrier shall have a contract or arrangement with 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 percent of covered persons within the county or service area • **Specialized services** available within 45 miles or 60 minutes average driving time, whichever is less, of 90 percent of covered persons within each county		Medicare in any county where 1,000 or more covered persons reside, if hospice care is covered under the health benefits plan in-network

State	Source	Geographic Criteria	Appointment Wait Times	Provider/Enrollee Ratio
		or service area: at least one hospital providing regional perinatal services, a hospital offering tertiary pediatric services, in-patient psychiatric service, residential SUD treatment centers, diagnostic cardiac catherization services in a hospital, specialty out-patient centers for HIV/AIDS, sickle cell disease, hemophilia, and cranio-facial and congenital anomalies, and comprehensive rehabilitation services • **Specialized services** 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: licensed long-term care facility with Medicare-certified skilled nursing beds, therapeutic radiation, magnetic resonance imaging center, diagnostic radiology,		

State	Source	Geographic Criteria	Appointment Wait Times	Provider/Enrollee Ratio
		emergency MH service (including a short term care facility for involuntary psychiatric admissions), outpatient therapy for MH/SUD conditions, and licensed renal dialysis • In any county or approved service area in which 20%+ of a carrier's projected or actual number of covered persons must rely upon public transport to access health care services, the driving times set forth shall be based upon average transit time using public transport, and the carrier shall demonstrate how it will meet the requirements		
New Mexico *(Standards apply to Managed Health Care Plans)*	N.M. Admin Code 13.10.22.8 Current through Jan. 14, 2020	• 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	• **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	• Must have a sufficient number of PCPs to meet the primary care needs of enrollees: 1) each covered person will have four primary care visits annually, averaging a total of one hour; 2) each PCP will see an average of four patients

State	Source	Geographic Criteria	Appointment Wait Times	Provider/Enrollee Ratio
		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 nature of the service area, the geographic location of each covered person, and the type of specialty care needed by the covered person population.	notification to the PCP or MHCP; • **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** scheduled within 4 months.	per hour; and 3) one full-time equivalent PCP will be available for every 1,500 covered persons.

State	Source	Geographic Criteria	Appointment Wait Times	Provider/Enrollee Ratio
		• 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		

State	Source	Geographic Criteria	Appointment Wait Times	Provider/Enrollee Ratio
		of residents in the county or service area and given the community's standard of care.		
New York	Network Adequacy Standards and Guidance Document[7]	**PCPs**: • **Metropolitan Areas**: 30 minutes by public transportation. • **Non-Metropolitan Areas**: 30 minutes or 30 miles by public transportation or by car. • In rural areas, transportation may exceed these standards if justified. **Non-PCPs**: • It is preferred that an insurer meet the 30-minute or 30-mile standard for other providers that are not primary care providers. A time and distance standard of 45 minutes/45 miles may be	• No quantitative criteria provided	• At least 1 hospital in each county. • At least 3 hospitals in Bronx, Erie, Kings, Monroe, Nassau, New York, Queens, Suffolk and Westchester. • Choice of 3 primary care physicians (PCPs) in each county, and potentially more based on enrollment and geographic accessibility • At least 2 of each specialist provider type, and potentially more based on enrollment and geographic accessibility • At least 2 behavioral health providers per county. • Choice of 2 primary dentists in service area and a ratio of at least 1 primary care

[7] https://www.dfs.ny.gov/insurance/health/Network_Adeq_standards_guidance_Instructions_9.15_Final.pdf; https://www.dfs.ny.gov/docs/insurance/health/network_adeq_submission_instructions.pdf

State	Source	Geographic Criteria	Appointment Wait Times	Provider/Enrollee Ratio
		used for the following rural counties for the following provider types: • **Pedodontist**: Allegany, Cayuga, Chemung, Essex, Franklin, Fulton, Hamilton, Herkimer, Jefferson, Lewis, Montgomery, Oneida, Otsego, Schoharie, Schuyler, St. Lawrence, Steuben and Tompkins. • **Oral Surgery**: Essex, Franklin, Lewis, Schoharie and Steuben. • **Orthodontics**: Broome, Cayuga, Chemung, Clinton, Essex, Franklin, Jefferson, Lewis, Madison, Oneida, Otsego, Schoharie, Schuyler, St. Lawrence and Tompkins.		dentist for every 2,000 insureds • At least 2 orthodontists, 1 pedodontist, and 1 oral surgeon
North Carolina *(Standards apply to Managed Care Health Benefit Plans)*	11 NC ADC 20.0302 Current through Jan. 22, 2020	• No quantitative criteria provided	• **Emergency services** must be available on a 24-hour, seven day per week basis	• No quantitative criteria provided
North Dakota	NDAC 45-06-07-06 (1994) Current through Jan. 2020	• No quantitative criteria provided	• **Emergency care services** available and accessible within the service area	• No quantitative criteria provided

State	Source	Geographic Criteria	Appointment Wait Times	Provider/Enrollee Ratio
(*Standards apply to Health Maintenance Organizations*)			twenty-four hours a day, seven days a week	
Ohio	N/A	• No quantitative criteria provided	• No quantitative criteria provided	• No quantitative criteria provided
Oklahoma (*Standards apply to Health Maintenance Organizations*)	OAC 365:40-5-40; 365:40-5-110 Current through March 2, 2020	• The "mean travel time" must be 30 minutes or less to the nearest primary or emergency care site from six equidistant points within the boundary of the service area.	• **Emergency services** must be available 24 hours a day, 7 days per week.	• No quantitative criteria provided
Oregon	OR ADC 836-053-0330 Current through Feb. 2020	• One way that plans can demonstrate compliance with network adequacy requirements is by meeting standards for Medicare Advantage plans, adjusted to reflect age and demographics of enrollees (includes standard for inpatient psychiatric facility services)	• No quantitative criteria provided	• No quantitative criteria provided
Pennsylvania	28 Pa. Code §§ 9.678; 9.679 (2001) Current through March 7, 2020	• Plan shall provide for at least 90% of its enrollees in each county in its service area, access to covered	• **PCPs**: Must provide office hours accessible to enrollees a minimum of 20 hours-per-week, be	• No quantitative criteria provided

State	Source	Geographic Criteria	Appointment Wait Times	Provider/Enrollee Ratio
		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 by the Federal Census Bureau, and within 45 miles or 60 minutes travel from an enrollee's residence or work in any other county • Standards apply to PCP, hospital, diagnostic and listed specialty services, including psychiatry.	available directly or through on-call arrangements with other qualified plan. PCPs 24 hours-per-day, 7 days-per-week for urgent and emergency care	
Rhode Island	N/A	• No quantitative criteria provided	• No quantitative criteria provided	• No quantitative criteria provided
South Carolina	Department of Insurance Bulletin Number 2013-04[8]	• No quantitative criteria provided	• No quantitative criteria provided	• One PCP per 2,000 members within 30-mile radius for 95% of the population in the service area. • One contracted hospital within county or 30-mile radius of 95% of the population in the service

[8] https://doi.sc.gov/DocumentCenter/View/3040/2013-04-Process-for-Filing-Amendments-to-Forms-to-Comply-with-ACA

State	Source	Geographic Criteria	Appointment Wait Times	Provider/Enrollee Ratio
				area if the county doesn't have a hospital. • Adequate number and type of specialists within a 50-mile radius of 95% of the population in the service area. • One OB-GYN within a 30-mile radius for 95% of the population in the service area.
South Dakota	SDCL § 58-17F-5 (2011) Current through 2020 Regular Session eff. March 16, 2020	• No quantitative criteria provided	• **Emergency Services**: Emergency services available 24 hours a day, 7 days a week	• No quantitative criteria provided
Tennessee (*Standards apply to Health Maintenance Organizations and Managed Health Insurance Issuers*)	T. C. A. § 56-7-2356 Current through2020 First Reg. Session, 111th Tenn. General Assembly through Jan. 24, 2020 Tenn. Comp. R. & Regs. 1200-08-33-.06 (HMO) Current through Oct. 13, 2019	**HMOs**: • **PCPs**: HMO shall ensure that members do not have to travel more than 30 miles or 30 minutes • **Nearest Participating Hospital**: HMO shall ensure that members do not need to travel more than approximately 30 minutes (this requirement may be waived if not feasible in a specific geographic area)	**HMOs**: • **Emergency Services**: HMO shall ensure that emergency care (including ambulance service) is available and accessible 24/7 **Managed Health Insurance Issuers**: • **Emergency Services**: Covered persons shall have access to health care services 24/7	• No quantitative criteria provided

State	Source	Geographic Criteria	Appointment Wait Times	Provider/Enrollee Ratio
		Managed Health Insurance Issuers: • **PCPs**: Must demonstrate an adequate number of PCPs within not more than 30 miles distance or 30 minutes travel time (at a reasonable speed)		
Texas *(Separate standards apply to Health Maintenance Organizations and Preferred Provider Organizations)*	HMO: 28 TAC § 11.1607 (2006) Current through Jan. 20, 2020 PPO: 28 TAC § 3.3704 (2013) Current through Jan. 10, 2020	**HMO**: • 30 miles for primary care and general care hospital • 75 miles for specialty care, special hospitals, and single health care plan physicians or providers **PPO**: • 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 non-rural areas and 60 miles in rural areas); and	**HMO**: • **Emergency care, general, special, and psychiatric hospital care:** 24 hours per day, 7 days per week with in the HMO's service area • **Urgent care**: Medical, dental, and behavioral health conditions within 24 hours • **Routine Medical Conditions**: within 3 weeks • **Routine Behavioral Health Conditions**: within 2 weeks • **Routine Dental Conditions**: within 8 weeks • **Preventative health services**: within 2 months for a child; within 3 months for an adult; and within 4 months for dental services	**HMO and PPO**: • No quantitative criteria provided

State	Source	Geographic Criteria	Appointment Wait Times	Provider/Enrollee Ratio
		specialty care and specialty hospitals (75 miles)	**PPO**: • **Emergency care:** 24 hours/day and 7 days/week • **Urgent care for medical and behavioral health conditions:** within 24 hours within designated health service area • **Routine Care Medical Conditions**: within 3 weeks • **Routine Care Behavioral Health Conditions**: within 2 weeks • **Preventative health services**: within 2 months for a child, or earlier if necessary for compliance with recommendations for specific preventative care services; and within 3 months for an adult	
Utah	N/A	• No quantitative criteria provided	• No quantitative criteria provided	• No quantitative criteria provided
Vermont	Vt. Admin. Code 4-5-3:5 Current through Jan. 2020	Travel times (under normal conditions) from residence or place of business, generally should not exceed:	Waiting times should generally not exceed the following:	• No quantitative criteria provided

State	Source	Geographic Criteria	Appointment Wait Times	Provider/Enrollee Ratio
(*Standards apply to Managed Care Organizations*)		• **PCP**: 30 minutes • **Routine, office-based MH/SUD**: 30 minutes • **Outpatient physician specialty care; Intensive outpatient; Partial hospital, residential or inpatient MH/SUD services; laboratory; pharmacy; general optometry; inpatient; imaging; and inpatient medical rehabilitation services**: 60 minutes • **Major trauma treatment; neonatal intensive care; and tertiary-level cardiac services**, including procedures such as cardiac catheterization and cardiac surgery: 90 minutes • Reasonable accessibility for other specialty services	• **Emergency Services**: Immediate access to emergency care for conditions that meet the definition of "emergency medical condition" • **Urgent Care**: 24 hours or a time frame consistent with the medical exigencies of the case for urgent care (outpatient MH/SUD care designated by the member or provider as non-urgent is not considered to be urgent care) • **Non-Emergency/Non-Urgent Care**: 2 weeks • **Preventative Care** (including routine physical examinations): 90 days • **Routine laboratory, imaging, general optometry, and all other routine services**: 30 days	
Virginia (*Standards apply to Health Maintenance Organizations*)	VA. CODE ANN. § 38.2-4312.3 (2011) Current through end of 2019 Reg Session	• No quantitative criteria provided	• **Urgent Need, Medical Emergency**: On a 24-hour basis, access must be provided to medical care or access by telephone to a	• No quantitative criteria provided

State	Source	Geographic Criteria	Appointment Wait Times	Provider/Enrollee Ratio
			physician or licensed health care professional with appropriate medical training who can refer or direct a member for prompt medical care in cases where there is an immediate, urgent need or medical emergency	
Washington (*Standards apply to Essential Health Benefit Services*)	WASH. ADMIN. CODE § 284-170-200 (2016) Current through Jan. 2, 2020	• **Hospitals and Emergency Services:** Each enrollee access within (30) miles in urban area and (60) miles in a rural area from either residence or workplace • **PCPs:** 80% of enrollees within the service area must be within (30) miles of a sufficient number of PCPs in an urban area and within (60) miles of a sufficient number of PCPs in a rural area from either their residence or work • **MH/SUD Providers:** requirements but no metrics. Adequate networks include crisis intervention and	• **Urgent**: For the essential health benefits category of ambulatory patient services, network must afford access to urgent appointments without PA within (48) hours, or with PA, within (96) hours of the referring provider's referral • **Non-Preventative Services**: Access to an appointment a PCP within (10) business days of requesting one • **Preventative Services**: Professionally recognized standards of practice • **Non-Urgent Specialist**: When an enrollee is referred to a specialist, has access to an appointment	• No quantitative criteria provided

State	Source	Geographic Criteria	Appointment Wait Times	Provider/Enrollee Ratio
		stabilization, psychiatric inpatient hospital services, including voluntary psychiatric inpatient services, and services from MH providers. Must review adequacy of the MH network at least 2 times/year and submit action plan if not met.	within (15) business days for non-urgent services • **Emergencies**: Emergency services must be accessible (24) hours per day, (7) days per week without unreasonable day	
West Virginia (*Standards apply to Health Maintenance Organizations*)	Informational Letter No. 112 (Nov. 1998)[9]	**Primary** Care • Urban: 30 miles/45 minutes • Rural: 45 miles/60 minutes **Pediatrician** • Urban: 30 miles/45 minutes • Rural: 60 miles/90 minutes **OB/GYN** • Urban: 30 miles/45 minutes • Rural: 60 miles/90 minutes **Specialist** • Urban: 30 miles/45 minutes	• No quantitative criteria provided	New county/region service area • **PCP** 1:120 • **OB/GYN** 1:240 • **Pediatrician** 1:360 • **Specialist** 1:2,000 Established county/region • **PCP** 1:2,500 • **OB/GYN** 1:5,000 • **Pediatrician** 1:7,500 • **Specialist** 1:8,000

[9] **https://www.wvinsurance.gov/Portals/0/pdf/pol_leg/info_letters/info_112.pdf?ver=2004-09-14-094500-000**

State	Source	Geographic Criteria	Appointment Wait Times	Provider/Enrollee Ratio
		• Rural: 60 miles/90 minutes **Hospital** • Urban: 30 miles/45 minutes • Rural: 60 miles/90 minutes		
Wisconsin	N/A	• No quantitative criteria provided	• No quantitative criteria provided	• No quantitative criteria provided
Wyoming	N/A	• No quantitative criteria provided	• No quantitative criteria provided	• No quantitative criteria provided
Medicare Advantage	Medicare Advantage Network Adequacy Criteria Guidance[10] (updated February 20, 2018) and HSD Reference File[11] (updated August 1, 2018) . 90% of beneficiaries residing in a county must have access to at least 1 provider/ facility for each type within the time and distance.	**Primary Care:** • Large metro: Within 10 minutes/5miles • Metro: Within 15 minutes/10 miles • Micro: Within 30 minutes/20 miles • Rural: Within 40 minutes/30 miles • CEAC: Within 70 minutes/60 miles **Psychiatry:** • Large metro: Within 20 minutes/10 miles	• No quantitative criteria provided	**Primary Care**: • Large metro: 1.67 • Metro: 1.67 • Micro: 1.42 • Rural: 1.42 • CEAC: 1.42 **Psychiatry**: • Large metro: .14 • Metro: .14 • Micro: .12 • Rural: .12 • CEAC: .12

[10] https://www.cms.gov/files/document/medicare-advantage-and-section-1876-cost-plan-network-adequacy-guidance-pdf
[11] https://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/index?redirect=/MedicareAdvantageApps/

State	Source	Geographic Criteria	Appointment Wait Times	Provider/Enrollee Ratio
		• Metro: Within 45 minutes/30 miles • Micro: Within 60 minutes/45 miles • Rural: Within 75 minutes/60 miles • CEAC: Within 110 minutes/100 miles **Other Specialty Care (see specific specialty):** • Large metro: Ranges from 20-30 minutes, 10-15 miles • Metro: Ranges from 30-60 minutes, 20-40 miles • Micro: Ranges from 50-100 minutes, 35-75 miles • Rural: Ranges from 75-110 minutes, 60-90 miles • CEAC: Ranges from 95-145 minutes, 85-130 miles **Inpatient Psychiatric Facility Services**: • Large metro: Within 30 minutes/15 miles • Metro: Within 70 minutes/45 miles • Micro: Within 100 minutes/75 miles		**Other Specialty Care (see specific specialties)**: • Large metro: Ranges from .01 to .28 • Metro: Ranges from .01 to .28 • Micro: Ranges from .01 to .24 • Rural: Ranges from .01 to .24 • CEAC: Ranges from .01 to .24

State	Source	Geographic Criteria	Appointment Wait Times	Provider/Enrollee Ratio
		• Rural: Within 90 minutes/75 miles • CEAC: Within 155 minutes/140 miles **Other Facilities (see specific facility type):** • Large metro: Ranges from 20-30 minutes, 10-15 miles • Metro: Ranges from 45-70 minutes, 30-45 miles • Micro: Ranges from 65-160 minutes, 50-120 miles • Rural: Ranges from 55-145 minutes, 50-120 miles • CEAC: Ranges from 95-155 minutes, 85-140 miles		

Federally-Facilitated Marketplaces[12]: "In recognition of the traditional role states have in developing and enforcing network adequacy standards, CMS will defer to States that have a sufficient network adequacy review process. In States with the authority and means to conduct network adequacy reviews, CMS will no longer conduct these reviews. For 2019 and beyond, CMS will defer to States' reviews in States with authority to enforce standards that are at least equal to the 'reasonable access standard' identified in §156.230 and means to assess issuer network adequacy. HHS also strongly encourages all issuers to consider increasing the use of telehealth services as part of their networks to ensure all consumers have access to all covered services.
In States that do not have the authority and means to conduct sufficient network adequacy reviews, CMS will apply a standard similar to the one used for the 2014 benefit year. CMS will rely on an issuer's accreditation (commercial, Medicaid, or Exchange) from an HHS-recognized accrediting entity. These include the three previously recognized accrediting entities for the accreditation of QHPs: Accreditation Association for Ambulatory Health Care (AAAHC), the National Committee for Quality Assurance (NCQA), and URAC. Unaccredited issuers in States determined not to have authority to enforce standards that are at least equal to the 'reasonable access standard' at §156.230 and means to assess issuer network adequacy would be required to submit an access plan (and cover sheet) as part of the QHP application. To show that the QHP's network meets the requirement in §156.230(a)(2), the access plan would need to demonstrate that an issuer has standards and procedures in place to maintain an adequate network consistent with the NAIC's Health Benefit Plan Network Access and Adequacy Model Act. For plan year 2018, CMS found all States participating in FFEs to have the required network adequacy means and authority. For plan year 2019, CMS does not anticipate any changes in its assessment of States with the means and authority for network adequacy review."

***Unable to access updated NCQA standards for 2018-19**

[12] Dept. of Health and Human Services, 2019 Letter to Issuers in the Federally-facilitated Exchanges (April 9, 2018) at 13. Available at **https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2019-Letter-to-Issuers.pdf**.
Centers for Medicare & Medicaid Services, Center for Consumer Information & Insurance Oversight. (2019, April 18). *2020 Letter to Issuers in the Federally-facilitated Exchanges.* Retrieved from **https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2020-Letter-to-Issuers-in-the-Federally-facilitated-Exchanges.pdf**.

Appendix 1(A): Travel Distance Standards (Maryland)

PROVIDER TYPE

PROVIDER TYPE	URBAN AREA MAX. DISTANCE (MI)	SUBURB. AREA MAX. DISTANCE (MI)	RURAL AREA MAX. DISTANCE (MI)
ALLERGY AND IMMUNOLOGY	15	30	75
APPLIED BEHAVIOR ANALYST	15	30	60
CARDIO. DISEASE	10	20	60
CHIROPRACTIC	15	30	75
DERMATOLOGY	10	30	60
ENDOCRIN.	15	40	90
ENT/OTOLARYNGOLOGY	15	30	75
GASTROENTEROLOGY	10	30	60
GENERAL SURGERY	10	20	60
OB/GYN	5	10	30
GYN ONLY	15	30	75
LCSW	10	25	60
NEPHROLOGY	15	25	75
NEUROLOGY	10	30	60
ONCOLOGY-MED. AND SURG.	10	20	60
ONC.-RAD.	15	40	90
OPHTHA.	10	20	60
PEDIATRICS-ROUTINE/PC	5	10	30
PHYSIATRY, REHAB. MED.	15	30	75
PLASTIC SURGERY	15	40	90
PODIATRY	10	30	60
PCP	5	10	30
PSYCHIATRY	10	25	60
PSYCHOLOGY	10	25	60
PULMONOLOGY	10	30	60
RHEUMATOLOGY	15	40	90
UROLOGY	10	30	60
OTHERS	15	40	90

FACILITY TYPE

FACILITY TYPE	URBAN AREA MAX. DISTANCE (MI)	SUBURB. AREA MAX. DISTANCE (MI)	RURAL AREA MAX. DISTANCE (MI)
ACUTE INPATIENT HOSPITALS	10	30	60
CRIT. CARE SERVICES - ICU	10	30	100
DIAGNOSTIC RADIOLOGY	10	30	60
INPATIENT PSYCHIATRIC FACILITY	15	45	75
OUTPATIENT DIALYSIS	10	30	50
OUTPATIENT INFUSION/CHEMO.	10	30	60
PHARMACY	5	10	30
SKILLED NURSING FACILITIES	10	30	60
SURGICAL SERVICES (OUTPATIENT OR AMBULATORY SURGICAL CENTER)	10	30	60
OTHER BH/SUD FACILITIES	10	25	60
ALL OTHERS	15	40	90

GROUP MODEL HMO PLANS: TRAVEL DISTANCE STANDARDS BY PROVIDER TYPE

PROVIDER TYPE	URBAN AREA MAX. DISTANCE (MI)	SUBURB. AREA MAX. DISTANCE (MI)	RURAL AREA MAX. DISTANCE (MI)
ALLERGY AND IMMUNOLOGY	20	30	75
APPLIED BEHAVIOR ANALYST	15	20	60
CARDIO. DISEASE	15	25	60
CHIROPRACTIC	20	30	75
DERMATOLOGY	20	30	60
ENDOCRIN.	20	40	90
ENT/OTOLARYNGOLOGY	20	30	75
GASTROENTEROLOGY	20	30	60
GENERAL SURGERY	20	30	60
OB/GYN	15	20	45
GYN ONLY	15	30	60
LCSW	15	30	75
NEPHROLOGY	15	30	75
NEUROLOGY	15	30	60
ONCOLOGY-MED. AND SURG.	15	30	60
ONC.-RAD.	15	40	90
OPHTHA.	15	20	60
PEDIATRICS-ROUTINE/PC	15	20	45
PHYSIATRY, REHAB. MED.	15	30	75
PLASTIC SURGERY	15	40	90
PODIATRY	15	30	90
PCP	15	20	45
PSYCHIATRY	15	30	60
PSYCHOLOGY	15	30	60
PULMONOLOGY	15	30	60
RHEUMATOLOGY	15	40	90
UROLOGY	15	30	60
OTHERS	20	40	90

FACILITY TYPE

FACILITY TYPE	URBAN AREA MAX. DISTANCE (MI)	SUBURB. AREA MAX. DISTANCE (MI)	RURAL AREA MAX. DISTANCE (MI)
ACUTE INPATIENT HOSPITALS	15	30	60
CRIT. CARE SERVICES - ICU	15	30	120
DIAGNOSTIC RADIOLOGY	15	30	60
INPATIENT PSYCHIATRIC FACILITY	15	45	75
OUTPATIENT DIALYSIS	15	30	60
OUTPATIENT INFUSION/CHEMO.	15	30	60
PHARMACY	5	10	30
SKILLED NURSING FACILITIES	15	30	60
SURGICAL SERVICES (OUTPATIENT OR AMBULATORY SURGICAL CENTER)	10	30	60
OTHER BH/SUD FACILITIES	15	30	60
ALL OTHERS	15	40	120

Appendix 1(B): Travel Distance Standards By Provider/Service Type For HMO Plans Offering MCPs (Missouri)

PROVIDER/SERVICE TYPE	URBAN COUNTY MAX. DISTANCE (MI)	BASIC COUNTY MAX. DISTANCE (MI)	RURAL AREA MAX. DISTANCE (MI)
PCPS	10	20	30
OB/GYN	15	30	60
NEUROLOGY	25	50	100
DERMATOLOGY	25	50	100
PHYSICAL MED/REHAB	25	50	100
PODIATRY	25	50	100
VISION CARE/PRIMARY EYE	15	30	60
ALLERGY	25	50	100
CARDIOLOGY	25	50	100
ENDOCRINOLOGY	25	50	100
GASTROENTEROLOGY	25	50	100
HEMATOLOTY/ONCOLOGY	25	50	100
INFECTIOUS DISEASE	25	50	100
NEPHROLOGY	25	50	100
OPTHAMOLOGY	25	50	100
ORTHOPEDICS	25	50	100
OTOLARYNOLOGY	25	50	100
PEDIATRIC	25	50	100
PULMONARY	25	50	100
RHEUMATOLOGY	25	50	100
UROLOGY	25	50	100
GENERAL SURGERY	15	30	60
PSYCHIATRIST (ADULT)	15	40	80
PSYCHIATRIST (CHILD)	22	45	90
PSYCHOLOGIST/OTHER THERAPIST	10	20	40
CHIROPRACTOR	15	30	60

PROVIDER/SERVICE TYPE	URBAN COUNTY MAX. DISTANCE (MI)	BASIC COUNTY MAX. DISTANCE (MI)	RURAL AREA MAX. DISTANCE (MI)
HOSPITAL (BASIC)	30	30	30
HOSPTIAL (SECONDARY)	50	50	50
INPATIENT MH FACILITY	25	40	75
MH TREATMENT PROVIDERS (AMBULATORY)	15	25	45
MH TREATMENT PROVIDERS (RESIDENTIAL)	20	30	50

Appendix 2(A): Specialties and Standards For Marketplace Plan Year 2018 Certification (Nevada)

SPECIALTY AREA	LARGE AREA MAX. TIME/DISTANCE (MIN/MILES)	METRO AREA MAX. TIME/DISTANCE (MIN/MILES)	MICRO AREA MAX. TIME/DISTANCE (MIN/MILES)	RURAL AREA MAX. TIME/DISTANCE (MIN/MILES)	COUNTIES WITH EXTREME ACCESS CONSIDERATIONS (CEAC) MAX. TIME/DISTANCE (MIN/MILES)
PRIMARY CARE		15/10	30/20	40/30	70/60
ENDOCRINOLOGY		60/40	100/75	110/90	145/130
INFECTIOUS DISEASES		60/40	100/75	110/90	145/130
ONCOLOGY – MEDICAL/SURGICAL		45/30	60/45	75/60	110/100
ONCOLOGY – RADIATION/RADIOLOGY		60/40	100/75	110/90	145/130
MH (INCLUDING SUD TREATMENT)		45/30	60/45	75/60	110/100
PEDIATRICS		25/15	30/20	40/30	105/90
RHEUMATOLOGY		60/40	100/75	110/90	145/130
HOSPITALS		45/30	80/60	75/60	110/100
OUTPATIENT DIALYSIS		45/30	80/60	90/75	125/110

Attachment B

Attachment B: Summary of Network Adequacy Requirements by State

State	Network Adequacy Standard *(states with specific standards for MH/SUD are in bold font)*
Alabama	Geographic Standards (travel distance)
Alaska	N/A
Arizona	Geographic Standards (travel time and distance) Appointment Wait Time Standards
Arkansas	Geographic Standards (travel distance)
California	**Geographic Standards** (travel time and distance) **Appointment Wait Time Standards** Provider/Enrollee Ratios
Colorado	**Geographic Standards** (travel distance) **Appointment Wait Time Standards** **Provider/Enrollee Ratios**
Connecticut	Provider/Enrollee Ratios and Calculation to determine the minimum number of providers
Delaware	**Geographic Standards** (travel distance) **Provider/Enrollee Ratios**
Florida	Geographic Standards (travel time) Appointment Wait Time Standards
Georgia	N/A
Hawaii	N/A
Idaho	Network adequacy standards must meet NCQA, AAAHC, or URAC standards
Illinois	Geographic Standards (travel time and distance) Appointment Wait Time Standards **Provider/Enrollee Ratios and Minimum Number of Providers**
Indiana	Network adequacy standards must comply with standards developed by NCQA
Iowa	N/A
Kansas	N/A
Kentucky	Geographic Standards (travel time and distance)
Louisiana	Network adequacy standards must meet the standards for accreditation of NCQA, American Accreditation Health Commission, Inc., or URAC
Maine	**Appointment Wait Time Standards** Provider/Enrollee Ratios
Maryland	**Geographic Standards** (travel distance) **Appointment Wait Time Standards**

State	Network Adequacy Standard *(states with specific standards for MH/SUD are in bold font)*
	Provider/Enrollee Ratios
Massachusetts	N/A
Michigan	N/A
Minnesota	**Geographic Standards** (travel time and distance) Appointment Wait Time Standards
Mississippi	N/A
Missouri	**Geographic Standards** (travel distance) **Appointment Wait Time Standards**
Montana	Geographic Standards (travel distance) Appointment Wait Time Standards Provider/Enrollee Ratios
Nebraska	N/A
Nevada	**Geographic Standards** (travel time and distance)
New Hampshire	**Geographic Standards** (travel time and distance) **Appointment Wait Time Standards**
New Jersey	**Geographic Standards** (travel time and distance) Appointment Wait Time Standards Calculation for minimum number of providers
New Mexico	Geographic Standards (travel time and distance) Appointment Wait Time Standards Calculation for minimum number of providers
New York	Geographic Standards (travel time and distance) **Provider/Enrollee Ratios and Minimum Number of Providers**
North Carolina	N/A
North Dakota	N/A
Ohio	N/A
Oklahoma	Geographic Standards (travel time)
Oregon	Relies on Medicare Advantage standards for **Geographic Standards** (travel time and distance)
Pennsylvania	**Geographic Standards** (travel time and distance) Appointment Wait Time Standards
Rhode Island	N/A
South Carolina	Calculation to determine the minimum number of providers
South Dakota	N/A
Tennessee	Geographic Standards (travel time and distance)
Texas	Geographic Standards (travel distance) **Appointment Wait Time Standards**
Utah	N/A
Vermont	**Geographic Standards** (travel time) Appointment Wait Time Standards

State	Network Adequacy Standard *(states with specific standards for MH/SUD are in bold font)*
Virginia	N/A
Washington	Geographic Standards (travel distance) Appointment Wait Time Standards
West Virginia	Geographic Standards (travel time and distance) Provider/Enrollee Ratios
Wisconsin	N/A
Wyoming	N/A

Attachment C

Attachment C: Non-Urgent Behavioral Health Wait Time Comparison (2018 – 2020)*

Carrier	2018 Report[1]	2019 Report	2020 Report
Aetna Health Ins.	**82% (in 14 days)**	**89%**	98%
Aetna Life Ins. Co.	**82% (in 14 days)**	**89%**	98% HMO
Aetna	NA	NA	98% PPO
CareFirst	95%	**57.5%**	**75%**
CareFirst BlueChoice	95%	**57.5%**	**75%**
CareFirst GHMS	95%	**57.5%**	**75%**
Cigna Life and Health Ins. Co.[1]	Missing data	**76%**	96%
Connecticut Gen. Life Ins. Co.	Missing data	**76%**	96%
Golden Rule Ins. Co.	72%	96%	95%
Kaiser Found. Health Plan of Mid-Atlantic States	**89.3%**	**84.3%**	**75%**
Kaiser Permanente Ins. Co.	Missing data	**28%**	**80.9%**
MAMSI Life and Health Ins. Co.	**72%**	96%	95%
Nexus ACO	NA	NA	95%
Optimum Choice Inc.	**72%**	96%	95%
United Healthcare Ins. Co. Choice Plus	**72%**	96%	95%
United Healthcare Ins. Co. Options PPO	NA	NA	95%
United Healthcare Ins. Co. (CORE)	NA	96%	95%
United Healthcare Ins. Co. Navigate	NA	NA	95%
United Healthcare Ins. Co. Navigate CVS	NA	NA	95%
United Healthcare of the Mid-Atlantic Inc. (CORE)	**72%**	96%	95%
United Healthcare of the Mid-Atlantic Inc. (Choice)	**72%**	96%	95%
Wellfleet (Cigna network)	NA	NA	96%

[1] Cigna's calculation for urgent care and non-urgent MH/SUD wait time in its 2020 report is based on a third-party assessment as opposed to first-hand data from providers. "[T]hey are best an approximation of what patients experience but are not a complete picture."

Attachment D

Attachment D: Urgent Care Appointment Wait Time Compliance (Medical/Mental Health/Substance Use Disorder)*

Carrier	2019 Report	2020 Report
Aetna Health Ins.[2]	• HMO: **85.0%** • PPO: **84.4%** Exchange Plans • HMO: 100% • PPO: 100% • EPO: 100%	Medical – 100% **MH/SUD – 92%**
Aetna Life Ins. Co.	Same as Aetna Health Ins.	HMO Same as Aetna Health Ins.
Aetna PPO	NA	PPO Same as Aetna Health Ins
CareFirst	PPO: **93%**	96%
CareFirst BlueChoice	HMO: 95.3%	95%
CareFirst GHMS	PPO: **93%**	96%
Cigna Life and Health Ins. Co.	• Primary Care: 100% • Specialty Care: **93%**	**91%**
Connecticut Gen. Life Ins. Co.	• Primary Care: 100% • Specialty Care: **93%**	**91%**
Golden Rule Ins. Co.	**92%**	**67%**
Kaiser Found. HP of M.A. States	100%	100%
Kaiser Perm. Ins. Co.	**42%**	**78.5%**
MAMSI Life and Health Ins. Co.	**92%**	**67%**
Nexus ACO	NA	**67%**
Optimum Choice Inc.	**92%**	**67%**
United Healthcare Ins. Co Choice Plus	**92%**	**67%**
United Healthcare Ins. Co Options PPO	NA	**67%**
United Healthcare Ins. Co. (CORE)	**92%**	**67%**
United Healthcare Ins. Co. Navigate	NA	**67%**

United Healthcare Ins. Co. Navigate CVS	NA	**67%**
United Healthcare of the M.A. Inc. (CORE)	**92%**	**67%**
United Healthcare of the M.A. Inc. (Choice)	**92%**	**67%**
United Healthcare of the M.A. Inc. Navigate	NA	**67%**
Wellfleet	NA	**67%**

* Bold designates standard is not satisfied

Attachment E

Attachment E: Telehealth Utilization for Appointment Wait Time

Carrier	Total % of Telehealth Appointments Counted as Part of Appointment Waiting Time Standard Results
Aetna Health Ins.	0%
Aetna HMO.	0%
Aetna PPO	0%
CareFirst (PPO)	0%
CareFirst BlueChoice (HMO)	0%
CareFirst GHMS	0%
Cigna Life and Health Ins. Co.	*Missing
Connecticut Gen. Life. Ins. Co.	*Missing
Golden Rule Ins. Co.	0%
Kaiser Found. HP of M.A. States	4%
Kaiser Perm. Ins. Co.[1]	N/A
MAMSI Life and Health Co.	0%
Nexus ACO	0%
Optimum Choice Inc.	0%
United Healthcare Ins. Co. Choice Plus	0%
United Healthcare Ins. Co. Options PPO	0%
United Healthcare Ins. Co. Core	0%
United Healthcare Ins. Co. Navigate	0%
United Healthcare Ins. Co. Navigate CVS	0%
United Healthcare of M.A. Inc. (CORE)	0%
United Healthcare of M.A. Inc. (Choice)	0%
Wellfleet	*Missing

[1] Does not currently maintain any systematic record "for purposes of member steerage to telehealth providers" but has added a question to its 2020 standards provider outreach to collect data on locations that offer telehealth.