Maryland
INSURANCE ADMINISTRATION

Network Adequacy: Overview of MIA Standards and Review Process

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What is Network Adequacy and How is it Evaluated?

- Network adequacy refers to a carrier's ability to deliver the benefits promised in the insurance contract by providing reasonable access to enough in-network primary and specialty care practitioners and facilities who are qualified to provide all the health care services covered by the health plan
- Network adequacy is evaluated at the aggregate level, not at the individual level, and it focuses on clinical appropriateness rather than consumer preferences

MIA Regulatory Standards for Health Benefit Plans
COMAR 31.10.44

- **Scope:** applies to carriers that issue or renew health benefit plans in Maryland and use a provider panel for a health benefit plan offered in Maryland
- **Authority:** Insurance Article, §§2-109(a)(1) and 15-112(a)—(d), Annotated Code of Maryland
- **Original effective date:** December 31, 2017 with first annual filing due July 1, 2018.
- **Revised:** effective May 15, 2023, with a deferred effective date for certain requirements until July 1, 2024.

Types of Network Adequacy Standards

- **Qualitative Standards** are network adequacy requirements based on subjective criteria that allow for flexibility in reporting and interpretation.
  - Example: “Networks must have sufficient types and numbers of providers to ensure enrollees can access care without unreasonable delay.”
    - Pro: help set general regulatory expectations
    - Con: difficult to measure and enforce objectively

- **Quantitative Standards** are network adequacy metrics that can be measured objectively
  - Example: “Network must include as least one in-network cardiologist within 10 miles of enrollee residence.”
    - Pro: measurement and enforcement is comparatively straightforward
    - Pro: facilitates analysis of trends over time and comparisons across carriers
    - Con: challenging to ensure appropriate thresholds are established

Maryland has both quantitative and qualitative Standards

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

(1) 1,200 enrollees for primary care;

(2) 2,000 enrollees for pediatric care;

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

(4) 2,000 enrollees for behavioral health care or services; and

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

	Urban Area Maximum Distance (miles)	Suburban Area Maximum Distance (miles)	Rural Area Maximum Distance (miles)
Gynecology, OB/GYN	5	10	30
Gynecology Only	15	30	75
Licensed Clinical Social Worker	10	25	60
Nephrology	15	25	75
Neurology	10	30	60
Oncology-Medical and Surgical	10	20	60
Oncology-Radiation/Radiation Oncology	15	40	90
Ophthalmology	10	20	60
Pediatrics-Routine/Primary Care	5	10	30

.03 Network Adequacy Standards.

A. Sufficiency Standards.

(1) A carrier shall develop and maintain a network of providers in sufficient numbers, geographic locations, and practicing specialties to ensure enrollees have access to participating providers for the full scope of benefits and services covered under the carrier's health benefit plan.

(2) A carrier shall establish written policies and procedures to implement a process for addressing network deficiencies that result in an enrollee lacking access to any providers with the professional training and expertise necessary to deliver a covered service without unreasonable travel or delay.

(3) A carrier shall clearly define and specify referral requirements, if any, to specialty and other providers.

(4) A carrier shall take reasonable steps to ensure that participating providers provide physical access, reasonable accommodations, and accessible equipment for enrollees with physical or mental disabilities.

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

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Quantitative Standards

- Travel Distance: maximum road distance to nearest provider from enrollee residence for various provider specialties and facilities
- Appointment Waiting Time: time between request for services and earliest in-person appointment offered for specified categories of somatic and behavioral health services
- Provider to Enrollee ratios: for specified service types such as PCP, OB/GYN, Pediatrics, and Mental Health & SUD*
- Essential Community Providers (“ECPs”): percentages contracted in the service area*

*Not applicable to Group-Model HMOs

Annual Access Plan Filings

- Network access plan filings due annually on July 1.
- Required contents:
  - Descriptions of policies and procedures related to qualitative measures
  - Supporting documentation for quantitative standards
  - Data on complaints, telehealth utilization, and out-of-network claims
  - Executive Summary
  - Waiver Justification

Executive Summary

(2) Appointment Waiting Time Standards

(a) For each appointment type listed in the chart below, list the calculated median waiting time to obtain an in-person appointment with a participating provider, in the following format:

	Median Appointment Waiting Time
Urgent care for medical services	18.6 hours
Inpatient urgent care for mental health services	21.5 hours
Inpatient urgent care for substance use disorder services	5.3 hours
Outpatient urgent care for mental health services	48.4 hours
Outpatient urgent care for substance use disorder services	46.1 hours
Routine primary care	1.9 calendar days
Preventive care/Well visit	6.3 calendar days

(c) List the total number of **essential community providers** in the carrier's network in each of the urban, rural, and suburban areas providing the services below. Additionally, list the total percentage of essential community providers available in the health benefit plan's service area that are participating providers for each of the nine categories shown in the chart.

	Urban number; percent	Suburban number; percent	Rural number; percent
(i) Medical services	252 ; 30%	119 ; 31%	248 ; 56%
(ii) Mental health services	124 ; 40%	61 ; 32%	81 ; 50%
(iii) Substance use disorder services	276 ; 35%	114 ; 30%	203 ; 52%

(d) List the total number of **local health departments** in the carrier's network providing the services in the chart below. Of all the health departments in the state providing the services below, list the percentage in the carrier's network.

Service	Number Offering Service in the Network	Percentage of Maryland Health Depts. Offering Service
(i) Medical services	22	92%
(ii) Mental health services	13	54%
(iii) Substance use disorder services	22	92%

Facility Type	Urban Area	Suburban Area	Rural Area
Acute Inpatient Hospitals	98.3%	100%	100%
Ambulatory Infusion Centers	98.3%	100%	100%
Critical Care Services — Intensive Care Units	98.3%	100%	100%
Diagnostic Radiology	100%	100%	100%
Inpatient Psychiatric Facility	100%	100%	100%
Opioid Treatment Services Provider	100%	100%	100%
Outpatient Dialysis	100%	100%	100%
Outpatient Mental Health Clinic	100%	100%	100%
Outpatient Substance Use Disorder Facility	100%	100%	100%
Pharmacy	100%	100%	100%
Residential Crisis Services	2.0%	93.7%	92.4%
Skilled Nursing Facilities	100%	100%	100%

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

6,751

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

19,611

Waiver Standards

- A carrier that fails to meet one or more of the quantitative standards is required to provide additional information to document their efforts to add a sufficient number of providers to the network
- The MIA may grant a one-year waiver of one or more of the standards if the carrier sufficiently demonstrates that:
  - ➢the providers necessary for an adequate network are not available or are unable to reach an agreement to contract with the carrier; or
  - ➢the reported failure to meet a standard is a result of limitations or constraints with the measurement methodology rather than an actual deficiency in the network

Waiver Standards (continued)

Required information when a regulatory standard is not met:

- An explanation of how many providers in each specialty or facility type that the carrier reasonably estimates it would need to include in its network to satisfy each unmet standard, and a description of the methodology used to calculate the estimated number of providers;
- A list of all providers related to each unmet standard and within the relevant service area that the carrier attempted to contract with, identified by name and specialty/facility type;
- A description of how and when the carrier last contacted the providers, and any reason each provider gave for refusing to contract with the carrier;
- An analysis of any trends in the reasons given by providers for refusing to contract with the carrier, and a description of the carrier's proposals or attempts to address those reasons and improve future contracting efforts;
- Identification of all incentives the carrier offers to providers to join the network;
- If applicable, a substantiated statement that there are insufficient numbers providers available within the relevant service area for covered services for which the carrier failed to meet a standard;
- A description of other efforts and initiatives undertaken by the carrier in the past year to enhance its network and address the deficiencies that contributed to each unmet standard;
- A description of steps the carrier will take to attempt to improve its network to avoid a future failure to meet a standard; and
- An explanation of any other mitigating factors that the carrier requests the Commissioner to consider.

Telehealth Credits

- Per Enrollee Travel Distance Mileage Credit
  - New for 2023
  - Relaxes mileage standard applicable to particular enrollees, when telehealth is available, accessible, and appropriate (e.g. 15 mile standard may be increased to 20 miles for specific enrollees when credit is granted)
  - Maximum credit of 5 miles for urban enrollees, 10 miles for suburban enrollees, and 15 miles for rural enrollees
  - Credit may be applied to no more than 10% of enrollees per provider type and geographic area
  - Carrier must demonstrate that telehealth is clinically appropriate and utilized for the requested specialty, and that telehealth services are available and accessible in the requested geographic region
  - Approval of credit is solely at MIA's discretion

Telehealth Credits (Continued)

- Wait Time Credit
  - New for 2023
  - Up to 10 additional percentage points may be applied toward meeting the required 90% threshold of appointments offered within the required maximum wait time
  - Carrier must demonstrate that telehealth is clinically appropriate and accessible for the requested appointment type
  - Carrier must provides coverage for a corresponding in-person service if the enrollee does not elect telehealth
  - Carrier must have written P&Ps to assist enrollees in obtaining a timely in-person appointment if telehealth is not clinically appropriate, available, or accessible
  - Approval of credit is solely at MIA's discretion

MIA Review Considerations

Carriers must complete standardized MIA-developed templates for each required component of the network access plan, and each access plan is evaluated based on:

- The carrier self-reported performance against each regulatory standard
- The quality and detail of the documentation justifying the reported compliance
- Detailed descriptions of carrier efforts to resolve network gaps or long wait times, supported by year-over-year improvement trends
- Detailed descriptions of carrier efforts to proactively assist enrollees impacted by network deficiencies

MIA Findings and Determinations

- Since 2019, MIA has imposed penalties ranging from $5,000 to $150,000 on carriers for various network deficiencies
- In recent years, most plans have been compliant or included sufficient justification for a waiver
- Some plans have instituted remediation efforts to make whole those members who obtained out-of-network care due to a deficient network
- 2023 filings showed regression in compliance due to limited time to comply with regulatory changes
- Continued “growing pains” are anticipated with new regulations in 2024, as several requirements are effective for the first time this year

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Visit the [MIA Network Adequacy Webpage]

- Consumers
  - Consumers Home
  - Consumer Outreach
  - Company and Producer Search
  - File A Complaint
  - Formulario De Solicitud De Comunicacion Confidencial
  - Hearings
  - Insurance Fraud
  - Natural Disaster Preparedness
  - Network Adequacy Regulations Information

Network Adequacy Regulations Information

Any questions or comments on Network Adequacy Regulations can be sent to: networkadequac

- Annual Filing Instruction for Carriers
- 2023 Access Plans
- 2022 Access Plans
- 2021 Access Plans
- 2020 Access Plans
- 2019 Access Plans
- 2018 Access Plans
- Meeting Schedule
- Network Adequacy Regulations

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Annual Filing Instructions for Carriers

- Annual Filing Instructions - SERFF
- Zip Code Population Density Classification
- Maryland Active Providers Directory

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Questions and Discussion

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