Cigna

Policy Name Measuring Availability of Practitioners and Providers		Policy Number PS-8
Business Segment HealthCare		
Initial Effective Date: 09/15/06	**Policy Committee Approval Date(s):** 1/12/21; 2/9/21; 4/27/21; 11/9/21; 7/26/22; 7/11/23; 9/12/23; 3/26/24; 5/14/24	
Replaces Policies: PS-4 Measuring Availability of Providers (HMO Products*)		

Purpose:
To describe Cigna's availability standards and the processes used to assure that all Medical networks across all product lines have a sufficient number and distribution of Practitioners and Providers to meet customers' availability, cultural, ethnic, racial, and linguistic needs, preferences, and expectations.

Policy Statement:
It is the policy of Cigna to ensure appropriate availability of primary care, specialty care, and hospital care for our customers. The organization contracts with practitioners and providers across all networks and for all product lines to meet the availability and cultural needs and preferences of our customers, establishes availability standards and assesses its networks against those standards.

Definitions:
- For purposes of this policy "customer" means an individual participant or member.
- Insured Products: customers insured in the PPO, EPO, OAP, OAP IN, Network, Network POS, Network Open Access, Network POS Open Access, LocalPlus®, Surefit®, and Connect products.
- HMO Products: customers insured in the HMO, HMO/POS, HMO Open Access and HMO POS Open Access products.
- Availability: the number and geographic distribution of Providers and Practitioners for Medical Primary Care, Medical Specialty Care, and Hospital Care.
- Practitioner: a licensed or certified professional that provides medical services.
- Provider: an organization or institution that provides medical services, such as a hospital.
- Geographic distribution: Calculated using the industry-standard Quest Analytics software to measure straight line distance from a customer's home zip code to a Provider access point, which is defined as an identified Provider and office location at which a customer can access services. Each Provider-location combination is counted individually, e.g., 2 individual Providers who share 2 office locations will be counted as a total of 4 access points: 1) Provider A at location X, 2) Provider B at location X, 3) Provider A at location Y, and 4) Provider B at location Y, because a customer would have 4 options for accessing services.
- CMS geographic distribution by county: CMS defines county by population. Some states have adapted these parameters. The 5 categories are:

Population and Density Parameters

County Type	Population	Density
Large Metro	≥ 1,000,000	≥ 1,000/sq. mile
---	500,000 – 999,999	≥ 1,500/ sq. mile
---	Any	≥ 5,000/ sq. mile
Metro	≥ 1,000,000	10 – 999.9/sq. mile
---	500,000 – 999,999	10 – 1,499.9/sq. mile
---	200,000 – 499,999	10 – 4,999.9/sq. mile
---	50,000 – 199,999	100 – 4,999.9/sq. mile
---	10,000 – 49,999	1,000 – 4,999.9/sq. mile
Micro	50,000 – 199,999	10 – 99.9 /sq. mile
---	10,000 – 49,999	50 – 999.9/sq. mile
Rural	10,000 – 49,999	10 – 49.9/sq. mile
---	<10,000	10 – 4,999.9/sq. mile
CEAC	Any	<10/sq. mile

- Ratio of Providers to Customers: Providers to customer ratios are normally calculated with the Provider count constant at 1, where the Provider count is based on unique Provider and the Customer count is based on customer's home zip code. To convert to a ratio in this format, simply divide the customer count by the Provider count, e.g. 3000 customers divided by 30 Providers equals "3000/30 = 100" – the ratio 1 to the result of the calculation (1:100 in this example).
- Urban: Population density is >3,000 people per square mile
- Suburban: Population density is 1,000-3,000 people per square mile
- Rural: Population density is <1,000 people per square mile
- Medical Practitioner Provider Types:
  - Medical Primary Care Provider (PCP): A physician duly licensed to practice medicine that is a contracted with Cigna to provide covered services in the field of General Medicine, Internal Medicine, Family Practice, and Pediatrics and has agreed to provide primary care services to Cigna Contract customers in accordance with Cigna Program Requirements. Unless specified by state mandate and contractually agreed to by the Provider and Cigna, Obstetricians and Gynecologists are defined as specialty care providers only and cannot act as primary care providers. See Attachment B for state mandates allowing additional Providers to provide primacy care services.
  - Medical Specialty Care Provider (SCP): A physician, who has advanced education and training in one clinical area of practice, is duly licensed to practice medicine and who is contracted with Cigna to provide specialty care services to Cigna Contract customers in accordance with Cigna Program Requirements. A High-Volume SCP provides services to the largest segment of the membership, inclusive of the OB/GYN Specialty. A High-Impact SCP treats conditions with high mortality and/or high morbidity rates and may require significant resources for appropriate treatment. An Oncologist is one High-Impact SCP type.

- Medical High-Volume Specialists: The High-Volume Specialists below are identified by researching claims data for a 12-month period and the number of transactions of the top five specialties, excluding hospital-based specialists (i.e. radiologists).
  - Cardiology: A physician duly licensed to practice medicine who is contracted with Cigna to provide Covered Services in the field of Cardiovascular Disease; Cardiology, Interventional, or Cardiovascular Surgery.
  - Dermatology: A physician duly licensed to practice medicine who is contracted with Cigna to provide Covered Services in the field of Dermatology.
  - OB/GYN (Obstetrician/Gynecologist): A physician or nurse practitioner duly licensed to practice medicine who is contracted with Cigna to provide Covered Services in the field of Gynecology, Maternal and Fetal Medicine, Midwifery, Women's Health Nurse Practitioner; Obstetrics, or Obstetrics and Gynecology.
  - Allergy & Immunology: A physician duly licensed to practice medicine who is contracted with Cigna to provide Covered Services in the field of Allergy & Immunology.
  - Orthopedic: A physician duly licensed to practice medicine who is contracted with Cigna to provide Covered Services in the field of Orthopedic Sports Medicine, Orthopedic Surgery, or Orthopedic Trauma.
- Medical High-Impact Specialists: The High Impact Specialists below are identified as specialists that treat conditions that have a high mortality morbidity rate or if the specialty treats conditions that require significant resources.
  - Hematology/Oncology: A physician duly licensed to practice medicine who is contracted with Cigna to provide Covered Services in the field of Gynecologic Oncology, Hospice and Palliative Medicine, Hematology, Oncology, or Radiation Oncology
  - Infectious Disease: A physician duly licensed to practice medicine who is contracted with Cigna to provide Covered Services in the field of HIV/AIDS Specialist or Infectious Disease.
  - Nephrology: A physician duly licensed to practice medicine who is contracted with Cigna to provide Covered Services in the field of Nephrology.
  - Neurology: A physician duly licensed to practice medicine who is contracted with Cigna to provide Covered Services in the field of Brain Injury Medicine, Clinical Neurophysiology, Neurology, or Neurological Surgery.
  - Pulmonary Medicine: A physician duly licensed to practice medicine who is contracted with Cigna to provide Covered Services in the field of Pulmonary Disease or Thoracic Surgery.
- Hospital: An institution which is contracted with Cigna to provide Covered Services: medical and surgical care.

- National Vendor Specialty Practitioner/Provider Types
  - Chiropractors: A physician duly licensed to practice medicine who is contracted with Cigna to provide Covered Services in the field of Chiropractic Medicine.
  - Physical Therapy/Occupational Therapy: A practitioner or provider which is contracted with Cigna to provide Physical Therapy or Occupational Therapy.
  - Outpatient Dialysis: A dialysis provider which is contracted with Cigna to provide dialysis services.
- Quest Analytics: Software program that determines the distance between a participant and defined provider types. The reports are used to evaluate the availability of providers within the network. This is accomplished by comparing the database of provider addresses to the database of participant addresses. The software assigns latitude and longitude according to one's physical address. This allows the software to pinpoint the distance between providers and participants according to mileage or driving time.
- Individual and Family Plan (IFP): Plan type typically offered on or off Marketplace.

- Essential Community Providers (ECP): Providers that serve predominately low-income and medically underserved individuals which include Federally Qualified Health Centers, Ryan White clinics, Family Planning clinics, Indian Health providers & facilities, ECP hospitals, Mental health facilities, Substance Abuse Disorder treatment centers, and other ECPs.
- High Performing Local Market Network: Network types that are typically narrower in terms of the number of providers and/or geography. (Surefit®, LocalPlus®, Connect, HMO Connect, Focus, Vantage, etc.)
- Significant Large Network Changes: Significant large network changes are network changes that may increase or decrease the access to participating providers in a given geography.

State/Federal Compliance: State specific mandates will override national standards when applicable. Annual review of networks (or as indicated in the requirements) in states where the standards are more stringent than the national standards will be facilitated by the National Team and shared with medical including Contracting & Compliance. Corrective action plans are developed as needed to resolve any adequacy gaps identified during the analysis.

For state specific Network Adequacy Requirements, please refer to Attachment A.

Procedure(s):

A. Cigna customers will have primary care, specialty care (when referred by a primary care provider (PCP) for HMO Product* customers only), and hospital care available to them.
B. Cigna establishes availability standards utilizing Federal/State standards and internal performance metrics.
C. Unless otherwise stated by a state-specific or Centers for Medicare & Medicaid Services (CMS) mandate, Cigna's availability standards for the ratio and geographic distribution of Practitioners and Providers are described on the tables below. Standards are identical for all medical networks whether the customer has an HMO product or Insured Product.

1. Ratios:

Medical Specialty Category	Ratio
Adult Primary Care Provider	1 Adult PCP per 300 customers
Pediatric Primary Care Provider	1 Pediatric PCP per 300 customers
Cardiology	1 Cardiologist per 10,000 customers
Dermatology	1 Dermatologist per 10,000 customers
OB/Gyn	1 OB/Gyn per 2,000 customers
Allergy & Immunology	1Allergy & Immunology per 2,000 customers
Orthopedics	I Orthopedic physician per 10,000 customers
Hematology/Oncology	1 Hematology/Oncologist per 10,000 customers
Infectious Disease	1 Infectious Disease physician per 10,0000 customers
Nephrology	1 Nephrologist per 10,000 customers
Neurology	1 Neurologist per 10,000 customers
Pulmonary Medicine	1 Pulmonary medicine physician per 10,000 customers

2. Geographic Distribution (Radius):

Medical			
Specialty Category	**Urban**	**Suburban**	**Rural**
Adult Primary Care Provider (see definitions)	1 GP, FP, or IM within 10 miles	1 GP, FP, or IM within 15 miles	1 GP, FP, or IM within 30 miles
Pediatric Primary Care Provider (see definitions)	1 PED within 15 miles	1 PED within 60 miles	1 PED within 75 miles
Cardiology	1 Cardiologist within 20 miles	1 Cardiologist within 35 miles	1 Cardiologist within 60 miles
Dermatology	1 Dermatologist within 20 miles	1 Dermatologist within 35 miles	1 Dermatologist within 60 miles
OB/Gyn	1 OB/GYN within 20 miles	1 OB/GYN within 35 miles	1 OB/GYN within 60 miles
Allergy & Immunology	1 Allergy & Immunology within 20 miles	1 Allergy & Immunology within 35 miles	1 Allergy & Immunology within 60 miles
Orthopedics	1 Orthopedic within 20 miles	1 Orthopedic within 35 miles	1 Orthopedic within 60 miles
Hematology/Oncology	1 Hem/Onc within 30 miles	1 Hem/Onc within 45 miles	1 Hem/Onc within 60 miles
Infectious Disease	1 Infectious Disease within 40 miles	1 Infectious Disease within 75 miles	1 Infectious Disease within 90 miles
Nephrology	1 Nephrologist within 40 miles	1 Nephrologist within 75 miles	1 Nephrologist within 90 miles
Neurology	1 Neurologist within 40 miles	1 Neurologist within 75 miles	1 Neurologist within 90 miles
Pulmonary Medicine	1 Pulmonologist within 40 miles	1 Pulmonologist within 75 miles	1 Pulmonologist within 90 miles
General Acute Care Hospital	1 Hospital within 25 miles	1 Hospital within 30 miles	1 Hospital within 35 miles

In remote or rural areas, occasionally these geographic availability guidelines are not able to be met due to lack of, or absence of, qualified Practitioners and/or Providers. The organization may need to alter the standard based on local availability. Supporting documentation that such situation exists must be supplied along with the proposed guideline changes to the appropriate Quality Committee for approval. Unless noted above or specified under state mandates outlined in Attachment A, Cigna's goal for meeting availability standards is 90%.

A. Evaluation of results:
1. Availability standards (geographic distribution and ratio of Practitioners and Providers to customers) are measured and analyzed annually.
2. Availability standards (geographic distribution and ratio of Practitioners and Providers to customers) are measured as needed when there is a significant termination such as a Hospital or large medical group when

access may be impacted. Alternative Providers may be recruited to address any access gap as a result of the termination.

3. Evaluation of customer network adequacy complaints
4. Cultural, ethnic, racial, and linguistic needs and preferences are measured and analyzed triennially and include monitoring of the following:
   a) Census data
   b) Customer Satisfaction Surveys
   c) Practitioner and/or Provider Demographics
   d) Review of complaints and appeal data.
5. Cigna uses a continuous quality improvement (CQI) process to identify opportunities for improvement using these steps:
   a) Collect/measure data
   b) Evaluate results
   c) Identify possible root causes or barriers
   d) Select opportunities
   e) Plan/implement intervention/Corrective Actions
   f) Determine intervention effectiveness
6. Reports are presented to the appropriate Quality Committee.

B. Essential Community Providers (ECP): For those states were Cigna participates on Marketplace or as required by law, the network offered will include Essential Community providers. The Market Network Advisors (MNA) will compare the plan year non-exhaustive list of ECP's to HCPM to confirm contract status of each ECP in the IFP service area. The MNA will complete the CMS ECP template or uploads to CMS MPMS as applicable annually to demonstrate compliance. The criteria is included below:

- Network must include 35% of all available ECP's in the service area.
- Network must include 35% of all available FQHC's in each county in the service area.
- Network must include 35% of all available Family Planning Clinics in each county in the service area.
- Network must include 1 of each available ECP in each ECP category in each county in the service area.
- Must outreach to at least 1 ECP in each ECP category & county annually.
- Must outreach to all available Indian Health Providers.

C. Nationally Contracted Vendors: Nationally contracted specialty vendors such as ASHN will be required to meet the access requirements listed below. The National Network Access Team will conduct the audit and share the findings with the National Contracting Team. The results will be shared with the vendor and the vendor will provide Cigna with any necessary corrective action plan.

National Vendor Specialties			
Specialty Category	**Urban**	**Suburban**	**Rural**
Chiropractors	2 Chiropractors within 15 miles	2 Chiropractors within 20 miles	2 Chiropractors within 30 miles
Physical Therapy/Occupational Therapy	2 Physical Therapy or Occupational Therapy locations within 15 miles	2 Physical Therapy or Occupational Therapy locations within 20 miles	2 Physical Therapy or Occupational Therapy locations within 30 miles
Outpatient Dialysis	1 Dialysis location within 15 miles	1 Dialysis location within 30 miles	1 Dialysis location within 60 miles

D. Individual and Family Plan (IFP) networks will be measured using the CMS standards or as required by law at least quarterly. QHP criteria is listed below. Criteria is 90% of eligible QHP beneficiaries must meet access at 90% for each specialty and specialty category except for Illinois which is 100%.

Not meeting adequacy for each requires submission of a justification to CMS and/or the state.

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CMS IFP Time AND Distance requirements - PY2024

Individual Provider Specialty Types	Specialty Codes	Provider Type(s)	Maximum Time and Distance Standards									
			Large Metro County		Metro County		Micro County		Rural County		Counties w/Extreme Access	
			Time	Distance	Time	Distance	Time	Distance	Time	Distance	Time	Distance
Allergy and Immunology	AL, AI, IG, PA, KI	PR	30	15	45	30	80	60	90	75	125	110
Cardiology	HD, AF, CE, CI, CD, PC, SC	PR	20	10	30	20	50	35	75	60	95	85
Cardiothoracic Surgery	TS	PR	30	15	60	40	100	75	110	90	145	130
Chiropractor	CH, CZ	PR	30	15	45	30	80	60	90	75	125	110
Dental			30	15	45	30	80	60	90	75	125	110
Dermatology	DR	PR	20	10	45	30	60	45	75	60	110	100
Emergency Medicine	EM, EP	PR, AS	20	10	45	30	80	60	75	60	110	100
Endocrinology	DI, EN, PE	PR	30	15	60	40	100	75	110	90	145	130
ENT/Otolaryngology	OT, PQ, HN	PR	30	15	45	30	80	60	90	75	125	110
Gastroenterology	GA, HT, PG	PR	20	10	45	30	60	45	75	60	110	100
General Surgery	SG, PS	PR	20	10	30	20	50	35	75	60	95	85
Gynecology, OG/GYN	FR, GY, MF, MW, MI, OB, OG, RE	PR	10	5	15	10	30	20	40	30	70	60
Infectious Disease	HV, ID, PI	PR	30	15	60	40	100	75	110	90	145	130
Nephrology	NE, PF	PR	30	15	45	30	80	60	90	75	125	110
Neurology	BI, NC, NJ, NU, PN, VN	PR	20	10	45	30	60	45	75	60	110	100
Neurosurgery	SN	PR	30	15	60	40	100	75	110	90	145	130
Occupational Therapy	OC	PR, AN	20	10	45	30	80	60	75	60	110	100
Oncology-Medical, Surgical	CO, GO, HE, ON, HO, HX	PR	20	10	45	30	60	45	75	60	110	100
Oncology-Radiation	RO, RT	PR	30	15	60	40	100	75	110	90	145	130
Opthalmology	OP	PR	20	10	30	20	50	35	75	60	95	85
Orthopedic Surgery	FS, OA, OU,SO, SH, OR, PV	PR	20	10	30	20	50	35	75	60	95	85
Outpatient Clinic Behavioral Health			10	5	15	10	30	20	40	30	70	60
Physical Medicine and Rehabilitation	AH, MM, OM, RB, PH, SI	PR	30	15	45	30	80	60	90	75	125	110
Physical Therapy	PT	PR, AN	20	10	45	30	80	60	75	60	110	100
Plastic Surgery	SP	PR	30	15	60	40	100	75	110	90	145	130
Podiatry	PO	PR	20	10	45	30	60	45	75	60	110	100
Primary Care - Adult			10	5	15	10	30	20	40	30	70	60
Includes: General Practice	GP, CF, PM	PR										
Includes: Geriatrics	GE, NX, NK	PR										
Includes: Internal Medicine	IM, DQ	PR										
Includes: Family Medicine	FP, NF, BS	PR										
Includes: Primary Care - Advanced Registered Nurse Practitioner	NH, NG	PR										
Primary Care - Pediatric	AM, CL, AJ, FD, CM, NL, NI, PD, DB	PR	10	5	15	10	30	20	40	30	70	60
Psychiatry			20	10	45	30	60	45	75	60	110	100
Pulmonology	PU, PL	PR	20	10	45	30	60	45	75	60	110	100
Rheumatology	PB, RH	PR	30	15	60	40	100	75	110	90	145	130
Speech Therapy	ST	PR, AN	20	10	45	30	80	60	75	60	110	100
Urology	UR, UP	PR	20	10	45	30	60	45	75	60	110	100
Vascular Surgery	SV, VR	PR	30	15	60	40	100	75	110	90	145	130

Facility Specialty Types	Specialty Codes	Provider Type(s)	Maximum Time and Distance Standards									
			Large Metro County		Metro County		Micro County		Rural County		Counties w/Extreme Access	
			Time	Distance	Time	Distance	Time	Distance	Time	Distance	Time	Distance
Acute Inpatient Hospital (must have emergency services available 24/7)	HS, EH, HC, VA	FA	20	10	45	30	80	60	75	60	110	100
Cardiac Catheterization Services	Hospital Services	Hospital Services	30	15	60	40	160	120	145	120	155	140
Cardiac Surgery Program	Hospital Services, CS	FA	30	15	60	40	160	120	145	120	155	140
Critical Care Services- Intensive Care Units (ICU)	Hospital Services	Hospital Services	20	10	45	30	160	120	145	120	155	140
Diagnostic Radiology (Free-standing, Hospital outpatient, ambulatory health facilities with	Hospital Services, XR, IA, DS	FA, AN	20	10	45	30	80	60	75	60	110	100
Inpatient or Residential Behavioral Health Services			30	15	70	45	100	75	90	75	155	140
Mammography	Hospital Services, MA	AN	20	10	45	30	80	60	75	60	110	100
Outpatient Infusion/Chemotherapy	Hospital Services, CA, IN, TR	FA, AN	20	10	45	30	80	60	75	60	110	100
Skilled Nursing Facilities	IC, LT, SN	FA	20	10	45	30	80	60	75	60	95	85
Surgical Services (outpatient or ASC)	Hospital Services, OS	FA, AN	20	10	45	30	80	60	75	60	110	100
Urgent Care	UC	AN	20	10	45	30	80	60	75	60	110	100

Significant Large Network Changes

A. On an annual basis, Cigna monitors each state/product to determine the % of change to that network over a 12-month period. The analysis is completed by counting the unique physicians, ancillaries, and hospitals between two points in time. States requiring notification of the significant change over a given percentage are included in the Attachment A.

B. Please refer to California section of this policy on the specific criteria used to determine the % change for California.

C. Availability Analysis is completed when there is a risk of a large provider or health system of terminating from the network. Large providers are defined as Hospitals, Health Systems, Groups with 50 or more physicians or a large ancillary provider.

Applicable Enterprise Privacy Policies:
https://iris.cigna.com/business_units/legal_department/enterprise_compliance/privacy/privacy_policies

Related Policies and Procedures: NA

Attachments:

- Attachment A – Comparison of State Network Adequacy Requirements to Cigna Standards
- Attachment B – State Mandates for Additional Primary Care Provider Types

Attachment A

Comparison of State and Marketplace Network Adequacy Requirements to Cigna Standards

In addition to the analysis of Cigna's national standards, states with more stringent or additional requirements are measured according to what is included in this Attachment.

States with Requirements that are More Stringent than Cigna standard:
*Indicates requirements that are met by Cigna standard

- **Arkansas**

  Network adequacy standards listed below must be met for 80% of covered individuals:

  - At least 1 PCP in 30 miles (Pharmacies are considered PCPs and are held to the same network adequacy standard, Home delivery cannot be included in determining adequacy)
  - At least 1 Specialist in 60 miles
  - At least 1 Hospital in 30 miles
  - At least 1 ECP in 30 miles
  - Emergency services access 24/7 within 30 miles
  - Pharmacy: covered individuals have access to a network pharmacy that is a retail community pharmacy within the following standards:
    - Urban: within two (2) miles of residence for at least 90% of covered individuals
    - Suburban: within five (5) miles of residence for at least 90% of covered individuals
    - Rural: within fifteen (15) miles of residence for at least 70% of covered individuals
  -

- **Arizona – HMO only**
  - Urban (zip code with more than 3,000 persons per square mile)
    - PCP - 10 miles or 30 minutes*
    - SCP - 15 miles or 45 minutes
    - Inpatient Hospital - 25 miles or 75 minutes*
  - Suburban (zip code area with 1,000 – 3,000 persons per square mile)
    - PCP - 15 miles or 45 minutes*
    - SCP - 20 miles or 60 minutes
    - Inpatient Hospital - 30 miles or 90 minutes*
  - Rural (zip code with fewer than 1,000 persons per square mile)
    - PCP - 30 miles or 90 minutes*

- **California**

- Plan will ensure network providers delivering covered services are within reasonable proximity of all enrollees.
- At least one full-time physician (including psychiatrists) per 1,200 covered persons and;*
- At least the equivalent of one full-time primary care physician per 2,000 covered persons*
- Primary Care Providers –within 30 minutes or 15 miles of each covered person's residence or workplace; accepting new patients to accommodate anticipated enrollment growth
- (Managed Care Plans Only) The number of covered persons per primary care physician may be increased by up to 1,000 additional covered persons for each full-time equivalent non-physician medical practitioner supervised by the primary care physician.
- Specialists - with sufficient capacity to accept covered persons within 60 minutes or 30 miles of a covered person's residence or workplace
- Adequate numbers of available primary care providers and specialists with admitting and practice privileges at network hospitals
- Hospital with sufficient capacity to accept covered persons within 30 minutes or 15 miles of a covered person's residence or workplace
- Adequate number of network outpatient retail pharmacies located in sufficient proximity to covered persons to permit adequate routine and emergency access
- Available ancillary, laboratory, and other services are available from network providers at locations within a reasonable distance from the prescribing provider
- Must include a sufficient number of providers to assure access to preventive services, including women's preventive care, which includes access to services and contraceptive methods.
- Networks for mountainous rural areas shall take into consideration typical patterns of winter road closures, so as to comply with access and timeliness standards throughout the calendar year.
- Monitor adequacy at least quarterly and demonstrate and attest to the Department assessment completed twice per year. When compliance monitoring discloses that the provider network is not sufficient to ensure timely access, conduct a prompt investigation identifying the cause(s), and implement corrective actions to bring the network into compliance. Advance written notice shall be given to all contracted providers affected by a corrective action, and shall include a description of the identified deficiencies, the rationale for the corrective action, and the name and telephone number of the person authorized to respond to provider concerns regarding the corrective action.
- Conduct a hospital capacity analysis annually
  - Upon reaching a 10% Change in the provider names in a network, a “Significant Network Change” filing must be submitted to the Regulator. “Change” includes both additions and deletions. Each network should be evaluated for a 10% Change by comparing the present-day roster against the roster that was approved by the Regulator for each of the components described below. Each of the following components/rosters in a network should separately be reviewed for a 10% Change: (1) Physicians/Professional services (2) Hospital/Facility services (3) Ancillary/Mental Health.
- If an insurer is unable to meet the required network access standards, the insurer may apply to the Commissioner for a discretional waiver of any network access standards and offer an alternate access delivery system. A waiver application must be resubmitted annually and meet specific criteria for consideration. Contact state compliance if this option needs to be explored.
- Review and evaluate, no less frequently than quarterly, the information available to the insurer regarding accessibility, availability, and continuity of care, including but not limited to information obtained through covered person and provider surveys, covered person grievances and appeals, and triage or screening services.

- **Colorado**
  - Network access plan filings are required to be filed annually for individual and group medical plans
  - A carrier providing a managed care plan (PPO,OAP, Network, HMO, etc.) must maintain a network that is sufficient in numbers and types of providers to assure that all covered benefits to covered persons will be accessible without unreasonable delay. In the case of emergency services, covered persons must have access to health care services twenty-four hours per day, seven days per week. Sufficiency will be determined based on the requirements below and may be established by reference to any reasonable criteria used by the carrier, including but not limited to:
    - Provider-covered person ratios by specialty, which may include the use of providers through telehealth for services that may appropriately be provided through telehealth;
    - Primary care provider-covered person ratios;
    - Geographic accessibility, which in some circumstances may require the crossing of county or state lines;
    - The volume of technological and specialty services available to serve the needs of covered persons requiring covered technologically advanced or specialty care; and
    - An adequate number of accessible acute care hospital services within a reasonable distance, travel time, or both.
  - The following four (4) measurement standards shall be used to evaluate a carrier's network adequacy:
    - Compliance with network adequacy instructions published by the DOI;
    - Compliance with network adequacy definitions contained in regulation;
    - Compliance with the measurement details contained in regulation; and
    - Compliance with the reporting methodologies contained in regulation.
  - Availability Standards

Provider/Facility Type	Large Metro	Metro	Micro
Primary Care	1:1000	1:1000	1:1000
Pediatrics	1:1000	1:1000	1:1000
OB/GYN	1:1000	1:1000	1:1000

  - Maximum Distances in Miles by Specialty and County Type

Individual Provider Specialty Types	Large Metro	Metro	Micro	Rural	CEAC
Primary Care	5	10	20	30	60
Gynecology, OB/GYN	5	10	20	30	60
Pediatrics - Routine/Primary Care	5	10	20	30	60
Allergy and Immunology	15	30	60	75	110
Cardiothoracic Surgery	15	40	75	90	130
Cardiology	10	20	35	60	85
Chiropractor	15	30	60	75	110
Dermatology	10	30	45	60	100
Emergency Medicine	10	30	60	60	100

Endocrinology	15	40	75	90	130
ENT/Otolaryngology	15	30	60	75	110
Gastroenterology	10	30	45	60	100
General Surgery	10	20	35	60	85
Gynecology only	15	30	60	75	110
Infectious Diseases	15	40	75	90	130
Nephrology	15	30	60	75	110
Neurology	10	30	45	60	100
Neuro Surgery	15	40	75	90	130
Oncology - Medical, Surgical	10	30	45	60	100
Oncology - Radiation	15	40	75	90	130
Ophthalmology	10	20	35	60	85
Orthopedic Surgery	10	20	35	60	85
Physical and Rehabilitative Medicine	15	30	60	75	110
Plastic Surgery	15	40	75	90	130
Podiatry	10	30	45	60	100
Pulmonology	10	30	45	60	100
Rheumatology	15	40	75	90	130
Urology	10	30	45	60	100
Vascular Surgery	15	40	75	90	130
OTHER MEDICAL PROVIDER	15	40	75	90	130
Pharmacy	5	10	20	30	60
Acute Inpatient Hospitals	10	30	60	60	100
Cardiac Surgery Program	15	40	120	120	140
Cardiac Catheterization Services	15	40	120	120	140
Critical Care Services – Intensive Care Units (ICU)	10	30	120	120	140
Outpatient Dialysis	10	30	50	50	90
Surgical Services (Outpatient or ASC)	10	30	60	60	100
Skilled Nursing Facilities	10	30	60	60	85
Diagnostic Radiology	10	30	60	60	100
Mammography	10	30	60	60	100
Physical Therapy	10	30	60	60	100
Occupational Therapy	10	30	60	60	100
Speech Therapy	10	30	60	60	100
Orthotics and Prosthetics	15	30	120	120	140
Outpatient Infusion/Chemotherapy	10	30	60	60	100
Urgent Care Facilities	10	30	60	60	100
OTHER FACILITIES	15	40	120	120	140

- A carrier must prepare an access plan prior to offering a new network plan, and shall notify the Commissioner of any material change to any existing network plan within fifteen (15) business days after the change occurs, and provide notice to customers 45 days prior to the change

- Issuers must ensure their provider networks have a sufficient number and geographic distribution of ECPs, where available, to ensure reasonable and timely access to a broad range of such providers for low-income, medically underserved individuals in the issuer's service area.
- There are four (4) ECP standards for issuer ECP submissions
    - General ECP Standard. Carriers utilizing this standard shall demonstrate in their "ECP/Network Adequacy Template" that at least 35 percent (35%) of available ECPs in each plan's service area participate in the plan's network. This standard applies to all carriers except those who qualify for the alternate ECP standard.
    - Alternate ECP Standard. Carriers utilizing this standard shall demonstrate in their "ECP/Network Adequacy Template" and justifications, that they have the same number of ECPs as defined in the general ECP standard (calculated as 35 percent (35%) of the ECPs in the carrier's service area), but the ECPs should be located within Health Professional Shortage Areas (HPSAs) or five-digit ZIP codes in which 30 percent (30%) or more of the population falls below 200 percent (200%) of the federal poverty level (FPL). An alternate ECP standard carrier is one that provides a majority of covered professional services through physicians it employs or through a single contracted medical group.
    - General ECP Standard for Colorado Option Standardized Plans Networks as specified in Colorado Insurance Regulation 4-2-80.
    - Alternate ECP Standard for Colorado Option Standardized Plans Networks as specified in Colorado Insurance Regulation 4-2-80.
- Colorado Public Options
    - Public Hearing
        - A carrier must notify the Commissioner of the reasons why the carrier is unable to meet the premium rate reduction or network adequacy requirements and submit the notification and related documents via SERFF to the Commissioner, and to the other Parties no later than March 1 of the year preceding the year in which the premium rates go into effect.
        - When the Division has alleged that a carrier has failed to meet the premium rate reduction or network adequacy requirements through a Complaint filed by the Division the carrier must submit to the Commissioner the notification and related documents within seven (7) days of receipt of the Complaint from the Division.
- Inclusion of Certified Nurse Midwives in the Colorado Option Standardized Plan Networks

  To address racial health disparities and improve perinatal health care coverage, carries must attest that at least one certified nurse midwife is available within the maximum road travel distance of any covered person in the Colorado Option standardized plan network based on the categories of geographic areas listed below:

    - Large Metro – maximum distance 5 miles
    - Metro – maximum distance 10 miles
    - Micro – maximum distance 20 miles

- Rural – maximum distance 30 miles
- CEACs -maximum distance 60 miles

- **Connecticut**
  - Each health carrier shall, for any plan that uses a provider network, establish and monitor the provider network to meet these minimum standards:
    - Ensure that a person has access to health care services within the maximum time and distance standards.
    - Ensure that the provider network has at least one primary care physician per two thousand (2,000) covered persons.
    - Ensure that the percentage of providers participating in the network that accept new patients is at least seventy percent (70%).
  - Provider Ratios:

Specialty	Minimum Ratio Standard for 1,000 covered persons
Allergy and Immunology	0.05
Cardiology	0.27
Chiropractor	0.10
Dermatology	0.16
Endocrinology	0.04
ENT/Otolaryngology	0.06
Gastroenterology	0.12
General Surgery	0.28
Gynecology, OB/GYN	0.04
Infectious Diseases	0.03
Nephrology	0.09
Neurology	0.12
Neurosurgery	0.01
Oncology - Medical, Surgical	0.19
Oncology - Radiation/Radiation Oncology	0.06
Ophthalmology	0.24
Orthopedic Surgery	0.20
Physiatry, Rehabilitative Medicine	0.04
Plastic Surgery	0.01
Podiatry	0.19
Psychiatry	0.14
Pulmonology	0.13
Rheumatology	0.07
Urology	0.12

Vascular Surgery	0.02
Cardiothoracic Surgery	0.01
Acute Inpatient Hospitals	12.2

- Maximum Time and Distance Standards (Minutes/Miles) for 90% of Members

SPECIALTY AREA	FAIRFIELD COUNTY (Large Metro)	ALL OTHER COUNTIES (Metro)
Allergy and Immunology	30/15	45/30
Cardiology	20/10	30/20
Cardiothoracic Surgery	30/15	60/40
Chiropractor	30/15	45/30
Dental	30/15	45/30
Pharmacy	20/10	30/20
Dermatology	20/10	45/30
Emergency Medicine	20/10	45/30
Endocrinology	30/15	60/40
ENT/Otolaryngology	30/15	45/30
Gastroenterology	20/10	45/30
General Surgery	20/10	30/20
Gynecology, OB/GYN	10/5	15/10
Infectious Diseases	30/15	60/40
Nephrology	30/15	45/30
Neurology	20/10	45/30
Neurosurgery	30/15	60/40
Occupational Therapy	20/10	45/30
Oncology - Medical, Surgery	20/10	45/30
Oncology - Radiation	30/15	60/40
Ophthalmology	20/10	30/20
Orthopedic Surgery	20/10	30/20
Mental Health - Psychiatry/Psychology	20/10	45/30

Mental Health - Child & Adolescent Psychiatry/Psychology	20/10	45/30
Substance Use Disorder Treatment	20/10	45/30
Child & Adolescent Substance Use Disorder Treatment	20/10	45/30
Outpatient Clinical Behavioral Health (Licensed, accredited, or certified professionals)	10/5	15/10
Physical Medicine and Rehabilitation	30/15	45/30
Physical Therapy	20/10	45/30
Plastic Surgery	30/15	60/40
Podiatry	20/10	45/30
Primary Care - Adult	10/5	15/10
Primary Care - Pediatric	10/5	15/10
Pulmonology	20/10	45/30
Rheumatology	30/15	60/40
Speech Therapy	20/10	45/30
Urology	20/10	45/30
Vascular Surgery	30/15	60/40
Acute Inpatient Hospitals (must have Emergency services available 24/7)	20/10	45/30
Cardiac Catheterization Services	30/15	60/40
Cardiac Surgery Program	30/15	60/40
Critical Care Services - Intensive Care Units (ICU)	20/10	45/30
Diagnostic Radiology (Free-standing; hospital outpatient; ambulatory health facilities with Diagnostic Radiology)	20/10	45/30
Inpatient or Residential Behavioral Health Facility Services	30/15	70/45
Mammography	20/10	45/30
Outpatient Infusion/Chemotherapy	20/10	45/30
Skilled Nursing Facilities	20/10	45/30
Surgical Services (Outpatient or ASC)	20/10	45/30
Urgent Care	20/10	45/30

- Material change notifications are required for:

- a change of twenty-five per cent or more in the participating providers in a health carrier's network or the type of participating providers available in a health carrier's network to provide health care services or specialty care to covered persons, or
- any change that renders a health carrier's network noncompliant with one or more network adequacy standards, including, but not limited to, (i) a significant reduction in the number of primary care or specialty care providers available in the network, (ii) a reduction in a specific type of participating provider such that a specific covered benefit is no longer available to covered persons, (iii) a change to a tiered, multitiered, layered or multilevel network plan structure, (iv) a change in inclusion of a major health system, as defined in section 19a-508c, that causes a network to be significantly different from what a covered person initially purchased, or (v) after notice, any other change the commissioner deems to be a material change.

- **District of Columbia**
  - Carriers shall submit to the Commissioner a Network Adequacy Report by September 1 of each year, for health plans being sold, issued, or renewed on or after January I of the subsequent year. The report must include but not limited to include:
    - information in its Network Adequacy Report summarizing call center statistics,
    - carriers must report that at least 20% of available essential community providers in each plan's service area participate in the plans network.
  - For any provider-to-covered person ratio, the ratio shall be formulated by dividing the number of providers in each network, as listed in the carrier's submitted Centers for Medicare and Medicaid Services (CMS) Qualified Health Plan (QHP) network template, by the number of covered persons with access to that same network. If a carrier submits more than one Network ID, then separate ratios shall be formulated for each Network ID. For plans that do not use QHP templates, separate ratios shall be formulated for each established network and identified in a manner substantially similar to the Network ID.

    Carriers shall provide services consistent with the following requirements:

    (1) The ratio of provider to covered persons by specialty:

Neurology	1:5,000
Cardiology	1:5,000
Hematology/Oncology	1:5,000
Dermatology	1:5,000
Rheumatology	1:5,000
Orthopedics	1 :5,000
Nephrology	1:5,000
Plastic Surgery	1:5,000

    (2) the ratio of providers to covered persons

Primary Care, Pediatrics, OB/GYN 1:2,000

(3) Physician accessibility:

- Contingent on the Commissioner providing the provider list, carriers shall contract with a minimum of thirty percent (30%) of the providers on the list provided by the Commissioner for each of the specialties:
    - Primary Care Pediatrics OB/GYN
    - Neurology
    - Cardiology Hematology / Oncology Dermatology Rheumatology Orthopedics
    - Nephrology
- Carriers shall have in their network at least thirty percent (30%) of all providers (not just those on the specialty list) with a primary practice address within the District of Columbia identified as having an office within half (1/2) of a mile of a Metrorail stop on the list of providers.

Material change notifications are required for the following, including but not limited to:

A. a change of twenty percent (20%) or greater reduction in the number of primary care or specialty care to a covered person, or

B. any change that renders a health carrier's network noncompliant with one or more network adequacy standards, including, but not limited to

1. a change of ten percent (10%) or more in the total number of network providers,
2. a reduction in a specific type of provider, such that the provider type or a specific covered service is no longer available,
3. a twenty percent (20%) change to a tiered, multi-tiered, layered or multilevel network plan structure,
4. a twenty percent (20%) change or greater covered persons since the prior filing.

- **Florida – HMO and non-HMO Lock-In Products (products with no Out-of-Network benefits)**
    - Specialty physician services, ancillary services, specialty inpatient hospital services and all other health services: 60 minutes (measured as avg. travel time from service area boundary to provider) [ASSUME: 60 miles]
    - PCP site and general inpatient hospital: 30 minutes (measured as avg. travel time from service area boundary to provider) [ASSUME: 30 miles]

- **Illinois**

Effective January 13, 2023:

- Except as provided under 4.2 below, for any network plan issued, delivered, or renewed on or after January 1, 2023, the filing must demonstrate compliance with the federal time and distance standards established in Tables 3.1 and 3.2 of the "2023 Letter to Issuers in the Federally facilitated Exchanges" published by CMS for each county in the service area. These standards prescribe the maximum limits of travel in minutes and miles that a beneficiary residing in a given county type may be expected to undertake to a preferred provider of a given provider specialty type. The IDOI will ensure that distance standards are measured no less stringently than straight-line distance (i.e., "how the crow flies") between the beneficiary and the preferred provider, but an insurer may apply more stringent standards that measure distance based on travel along existing roads. Time standards must be evaluated based on estimated driving time from the beneficiary to the preferred provider using mapping output data for travel along existing roads. Measurements of driving time must not be exclusively based on nor, if an average driving time is used, disproportionately weighted toward weekends, any day during the week of a federal or State holiday, or times outside the range of 8 am through 5 pm.
- Insurers must use a comparable process, strategy, evidentiary standard, and other factors in the development and application of the network standards for timely and proximate access to treatment for mental, emotional, nervous, or substance use disorders or conditions that are used for the treatment for medical and surgical conditions. Therefore, the network adequacy standards for proximate access must be equally applied to treatment facilities and providers for mental, emotional, nervous, or substance use disorders or conditions as specialists providing medical or surgical benefits pursuant to both Illinois and federal Mental Health Parity requirements.
- The network adequacy standards for timely and proximate access to treatment for mental, emotional, nervous, or substance use disorders or conditions, must at a minimum, satisfy the following requirements:
    - For beneficiaries residing in the metropolitan counties of Cook, DuPage, Kane, Lake, McHenry and Will, network adequacy standards for timely and proximate access means a beneficiary must not have to travel more than 30 minutes or 30 miles from the beneficiary's residence to receive outpatient treatment.
    - For beneficiaries residing in all other Illinois counties, network adequacy standards for timely and proximate access means a beneficiary must not have to travel longer than 60 minutes or 60 miles from the beneficiary's resident to receive outpatient treatment.
    - For beneficiaries residing in all Illinois counties, network adequacy standards means a beneficiary must not have to travel longer than 60 minutes or 60 miles from the beneficiary's residence to receive inpatient or residential treatment. If there is no in-network facility or provider available for a beneficiary to receive timely and proximate access to treatment in accordance with the above network adequacy standards, the insurer must provide necessary exceptions to its network to ensure admission and treatment with a provider or at a treatment facility in accordance with the above network adequacy standards.
- The insurer must provide evidence of its arrangements under which, if the network plan has no preferred provider available that meets these network adequacy standards, in relation to a beneficiary, it will make the necessary exceptions to its network to ensure admission and treatment

with a non-preferred provider or facility at no greater cost to the beneficiary than if the service or treatment had been provided by a preferred provider

- The requirement under Federal law that insurers offering QHPs demonstrate compliance with the quantitative time and distance standards in Tables 3.1 or 3.2 of the 2023 Letter for Outpatient Clinical Behavioral Health, Psychiatry, and Inpatient or Residential Behavioral Health Facility Services. The IDOI will defer to the U.S. Department of Health and Human Services to enforce those standards for QHPs, including the evaluation of an insurer's justifications for exceptions. However, for purposes of demonstrating compliance with the maximum travel and distance standards adopted by Illinois, an insurer may elect to demonstrate to the IDOI that the network plan actually complies with the federal time and distance standards without an exception in any county where the federal standards match or exceed the standards provided under NATA.
- Network plans must demonstrate compliance with the following minimum provider ratios. For health care professionals, the provider ratios below are expressed in terms of preferred providers to beneficiaries. For facilities, the provider ratios are expressed in terms of the number of facilities per county:
    - Primary care physician, general practice, family practice, internal medicine, or primary nurse practitioner - 1:1,000
    - Allergy/Immunology - 1:1,000
    - Cardiology - 1:10,000
    - Chiropractic - 1:10,000
    - Dermatology - 1:10,000
    - Endocrinology - 1:10,000
    - ENT/Otolaryngology - 1:10,000
    - Gastroenterology - 1:10,000
    - General Surgery - 1:5,000
    - Gynecology or OB/GYN - 1:2,500
    - Infectious Diseases - 1:15,000
    - Nephrology - 1:10,000
    - Neurology - 1:20,000
    - Oncology/Radiation - 1:15,000
    - Ophthalmology - 1:10,000
    - Orthopedic Surgery - 1:10,000
    - Physiatry/Rehabilitative Medicine - 1:15,000
    - Plastic Surgery - 1:20,000
    - Behavioral Health - 1:5,000
    - Pulmonology - 1:10,000

- Rheumatology - 1:10,000
- Urology - 1:10,000
- Acute inpatient hospital with emergency services available 24 hours a day, 7 days per week - one per county; and
- Inpatient or residential behavioral health facility - one per county;

- Within 15 days after any material change in an approved network plan, an insurer must submit a material change filing. Material change means a significant reduction in the number of providers available in a network plan, including, but not limited to a reduction of 10% or more of a provider specialty type in the network as a whole; the removal of a major health system that causes a network to be significantly different within one or more counties from the network when the beneficiary purchased the plan; when the network's provider ratio for any type of provider no longer satisfies the requirements; and when the network no longer satisfies the time and distance standards in any county for any type of provider described or incorporated in the requirements above.
- Before sending any notice of nonrenewal or termination required by Illinois law, an insurer must file informationally with the IDOI through SERFF a sample copy of the notices to providers and beneficiaries. Insurers must also include these notices in its annual network filings. Anytime the plan changes the letter template, the health care plan is required to file the revised version before using it in any future termination notice.
- These ratio and time and distance standards apply to the lowest cost-sharing tier of any tiered network that is used for individual health benefit plans (IFP).
- The network plan may consider use of other health care service delivery options, such as telemedicine or telehealth, mobile clinics, and centers of excellence, or other ways of delivering care to partially meet the requirements.
- If unable to comply with the provider ratios, time, and distance standards (100% of members with access), insurer may request an exception.
- The IL DOI's current requirements for network access minimum ratio of providers to plan members and maximum travel and distance standards can be found at:

  http://insurance.illinois.gov/HealthInsurance/NetworkAdequacyTransparencyChecklist.pdf

Individual Provider Specialty Type	Maximum Time and Distance Standards									
	Large Metro County		Metro County		Micro County		Rural County		CEAC	
	Time	Dist	Time	Dist	Time	Dist	Time	Dist	Time	Dist
Allergy and Immunology	30	15	45	30	80	60	90	75	125	110
Cardiology	20	10	30	20	50	35	75	60	95	85
Chiropractor	30	15	45	30	80	60	90	75	125	110
Dermatology	20	10	45	30	60	45	75	60	110	100
Endocrinology	30	15	60	40	100	75	110	90	145	130

ENT/Otolaryngology	30	15	45	30	80	60	90	75	125	110
Gastroenterology	20	10	45	30	60	45	75	60	110	100
General Surgery	20	10	30	20	50	35	75	60	95	85
Gynecology, OG/BYN	10	5	15	10	30	20	40	30	70	60
Infectious Diseases	30	15	60	40	100	75	110	90	145	130
Nephrology	30	15	45	30	80	60	90	75	125	110
Neurology	20	10	45	30	60	45	75	60	110	100
Oncology - Radiation	30	15	60	40	100	75	110	90	145	130
Ophthalmology	20	10	30	20	50	35	75	60	95	85
Orthopedic Surgery	20	10	30	20	50	35	75	60	95	85
Physiatry/Rehabilitative Medicine	30	15	45	30	80	60	90	75	125	110
Plastic Surgery	30	15	60	40	100	75	110	90	145	130
Primary Care Physician (Adult)	10	5	15	10	30	20	40	30	70	60
Primary Care Physician (Child)	10	5	15	10	30	20	40	30	70	60
Pulmonology	20	10	45	30	60	45	75	60	110	100
Rheumatology	30	15	60	40	100	75	110	90	145	130
Urology	20	10	45	30	60	45	75	60	110	100

Facility Specialty Type	Maximum Time and Distance Standards									
	Large Metro County		Metro County		Micro County		Rural County		CEAC	
	Time	Dist	Time	Dist	Time	Dist	Time	Dist	Time	Dist
Acute Inpatient Hospitals (Must have Emergency services available 24/7)	20	10	45	30	80	60	75	60	110	100
Cardiac Catheterization Services	30	15	60	40	160	120	145	120	155	140
Cardiac Surgery Program	30	15	60	40	160	120	145	120	155	140
Critical Care Services - Intensive Care Units (ICU)	20	10	45	30	160	120	145	120	155	140
Diagnostic Radiology (Freestanding; hospital outpatient; ambulatory health facilities with Diagnostic Radiology)	20	10	45	30	80	60	75	60	110	100

Mammography	20	10	45	30	80	60	75	60	110	100
Outpatient Infusion/Chemotherapy	20	10	45	30	80	60	75	60	110	100
Skilled Nursing Facilities	20	10	45	30	80	60	75	60	95	85
Surgical Services (Outpatient or ASC)	20	10	45	30	80	60	75	60	110	100
Urgent Care	20	10	45	30	80	60	75	60	110	100

- **Kansas**
  - 1 Pharmacy every 10 miles and every 30 miles for underserved communities

- **Maryland**
  - Must file Network Access Plan (NAP) annually July 1st including documentation of how the NAP meets each network sufficiency standard for: Geographical Accessibility of Providers, Waiting and Times for Appointments with Providers, and Provider-to-Customer Ratios, and a list of all changes made to the NAP filed the previous year.
  - Measuring availability for each Medical Specialty category is conducted by utilizing the designation(s) the provider has indicated. As an example, an Obstetrician may self-designate as a primary care provider and a specialty care provider and will be measured in the primary care category and the specialist category.
  - Measuring availability for Primary Care Services is conducted by utilizing the designation the provider has indicated. If a Gynecologist, Pediatrician, Certified Registered Nurse Practitioner, General Medicine, Internal Medicine, or Family Practice provider has self-designated as primary care, that provider will be measured in the primary care category.
  - The travel distance standards do not apply to the following: (a) Home health care; (b) Durable medical equipment; (c) Transplant programs (heart, lung, kidney, liver or pancreas)
  - All other provider and facility types including on the carrier's provide panel but not listed in the Travel Distance Standard chart, including physical therapists and licensed dietitian-nutritionist, must be individually required to meet maximum distance standards of 15 miles for Urban, 40 miles for Suburban, and 90 miles for Rural areas.
  - Provider to Enrollee Ratios: Provider Networks must have at least one (1) physician/provider for:
    - 1,200 enrollees for primary care
    - 2,000 enrollees for pediatric care
    - 2,000 enrollees for obstetrical/gynecological care
  - The ratios are calculated using the methodology below:
    - The number of enrollees covered under all health benefit plans issued by the carrier in Maryland that use the provider panel; and
    - The number of providers in that provider panel with practicing locations:

- In Maryland; or
- Within the applicable maximum travel distance standard specified in regulation .05 (Travel Distance Standards) outside the geographic boundaries of Maryland.

- Travel Distance Standards:
  - "Urban area" means a zip code that, according to the Maryland Department of Planning has a human population equal to or greater than 3,000 per square mile.
  - "Suburban area" means a zip code that, according to the Maryland Department of Planning has a human population equal to or greater than 1,000 per square mile but less than 3,000 per square mile.
  - "Rural area" means a zip code that, according to the Maryland Department of Planning has a human population of less than 1,000 per square mile.

Time and Distance Standards are listed below

SPECIALTY	MAXIMUM DISTANCE (MILES)		
	URBAN	SUB-URBAN	RURAL AREA
MEDICAL			
Facilities			
Acute Inpatient Hospitals	10	30	60
Ambulatory Infusion Therapy Center	10	30	60
Critical Care Services—Intensive Care Unit	10	30	100
Diagnostic Radiology	10	30	60
Outpatient Dialysis	10	30	50
Skilled Nursing Facilities	10	30	60
Surgical Services Outpatient or Ambulatory Surgical Center)	10	30	60
All other licensed or certified facilities under contract with the carrier that are not listed	15	40	90
Practitioners			
Allergy and Immunology	15	30	75
Cardiovascular Disease	10	20	60
Chiropractic	15	30	75
Dermatology	10	30	60
Endocrinology	15	40	90
ENT/Otolaryngology	15	30	75
Gastroenterology	10	30	60
General Surgery	10	20	60
Gynecology, OB/GYN Nurse – Midwifery/Certified Midwifery	5	10	30
Nephrology	15	25	75
Neurology	10	30	60

Cigna

SPECIALTY	MAXIMUM DISTANCE (MILES)		
	URBAN	SUB-URBAN	RURAL AREA
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
Plastic Surgery	15	40	90
Podiatry	10	30	60
Primary Care Physician – non-Pediatric	5	10	30
Pulmonology	10	30	60
Rheumatology	15	40	90
Urology	10	30	60
All other licensed or certified providers under contract with the carrier that are not listed	15	40	90
PHARMACIES			
All	5	10	30

HMO Time and Distance Standards are listed below

SPECIALTY	MAXIMUM DISTANCE (MILES)		
	URBAN	SUB-URBAN	RURAL AREA
MEDICAL			
Allergy and Immunology	20	30	75
Cardiovascular Disease	15	25	60
Chiropractic	20	30	75
Dermatology	20	30	60
Endocrinology	20	40	90
ENT/Otolaryngology	20	30	75
Gastroenterology	20	30	60
General Surgery	20	30	60
Gynecology, OB/GYN Nurse-Midwifery/Certified Midwifery	15	20	45
Nephrology	15	30	75
Neurology	15	30	60
Oncology-Medical, Surgical	15	30	60
Oncology-Radiation/Radiation Oncology	15	40	90
Ophthalmology	15	20	60
Pediatrics-Routine/Primary Care	15	20	45
Plastic Surgery	15	40	90
Podiatry	15	30	90
Primary Care (non-pediatric)	15	20	45
Pulmonology	15	30	60
Rheumatology	15	40	90
Urology	15	30	60
All Other licensed or certified providers under contract with a carrier not listed	20	40	90
Facility Type	Urban Area	Suburban	Rural Area

SPECIALTY	MAXIMUM DISTANCE (MILES)		
	URBAN	SUB-URBAN	RURAL AREA
	Maximum Distance (miles)	Area Maximum Distance (miles)	Maximum Distance (miles)
Acute Inpatient Hospitals	15	30	60
Ambulatory Infusion Therapy Center	15	30	60
Critical Care Services-Intensive Care Units	15	30	120
Diagnostic Radiology	15	30	60
Inpatient Psychiatric Facility	15	45	75
Opioid Treatment Services Provider	15	30	60
Outpatient Dialysis	15	30	60
Outpatient Mental Health Clinic	15	30	60
Outpatient Substance Use Disorder Facility	15	30	60
Pharmacy	5	10	30
Residential Crisis Services	15	30	60
Skilled Nursing Facilities	15	30	60
Substance Use Disorder Residential Treatment Facility	15	30	60
Surgical Services (Outpatient or Ambulatory Surgical Center)	10	30	60
All other licensed or certified facilities under contract with a carrier not listed	15	40	120

- Essential Community Providers:
  (1) Each network will include at least 30 percent of the available essential community providers in each of the urban, rural, and suburban areas including health departments.
  (2) Each group model HMO plan shall demonstrate that its own providers located in Health Professional Shortage Areas or low-income zip codes within its service area perform at or above the 50th percentile on the following two HEDIS measures:
    (a) Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment; and
    (b) Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults
  (3) Each group model HMO plan shall demonstrate that it has alternative standards for addressing the needs of low income, medically underserved individuals (i.e., narrative or alternate standard justification to the essential community provider requirement)

- A carrier must continuously monitor its provider network for compliance with these requirements and must conduct internal compliance audits for the standards listed in regulation .05 (Travel & Distance Standards), .06 (Appointment Wait Times standards, and .07 (provider to Enrollee Ratio standards) at least quarterly.

- **Missouri - HMO**
  - Annually, HMOs must file an access plan outlining how the HMO meets the state's requirements for network adequacy by March 1st.

- MO definitions:
    - Urban: county population 200,000 or more;
    - Basic: county population 50,000 - 199,999;
    - Rural: county population fewer than 50,000.
    - Population figures based on census data as reported in the latest edition of the Official Manual of the State of Missouri
- Urban, Basic, Rural County Standards per provider type

  Physicians
    - PCPs 10 20 30 *
    - Obstetrics/Gynecology 15 30 60
    - Neurology 25 50 100
    - Dermatology 25 50 100 *
    - Physical Medicine/Rehab 25 50 100
    - Podiatry 25 50 100
    - Vision Care/Primary Eye Care 15 30 60
    - Allergy 25 50 100
    - Cardiology 25 50 100 *
    - Endocrinology 25 50 100
    - Gastroenterology 25 50 100
    - Hematology/Oncology 25 50 100
    - Infectious Disease 25 50 100
    - Nephrology 25 50 100
    - Ophthalmology 25 50 100 *
    - Orthopedics 25 50 100 *
    - Otolaryngology 25 50 100 *
    - Pediatric 25 50 100
    - Pulmonary Disease 25 50 100
    - Rheumatology 25 50 100
    - Urology 25 50 100
    - General surgery 15 30 60
    - Chiropractor 15 30 60

  Hospitals

- Basic Hospital 30 30 30
- Secondary Hospital 50 50 50

Tertiary Services

- Level I or Level II trauma unit 100 100 100
- Neonatal intensive care unit 100 100 100
- Perinatology services 100 100 100
- Comprehensive cancer services 100 100 100
- Comprehensive cardiac services 100 100 100
- Pediatric subspecialty care 100 100 100

Ancillary Services

- Physical Therapy 30 30 30
- Occupational Therapy 30 30 30
- Speech Therapy 50 50 50
- Audiology 50 50 50

Pharmacy

- Pharmacy 10 20 30

- **Montana**
  - Deems insurers that meet the following requirements to have an adequate network for that category of health care providers:
    - the network includes at least 80% of the licensed individual physicians actively practicing in the state of Montana;
    - the network includes at least 80% of the licensed individual non-physician health care providers actively practicing in the state of Montana; and
    - The network includes at least 90% of those facilities licensed and operating as hospitals in the state of Montana.
  - If percentages not met, requires all networks to provide adequate choice of each type of provider and facility, including but not limited to: *
    - physicians;
    - pharmacies;
    - hospitals;
    - surgi-centers; and
  - If percentages not met, requires sufficiency and adequacy determinations to be based on "reasonable criteria," "Reasonable criteria" may include: *

- provider to covered person ratios by specialty
- primary care provider to covered person ratios
- geographic accessibility
- waiting times for appointments with participating providers
- the volume of specialty services available to serve the needs of covered persons requiring specialty care.

- Effective January 1, 2022, the Montana Pharmacy Benefit Manager Oversight Act establishes the standards and criteria for the licensure and regulation of PBMs that provide claims processing services or other prescription drug or device services for health benefit plans and workers' compensation insurance carriers. One such standard that the law requires relates to network adequacy standards.
  - A PBM must establish and maintain a pharmacy network that is sufficient in numbers to ensure all pharmacist services are accessible without unreasonable delay, within a reasonable proximity to the business or personal residence of an enrollee or an injured worker of a workers' compensation insurance carrier, and with sufficient choice based on the availability of retail pharmacies.
  - The Insurance Commissioner may consider reasonable criteria or standards to determine the sufficiency and adequacy of a pharmacy network, including:
    - Whether the pharmacy network includes at least 80% of retail pharmacies;
    - The criteria the PBM used to build a pharmacy network, including the criteria used to select pharmacies for participation in the pharmacy network;
  - A PBM may not use mail-order pharmacies to meet network adequacy requirements for a pharmacy network.
  - A PBM may not require an enrollee or an injured worker of a workers' compensation insurance carrier to use any pharmacy, including a mail-order pharmacy, in which the PBM has an ownership interest, either directly or indirectly through an affiliate, holding company, or subsidiary, for prescriptions, refills, or specialty drugs regardless of day supply.
  - A PBM must monitor, on an ongoing basis, the ability and capacity of the pharmacy network to furnish pharmacist services to an enrollee or an injured worker of a workers' compensation insurance carrier.
  - A PBM must file and update the report required in (1)(a), above, with the commissioner if the number of pharmacies in the pharmacy network decreases by more than 5% during the year.

- **North Carolina**
  - Each network plan carrier must develop a methodology to determine the size and adequacy of the provider network necessary to serve the members. The methodology must provide for the development of performance targets that address the following:

- The number and type of primary care physicians, specialty care providers, hospitals, and other provider facilities, as defined by the carrier.
- A method to determine when the addition of providers to the network will be necessary based on increases in the membership of the network plan carrier.
- A method for arranging or providing health care services outside of the service area when providers are not available in the area.

- Each carrier must establish performance targets for member accessibility to primary and specialty care physician services and hospital-based services. Carriers must also establish similar performance targets for health care services provided by providers who are not physicians. Carriers must establish written policies and performance targets that address the following:
  - The proximity of network providers, as measured by such means as driving distance or time a member must travel to obtain primary care, specialty care, and hospital services, taking into account local variations in the supply of providers, and geographic considerations.
  - The availability to provide emergency services on a 24-hour, 7 day per week basis.
  - Emergency provisions within and outside of the service area.
  - The average or expected waiting time for urgent, routine, and specialist appointments.
- Each carrier must monitor compliance with this law at least annually. This can be done by means of site visits or review of information gathered by the carrier. The documentation of these activities must be maintained for a period of at least 5 years.
- Must establish targets for customer accessibility
- Targets have been established for the following types of health care professionals:
  - Primary Care Physician (includes Family Practice, Internal Medicine and General Practice)
  - Pediatrician
  - Obstetrician/Gynecologist
  - Specialist (includes top ten highest volume specialties using customer claims data for a twelve (12) month period)
  - Non-Physician (includes top ten highest volume non-physician provider types using customer claims data for a twelve (12) month period)
  - Inpatient Facility (includes hospitals)
  - Outpatient Facility (includes ambulatory surgical centers, skilled nursing facilities, etc...)
- Network Density or Ratio of Providers to covered lives will be measured using the methodology outlined in the definition section of this policy, using the standards below. Providers include Providers from NC and NC bordering counties. Customers are defined as insured residents of North Carolina regardless of situs state.
- Driving Distance or Geographic Distribution (# of Providers within # of miles) by Urban, Suburban, and Rural will be measured using the methodology outlined in the definition section of this policy, using the standards below. Providers include Providers from NC and NC bordering counties. Customers are defined as insured residents of North Carolina regardless of situs state.

Provider	Ratio Standard (Providers per covered lives)	Urban Mileage (Providers within # miles)	Suburban Mileage (Providers within # miles)	Rural Mileage (Providers within # miles)

PCP	1:300	1:10 – 90%	1:15 – 90%	1:50 – 90%
Pediatrician	1:300	1:10 – 90%	1:15 – 90%	1:50 – 90%
OB/GYN	1:300	1:10 – 90%	1:15 – 90%	1:50 – 90%
Specialists	1:1,000	2:15 – 90%	2:20 – 90%	2:50 – 90%
Non-MD	1:1,000	2:15 – 90%	2:20 – 90%	2:50 – 90%
Inpatient Facility	1:10,000	1:25 – 90%	1:30 – 90%	1:35 – 90%
Outpatient Facility	1:10,000	1:25 – 90%	1:30 – 90%	1:35 – 90%
MH/CD Psychiatry	1:1,500	1:15 – 95%	1:15 – 95%	1:25 – 85%
MH/CD Non-MD	1:800 Masters level clinician 1:1,500 Psychologist/NP	1:15 Masters level clinician – 98% 1:15 Psychologist/NP – 95%	1:15 Masters level clinician – 98% 1:15 Psychologist/NP – 95%	1:25 Masters level clinician – 90% 1:25 Psychologist/NP – 85%
MH/CD Inpatient Facilities Pre-Stabilization	1:10,000	1:20 – 80%	1:20 – 80%	1:30 – 80%
MH/CD Inpatient Facilities Post-Stabilization	1:10,000	1:20 – 80%	1:20 – 80%	1:30 – 80%

- Annually, must measure results separately for provider types above for the following categories:
    - Driving distance or Geographic Distribution (# of providers within # of miles) by Urban, Suburban, Rural) Reports must be produced and presented to Committee on an annual basis using provider counts and membership counts as of 12/31 of the measurement year.
    - Network density or ratio of providers to covered lives must be produced and presented to Committee using provider counts and membership counts as of 12/31 of the measurement year.
    - Border counties include:
        - Georgia: Fannin, Rabun, Towns, Union
        - South Carolina: Cherokee, Chesterfield, Dillon, Greenville, Horry, Lancaster, Marlboro, Oconee, Pickens, Spartanburg, York
        - Tennessee: Blount, Carter, Cocke, Greene, Johnson, Monroe, Polk, Sevier, Unicoi
        - Virginia: Bristol, Brunswick, Carroll, Chesapeake City, Danville City, Emporia, Galax, Grayson, Greensville, Halifax, Henry, Martinsville, Mecklenburg, Patrick, Pittsylvania, Smyth, Southampton, Suffolk City, Virginia Beach City, Washington
- Must measure results separately for the following legal entities/products:

- Cigna HealthCare of North Carolina, Inc.
- Connecticut General Life Insurance Company, Inc. – POS
- Connecticut General Life Insurance Company, Inc. – PPO
- Cigna Health and Life Insurance Company, Inc. – POS
- Cigna Health and Life Insurance Company, Inc. PPO

- Customer driver files will be provided for the network density and driving distance analysis and such customer files will be run according to the legal entities/products above
- Must provide explanation/corrective action for any results falling below goals

- **New Hampshire**

Standards for Geographic Accessibility

- Geographic access standards shall be calculated based on population densities of persons under the age of 65. Geographic access standards shall be measured in terms of distance or travel times for a person under normal conditions from specific zip codes.
- A carrier must meet the service specific requirement by county for persons living in one of the 2 zip codes for the following counties:
  - Coos - Lancaster 03584 or Berlin 03570;
  - Carroll -Conway 03813 or Wolfeboro 03894;
  - Belknap - Laconia 03246 or Alton 03809;
  - Sullivan -Claremont 03743 or Newport 03773;
  - Strafford - Rochester 03867 or Dover 03820;
  - Cheshire -Keene 03431 or Jaffrey 03452;
  - Hillsborough -Nashua 03060 or Manchester 03103; and
  - Rockingham - Portsmouth 03801 or Derry 03038.
- A carrier must meet the service specific requirement for Merrimack County for persons living in the Concord 03301 zip code.
- A carrier must meet the service specific requirement for Grafton County for persons living in 2 of the following zip codes:
  - Littleton 03561;
  - Plymouth 03264; or
  - Lebanon 03748.
- Geographic access standards are based on the following county groupings: "URBAN", "MIDDLE", and "RURAL". Maximum travel distances or times are based on the service type, county, and specific zip code within the county as follows:
  - For URBAN counties, including Strafford, Hillsborough, and Rockingham counties:
    - 10 miles or 15 minutes driving time for core services;
    - 20 miles or 30 minutes driving time for common services; and
    - 40 miles or one hour driving time for specialized services;
  - For MIDDLE counties, including Merrimack, Belknap, Cheshire, Grafton, Carroll, and Sullivan counties:
    - 20 miles or 40 minutes driving time for core services;
    - 40 miles or 80 minutes driving time for common services; and

        - 70 miles or 2 hours driving time for specialized services; and
    - For RURAL counties, including Coos county:
        - 30 miles or one hour driving time for core services;
        - 80 miles or 2 hours driving time for common services; and
        - 125 miles or 2 1/2 hours driving time for specialized services.
- For the purposes of network adequacy review services will be classified as "Core", "Common" or "Specialized". Please refer to the attachment in CI NH: PROVIDER NETWORKS: NETWORK ADEQUACY for a listing of those services.
- All other covered services that are not listed in the attachment will be available from providers within New England.
- Prescription medications from a retail pharmacy must be available within the time and distance standards equal to those associated with the "Core" services for a specific county.

- **New Jersey**
    - 2 PCPs in 10 miles/ or 30 minutes (whichever is less) of 90% of enrollees
    - Calculate 4 PCP visits per year per member, avg. 1 hour per year per member; 4 patient visits per hour per PCP.
    - Verify PCPs are committed to a specific number of hours that cumulatively add up to projected clinic hour needs of projected number of covered persons by county or service area.
    - Specialists: 45 miles/ 1 hour of 90% enrollees
        - Cardiologist;
        - Dermatologist;
        - Endocrinologist;
        - ENT;
        - General surgeon;
        - Neurologist;
        - Obstetrician/gynecologist;
        - Oncologist;
        - Ophthalmologist;
        - Optometrist;
        - Orthopedist;
        - Oral surgeon;
        - Urologist;
    - Comprehensive rehabilitation services, Specialty out-patient centers for HIV/AIDS, sickle cell disease, hemophilia, and cranio-facial and congenital anomalies: 45 miles/ 60 minutes for 90% enrollees
    - Long-term care facility, therapeutic radiation, MRI center, diagnostic radiology, emergency, renal dialysis: 20 miles/ 30 minutes for 90% enrollees

- Contract with 1 home health agency and 1 hospice where 1,000 or more covered persons live
- Acute care hospital: 20 miles/ 30 minutes for 90% enrollees
- Hospital with perinatal services, tertiary pediatric services, and diagnostic cardiac catheterization services: 45 miles/ 60 minutes for 90% enrollees
- Surgical facilities: 20 miles/ 30 minutes for 90% enrollees
- Per feedback from state, measuring at county level

- **New Mexico**
  - If population 50K or >, 2 PCPs: 20 miles/ 20 minutes for 90% enrollees
  - If population <50K, 2 PCPs: 60 miles/ 60 minutes for 90% enrollees
  - Calculation: each enrollee 4 PCP visits annually, averaging a total of 1 hour; PCPs see 4 patients/hour.
  - No specific standards for specialists but required to have standards.
  - If population 50K or >, 1 acute hospital: 30 miles/ 30 minutes for 90% enrollees*
  - If population <50K, acute hospital: 60 miles/ 60 minutes for 90% enrollees*
  - Recognize “centers of excellence” out of state
  - Sufficient number of health professionals such as registered and licensed practical nurses, must be available to ensure delivery of covered health care services. *
  - Surgical facilities must be reasonably available, given the population of the service area and the facilities available in or around the service area. Surgical facilities may include acute care hospitals for major surgery, hospitals for minor surgical procedures, licensed ambulatory surgical facilities, and Medicare eligible surgical practices reasonably available. *
  - Tertiary and specialized services must be available as follows (Access Plan must describe geographic location of and enrollees' accessibility to the following):
    - 1 hospital providing regional perinatal services;
    - 1 hospital offering tertiary pediatric services;
    - 1 hospital offering diagnostic cardiac catheterization services;
  - Specialized services must be available as follows (Access Plan must describe geographic location of and enrollees' accessibility to the following):
    - 1 therapeutic radiation provider
    - 1 magnetic resonance imaging center;
    - 1 diagnostic radiology provider, including x-ray, ultrasound, and CAT scan; and
    - 1 licensed renal dialysis center.
  - 1 licensed home health care provider must be available if 3,000 or more enrollees live there, if home health care is provided as a supplemental health care service
  - 1 PCP per 1,500 enrollees*

- **New York**
  - At least 3 PCPs and at least 2 providers in non-PCP specialties from which enrollee may select per county. But must “account for providers in rural areas”.
  - At least one hospital in each county; however, for Bronx, Erie, Kings, Monroe, Nassau, New York, Queens, Suffolk, and Westchester counties the network should include at least 3 hospitals
  - Time and Distance Standards For Primary Care Providers:
    - 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.
- Time and Distance Standards For Providers That Are Not Primary Care Providers
  - It is preferred that an insurer meet the 30 minute or 30-mile standard for other providers that are not primary care providers.
- A stand-alone vision network should include the following provider types in each county (or expanded county area): 2 ophthalmologists, 2 optometrists, or 1 ophthalmologist and 1 optometrist
- For network adequacy purposes, a service area is defined as a county. For counties other than Bronx, Kings, New York, Queens and Richmond, the county will be "extended" to include portions of adjacent counties because of health care resources and the utilization patterns of consumers ("expanded county area"). This extension will expand the county border approximately 10 miles into contiguous counties.
- Current review standards are posted at https://www.dfs.ny.gov/apps_and_licensing/health_insurers/network_adequacy_oon_standards_guidance

- **Oklahoma**
  - PBMs must satisfy the below access requirements based on urban, suburban and rural service areas. Mail order pharmacies cannot be used to meet the access standards. Rural:
    - At least 70% of covered individuals live within 15 miles of a participating retail pharmacy
    - At least 70% of covered individuals live within 18 miles of a preferred participating retail pharmacy
  - Suburban:
    - At least 90% of covered individuals live within 5 miles of a participating retail pharmacy
    - At least 90% of covered individuals live within 7 miles of a preferred participating retail pharmacy
  - Urban:
    - At least 90% of covered individuals live within 2 miles of a participating retail pharmacy
    - At least 90% of covered individuals live within 5 miles of a preferred participating retail pharmacy
  - Each PBM licensed in the State must complete and submit to the Department, on a semi-annual basis, its Oklahoma PBM Semi-Annual Retail Pharmacy Network Access Report. Reports must be submitted electronically using the templates provided by the state. The reports are due February 15th and August 15th of each calendar year.
    - The GeoAccess report due in February of a calendar year will cover the reporting time-period of July 1 through December 31 of the immediately preceding calendar year.
    - The GeoAccess report due in August of a calendar year will cover the reporting time-period of January 1 through June 30 of the same calendar year in which the report is due.

- Note: The regulation provides for slightly earlier deadlines, but the OK Office of the Attorney General confirmed that the reports will not be due until 2/15 and 8/15 of each calendar year.

- Insurers are also required to monitor a PBM's retail pharmacy network access for compliance with the retail pharmacy network access requirements described above. Insurers are required to, on a semi-annual basis, complete and submit to the Department its network adequacy audit of the PBMs with which the insurer contracts and/or partners to serve the insurer's members within the state of Oklahoma. This report is due every April 30th and October 31st of each calendar year.
    - A health insurer's GeoAccess report due in April of a calendar year will cover the time-period of July 1 through December 31 of the immediately preceding calendar year.
    - A health insurer's GeoAccess report due in October of a calendar year will cover the reporting time-period of January 1 through June 30 of the same calendar year in which the report is due.

- **Pennsylvania**
    - Managed Care Plans (HMO/Network/POS included behavioral embedded in medical) must provide at least 90% of its enrollees in each county in its service area, access to covered services (physician and inpatient hospital) that are within 20 miles or 30 minutes travel from an enrollee's residence or work in a county designated as a metropolitan statistical area (MSA) (urban), and within 45 miles or 60 minutes travel from an enrollee's residence or work in any other county (non-urban)
    - A plan shall at all times assure enrollee access to primary care providers, specialty care providers and other health care facilities and services necessary to provide covered benefits. At a minimum, the following health care services must be available in accordance with the standards above:
        - General acute inpatient hospital services.
        - Common laboratory and diagnostic services.
        - Primary care.
        - General surgery.
        - Orthopedic surgery.
        - Obstetrical and gynecological services.
        - Ophthalmology.
        - Allergy and immunology.
        - Anesthesiology.
        - Otolaryngology.
        - Physical medicine and rehabilitation.
        - Neurology.
        - Neurological surgery.
        - Urology.

- **Rhode Island**
    - Each network plan must maintain a sufficient number of providers to provide timely access to professional, facility and other providers and that covered services for customers, including children, adults and low-income, medically underserved beneficiaries, children and adults with

serious chronic and/or complex health conditions or physical and/or mental disabilities and persons with limited English proficiency will be accessible without unreasonable delay

- Monitor the status of each network plan's network adequacy at least quarterly
- Customer has access to emergency services 24 hours a day, seven days a week

o Notify the office of the Health Insurance Commissioner at least thirty (30) calendar days prior to any substantial systemic change to any of its certified network plans. Substantial systemic change" means any modification of a health care entity's network plan's contracting, credentialing, operational policies and/or procedures relevant to these regulations adversely affecting beneficiaries, a group of providers, an entire specialty provider type, a hospital, a facility provider, or a delegate having responsibilities, or any other health care entity's modification relevant to these regulations that may impact a significant portion of its beneficiaries' access to a network provider, the availability of network providers, or the quality and continuity of care.

Regarding termination of large provider groups, hospitals that are located outside of Rhode Island:

This law is regulating an insurer's network not specifically the providers. Any network that is used for fully insured plans situsedin RI needs to be assessed for any impact to the adequacy of that network when we make any changes – such as terminations of provider groups or hospitals, regardless where those providers or hospitals are located.

If a provider group or hospital group terminates from the network, no matter what state they are in – we would need to follow these RI requirements and determine if it meets the definition of "substantial systemic change". It is does meet that definition we would need to notify the state 30 days before the termination takes affect and would need to send notices to providers and members with the required language. The biggest risk of terminations impacting the adequacy of the network would most likely be with terminations in the states surrounding/close to RI.

o **South Carolina**

- Issuers must develop and maintain an adequate network of providers to ensure access to appropriate care. This applies to any plan that either requires enrollees to use, or creates incentives to use, the plan's participating provider network. The issuer must certify annually to the department that the network continues to meet South Carolina adequacy guidelines. The HMO plan certification is due by February 1 each year.
- Minimum radius requirements:
  - One primary care physician (PCP) per 2000 members within a 30-mile radius for 95% of the population of the area to be served. If a radius map cannot demonstrate this, the Issuer may state that it generally meets this requirement, and how this was determined.
  - One contracted hospital within the county, or within a 30-mile radius of 95% of the population of the area to be served.
  - A tertiary care facility within a reasonable travel distance.

- An adequate number and type of specialists within a 50-mile radius 95% of the population of the area to be served. Mileage standards do not apply to subspecialists, the insurer should describe how it will assure access to sub-specialists.
- One OB-GYN within a 30-mile radius 95% of the population of the area to be served.
- At least one pharmacy within a 20-mile radius of all enrollees.

- **Tennessee**
  - Insurers/HMOs offering managed health care plans must have network adequacy requirements that include Primary care provider-covered person ratios; and Geographic accessibility standards.
  - PCPs: no more than 30 miles or /30 minutes
  - Inpatient Hospitals: Required; approximate 30 minutes travel time
  - Specialists: Required; no specific standard except "reasonable" distance*
  - Insurers/HMOs must file an initial network adequacy filing for their managed care plan; and then must file a standards description update annually.
  - Insurers/HMOs must file an initial network adequacy filing for their managed care plan; and then must file a standards description update annually. Material change to an approved network plan must be reported at least fifteen (15) days before such change, including each change that would result in a failure to satisfy the requirements. Upon receiving the report, the commissioner shall reevaluate the issuer's network plan for compliance with the network adequacy standards.
  - **Corrective Action**
    - If the commissioner determines that a managed health insurance issuer has not met the sufficiency standards, then the commissioner will require a modification to the network or may institute a corrective action plan to ensure access for enrollees. The commissioner may take other disciplinary action for violations as permitted.
    - The commissioner will develop an appeals procedure and forms where an enrollee of the managed health insurance issuer, contractor of a managed health insurance issuer, or a healthcare provider or facility may file a request for review of network adequacy and sufficiency of the managed health insurance issuer network. The department will complete such review within ninety (90) days of submission to the department.
  - "Material change" means a significant reduction in the number of providers available in a network plan, including, but not limited to, a reduction of ten percent (10%) or more of a specific type of provider in a geographic market, the removal of a major health system that causes a network to be significantly different from the network when the beneficiary enrolled in the network plan, or a change that would cause the network to no longer satisfy the requirements of this section or the commissioner's rules for network adequacy.

- **Texas**

  Non-HMO Requirements:

  - 90% of members have access to 2 providers within the standards and 100% o of members have access to 2 providers within the time/distance (miles) standards:

	Large Metro		Metro		Micro		Rural		CEAC	
Provider Type	**Time**	**Dist**	**Time**	**Dist**	**Time**	**Dist**	**Time**	**Dist**	**Time**	**Dist**
Physicians										

Cigna

	Large Metro		Metro		Micro		Rural		CEAC	
Allergy and Immunology	30	15	45	30	80	60	90	75	125	110
Cardiology	20	10	30	20	50	35	75	60	95	85
Cardiothoracic Surgery	30	15	60	40	100	75	110	90	145	130
Dermatology	20	10	45	30	60	45	75	60	110	100
Emergency Medicine	20	10	45	30	80	60	75	60	110	100
Endocrinology	30	15	60	40	100	75	110	90	145	130
Ear, Nose, and Throat/Otolaryngology	30	15	45	30	80	60	90	75	125	110
Gastroenterology	20	10	45	30	60	45	75	60	110	100
General Surgery	20	10	30	20	50	35	75	60	95	85
Gynecology and Obstetrics	10	5	15	10	30	20	40	30	70	60
Infectious Diseases	30	15	60	40	100	75	110	90	145	130
Nephrology	30	15	45	30	80	60	90	75	125	110
Neurology	20	10	45	30	60	45	75	60	110	100
Neurosurgery	30	15	60	40	100	75	110	90	145	130
Oncology: Medical, Surgical	20	10	45	30	60	45	75	60	110	100
Oncology: Radiation	30	15	60	40	100	75	110	90	145	130
Ophthalmology	20	10	30	20	50	35	75	60	95	85
Orthopedic Surgery	20	10	30	20	50	35	75	60	95	85
Physical Medicine and Rehabilitation	30	15	45	30	80	60	90	75	125	110
Plastic Surgery	30	15	60	40	100	75	110	90	145	130
Primary Care: Adults	10	5	15	10	30	20	40	30	70	60
Primary Care: Pediatric	10	5	15	10	30	20	40	30	70	60
Psychiatry	20	10	45	30	60	45	75	60	110	100
Pulmonology	20	10	45	30	60	45	75	60	110	100
Rheumatology	30	15	60	40	100	75	110	90	145	130
Urology	20	10	45	30	60	45	75	60	110	100
Vascular Surgery	30	15	60	40	100	75	110	90	145	130
Health Care Practitioners										
Chiropractic	30	15	45	30	80	60	90	75	125	110
Occupational Therapy	20	10	45	30	80	60	75	60	110	100
Physical Therapy	20	10	45	30	80	60	75	60	110	100
Podiatry	20	10	45	30	60	45	75	60	110	100

	Large Metro		Metro		Micro		Rural		CEAC	
Speech Therapy	20	10	45	30	80	60	75	60	110	100
Institutional Providers										
Acute Inpatient Hospitals (Emergency Services Available 24/7)	20	10	45	30	80	60	75	60	110	100
Cardiac Catheterization Services	30	15	60	40	160	120	145	120	155	140
Cardiac Surgery Program	30	15	60	40	160	120	145	120	155	140
Critical Care Services: Intensive Care Units	20	10	45	30	160	120	145	120	155	140
Diagnostic Radiology (Freestanding; Hospital Outpatient; Ambulatory Health Facilities with Diagnostic Radiology)	20	10	45	30	80	60	75	60	110	100
Inpatient or Residential Behavioral Health Facility Services	30	15	70	45	100	75	90	75	155	140
Mammography	20	10	45	30	80	60	75	60	110	100
Outpatient Infusion/Chemotherapy	20	10	45	30	80	60	75	60	110	100
Skilled Nursing Facilities	20	10	45	30	80	60	75	60	95	85
Surgical Services (Outpatient or Ambulatory Surgical Center)	20	10	45	30	80	60	75	60	110	100
Settings										
Outpatient Clinical Behavioral Health (Licensed, Accredited, or Certified)	10	5	15	10	30	20	40	30	70	60
Urgent Care	20	10	45	30	80	60	75	60	110	100

- Ensure that members have the option of facilities of pediatric, for-profit, nonprofit, and tax-supported institutions, with special consideration to contracting with teaching hospitals and hospitals that provide indigent care or care for uninsured individuals as a significant percentage of their overall patient load, and teaching facilities that specialize in providing care for rare and complex medical conditions and conducting clinical trials. This provision is not applicable to EPOs

if the plan has contracted with enough hospitals to be capable of meeting the inpatient and outpatient health care benefits for current and projected members, or has received a waiver.

- Include an adequate number of preferred provider physicians who have admitting privileges at one or more contracted hospitals to make any necessary hospital admissions within the service area.
- Contract with general, specialty, pediatric, and psychiatric hospitals.
- For any physician or specialty that is not listed out in the attached grid, the maximum distance in any county classification is 75 miles. The commissioner may change this based on supply patterns or utilization.
- Plans are required to maintain adequate number of below specialties at each hospital, ambulatory surgical center, or freestanding medical care facility that credentials these specialties to ensure appropriate access to care, including covered clinical trials:
    - emergency medicine
    - anesthesiology
    - pathology
    - radiology
    - neonatology
    - oncology (including medical, surgical, and radiation oncology)
    - surgery
    - hospitalist
    - intensivist, and
    - diagnostic services (including radiology and laboratory services)
- An insurer may apply for waiver from one or more of the network adequacy requirements. It may be granted after The Commissioner receives public testimony at a public hearing that there is good cause for the waiver. Waivers are limited to a 1 year period, and can only be leveraged twice in a row for the same standard in the same county unless the insurer can demonstrate multiple good faith attempts to bring the plan into compliance during each prior waiver period. Waivers cannot be given more than 4 times within a 21-year period for each county for issues that can be remedied through good faith efforts. The only exception to the waiver limits is if there aren't any non-contracted providers in the service area. All waiver information must be included in all promotional or advertising materials used for the plan that has been granted the waiver. Balance billing prohibitions can only be referenced in the access plan to explain how the insurer will coordinate care to limit the likelihood of balance billing, but not to justify a departure from the adequacy standards.
- Public hearings will be set by the Commissioner to determine whether a waiver should be granted if there are available uncontracted providers, or if the insurer hasn't completed a complete corrective action plan for a material deviation. The Commissioner will notify providers of the public hearing that may have been targeted through the good faith efforts. Evidence and testimony submitted by the insurer will be assessed by the Commissioner, including the total number of providers in each provider type within the county and service area and whether or not there has been a good faith effort to contract, and the total number of facilities and availability of the providers listed above in #1. Evidence can also include population density and geographical information used to determine the possibility of meeting the travel time requirements, and the

availability of services, population and density within the county and service area. Waivers may not be granted without a public hearing.

HMO Requirements:

- PCP: Non-HMO: 30 miles in non-rural areas; 60 miles in rural areas. Rural means county with less than 50,000 or areas designated by the Commissioner.
- SCP and other facilities: 75 miles
- General Acute hospital: Non-HMO: 30 miles in non-rural areas; 60 miles in rural areas. Rural means county with < 50,000 or areas designated by the Commissioner. HMO: 30 miles in all areas.
- Specialty or psychiatric hospital: 75 miles
- Network adequacy must be assessed using TX's standards via Annual Report to TX to identify and address gaps. Due 4/1 for non-HMO and 8/15 for HMO networks.
- The Commissioner will conduct an examination of network adequacy for PPO and EPO products every 3 years - or when they believe it is necessary.

- **Vermont**
  - PCP: 30 minutes
  - Outpatient physician specialty care, inpatient, imaging, Laboratory, x-ray, pharmacy, general optometry, MRI, inpatient medical rehabilitation: 60 minutes
  - Cardiac catheterization, major trauma treatment, neonatal intensive care, tertiary-level cardiac services and open-heart surgery services: 90 minutes
  - Other specialty hospital services, including major burn care, organ transplantation and specialty pediatric care: "reasonable accessibility"
  - Recognize centers of excellence outside of state
  - The commissioner shall grant an exception to the requirements of this section if the managed care organization can demonstrate with specific data that the requirement of travel time standards and waiting time standards are not feasible in a particular service area or part of a service area.
  - An annual report of network adequacy with respect to travel times from residence or place of business is required.

- **Washington**
  - The following criteria will be used to assess whether an insurer meets network adequacy requirements:
    - The number of customers within each service area living in certain types of institutions or who have chronic, severe, disabling medical conditions, as determined by the population the insurer is covering and the benefits provided;
  - For primary care providers the following must be demonstrated:
    - The ratio of primary care providers to customers within the insurer's service area as a whole meet or exceeds the average ratio for Washington state for the prior plan year;
    - The network includes such numbers and distribution that 80% (eighty percent) of customers within the service area are within 30 (thirty) miles of a sufficient number of primary care providers in an urban area and within 60 (sixty) miles of a sufficient number of primary care providers in a rural area from either their residence or work; and

- Each issuer must ensure at all times that there are a sufficient number of pediatricians in the service area accepting new patients to accommodate new enrollees if the plan is open to new enrollment, and to ensure that existing enrolled children have the ability to change pediatricians. *

- For specialty care providers the following must be demonstrated:
  - The network includes such numbers and distribution that 80% (eighty percent) of customers within the service area are within 30 (thirty) miles of a sufficient number of specialty care providers in an urban area and within 60 (sixty) miles of a sufficient number of specialty care providers in a rural area from either their residence or work; and
- Indian Health Care Provider Requirements
  - To provide adequate choice to customers who are American Indians/Alaska Natives, each health insurer must maintain arrangements that ensure that American Indians/ Alaska Natives who are customers have access to covered medical health services provided by Indian health care providers.

- An issuer of a health plan must maintain and monitor, on an ongoing basis, the ability and clinical capacity of its network providers and facilities to furnish covered health plan services to enrollees. An issuer must notify the commissioner in writing within fifteen days of a change in its network as described below:
  - A reduction, by termination or otherwise, of ten percent or more in the number of either specialty providers, or facilities participating in the network;
  - The initial time frame for measuring this reduction is from the network's initial approval date until the January 1st following the initial approval date.
  - After the January 1st following the network's initial approval date, the time frame for measuring this reduction is from January 1st to the following January 1st.
  - Termination or reduction of a specific type of specialty provider on the American Board of Medical Specialties list of specialty and subspecialty certificates, where there are fewer than two of the specialists in a service area;
  - An increase or reduction of twenty-five percent or more in the number of enrollees in the service area since the annual approval date;
  - A reduction of five percent or more in the number of primary care providers in the service area who are accepting new patients;
  - The termination or expiration of a contract with a hospital or any associated hospital-based medical group within a service area;
  - A fifteen percent reduction in the number of providers or facilities for a specific chronic condition or disease participating in the network where the chronic condition or disease affects more than five percent of the issuer's enrollees in the service area. For purposes of monitoring, chronic illnesses are those conditions identified (or recognized) by the Centers for Medicare and Medicaid Services within the most current version of the Centers for Medicare and Medicaid Chronic Conditions Data Warehouse data base available on the CMS.gov web site; or
  - Written notice to the commissioner must include the issuer's preliminary determination whether the identified changes in the network require an alternate access delivery request.
- Effective 01/01/2020, when determining the adequacy of a proposed provider network, or the ongoing adequacy of an in-force provider network, the commissioner will consider whether it includes a sufficient number of contracted providers of emergency and surgical or ancillary

services at the carrier's contracted in-network hospitals or ambulatory surgical facilities, to reasonably ensure enrollees have in-network access to covered benefits delivered there.

- **West Virgina**
  - A health carrier providing a network plan must maintain a network that is sufficient in numbers and appropriate types of providers, including those that service predominantly low-income, medically underserved individuals, to assure that all covered services to covered persons, including children and adults, will be accessible without unreasonable travel or delay.
  - Customers must have access to emergency services 24 hours per day, seven days per week.
  - The Commissioner will publish a notice with the county designation of each West Virginia county by July 1st of each year or as soon as that information becomes available from CMS.
  - At least 90 percent of a health carries members must live within the maximum distance to at least one provider of each type to satisfy geographic accessibility network adequacy standards.

  - **Effective 01.01.2025, the Time and Distance Standards include:**

West Virginia Time AND Distance requirements - Eff 1/1/2025

90% of Cigna customers

Individual Provider Specialty Types	Maximum Time and Distance Standards									
	Large Metro County		Metro County		Micro County		Rural County		Counties w/Extreme Access Considerations	
	Time	Distance	Time	Distance	Time	Distance	Time	Distance	Time	Distance
Allergy and Immunology	30	15	45	30	80	60	90	75	125	110
Cardiology	20	10	30	20	50	35	75	60	95	85
Cardiothoracic Surgery	30	15	60	40	100	75	110	90	145	130
Chiropractor	30	15	45	30	80	60	90	75	125	110
Dermatology	20	10	45	30	60	45	75	60	110	100
Emergency Medicine	20	10	45	30	80	60	75	60	110	100
Endocrinology	30	15	60	40	100	75	110	90	145	130
ENT/Otolaryngology	30	15	45	30	80	60	90	75	125	110
Gastroenterology	20	10	45	30	60	45	75	60	110	100
General Surgery	20	10	30	20	50	35	75	60	95	85
Gynecology, OG/GYN	10	5	15	10	30	20	40	30	70	60
Infectious Disease	30	15	60	40	100	75	110	90	145	130
Nephrology	30	15	45	30	80	60	90	75	125	110

Neurology		20	10	45	30	60	45	75	60	110	100
Neurosurgery		30	15	60	40	100	75	110	90	145	130
Occupational Therapy		20	10	45	30	80	60	75	60	110	100
Oncology-Medical, Surgical		20	10	45	30	60	45	75	60	110	100
Oncology-Radiation		30	15	60	40	100	75	110	90	145	130
Ophthalmology		20	10	30	20	50	35	75	60	95	85
Orthopedic Surgery		20	10	30	20	50	35	75	60	95	85
Physical Medicine and Rehabilitation		30	15	45	30	80	60	90	75	125	110
Physical Therapy		20	10	45	30	80	60	75	60	110	100
Plastic Surgery		30	15	60	40	100	75	110	90	145	130
Podiatry		20	10	45	30	60	45	75	60	110	100
Primary Care - Adult		10	5	15	10	30	20	40	30	70	60
Includes	General Practice										
	Geriatrics										
	Internal Medicine										
	Family Medicine										
	Primary Care - Advanced Registered Nurse Practitioner										
Primary Care - Pediatric		10	5	15	10	30	20	40	30	70	60
Pulmonology		20	10	45	30	60	45	75	60	110	100
Rheumatology		30	15	60	40	100	75	110	90	145	130
Speech Therapy		20	10	45	30	80	60	75	60	110	100
Urology		20	10	45	30	60	45	75	60	110	100
Vascular Surgery		30	15	60	40	100	75	110	90	145	130

Facility Specialty Types	**Maximum Time and Distance Standards**									
	Large Metro County		**Metro County**		**Micro County**		**Rural County**		**Counties w/Extreme Access Considerations**	
	Time	**Distance**	**Time**	**Distance**	**Time**	**Distance**	**Time**	**Distance**	**Time**	**Distance**

Acute Inpatient Hospital (must have emergency services available 24/7)	20	10	45	30	80	60	75	60	110	100
Cardiac Catheterization Services	30	15	60	40	160	120	145	120	155	140
Cardiac Surgery Program	30	15	60	40	160	120	145	120	155	140
Critical Care Services-Intensive Care Units (ICU)	20	10	45	30	160	120	145	120	155	140
Diagnostic Radiology (Free-standing, Hospital outpatient, ambulatory health facilities with Diagnostic Radiology)	20	10	45	30	80	60	75	60	110	100
Mammography	20	10	45	30	80	60	75	60	110	100
Outpatient Infusion/Chemotherapy	20	10	45	30	80	60	75	60	110	100
Skilled Nursing Facilities	20	10	45	30	80	60	75	60	95	85
Surgical Services (outpatient or ASC)	20	10	45	30	80	60	75	60	110	100
Urgent Care	20	10	45	30	80	60	75	60	110	100

Material Change:

The health carrier must notify the commissioner of any material change to any existing network plan within 15 business days after the change occurs. The carrier must include in the notice to the commissioner a reasonable timeframe when the carrier will submit the access plan to the commissioner for approval or file with the commissioner, as appropriate, an update to an existing access plan.

"material change" means changes to the health carrier's network of providers or type of providers available in the network to provide health services or specialty health care services to covered persons that may render the carrier's network non-compliant with one or more network adequacy standards. Types of changes that would be considered material include:

a) a significant reduction in the number of primary or specialty care physicians available in a network;

b) a reduction in a specific type of provider such that a specific covered service is no longer available;

c) a change to a tiered, multi-tiered, layered or multi-level network plan structure; and

d) a change in inclusion of a major health system that causes the network to be significantly different from what the covered person initially purchased

States with Requirements that are Less Stringent than Cigna Standard:

- **Florida - Applicable to Network [FlexCare EPP] Only**
  - Geographic availability of exclusive providers must reflect the usual travel times within the community. The number of exclusive providers in the service area is sufficient, with respect to current and expected policyholders, to deliver adequately all services or to make referrals
- **Hawaii**
  - On or before Jan. 1 of each year each managed care plan shall file a report to demonstrate the adequacy of its network to the insurance commissioner.
  - A provider network shall be considered adequate if it provides access to sufficient numbers and types of providers to ensure that all covered services will be accessible without unreasonable delay, after taking into consideration geography. The commissioner shall also consider any applicable federal standards on network adequacy. A certification from a national accreditation organization shall create a rebuttable presumption that the network of a managed care plan is adequate.
- **Indiana – HMO only**
  - HMOs in Indiana must demonstrate to the Commissioner that the HMO has developed an access plan to meet the needs of the HMO's enrollees. This includes vulnerable and underserved enrollees as well as enrollees from major population groups who speak a primary language other than English.
- **Kansas**
  - Carriers are required to maintain a provider network that is sufficient in numbers and types of providers to assure that all covered services will be accessible without unreasonable delay. Sufficiency may be established by reference to any reasonable criteria used by the carrier, including but not limited to: (1) provider-enrollee ratios by specialty; (2) PCP-enrollee ratios; (3) geographic accessibility; (4) waiting times for appointments with participating providers; (5) hours of operation; and (6) the availability of technological and specialty services to serve the needs of enrollees requiring technologically advanced or specialty care.
- **Louisiana**
  - Insurers shall maintain a network that is sufficient in numbers and types of health care providers to ensure that all health care services to covered persons will be accessible without unreasonable delay. Specific requirements include:
    - Ratios of health care providers to covered persons by specialty, ratios of primary care providers to covered persons, geographic accessibility, and volume of technological and specialty services available to serve the needs of covered persons requiring technologically advanced or specialty care.

- Insurer shall establish and maintain adequate arrangements to ensure reasonable proximity of participating providers to the primary residences of covered persons.
- Insurer shall annually file with the commissioner of insurance, an access plan for each of the health benefit plans that the health insurance issuer offers in this state. In lieu of meeting the filing requirements, a health insurance issuer shall submit proof of accreditation from the National Committee for Quality Assurance (NCQA) or American Accreditation Healthcare Commission, Inc./URAC to the commissioner, including an affidavit and sufficient proof demonstrating its accreditation for compliance with the network adequacy requirements.
- A health insurance issuer shall file any proposed material changes to the access plan with the commissioner prior to implementation of any such changes.
- Additionally, a health insurance issuer shall inform the commissioner if the health insurance issuer enters a new service or market area and shall submit an updated access plan demonstrating that the health insurance issuer's network in the new service or market area is adequate and consistent with the network adequacy requirements.

- **Maine**
  - Must analyze performance against the standards at least annually using methodology selected that allows direct measurement against standards for PCPs, and SCPs
  - Must report annually to the state on March 1st an access plan which includes network adequacy standards. Additionally, if a carrier loses 5 or more PCPs in any county in any 30-day period, it must be reported to the Maine regulators within 10 days.
  - 1 PCP per 2,000 enrollees, including general and internal medicine, family practice, and pediatrics. *
  - Specialty Care. To ensure reasonable access to specialty care practitioners within its delivery system, the carrier shall: *
    - Define the types of practitioners who serve as high-volume specialty care practitioners. At a minimum, high-volume specialties shall include obstetrics/gynecology, cardiology, dermatology, ophthalmology, orthopedic surgery, gastroenterology, and other specialties that the carrier determines to be high-volume.
    - Establish quantifiable and measurable standards for the number and geographic distribution of each type of high-volume specialty care practitioner.
  - A carrier must provide a reasonably adequate retail pharmacy network for the provision of prescription drugs for its covered persons. A mail order pharmacy may not be included in determining the adequacy of a retail pharmacy network.

- **Massachusetts**
  - Must file with the Commissioner an access analysis for each plan biennially by July 1st. Must also prepare an access analysis prior to offering a plan that includes a Provider Network and must update an existing access analysis whenever the Carrier makes any Material Change to an existing plan. The access plan shall describe or contain at least the following:
    - A summary of Network adequacy standards;
    - The process for monitoring and assuring on an ongoing basis the sufficiency of the Network(s);

- A report developed using a Network accessibility analysis system such as GeoNetworks, which shall include the following, or, for Carriers in a new geographic area(s) or an area(s) that does not currently have Insureds, estimates for the following, as applicable;
    - Maps showing the residential location of Insureds in Massachusetts, Primary Care Providers for both adults and children, specialty care practitioners, and institutional Providers;
    - Network adequacy standards;
    - Geographic access tables illustrating the geographic relationship between Providers and Insureds, or for proposed plans or Service Areas, the population according to the Carrier's standards for every city and town, including at a minimum the percentage of Insureds meeting the Carrier's standard(s) for access through its Network to 1) Primary Care Providers, 2) specialty care Health Care Professionals, 3) inpatient acute tertiary care.

- **Mississippi**
    - Insurers and HMOs offering managed care plans in the state of Mississippi must obtain certification as a managed care plan. Such certification must be renewed annually. One of the components of the requirements is that the managed care plan demonstrates that its provider network has providers of sufficient number throughout the service area to assure reasonable access to care with minimum inconvenience by plan enrollees and without unreasonable delay.
    - Health Maintenance Organization Network Adequacy Requirements (applicable only to HMO, POS)
        - Modifications or amendments to the above should be filed with the Commissioner but shall be deemed approved unless disapproved within 30 days.
        - To determine sufficiency, health carriers may use reasonable criteria, including but not limited to:
            - Provider-covered person ratios by specialty
            - Primary care provider-covered person ratios
            - Geographic Accessibility
            - Volume of technological and specialty services available to serve the needs of covered persons requiring technologically advanced or specialty care

- **Nebraska**
    - A carrier must prepare a new access plan prior to offering a new managed care plan. Additionally, carriers must update existing access plans whenever material changes are made (note: material change is not defined).
    - Health carriers must maintain a sufficient network. Sufficiency will be determined by reasonable criteria used by the health carrier, including, but not limited to:
        - provider-covered person ratios by specialty;
        - primary care provider-covered person ratios;
        - geographic accessibility;
        - the volume of technological and specialty services available to serve the needs of covered persons requiring technologically advanced or specialty care.

- **South Dakota**

- Must maintain a network that is sufficient in numbers and types of providers to assure accessibility of all covered services without unreasonable delay. Access to emergency services must be provided 24 hours a day, 7 days a week to treat emergency medical conditions that require immediate medical attention.
- Criteria used by the carrier may include:
  - Provider-covered person ratios by specialty;
  - Primary care provider-covered person ratios;
  - Geographic accessibility;
  - The volume of technological and specialty services available to service the needs of covered persons requiring technologically advanced or specialty care.
- Health carriers must file with the Director an Access Plan for each managed care plan offered in the state of South Dakota. Access Plans must be filed prior to offering a new managed care plan; and annual updates must be filed for each existing Access Plan.
- Must have a process for monitoring and assuring on an ongoing basis the sufficiency of the network to meet the health care needs of populations that enroll in managed care plans.

- **Virginia**
  - Managed Care Health Insurance Plans (MCHIPs) in the state of Virginia must provide a sufficient number and mix of services, specialists and practice sites to meet covered persons' health care needs, including providers serving high risk populations or those specializing in the treatment of costly conditions. Network adequacy criteria include travel times as well as appointment times.
  - MCHIPs must set reasonable and adequate standards for the number and geographic distribution of all providers. Standards must address acceptable average travel times or distance to:
    - the nearest primary care delivery site;
    - the nearest specialty care site; or
    - the nearest institutional service site (acute care hospitals, surgical facilities including tertiary care or other specialty hospitals, licensed outpatient surgical hospitals, psychiatric inpatient facilities);
    - for covered persons in the service area. The standards must be realistic for the community served, the delivery system utilized and clinical safety.
  - At least annually, an MCHIP must collect and analyze data to measure performance against the standards developed for geographic accessibility. The analysis must be used to identify opportunities for improvement and the MCHIP must undertake interventions to improve performance. The effectiveness of any interventions implemented must also be measured against the standards.

- **Wisconsin**
  - Health carriers in the state of Wisconsin that offer defined network plans must provide covered benefits by plan providers with reasonable promptness with respect to geographic location. Geographic availability shall reflect the usual medical travel times within the community.
  - Carriers must develop an Access Plan to meet the needs of enrollees who are members of underserved populations. If a significant number of enrollees of the plan customarily use languages other than English, the defined network plan must provide access to translation services fluent in those language to the greatest extent possible.

- Carriers should ensure that an enrollee has adequate choice among participating providers and that the providers are accessible and qualified. Defined network plans must have sufficient number and type of providers to adequately deliver all continued services based on the demographics and health status of current and expected enrollees under the plan. Preferred provider plans must also have a sufficient number and type of participating providers to adequately deliver all covered services, including at least one primary care provider and a participating OB/GYN accepting new enrollees.
- Carriers must file an annual certification with the commissioner by August 1 of each year certifying compliance with Wisconsin's access standards for the previous year. The certification must be submitted on the state-prescribed form and signed by an officer of the company. See the attachment below for a sample certification form, which may also be found on the Wisconsin OCI website at http://oci.wi.gov/ociforms/26-110.pdf

Attachment B – State Mandates for Additional Primary Care Provider Types

State mandates state that the following Health Care Professionals may provide primary care services to Cigna Contract customers in accordance with Cigna Program Requirements in the states listed below:

- **Obstetricians and Gynecologists:** California, Delaware, Idaho, Illinois, Indiana, Maine, Maryland, Minnesota, Missouri, Nebraska, New Jersey, New Mexico, Oregon, Utah, West Virginia, Wyoming
- **Nurse Practitioners**: Arizona, California, Colorado, Connecticut, Delaware, Florida, Hawaii, Iowa, Louisiana, Maine, Maryland, Massachusetts, Minnesota, New Hampshire, New Jersey, New Mexico, New York, Oregon (if specializes in Women's Health), Rhode Island, Tennessee, Texas, West Virginia, Wyoming
- **Physician Assistants**: Arizona, California, Colorado, Delaware, Florida, Hawaii, Iowa, Louisiana, Maine, Massachusetts, Minnesota, New Jersey, New Mexico, New York, Oregon (if specializes in Women's Health), Rhode Island, Tennessee, Texas, Vermont, Wyoming
- **Certified Nurse Midwives**: Arizona, Florida, Hawaii, Iowa, Louisiana, Maryland, New Jersey, New Mexico, New York, Oregon (if specializes in Women's Health), Rhode Island, Texas, West Virginia
- **Naturopaths**: New Hampshire, Oregon (if specializes in Women's Health), Vermont
- **Chiropractors**: Illinois