Michigan Network Adequacy Guidance
I. Overview

The Michigan Department of Insurance and Financial Services (DIFS) publishes this document as guidance on its healthcare provider network adequacy minimum standards and general requirements.


Michigan insurance statutes require the filing and approval of insurance rates and forms, network, and service area filings prior to dissemination and use. Existing law requires issuers to submit all filings through the National Association of Insurance Commissioners (NAIC) System for Electronic Rates and Forms Filing (SERFF). Network and service area approval must be issued from DIFS through SERFF before an issuer may offer/market its network products or plans.

DIFS has adopted the same adequacy standards for issuer networks and service areas regardless market participation.

II. Federal & State Authority

A. Federal

45 CFR Parts 146, 147, 155, 156

B. State

MCL 500.3428, 3476
MCL 500.3509, 3513, 3528, 3529, 3530, 3531
MCL 550.1501c

III. Service Area

Consistent with 45 C.F.R. § 155.1055(a), DIFS considers the service area of a plan to be the county or set of counties (or partial counties) in which covered health services are generally available and readily accessible to members and where health issuers are approved to market their contracts. The service area of a Qualified Health Plan (QHP)\(^1\) must be established without regard to racial, ethnic, language, or health status-related factors as specified under § 2705(a)

\(^1\) The ACA defines a QHP an insurance plan that is certified by the Health Insurance Marketplace/Exchange, provides essential health benefits, follows established limits on cost-sharing, and meets other requirements outlined in the application process.
of the Public Health Service (PHS) Act, or other factors that exclude specific high utilizing, high cost or medically-underserved populations. DIFS applies the same criteria to the service areas of non-QHPs.

In Michigan, there are 83 counties consisting of a varied number of townships and cities. Each county has an associated designation of either rural, micropolitan, or metropolitan. This designation is determined by the United States Office of Management and Budget as reported by the U.S. Census Bureau. See Appendix B.

In conducting service area reviews, DIFS considers the county designation, relative availability of providers, enrollment projections, and whether DIFS’ 30-minute travel standard can be met with or without exceptions. (See Michigan Service Area Maps.) Issuers must request approval by service area/county to market products/plans to provide covered health care services to potential members.

DIFS grants service area approval by county based upon the sufficiency of the associated contracted provider network. DIFS may grant full approval of an entire county or partial approval specifying in which township(s) and/or city(ies) an issuer may market its product(s).

Partial service areas are not permitted for stand-alone dental plans (SADPs).

Issuers are prohibited from marketing network products in any service area not approved by DIFS.

IV. Commercial Network Standards & Requirements

A. Commercial Network Standards

All issuers are responsible for complying with applicable state and federal standards.

DIFS distinguishes network providers as those credentialed and either employed by or having executed contracts (signed by all parties), or participating provider agreements, with the issuer. Issuers must submit detailed network provider data to DIFS only for providers that meet this criteria.

Issuers’ contracted provider networks must:
1. Provide access to covered health care and services assuring continuity and quality.
2. Provide, within the geographic area served by the issuer’s network, covered health services that are available, accessible, and provided as promptly as appropriate to members assuring continuity, availability, and accessibility to members 24 hours a day and 7 days a week for the treatment of emergency illness or injury.
3. Reasonable provisions for members to obtain emergency health services both in and outside the service area.
4. Maintain provider network(s) sufficient in numbers and types of providers, including providers specializing in mental health and substance use disorder services, to ensure all services are available and accessible without unreasonable delay.
5. Ensure reasonable proximity of participating providers to the business or personal residence of members.
6. When the number and/or type of participating providers is insufficient, ensure members obtain covered benefits at no greater cost than if the benefit were obtained from in-network provider(s).

7. Include sufficient numbers and types of providers that offer Essential Health Benefits (EHB).

8. Include sufficient numbers and geographic distribution of Essential Community Providers (ECPs), where available, to ensure reasonable and timely access to a broad range of providers for low income and medically underserved individuals (45 CRF 156.235)
   a. ECP network concentration must meet all Center for Consumer Information and Insurance Oversight (CCIIO), Centers for Medicare & Medicaid Services (CMS) ECP rulemaking standards.

9. Operate in a manner that provides members with continuity of care in accordance with applicable federal and state regulations and laws.

10. Include providers for Telehealth or Telemedicine

i. **Provider Directory**

Issuers must maintain provider directories:
   a. Accessible by a clearly identifiable link or tab and without creating an account or entering a policy number
   b. Updated at least monthly for accuracy
   c. Including the following:
      i. Whether provider accepts new patients
      ii. Provider type
      iii. Specialty/sub-specialty/ies
      iv. Location(s)
      v. Contact information
      vi. Any accommodations for individuals with limited English proficiency and people with disabilities
      vii. Clearly identifiable plan(s) and provider network(s) associated with each provider
      viii. Hospitals where network physicians have admitting privileges
   d. **Excluding** providers that:
      i. are not licensed, when required in Michigan
      ii. have a license that is not active (lapsed, revoked, suspended, voluntarily surrendered or terminated),
      iii. have been sanctioned or prohibited from participation in federal health care programs under either Section 1128 or Section 1128A of the Social Security Act
      iv. are retired or deceased
      v. no longer offer health care services

ii. **Tiered Networks**

Network adequacy standards apply to the lowest cost-sharing tier of any tiered network. The use of tiered provider networks must ensure that members of all ages have access to all covered services, including specialty services, without additional cost sharing or administrative burdens. Tiered networks must not be designed solely on the basis of cost nor impede the provision of timely and high-quality care.
For multiple network tiers of in-network providers (i.e. an in-network tier of preferred providers with more generous cost-sharing to members than a separate in-network tier of participating providers), tiering should be:

- Based on reasonable factors such as quality, performance, and market standards,
- Determined in accordance with the rules for non-quantitative treatment limitations at 45 CFR §146.136(c)(4)(i),
- Without regard to whether a provider is a mental health (MH) or substance use disorder (SUD) or a medical/surgical (M/S) provider, and
- Derived using methodology for MH/SUD network tiers that are comparable to and applied no more stringently than methodology used for M/S network tiers.

**B. Commercial Network Requirements**

All issuers are responsible for complying with applicable state and federal requirements.

Each designated provider network must include a sufficient number and type of providers, including providers specializing in mental health and substance use disorder services to ensure covered services are available and accessible to members without unreasonable delay. This includes geographic accessibility (meeting time/distance standards) in relation to where members live or work and accessibility for persons with disabilities or limited English proficiency.

Additionally, 45 CFR §156.235 establishes requirements for inclusion of ECPs in issuer networks offered On Marketplace. ECPs predominantly serve low-income and medically underserved individuals. ECPs are defined in section 340B(a)(4) of the Public Health Service Act; and 1927(c)(1)(D)(i)(IV) of the Social Security Act. ECPs are provider organizations that by legal obligation, organizational mission, or geographic location serve a patient population that has been at risk for inadequate access to care. See CMS’s Application Materials, ECP and Network Adequacy.

Issuers must identify all networks on all applicable templates and supporting documentation. Issuers are prohibited from offering any network identified in member coverage materials but not included on the Plans and Benefits (PBT), Network ID, ECP/Network Adequacy, and the Michigan Network Data Templates, Network Adequacy Checklists, and Network Submission Summary, as applicable.

To ensure DIFS’ ability to accurately evaluate networks, issuers are required to identify all networks on the Checklist for Individual and Small Group Medical Plans - Network Adequacy (FIS 2313 and 2314). Additional provider network information should be included in the Network Submission Summary under Supporting Documentation in SERFF to further detail network configurations.

For tiered networks, issuers must clearly:

1. identify tiers
2. explain basis for tiering (performance, quality, cost)
3. associate providers with respective tier(s) in which provider participates
4. illustrate member access and cost-sharing relative to utilization of providers in each tier
State and federal template and documentation requirements for issuers depend on whether issuer seeks:

- Certification of Individual or Small Group QHPs or Stand-Alone Dental Plans (SADPs)
- To market Individual or Small Group QHPs or SADPs On, On/Off Marketplace, or Off Marketplace only
- A Service Area Expansion as an HMO for Large Group or as an AFDS

Issuers seeking certification of QHPs and SADPs must submit required templates and documentation during the annual submission period. Service Area Expansion filings for HMO Large Group and AFDS may be submitted at any time.

i. Required Templates & Documentation

a. QHP On & On/Off Marketplace

**FEDERAL TEMPLATES**
- Plans and Benefits Template
- Network ID Template
- Service Area Template
- ECP/Network Adequacy Template (ECP section only)

**SUPPORTING DOCUMENTATION**

**State**
- Michigan Network Data Template (FIS 2273)
- Checklist for Individual and Small Group MEDICAL Plans – NETWORK ADEQUACY (FIS 2313)
- Network Attestation
- Network Coverage Attestation
- Network Submission Summary

**Federal**
- State Partnership Exchange Issuer Program Attestation Response Form
- ECP Analysis
- Patient Safety Attestation

b. QHP Off Marketplace Only

**FEDERAL TEMPLATES**
- Plans and Benefits Template
- Network ID Template
- Service Area Template

**SUPPORTING DOCUMENTATION**

**State**
- Michigan Network Data Template (FIS 2273)
- Checklist for Individual and Small Group MEDICAL Plans – NETWORK ADEQUACY (FIS 2313)
- Network Attestation
- Network Coverage Attestation
- Network Submission Summary
c. Service Area Expansions (HMO Large Group & AFDS)

SUPPORTING DOCUMENTATION

- Michigan Network Data Template
- Network Attestation
- Network Coverage Attestation
- Network Submission Summary
- First and last (signature) pages (including applicable amendments) of executed affiliated hospital provider contract(s)
- Financial review information

ii. Detail of Required Template & Documentation

State of Michigan required template and documentation must be submitted under Supporting Documentation in SERFF

**Michigan Network Data Template (FIS-2273):** DIFS' intake form (Excel workbook comprised of 2 worksheets) used to collect detailed contracted network provider data, including:

1. Request Summary Worksheet
   - A. HIOS Issuer ID (if applicable)
   - B. Issuer (Carrier) Legal Name
   - C. Requested County/Service Area
   - D. County Designation
   - E. Whether seeking full or partial county approval
     - i. If partial, identification of townships and cities
   - F. Plan Type (HMO, PPO, POS, EPO)
   - G. Network Product (On Marketplace, Off Marketplace, Both, Commercial)
   - H. [Plan ID is no longer collected here]
   - I. Network ID
   - J. Network Provider Directory URL
   - K. 3-year enrollment projections

2. Network Data Worksheet
   - A. HIOS Issuer ID (if applicable)
   - B. Issuer (Carrier) Legal Name
   - C. Carrier (Issuer) Legal Name
   - D. Provider location (by Michigan county, mail, mobile, or out-of-state)
   - E. Network identification (ID)
   - F. [National Provider Identification (NPI) is no longer collected here]
   - G. Provider Name
   - H. Provider Type
   - I. Provider Sub-specialty/ies (up to 3)
   - J. Provider Address (physical address)
   - K. Hospital Admitting Privileges (PCPs and Specialists/Physicians)
   - L. Whether provider is accepting new patients (PCPs, Specialists, Dental)
   - M. [Whether provider is an ECP and if so, ECP Category is no longer collected here]

See Michigan Network Data Template Instructions.
Checklist for Individual and Small Group Medical Plans - Network Adequacy (FIS 2313):
Required to be completed and submitted in SERFF in Supporting Documentation to assist
issuer in binder submission and DIFS’ review of health care provider networks. It is not
intended to be an all-inclusive listing of requirements.

This checklist is unique to DIFS for issuers seeking certification or recertification of
QHPs/SADPs. It is not required for Service Area Expansion filings.

**Network Attestation:** A written verification from issuer’s authorized representative that all
providers included on the Michigan Network Data Template are currently employed by or have
executed contracts or agreements (signed by both parties) as participating providers with issuer
as of the date of submission and have met all credentialing requirements.

**Network Coverage Attestation:** A written verification from issuer’s authorized representative
that if there is an insufficient number or type of participating providers in issuer’s contracted
provider network to provide a covered benefit, issuer ensures that the member will obtain the
covered benefit in a timely manner, geographically accessible, and at no greater cost than if the
benefit were obtained from an in-network provider.

**Network Submission Summary:** All issuers must submit a narrative in SERFF under
Supporting Documentation to provide DIFS with greater clarity of the submission for network
and service area approval. Recommended to include in the summary, as appropriate:
1. Description of creation of provider network(s)
2. Provider network design(s) and any limitations
3. Whether issuer conducts provider negotiations and manages its own network or
leases a network
4. Any criterion for provider selection
5. Any quantitative and qualitative standards issuer used to determine network
sufficiency and how issuer measures such standards
6. Documentation of issuer’s provider access–related policies and procedures (e.g., out-
of-network referral procedures, network design methodology, telemedicine/ telehealth
policies)
7. Explanation of any unique circumstances
   a. Changes in composition of network from any prior request for approval (e.g.
gain/loss of providers/provider contracts such as hospitals, provider groups, or
   clinic systems)
8. Specific descriptions of any telemedicine or telehealth provider services
   a. any services exclusively provided by either telemedicine or telehealth
   b. how issuer defines
9. Identification and explanation of any provider type and/or sub-specialty for which
issuer is unable to secure contract(s) including:
   a. Whether sufficient qualified providers are available in the county
   b. Whether any active outreach and provider contracting efforts have been made
and results (e.g., rural counties or when specialty is limited in number and/or
issues related to unsuccessful contract negotiations with local provider(s))
   c. Provider does not meet issuer’s credentialing requirements
   d. Explain steps issuer has taken to ensure members’ access to provider
10. If requesting approval for partial county/ies:
   a. Demonstrate why serving a geographic area less than the entire county is
necessary, nondiscriminatory, and in the best interest of members
b. Identify differences/similarities between excluded and included portions of service area
11. Note any reliance on providers located in adjacent or auxiliary counties to augment network providers in the requested county/ies

Financial Review Information: Required for HMO Large Group and AFDS Service Area Expansion SERFF filings only; Not required for QHPs or SADPs. Issuers must submit:
- Two-years’ financial projections
  - Balance sheet
  - Income statement
  - Cash flow
  - Risk-based capital (RBC) level
- 3-Years’ Enrollment Projections

Federal Templates must be completed and validated according to CMS’ QHP Application Issuer Application Instructions and submitted in SERFF Plan Management Binder under Templates.

Plans and Benefits Template: Connects network(s) and service area(s) with plan variation information, covered benefits, and cost-sharing.

Network ID Template: Identifies number of issuer’s proposed network(s), network name, and identification number.

This template must be completed before the ECP/Network Adequacy Template as the ECP template requires the import of the Network ID.

Service Area Template: Identifies issuer’s requested service area(s) for plans it intends to market by name, identification number and the counties each service area is comprised.

Essential Community Provider (ECP)/Network Adequacy Template: The ECP section of this template collects information demonstrating whether issuer’s network(s) meets either the General or Alternate ECP Standard as required by CMS’ for a sufficient number and geographic distribution of ECPs within each service area, where available.

Please note:
- a. The Network ID Template must be completed first and then imported into the ECP/Network Adequacy Template.
- b. Complete ONLY the ECP section of this template. See Instructions for the ECP/Network Adequacy Template.
- c. DO NOT complete the Network Adequacy section or select Create Individual; Facility, Pharmacy, Non-MD/DO tabs
- d. Validate template and save before submitting in SERFF under Templates

Federal documentation must be submitted in SERFF Plan Management Binder under Supporting Documentation.

State Partnership Exchange Issuer Program Attestation Response Form: Issuers must agree to adhere to all certification standards and operational applicable requirements in 45 CFR Parts 146, 147, 153, 155, and 156.
ECP Analysis: QHP Issuers must submit the results of the ECP Tool which determines whether the ECP standards are met.

Patient Safety Attestation: QHP Issuers that contract with hospitals, as defined by the Social Security Act in section 1861(e), with more than 50 beds must comply with 45 CFR 156.1110. Issuers must include in their Binder submission, under the Supporting Documentation tab, an attestation to verify issuer is compliant with the Patient Safety Standards in accordance with this section.

V. Evaluation Factors

When evaluating networks for adequacy, DIFS considers factors that contribute to, affect, or influence an issuer’s ability to provide an adequate network, including the following:

1. Anticipated enrollment
2. 30-minute travel standard
3. Hospital coverage (See DIFS’ Network Adequacy-Michigan Service Area Maps to evaluate hospital travel times searchable by county or hospital name.)
4. Admitting privileges
5. Accepting new patients
6. Location of network providers
7. Availability of providers
8. County designation (See Appendix B)
9. Adjacent/contiguous county providers
10. Mail, mobile, and out of state providers
11. Mental health and substance abuse providers
12. ECPs
13. Numbers of providers
14. Type(s) of providers (See Appendix A)

VI. Stand-Alone Dental (SADP) Network Standards & Requirements

A. SADP Network Standards

To the extent applicable, the aforementioned network adequacy access and availability standards also apply to SADP networks. DIFS applies the same criteria to all SADP issuers regardless market participation.

SADP issuer networks must include dental providers that are available and accessible in each service area to deliver Michigan pediatric dental essential health benefits. Generally, these services can be delivered by general dentists. However, some require endodontic, periodontic, prosthodontic, and oral and maxillofacial surgical dental specialists. Minimally, DIFS expects SADP issuer networks to include these dental specialists in each of the metropolitan counties within issuer’s requested service area(s), where available. SADP issuer networks must also include dental providers located within the boundaries of each county in the requested service area.
DIFS considers the relative availability of dental provider types and sub-specialties and the county designations within SADP issuer’s requested service area(s). Appendix B lists Michigan county designations.

SADP service areas must cover a minimum geographical area that is at least an entire county or group of counties. DIFS does not permit partial counties for SADPs.

See also II. Commercial Network Standards and Requirements, as relevant to SADPs.

B. SADP Network Requirements

State and federal template and documentation requirements for SADPs are similar to those for QHPs.

**Essential Community Provider (ECP)**
All SADP issuers, regardless market participation, must meet requirements for inclusion of ECPs intended to ensure networks include a broad range of ECPs to serve the unique needs of certain populations. SADP issuers must have a sufficient number and geographic distribution of ECPs, where available. CMS has established two ECP standards: the general ECP standard and the alternate ECP standard. For information to satisfy either standard, see CMS’ site for QHP Information and Guidance, Application Materials, ECP and Network Adequacy.

See also II. Commercial Network Standards and Requirements, as relevant to SADPs.

i. **Required SADP Templates & Documentation**

**FEDERAL TEMPLATES**
- Plans and Benefits Template
- Network ID Template
- Service Area Template
- ECP/Network Adequacy Template (ECP section only)

**SUPPORTING DOCUMENTATION**

Federal
- State Partnership Exchange Issuer Program Attestation Response Form
- ECP Analysis

State
- Michigan Network Data Template (FIS 2273)
- Checklist for Individual and Small Group STAND-ALONE DENTAL Plans – NETWORK ADEQUACY (FIS 2314)
- Network Attestation
- Network Coverage Attestation
- Network Submission Summary
ii. Detail of SADP Required Templates & Documentation

Checklist for Individual and Small Group Stand-Alone Dental Plans – Network Adequacy (FIS 2314): Required to be completed and submitted in SERFF in Supporting Documentation to assist issuer in binder submission and DIFS’ review of health care provider networks. It is not intended to be an all-inclusive listing of requirements.

See also II. Commercial Network Standards and Requirements, C. Network Requirements, iii. Detail of Required Templates & Documentation, as applicable to SADPs.

VII. Medicaid

On October 13, 2015, the Michigan Department of Health and Human Services (MDHHS) re-procured its Medicaid managed care contracts. MDHHS awarded five-year Medicaid contracts to HMOs to provide health care services to eligible beneficiaries in Michigan (January 1, 2016 – December 31, 2020). MDHHS has the option to extend the term of these contracts for up to three additional years, potentially out through December 31, 2023. Expansion of, or changes to, any Medicaid service area are at the sole discretion of MDHHS during the contract term.

DIFS is not reviewing Medicaid service area expansion filings as Medicaid service areas are set and MDHHS will not award new Medicaid service area expansions until the next re-bid, October 2021 at the soonest.

VIII. Medicare Advantage

Medicare Advantage plans seeking a service area expansion should contact DIFS’ Office of Insurance Evaluation to obtain state certification as to licensure and solvency concerning the expansion sought.

The federal government expressly preempts any State law or regulation other than for licensure and plan solvency for Medicare Advantage plans (Medicare Modernization Act amended section 1856(b)(3) of the SSA and 42 CFR 422.402). Thus, DIFS has no authority to review the health care provider network(s) of Medicare Advantage plans.

CMS has network adequacy requirements and criteria and, at a minimum, conducts reviews at the initial application and every three years thereafter, unless there is a triggering event such as a request for service area expansion.
## IX. Appendices

### A. Provider Type/Specialty/Sub-Specialty List

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<tr>
<th>PCP³</th>
<th>Internal Medicine</th>
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**Specialist**

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**Ancillary**

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**Dental³**

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**Pharmacy**

**Hospital³**

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² This list is not intended to be exclusive of all provider types available in Michigan nor a limitation of the types of providers issuers should include in networks.

³ CMS has historically focused on this provider type and/or specialty/sub-specialty CMS has historically focused on this provider type and/or specialty/sub-specialty
B. Michigan County Designations

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C. State and Federal Resources

1. 45 CFR §146, 147, 155, and 156
2. DIFS’ Bulletins for 2020 Form and Rate Filing Requirements for Medical and Stand-Alone Dental Plans
3. Essential Community Providers
4. Michigan Dental EHB services
5. Michigan Essential Health Benefits
7. Michigan Network Data Template and Instructions
8. Network Adequacy-Michigan Service Area Maps
9. Qualified Health Plan Certification Information and Guidance
10. Letter to Issuers in the Federally-facilitated Marketplaces
11. HHS Notice of Benefit and Payment Parameters