Michigan Network Adequacy Guidance

Updated 3.25

Contents

1. Overview

The Michigan Insurance Code (Code) and the Patient Protection and Affordable Care Act (ACA) set requirements and standards for health care provider networks of health and dental insurers, health maintenance organizations (HMOs), and alternative financing and delivery systems (AFDS) (issuers). Issuers include medical plans seeking health insurance marketplace/exchange (marketplace) certification known as qualified health plans (QHPs[1]), ACA-compliant medical plans, and stand-alone dental plans (SADPs) seeking on- and/or off-marketplace certification.

The Michigan Department of Insurance and Financial Services (DIFS) publishes this guidance to document its healthcare provider network adequacy standards and requirements for issuers, within its regulatory jurisdiction, offering health plans utilizing provider networks in Michigan.

DIFS uses the National Association of Insurance Commissioners' (NAIC's) System for Electronic Rates and Forms Filing (SERFF).

2. Authority

All issuers are responsible for complying with applicable state and federal requirements, including any not listed. Certain requirements may apply only to network plans intended to be sold on-marketplace.

2.1. Federal

- 45 CFR Parts 146, 147, 155, 156
- 42 U.S.C. § 300gg-1, et seq.; § 18001, et seq.
- 29 U.S.C § 1185a

2.2. State

Michigan Insurance Code

- MCL 500.116
- MCL 500.3428, 3476
- MCL 500.3501, 3509, 3513, 3528, 3529, 3530, 3531

Nonprofit Health Care Corporation Reform Act

- MCL 550.1501c

3. Service Area

"Service area" means:

- A defined geographical area in which covered health services are generally available and readily accessible to enrollees and where health maintenance organizations may market their contracts (MCL 500.3501(h)), and
- That term as defined in section 3501 unless the context requires otherwise (MCL 500.116).

Michigan has 83 counties designated as either: Large Metro, Metro, Micro, Rural, and Counties with Extreme Access Considerations (CEAC). See Appendix 9.2 Michigan County Designations and CMS' current year Health Service Delivery Reference File.

Partial counties **may** be included in service areas of **medical** network plans and ***not SADPs***.

[1] The ACA defines a QHP as 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.

Issuers must receive DIFS' approval before marketing network products/plans in Michigan or changing an approved service area.

4. Commercial Medical Network Requirements & Standards

Issuer networks must:

- Meet DIFS' measurement criteria for additional provider specialties as set forth below.
- Meet CMS' Medicare Advantage (MA):
  - Time and distance standards and underlying 90 percent access requirement. See 2023 Final Letter to Issuers in the Federally-facilitated Exchanges (PY23 Final Letter) and QHP Population Sample File (based on U.S. Census data for marketplace-eligible enrollees).
- Have a sufficient number and type of providers to ensure covered benefits are available and accessible to enrollees without unreasonable delay, including those:
  - Specializing in mental health and substance use disorder services, and
  - Offering Essential Health Benefits (EHBs)
- Provide health care and services promptly and appropriately, ensuring continuity and acceptable quality of health care
- Provide emergency health services in the service area (approved by DIFS) that are available and accessible to enrollees 24 hours/day and 7 days/week
- Reasonably provide for enrollees to obtain emergency health services in and out of the designated service area
- Maintain reasonable proximity of providers to the business or residence of enrollees and accessibility for persons with disabilities and/or limited English proficiency
- Include providers of telehealth
- Include Essential Community Providers (ECPs) and comply with CMS' ECP standards (45 CFR 156.235) (QHPs & SADPs)

If the number and/or type of participating providers in an issuer's network is insufficient to provide a covered benefit, issuer must ensure enrollee obtains the covered benefit at no greater cost than if obtained from in-network provider(s).

4.1. DIFS' Additional Provider Specialties & Measurement Criteria

Provider Specialty	Measurement Criteria
Anesthesiology	Max 30-min travel time standard regardless county designation
Outpatient Dialysis	Max 30-min travel time standard regardless county designation
DME	Max 30-min travel time standard regardless county designation
Home Health	Max 30-min travel time standard regardless county designation
Home Infusion	Max 30-min travel time standard regardless county designation
Hospice	Max 30-min travel time standard regardless county designation
Laboratory	Max 30-min travel time standard regardless county designation
Midwife	Max 30-min travel time standard regardless county designation
Optometry	Max 30-min travel time standard regardless county designation
Pathology	Max 30-min travel time standard regardless county designation
Oral & Maxillofacial Surgery	See 4.3 Time and Distance Standards for SADPs
Ambulance [Land Transportation only]	None; DIFS collects for information only at this time
Pharmacy	Max 30-min travel time standard regardless county designation (New PY26)

4.2. Time &/or Distance Standards

In addition to the criteria in the table above, DIFS applies CMS' Medicare Advantage time and distance standards and underlying 90 percent access requirement to networks submitted in *Service Area Expansion filings* (in addition to networks submitted in individual and small group medical and SADP plan management binders). See tables below and QHP Population Sample File.

To count towards meeting the time and distance standards, individual and facility providers listed on the below tables must be appropriately licensed, accredited, or certified to practice in their state, as applicable, and must have in-person services available.

4.3. Time & Distance Standards - Individual Provider Specialty Types for Medical Networks

Individual Provider Specialty Types	Maximum Time and Distance Standards[a]									
	Large Metro County		Metro County		Micro County		Rural County		Counties with Extreme Access Considerations (CEAC)	
	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
Dental	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, OB/GYN	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
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

Individual Provider Specialty Types	Maximum Time and Distance Standards[a]									
	Large Metro County		Metro County		Micro County		Rural County		Counties with Extreme Access Considerations (CEAC)	
	Time	Distance	Time	Distance	Time	Distance	Time	Distance	Time	Distance
Ophthalmology	20	10	30	20	50	35	75	60	95	85
Orthopedic Surgery	20	10	30	20	50	35	75	60	95	85
Outpatient Clinical Behavioral Health (licensed, accredited, or certified professionals)	10	5	15	10	30	20	40	30	70	60
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
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
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

[a] Time standard is measured in minutes. Distance standard is measured in miles.

4.4. Time & Distance Standards - Facility Specialty Types for Medical Networks

Facility Specialty Type	Maximum Time and Distance Standards[a]									
	Large Metro County		Metro County		Micro County		Rural County		Counties with Extreme Access Considerations (CEAC)	
	Time	Distance	Time	Distance	Time	Distance	Time	Distance	Time	Distance
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 (free-standing; 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 ASC)	20	10	45	30	80	60	75	60	110	100
Urgent Care	20	10	45	30	80	60	75	60	110	100

[a] Time standard is measured in minutes. Distance standard is measured in miles.

4.5. Time & Distance Standards for SADP Networks

Individual Provider Specialty Type	Maximum Time and Distance Standards[a]									
	Large Metro County		Metro County		Micro County		Rural County		Counties with Extreme Access Considerations (CEAC)	
	Time	Distance	Time	Distance	Time	Distance	Time	Distance	Time	Distance
Dental	30	15	45	30	80	60	90	75	125	110

[a] Time standard is measured in minutes. Distance standard is measured in miles.

4.6. Appointment Wait Time Standards

DIFS adopted CMS' appointment wait time standards for individual and small group medical (and SADP) networks. See table below.

4.6.1 Appointment Wait Time Standards

Provider/Facility Specialty Type	Appointments Must Be Available Within
Behavioral Health	10 business days
Primary Care (Routine)	15 business days
Specialty Care (Non-Urgent)	30 business days

(Sources PY23 Final Letter.& Appointment Wait Time FAQs)

4.7. Essential Community Providers

An essential community provider (ECP) is a medical or dental provider that serves predominantly low-income and medically underserved individuals.

QHP and SADP issuer networks must:

- Include a sufficient number and geographic distribution of a broad range of ECPs, where available, to ensure reasonable and timely access (45 CFR § 156.230 and 235), and
- Satisfy CMS' applicable ECP Standards. See CMS' QHP Information and Guidance.

Issuers must create an ECP Justification when CMS' ECP Standards are not met and submit in Supporting Documentation of SERFF binder.

4.8. Provider Directory

Issuers must publish online **updated, accurate,** and **complete** provider directories potential enrollees can access by a clearly identifiable link/URL or tab without creating an account, entering a policy number, or otherwise navigating the site, **including**:

+ Whether provider accepts new patients
+ Provider specialty
+ Location(s)
+ Contact information
+ Any accommodations for individuals with limited English proficiency and/or disabilities
+ Clearly identifiable plan(s) and provider network(s) associated with each provider
+ Hospitals where network physicians have admitting privileges
+ Network tier provider participates, as applicable
+ Whether individual providers offer telehealth

and **excluding** providers that:

– Are not authorized to practice a health profession in Michigan
– Have an inactive license

- Are sanctioned or prohibited from participation in federal health care programs under either Section 1128 or Section 1128A of the Social Security Act
- No longer offer health care services

See 45 CRF 156.230(b)

4.9. Tiered Networks

Tiered networks must:

- Be based on reasonable factors such as quality, performance, and market standards
- Not be solely based on cost nor impede the provision of timely and high-quality care
- Ensure enrollees of all ages have access to all covered services, including specialty services, without additional cost sharing or administrative burdens
- Comply with rules for non-quantitative treatment limitations at 45 CFR § 146.136
- Be designed without regard to whether a provider is a mental health (MH), or substance use disorder (SUD) or a medical/surgical (M/S) provider
- Ensure any methodology used for MH/SUD network tiers are **comparable to** and applied **no more stringently** than that used for M/S network tiers

Issuers must clearly convey to DIFS:

- Identity of tiers
- Basis for tiering (performance, quality, cost)
- What tier(s) providers participate
- Which, if any, provider belongs exclusively to one tier and if so, why
- Enrollee access and cost-sharing relative to utilization of providers in each tier

See instructions (internal) for Michigan Network Adequacy Template (FIS 2385) to identify tier(s) associated with network providers.

4.10. Essential Community Providers

An essential community provider (ECP) is a medical or dental provider that serves predominantly low-income and medically underserved individuals.

DIFS follows CMS' standards and requirements for ECPs. Follow direction from CMS for submitting ECP data. See CMS' web page QHP Certification Application Materials for Application Instructions, ECPs, Program Attestations, and Frequently Asked Questions.

QHP and SADP issuer networks must:

- Include a sufficient number and geographic distribution of a broad range of ECPs, where available, to ensure reasonable and timely access (45 CFR § 156.230 and 235), and
- Satisfy CMS' applicable ECP Standards. See CMS' QHP Information and Guidance.

4.11. Required Templates & Supporting Documentation

Requirements may depend on market offering/participation and whether standards are met.

4.11.1 Medical On and/or Off Marketplace Plan Networks

Federal Templates

- Plans and Benefits
- Network ID
- Service Area

Supporting Documentation

Federal

- State Partnership Exchange (SPE) Issuer Program Attestation Response
- Service Area Partial County Supplemental Response, as applicable

State

- Michigan Network Adequacy Template (FIS 2385)
- Checklist for Individual and Small Group MEDICAL Plans – NETWORK ADEQUACY (FIS 2313)
- Network Attestation
- Network Coverage Attestation
- Appointment Wait Time Attestation
- Network Submission Summary
- Network Adequacy Justification, as applicable
- ECP Justification, as applicable

4.11.2 Medical Off Marketplace Only Plan Networks

Federal Templates:

- Plans and Benefits
- Network ID
- Service Area

Supporting Documentation
State

- Michigan Network Adequacy Template (FIS 2385)
- Checklist for Individual and Small Group MEDICAL Plans – NETWORK ADEQUACY (FIS 2313)
- Network Attestation
- Network Coverage Attestation
- Appointment Wait Time Attestation
- Network Submission Summary
- Network Adequacy Justification, as applicable

4.11.3 Service Area Expansions (Large Group HMOs & AFDS)

Supporting Documentation

- Michigan Network Adequacy Template (FIS 2385)
- Network Attestation
- Network Coverage Attestation
- Network Submission Summary
- Network Adequacy Justification, as applicable
- Executed Network Hospital Contracts
- Financial Information

4.12. Detail of Templates & Supporting Documentation

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

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

Service Area Template: Identifies issuer's proposed service area(s), for plans it intends to market, by name, identification number, and the counties comprising each service area.

Issuers must inform DIFS of any service area data change, including:

1. Revising Service Area Template to:
    a. change any service area name or ID
    b. add or remove a service area
    c. add or remove a county/ies to a service area
    d. change a county from full to partial
    e. change a county from partial to full
    f. add or remove a zip code(s) associated with a partial county
2. Revising the Plans and Benefits Template (PBT) to:
    a. Change a service area ID
    b. Add or remove a service area ID
3. Any change to the list of counties associated with a particular plan

Any change to the Service Area Template must be accurately reflected on the Michigan Network Adequacy Template (FIS 2385).

After DIFS' final transfer of binder data to CMS, service area data may only be changed with DIFS' approval and submission of a Data Change Request (DCR) to CMS. Submission of the DCR to CMS is through the Plan Management Community and must include an explanation and justification for the change(s) and evidence of DIFS' approval, and the DCR Supplement. See CMS' QHP Information and Guidance for Service Area and Data Change Windows.

State Partnership Exchange Issuer Program Attestation Response Form: Medical issuers of on- and/or off-marketplace and all SADP issuers must agree to adhere to all certification standards and operational applicable requirements in 45 CFR Parts 146, 147, 153, 155, and 156.

Service Area Partial County Supplemental Response: Federal form required by DIFS when issuer proposes a partial county in a service area. This form must be completed and explain why issuer cannot provide service to an entire county.

Michigan Network Adequacy Template (FIS 2385): Macro-enabled Excel file (*.xlsm) for collecting individual and small group medical and SADP network provider and service area data. (Instructions are contained in this template.) New for PY25 this data collection file will also be used for Service Area Expansion filings.

Checklist for Individual and Small Group MEDICAL Plans – NETWORK ADEQUACY (FIS 2313): Word document required to be completed to ensure comprehensive and accurate binder submissions. This checklist is not intended to be an all-inclusive list of requirements. One checklist should be submitted in each binder for each market.

Attestations: Issuer created verifications, including:

- Title of attestation
- Issuer name
- Name and title of issuer's authorized representative
- Signed by issuer's authorized representative

Network Attestation: Issuer verification that all providers included on the Michigan Network *Adequacy* Template (FIS 2385) (as applicable), on the date of submission in SERFF are:

- Credentialed, and either
    - Employed by issuer, or

- Have executed contracts/agreements (signed by both parties) as participating providers with issuer

Network Coverage Attestation: Issuer verification that if it has an insufficient number or type of participating providers to provide a covered benefit, issuer ensures the enrollee obtains the covered benefit in a timely manner, geographically accessible, and **at no greater cost** to the enrollee than if obtained from in-network providers.

Appointment Wait Time Attestation: Issuer verification of compliance with CMS' appointment wait time standards and access requirement for provider network(s). See QHP Appointment Wait Time FAQs.

Network Submission Summary: Issuer created narrative to provide DIFS with greater clarity of issuer's network and service area submission, such as:

- Availability/lack of providers in a requested county
- Referral patterns when health care services are not available
- Reliance on network providers in adjacent county/ies when providers are not available in a county
- Any network designs with cost-sharing differentials for providers in levels or tiers
- Changes to network and/or service area from prior year

Network Adequacy Justification: *Required of all issuers when network adequacy standards are **not** met*. Issuer creates and submits in Supporting Documentation of SERFF binder, detailing:

- Reasons standard(s) not met
- Mitigating measures issuer is taking to ensure enrollee access to respective provider specialty types
- Information concerning enrollee complaints regarding network adequacy
- Frequency and sources for monitoring provider availability
- Issuer's efforts to recruit additional providers

See PY23 Final Letter and CMS' QHP Applications Materials and FAQs for Network Adequacy.

ECP Justification: *Required of QHP and SADP issuers when CMS' ECP Standards are **not** met.* Issuer creates and submits in Supporting Documentation of SERFF binder, detailing:

- Reasons ECP standard(s) was not met
- Mitigating measures issuer is taking to ensure enrollee access to ECPs
- Information concerning enrollee complaints regarding access to ECPs
- Frequency and sources for monitoring provider availability
- Issuer's efforts to recruit additional ECPs

See PY24 Final Letter and CMS' QHP Applications Materials and FAQs for ECPs.

Executed Network Hospital Contracts: Minimally, Service Area Expansion Filings must include the following, on affiliated provider contract templates previously approved by DIFS (MCL 500.3529):

- First page, defining all parties
- Signature page(s), including signatures for named parties
- Applicable amendments

Financial Information:

- Two-years' financial projections

    - Balance sheet
    - Income Statement
    - Cash flow
    - Risk-based capital (RBC) level
- Three-years' membership enrollment projections, by county:
    - Number of enrollees and prospective enrollees (include in cover letter and on Michigan Network Adequacy Template (FIS 2385)

5. Evaluation Factors

In determining network adequacy, DIFS considers:

Enrollment Projections: Issuers must ensure reasonable levels of access for all covered benefits for anticipated enrollment.

Time and Distance Standards: DIFS adopted CMS' Medicare Advantage time and distance standards and access requirements. See PY23 Final Letter and QHP Population Sample File. In PY25, DIFS added additional provider specialties and associated measurement criteria to CMS' specialties and criteria.

Hospital Admitting Privileges: Most network physicians should have admitting privileges at network hospitals. For any network physicians that do not, issuers should explain how such physicians will attend to enrollees within network hospitals (i.e., use of hospitalists as liaisons).

Acceptance of New Patients: Issuer networks must include providers accepting new patients (Primary Care Physicians, Specialists, and Dentists) and providers with the capacity to maintain issuer's current enrollment and additional enrollees. DIFS recognizes a network provider's mere acceptance of new patients does not satisfy the requirement for the provider to have sufficient availability or ability to serve additional enrollees.

County Designation: DIFS aligned with CMS' classification of counties into five county type designations: Large Metro, Metro, Micro, Rural, and Counties with Extreme Access Considerations (CEAC). The county type designation method is based on the population size and density parameters of individual counties used by the U.S. Census Bureau of "urbanized areas" and "urban clusters," and the U.S. Office of Management and Budget of "metropolitan" and "micropolitan." See current plan year's QHP Issuer Application Instructions: Network Adequacy Standards.

Mail, Mobile, and Out-of-State Providers: DIFS recognizes the physical location of a network provider may not reflect where services are available. Issuers should make clear when providers serve locations beyond the physical address(es) of the provider listed on the relevant Michigan network provider data collection template.

This information should be included in the Network Submission Summary to avoid the appearance of any deficiency or gap in services.

Telemedicine/Telehealth: DIFS requires issuer networks to include providers offering services by alternate means in addition to in-person visits and identify on the Michigan Network Adequacy Template (FIS 2385).

Claims: DIFS requires information whether individual provider specialties have submitted claims within six months (of the end of the former plan year) for *individual and small group medical and*

SADP networks. This information is collected on the Michigan Network Adequacy Template (FIS 2385).

Attestations: DIFS requires Network, Network Coverage, and Appointment Wait Time Attestations for issuers to verify certain criteria is met.

Supplemental Justifications: DIFS requires issuers to create and submit a Network Adequacy and/or ECP Justification when applicable requirements or standards are not met.

6. SADP Network Requirements & Standards

In 2024, DIFS added Oral Surgery as a provider specialty collected on the Michigan Network Adequacy Template (FIS 2385). The criteria in 6.1 Time & Distance Standards for SADP Networks applies.

DIFS adopted CMS' time and distance and underlying 90% access requirement. See tables below and CMS Population Sample File.

DIFS requires issuers create and submit a Network Adequacy Justification when network adequacy standards are not met.

6.1. Time & Distance Standards for SADP Networks

Individual Provider Specialty Type	Maximum Time and Distance Standards[a]									
	Large Metro County		Metro County		Micro County		Rural County		Counties with Extreme Access Considerations (CEAC)	
	Time	Distance	Time	Distance	Time	Distance	Time	Distance	Time	Distance
Dental	30	15	45	30	80	60	90	75	125	110

[a] Time standard is measured in minutes. Distance standard is measured in miles.

(Source current plan year QHP Issuer Application Instructions: Network Adequacy Standards)

For SADPs, only the dental provider specialty within the Specialty Care (Non-Urgent) category of appointment wait time standards will apply. The dental provider specialty includes all dental providers (including general dentists and dental specialists) listed in the 'NUCCTaxonomyCode' tab of the Michigan Network Adequacy Template (FIS 2385). (In 2024, DIFS added the provider specialty Oral Surgery.)

The commercial medical network adequacy access and availability standards (above) apply to SADP networks and service area expansion filings, as relevant.

6.2. Appointment Wait Time Standards

Provider/Facility Specialty Type	Appointments Must Be Available Within
Specialty Care (Non-Urgent)	30 business days

(Sources PY23 Final Letter.& Appointment Wait Time FAQs)

For SADPs, only the dental provider specialty within the Specialty Care (Non-Urgent) category of appointment wait time standards applies.

6.3. Essential Community Provider

DIFS follows CMS' standards and requirements for ECPs. Follow direction from CMS for submitting ECP data. See CMS' web page CMS' QHP Information and Guidance for Application Instructions, ECPs, Program Attestations, and Frequently Asked Questions.

All SADP issuer networks, regardless of market offering, must:

- Include a sufficient number and geographic distribution of a broad range of ECPs, where available, to ensure reasonable and timely access (45 CFR § 156.230 and 235), and
- Satisfy CMS' applicable ECP Standards. See CMS' QHP Information and Guidance.

SADP Templates & Documentation

Federal Templates

- Plans and Benefits
- Network ID
- Service Area

State

- Michigan Network Adequacy Template (FIS 2385)
- Checklist for Individual and Small Group STAND-ALONE DENTAL Plans – Network Adequacy (FIS 2314)
- Network Attestation
- Network Coverage Attestation
- Appointment Wait Time Attestation
- Network Submission Summary
- Network Adequacy Justification, as applicable

Federal

- State Partnership Exchange Issuer Program Attestation Response

6.3.1 Detail of SADP Templates & Documentation

Checklist for Individual and Small Group STAND-ALONE DENTAL Plans – NETWORK ADEQUACY (FIS 2314) Macro-enabled Word document required to be completed and submitted in SERFF binder in Supporting Documentation to assist issuers in complete and accurate binder submissions and DIFS' review of health care provider networks and service areas. This checklist is not intended to be an all-inclusive list of requirements. One checklist should be submitted in each binder for each market.

See Detail of Required Templates and Documentation for commercial medical networks above.

7. Medicaid Service Area Expansions

DIFS is responsible for the initial review and determination of an HMO's Medicaid network and service area upon application for licensure in Michigan and when any service area expansion is sought. However, the Michigan Department of Health and Human Services (MDHHS) administers the Medicaid program in Michigan and establishes standards for network adequacy. MDHHS conducts Medicaid program network adequacy reviews and issues all final approvals for Medicaid Service Area Expansions.

Any change to a Medicaid service area is at the sole discretion of MDHHS during the contract term. MDHHS requires HMO service areas to comply with the ten state designated Prosperity Regions.

DIFS performs a financial and cursory network review. Medicaid HMO networks must comply with Chapter 35 of the Code and include sufficient number and types of providers to ensure covered services are accessible and available without unreasonable delay.

Service Area Expansion Filings for Medicaid HMOs must be submitted to DIFS through SERFF and include:

- *Cover Letter
- **Michigan Network Adequacy Template (FIS 2385)
- Medicaid Network Attestation
- Network Coverage Attestation
- Financial information
    - Two-years' financial projections
        - Balance sheet
        - Income statement
        - Cash flow
        - Risk-based capital (RBC) level
            - Three-years' enrollment projections
                - Estimated number of enrollees issuer expects in the following 3 years for each county expansion is sought
                    - *Identify in Cover Letter *and* on **Michigan Network Adequacy Template FIS 2385

The Medicaid Network Attestation verifies HMO's contracted provider network meets MDHHS' network adequacy standards. It also specifies whether use of MDHHS' Hospital Access Agreement is necessary to meet the network adequacy standards if not enough hospitals are contracted.

Sample Medicaid Network Attestation:

> I attest that [HMO] meets the Medicaid network adequacy standards as outlined by the Michigan Department of Health and Human Services, Administrator of the Michigan Medicaid program and contracts.
>
> [If the Hospital Access Agreement is used to meet network adequacy standards, add the following: [HMO] further attests that to meet hospital access standards in [name of count/ies], [HMO] relies on the MDHHS Hospital Access Agreement.]
>
> [Signature of HMO Authorized Representative]
> [Name of HMO Authorized Representative]
> [Title of HMO Authorized Representative]

The Hospital Access Agreement is between MDHHS and participating hospitals and outlines service and payment terms for noncontracted hospitals servicing Medicaid beneficiaries, created to bridge the gap between HMOs and noncontracted hospitals. The list of hospitals that have signed and executed the Hospital Access Agreement is available through MDHHS.

8. Medicare Advantage Service Area Expansions

The federal government preempts any state law or regulation other than for licensure and plan solvency for Medicare Advantage (MA) plans (Medicare Modernization Act amended section 1856(b)(3) of the SSA and 42 CFR 422.402). Thus, DIFS has no authority pertaining to provider contracts or network adequacy over MA plans.

CMS establishes MA network adequacy criteria and issues related guidance. CMS conducts network adequacy reviews at the initial application for MA plans and every three years thereafter, unless there is a triggering event.

For state authorization of the "CMS State Certification Form" in CMS' "Part C-Medicare Advantage and 1876 Cost Plan Expansion Application" for MA service area expansions, HMOs should contact DIFS' Office of Insurance Evaluation at 517-284-8762 or toll free at 877-999-6442. This authorization **does not** depend on DIFS' approval of the same service area for HMO's commercial and/or Medicaid health plans in Michigan.

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9. Appendix

9.1. Specialty Types & Codes

9.1.1 Individual Provider Specialty Types & Codes

Individual Provider Specialty Types (51)
001 General Practice
002 Family Medicine
003 Internal Medicine
004 Geriatrics
005 Primary Care – PA
006 Primary Care - Advanced Reg NP
007 Allergy and Immunology
008 Cardiology
010 Chiropractor
011 Dermatology
012 Endocrinology
013 ENT/Otolaryngology
014 Gastroenterology
015 General Surgery
016 Gynecology (OB/GYN)
017 Infectious Diseases
018 Nephrology
019 Neurology
020 Neurosurgery
021 Oncology - Medical & Surgical
022 Oncology – Radiation
023 Ophthalmology
025 Orthopedic Surgery
026 Physical Medicine & Rehabilitation
027 Plastic Surgery
028 Podiatry
029 Psychiatry
030 Pulmonology
031 Rheumatology
033 Urology
034 Vascular Surgery
035 Cardiothoracic Surgery
037 Emergency Medicine
049 Physical Therapy
050 Occupational Therapy
051 Speech Therapy
101 Primary Care - Pediatric
102 Social Worker
103 Psychologist
105 Marriage & Family Therapist
106 Addiction (SUD) Counselor
107 Counselor (Mental Health & Professional)
108 Behavioral Health - Advanced Practice RN
201 Dental - General
202 Dental - Orthodontist
203 Dental - Periodontist
204 Dental - Endodontist
206 Dental - Prosthodontist
P201 - Pediatric Dental
800 Addiction Medicine Physician
801 Behavioral Analyst

9.1.2 Facility Specialty Types & Codes

Facility Specialty Types (15)
040 Acute Inpatient Hospitals (Must have emergency services available 24/7)
041 Cardiac Surgery Program
042 Cardiac Catheterization Services
043 Critical Care Services - Intensive Care Units (ICU)
045 Surgical Services (Ambulatory Surgical Centers and Outpatient Hospital)
046 Skilled Nursing Facilities
047 Diagnostic Radiology (Free-standing; hospital outpatient; ambulatory health facilities with Dx Radiology)
048 Mammography
052 Inpatient Psychiatry (Free-standing inpatient behavioral health facility and behavioral health beds within an Acute Care Hospital)
057 Outpatient Infusion/Chemotherapy
072 Substance Abuse Rehabilitation Facility (Hospital unit and residential treatment facility)
076 Mental Health Residential Treatment Facility (Mental Illness; Psychiatric)
080 Urgent Care
P072 Children's Substance Abuse Rehabilitation Facility
P076 Children's Residential Treatment Facility (Mental Illness; Psychiatric)

9.2. Michigan County Designations (New PY26)

#	Peninsula	MI County *No Hospital	Designations PY25	PY26
1	Lower	**Alcona***	Rural	Rural
2	Upper	Alger	CEAC	CEAC
3	Lower	Allegan	Metro	Metro
4	Lower	Alpena	Micro	Micro
5	Lower	**Antrim***	Micro	Micro
6	Lower	Arenac	Rural	Rural
7	Upper	Baraga	CEAC	CEAC
8	Lower	Barry	Metro	Metro
9	Lower	Bay	Metro	Metro
10	Lower	Benzie	Micro	Micro
11	Lower	Berrien	Metro	Metro
12	Lower	Branch	Micro	Micro
13	Lower	Calhoun	Metro	Metro
14	Lower	Cass	Metro	Metro
15	Lower	Charlevoix	Micro	Micro
16	Lower	**Cheboygan***	Rural	Rural
17	Upper	Chippewa	Rural	Rural
18	Lower	Clare	Micro	Micro
19	Lower	Clinton	Metro	Metro
20	Lower	Crawford	Rural	Rural
21	Upper	Delta	Rural	Rural
22	Upper	Dickinson	Rural	Rural
23	Lower	Eaton	Metro	Metro
24	Lower	Emmet	Micro	Micro
25	Lower	Genesee	Metro	Metro
26	Lower	Gladwin	Micro	Micro
27	Upper	Gogebic	Rural	Rural
28	Lower	Grand Traverse	Metro	Metro
29	Lower	Gratiot	Micro	Micro
30	Lower	Hillsdale	Micro	Micro
31	Upper	Houghton	Rural	Rural
32	Lower	Huron	Rural	Rural
33	Lower	Ingham	Metro	Metro
34	Lower	Ionia	Metro	Metro
35	Lower	Iosco	Rural	Rural
36	Upper	Iron	~~CEAC~~	Rural
37	Lower	Isabella	Metro	Metro
38	Lower	Jackson	Metro	Metro
39	Lower	Kalamazoo	Metro	Metro
40	Lower	Kalkaska	Rural	Rural
41	Lower	Kent	Metro	Metro
42	Upper	**Keweenaw***	CEAC	CEAC
43	Lower	**Lake***	Rural	Rural
44	Lower	Lapeer	Metro	Metro
45	Lower	**Leelanau***	Micro	Micro
46	Lower	Lenawee	Metro	Metro
47	Lower	Livingston	Metro	Metro
48	Upper	Luce	CEAC	CEAC
49	Upper	Mackinac	Rural	Rural
50	Lower	Macomb	Large Metro	Large Metro
51	Lower	Manistee	Rural	Rural
52	Upper	Marquette	Micro	Micro
53	Lower	Mason	Micro	Micro
54	Lower	Mecosta	Micro	Micro
55	Upper	**Menominee***	Rural	Rural
56	Lower	Midland	Metro	Metro
57	Lower	**Missaukee***	Rural	Rural
58	Lower	Monroe	Metro	Metro
59	Lower	Montcalm	Micro	Micro
60	Lower	**Montmorency***	Rural	Rural
61	Lower	Muskegon	Metro	Metro
62	Lower	Newaygo	Micro	Micro
63	Lower	Oakland	Large Metro	Large Metro
64	Lower	Oceana	Micro	Micro
65	Lower	Ogemaw	Rural	Rural
66	Upper	Ontonagon	CEAC	CEAC
67	Lower	Osceola	Rural	Rural
68	Lower	**Oscoda***	Rural	Rural
69	Lower	Otsego	Rural	Rural
70	Lower	Ottawa	Metro	Metro
71	Lower	**Presque Isle***	Rural	Rural
72	Lower	**Roscommon***	Rural	Rural
73	Lower	Saginaw	Metro	Metro
74	Lower	Sanilac	Rural	Rural
75	Upper	Schoolcraft	CEAC	CEAC
76	Lower	Shiawassee	Metro	Metro
77	Lower	St. Clair	Metro	Metro
78	Lower	St. Joseph	Metro	Metro
79	Lower	Tuscola	Micro	Micro
80	Lower	Van Buren	Metro	Metro
81	Lower	Washtenaw	Metro	Metro
82	Lower	Wayne	Large Metro	Large Metro
83	Lower	Wexford	Micro	Micro

9.3. State & Federal Resources

1. 45 CFR §146, 147, 155, and 156
2. Michigan Insurance Code
3. DIFS' Insurance Bulletins - Form & Rate Filing Requirements for Medical & SADPs
4. Michigan EHBs
5. Michigan Pediatric Dental EHBs
6. Michigan Network Adequacy Template (FIS 2385)
7. CMS' Qualified Health Plan Certification Information and Guidance
8. Letters to Issuers in the Federally-facilitated Marketplaces
9. HHS' Notice of Benefit and Payment Parameters