Cigna

Policy Name Measuring Availability of Health Care Professionals (Insured Products*)	Policy Number PS-8
Business Segment HealthCare	
Initial Effective Date: 09/15/06	Policy Committee Approval Date(s): 12/11/12; 12/10/13; 05/27/14; 10/14/14; 10/28/14; 12/16/14
Replaces Policies: N/A	

Purpose:

- To ensure that Cigna maintains an adequate network of Health Care Professionals (HCP) and monitors how effectively the network meets the needs and preferences of its clients.
- To ensure that the participating providers/Health Care Professionals (HCP) and provider network meets the availability needs of clients by annually assessing three (3) aspects of availability:

1. Geographic distribution - participating HCP(s) are within reasonable proximity to customers.
2. Number of HCP(s) - an adequate number of participating HCP(s) are available, and
3. Cultural, ethnic, racial and linguistic needs and preferences of participating providers/HCP(s) meet the cultural, ethnic, racial and linguistic needs and preferences of clients.

Policy Statement:

A. Cigna clients will have primary care, specialty care and/or hospital care available to them.

B. Cigna will abide by any state statutes regarding number of required physicians for a given network.

C. The Cigna National Network Development Team (National Team) will conduct an annual audit of provider availability by state/market. The audits will be conducted utilizing available software such as GEO Access or Map Xtreme, using established standards to ensure a sufficient number of participating HCP(s) for the clients within the designated service area

D. Unless otherwise stated by a state-specific mandate, the following availability standards are followed:

1. Medical HCP - Primary Care
   - Minimum of one Medical HCP – primary care per 300 participants

   Urban
   - One General Practice, Internal Medicine or Family Practice provider within 10 miles
   - One Pediatric provider within 10 miles

   Suburban
   - One General Practice, Internal Medicine or Family Practice provider within 15 miles
   - One Pediatric provider within 15 miles

   Rural

- One General Practice, Internal Medicine or Family Practice provider within 50 miles
- One Pediatric provider within 50 miles

2. Medical HCP – Obstetrician/Gynecologist (OB/GYN)

Urban
- One OB/GYN provider within 10 miles

Suburban
- One OB/GYN provider within 15 miles

Rural
- One OB/GYN provider within 50 miles

3. Medical HCP – Hematology/Oncology (LocalPlus only)

Urban
- One Hematologist/Oncologist within 15 miles

Suburban
- One Hematologist/Oncologist within 20 miles

Rural
- One Hematologist/Oncologist within 50 miles

4. Medical HCP – High-Volume Specialty Care
   - Minimum of one Medical HCP – specialty care per 1000 participants

Urban
- Two separate High-Volume Specialists within 15 miles

Suburban
- Two separate High-Volume Specialists within 20 miles

Rural
- Two separate High-Volume Specialists within 50 miles

5. Hospitals
   1. One hospital within 25 miles (urban)
   2. One hospital within 30 miles (suburban)
   3. One hospital within 35 miles (rural)

* In remote or rural areas, occasionally these geographic availability guidelines are not able to be met due to lack of, or absence of, qualified providers and/or hospital facilities. 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.

E. Operational Performance Standards: Contracting/Provider Services and the National Network Development Team will meet availability standards per NCQA standards and any state statutes 90% of the time.

F. Cigna evaluates the ethnic, cultural, racial and linguistic needs of clients to ensure that there is sufficient availability to ethnically diverse Medical HCP-Primary Care HCP(s).

G. Annual Reporting: The Contracting Network Development and Competitive Insights Team analyze results and reports the results to the appropriate Quality Committee.

H. Corrective Action Plans: The Contracting Network Development and Competitive Insights Team develop and implements corrective action plans which must be approved by the above mentioned committee.

Definitions:
For purposes of this policy "customer" means an individual participant or member.

- *Insured Products is defined as customers insured in the PPO, EPO, OAP, OAP IN, Network, Network POS, Network Open Access, Network POS Open Access, LocalPlus products
- Availability: is defined as the number and geographic distribution of primary care physicians (PCPs) and high-volume Specialty Physicians.
    - Geographic distribution is calculated using the industry-standard GeoAccess software to measure estimated driving distance from a customer's home zip code to a HCP access point, which is defined as an identified HCP and office location at which a customer can access services. Each HCP-location combination is counted individually, e.g. 2 individual HCPs who share 2 office locations will be counted as a total of 4 access points: 1) HCP A at location X, 2) HCP B at location X, 3) HCP A at location Y, and 4) HCP B at location Y, because a customer would have 4 options for accessing services.
    - Ratio of HCPs to Customers –HCPs to customer ratios are normally calculated with the HCP count constant at 1, where the HCP count is based on unique HCP 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 HCP count, e.g. 3000 customers divided by 30 HCPs equals "3000/30 = 100" – the ratio 1 to the result of the calculation (1:100 in this example).
- Urban: Population density is >3000 people per square mile
- Suburban: Population density is 1000-3000 people per square mile
- Rural: Population density is <1000 people per square mile

- Medical HCP - Primary Care: A physician duly licensed to practice medicine that is a Participating Provider with Cigna. Physician will provide Covered Services in the field of General Medicine, Internal Medicine, Family Practice and Pediatrics. Unless specified by state mandate and contractually agreed to by the provider and Cigna, Obstetricians and Gynecologists are defined as specialty care HCP(s) only and cannot act as primary care providers.
- OB/GYN (Obstetrician/Gynecologist): A physician duly licensed to practice medicine who is a Participating Provider with Cigna to provide Covered Services in the field of Obstetrics and Gynecology.
- Hematology/Oncology. A physician duly licensed to practice medicine who is a Participating Provider with Cigna to provide Covered Services in the field of Hematology/Oncology.
- High-Volume Specialists: The High Volume Specialists are identified by researching claims data for a 12-month period and the number of transactions of the top five specialties, excluding non-physician specialists and hospital-based specialists (i.e. radiologists).
- Hospital: An institution which is a participating provider with Cigna to provide Covered Services: medical and surgical care.
- GEO ACCESS®: 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.
- Map Xtreme®: An Intranet based analysis tool to view the zip code-based dispersion of network providers and network participants. In addition, the user will be able to create and view zip code based maps of network coverage.
- Contracting/Provider Services are the Contracting/Provider Services teams that are responsible for the local markets.
- National Network Development Team (National) is responsible for identifying network development opportunities.
- For purposes of this policy "customer" means an individual participant or member.

State/Federal Compliance:
Attachments A & B

Procedure(s):

PROCEDURE I: Measure Provider Availability		
	Complete Annual Analysis	
1	At least annually, the Contracting Network Development and Competitive Insights Team (National Team) completes an analysis to determine compliance with provider availability standards for: • Medical HCP(s) - Primary care	National Contracting Network Development and Competitive Insights Team

	• OB/GYN • Hematology/Oncology (LocalPlus only) • High-Volume Specialists • Hospitals	
2a	National Contracting Network Development and Competitive Insights Team submit a request to produce the membership by zip code report. This report includes current product-specific membership information for each state.	National Contracting Network Development and Competitive Insights Team
2b	The designated unit producing the membership by state file returns the report to the National Contracting Network Development and Competitive Insights Team within 5 working days.	Membership Reporting Team
3	Upon receipt of membership file, National Contracting Network Development and Competitive Insights Team verify that the membership data is accurate.	National Contracting Network Development and Competitive Insights Team
	Identify Key Specialty Physicians	
4a	The National Contracting Network Development and Competitive Insights Team identify the five (5) highest volume specialties using patient claims data for a twelve (12) month period. • Non-physician specialists and hospital-based specialists such as radiologists are not considered High Volume Specialty Physicians. • Analysis for behavioral health participating providers/HCP(s) is performed by Cigna Behavioral Health.	National Contracting Network Development and Competitive Insights Team
4b	Once the high volume specialties are identified, the National Contracting Network Development and Competitive Insights Team) requests geographic access reports such as GEO Access from the Sales Support unit or utilizes Map Xtreme report to determine compliance with the availability standards listed in the Policy Section of this document.	National Contracting Network Development and Competitive Insights Team
5a	The National Network Development Team completes and submits online GEO Access Report request to Sales Support Unit. The online GEOAccess Request form is located on the Sales Tool Box at: http://sales.healthcare.cigna.com/GeoCentral/GeoCentralRequestForm.asp	National Contracting Network Development and Competitive Insights Team
5b	To ensure consistency in report format and methodology used, the request should be submitted using standard parameters.	National Contracting Network Development and Competitive Insights Team
6a	The GEO Access Team completes analysis and returns completed reports within 10 working days.	GeoAccess Team (Sales Support)
6b	The GEO Access Team ensures that reports are prepared with consistent format and methodology required for NCQA provider availability measurement.	GeoAccess Team (Sales Support)
7	The National Contracting Network Development and Competitive Insights Team, as applicable, receive the report and review it for completeness and accuracy.	National Contracting Network Development and Competitive Insights Team
8	The National Contracting Network Development and Competitive Insights Team analyze the gaps in provider/HCP availability by zip code and by state based on	National Contracting Network Development and

	the findings.	Competitive Insights Team
9	National Contracting Network Development and Competitive Insights Team works with Regional Access Leads and local Contracting teams to develop plans to correct any deficiencies identified.	National Contracting Network Development and Competitive Insights Team, Regional Access Leads, and Contracting & Provider Services
	Presenting Reports	
10a	The National Contracting Network Development and Competitive Insights Team presents the reports to the appropriate Quality Committee along with a local action plan, if deficiencies in provider availability are identified.	National Contracting Network Development and Competitive Insights Team
10b	If no deficiencies are identified, the reporting cycle to the Quality Committee is once per year.	Quality Committee
10c	If deficiencies are identified, the Quality Committee determines the appropriate follow-up reporting frequency (i.e. twice annually or quarterly.)	Quality Committee
	Annual Review and Update of this Policy and Procedure	
11a	Once per year, Compliance (Regulatory and Public Affairs) completes a review and update of the state-specific requirements related to this Policy & Procedure. The Quality Organization completes a review and update of NCQA requirements related to this policy.	Compliance (Regulatory & Public Affairs) and Quality Organization
11b	The Compliance and Quality Organizations assess the current policy and procedure to identify any required changes to the Policy and Procedure and communicate recommended changes to National Contracting/Provider Services.	Compliance & Quality Organizations
11c	Following receipt of updates from Compliance and Quality, National Contracting & Provider Services completes review and update of the Policy and Procedure and completes communication of changes, if required, to appropriate matrix partners.	National Contracting Network Development and Competitive Insights Team

Procedure II: Cultural, ethnic, racial and linguistic analysis		
	Complete Biennial Analysis	
1.	Every other year, National Network and Provider Reporting Team obtains census data for service areas to determine the cultural and ethnic breakdown of the general population for each state by specifically reviewing the top two (2) non-English languages spoken. Census data is available online at www.census.gov.	Contracting/Provider Services
2.	National Network and Provider Reporting Teams utilize these reports to assess the ethnicity and cultural needs of the general population when reviewing recruitment efforts for the network. Examples of assessing the cultural and ethnic breakdown can include the following: • A review and ranking of the languages spoken by the general population. • A concentration on the subset of the population that is considered linguistically isolated or only speaks a foreign language. • A review of HCP(s) in the service area that speak the languages identified and an attempt to recruit HCP(s) to meet the cultural and ethnic needs of clients, provided that these HCP(s) exist in specific areas of need and meet Cigna's credentialing	Contracting/Provider Services

	standards. • Contracting/Provider Services will consider requests from participants and/or employers to recruit HCP(s) who will meet required ethnic or cultural needs.	
	Present analyses and action plans	
3a	Once per year, National Network and Provider Reporting Team present the reports to the Provider Services Leads.	National Network and Provider Reporting Team and Provider Services Leads
3b	Once per year, National Provider Services, on behalf of the Provider Services Leads, presents the reports to the appropriate Quality Committee along with a local action plan, if deficiencies are identified.	National Provider Services, Provider Services Leads, and Quality Committee
3c	Revisions will be made accordingly after committee review and discussion.	Hub Provider Service Leads and Quality Committee
3d	If no deficiencies are identified, the reporting cycle to the Quality Committee is once every two years.	Quality Committee
3e	If deficiencies are identified, the Quality Committee determines the appropriate reporting frequency (i.e. twice annually or quarterly.)	Quality Committee

Applicable Privacy Policies & Procedures:
N/A

Related Policies and Procedures:
PS-4 Measuring Availability of Health Care Professionals (HMO Products)

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 Network Adequacy Requirements to Cigna Standards

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

- California
  - At least one full-time physician to 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 – (with sufficient capacity to accept covered persons) within 30 minutes or 15 miles of each covered person's residence or workplace
  - Specialists - within 60 minutes or 30 miles of a covered person's residence or workplace
  - Mental Health Professionals - within 30 minutes or 15 miles of a covered person's residence or workplace
  - Hospital - within 30 minutes or 15 miles of a covered person's residence or workplace
- Delaware
  - Surgical facilities/inpatient facilities: no greater than 30 miles or/ 40 minutes for 90% enrollees
- Kansas
  - 1 Pharmacy every 10 miles and every 30 miles for underserved communities
- North Carolina
  - Must establish targets for customer accessibility to 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 bordering counties and customers are defined by the North Carolina Annual Managed Care requirements and include customers from bordering counties that utilized North Carolina Providers.
  - Driving Distance or Geographic Distribution (# of Providers within # of miles) by Urban, Suburban, Rural will be measured using the methodology outlined in the definition section of this policy, using the standards below. Providers include Providers from bordering counties and customers are defined by the North Carolina Annual Managed Care requirements and include customers from bordering counties that utilized North Carolina Providers.

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%

- Annually, must measure results separately for provider types above for the following categories:
    - Provider counts by county on 12/31 of measurement year (including border counties) where provider is counted only once per county
    - Unique provider counts on 12/31 of measurement year (including border counties) where unique provider is counted only once
    - Unique providers leaving network during measurement year (including border counties) where unique provider is counted only once
        - Involuntary (terminated with cause)
        - Voluntary (resignation, retirement, relocation, etc.)
    - Unique providers joining network during measurement year (including border counties) where unique provider is counted only once
    - Unique provider totals must equate to prior measurement year's unique provider total plus unique providers joining during the measurement year, and minus the unique providers leaving during the measurement year. If not, explanation must be provided.
    - Network density or ratio of providers to covered lives
    - Driving distance or Geographic Distribution (# of providers within # of miles) by Urban, Suburban, Rural
    - 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
    - Plastic/thoracic surgeons: 50% greater than other specialists
    - Pharmacy: within 15 miles/ or 45 minutes
    - Outpatient MH services: within 25 miles/ or 45 minutes
    - 2 open panel PCPs within 15 miles/ 40 minutes of 90% enrollees*
    - Most specialists: 45 miles/ 60 minutes travel time to 90% enrollees*
    - Inpatient Hospital - 45 miles/ 60 minutes - Except diagnostic cardiac cath, trauma, NICU and open-heart surgery services: 80 miles/ 120 minutes. Centers of Excellence can be wherever; New England locations preferred.*
- 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
    - Rehab, outpatient centers, SA centers, diagnostic cardiac cath, inpatient psych,: 45 miles/ 60 minutes
    - LTC, therapeutic radiation, MRI, diagnostic radiology, emergency MH service, outpatient MH/SA, renal dialysis: 20 miles/ 30 minutes
    - 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: 45 miles/ 60 minutes
    - Surgical facilities: 20 miles/ 30 minutes
- New York
    - At least 3 PCPs from which enrollee may select. But must “account for providers in rural areas”.

- Pennsylvania
    - 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)
- Tennessee
    - PCPs: no more than 30 miles or /30 minutes
    - Inpatient Hospitals: 30 minutes
    - Specialists: Required; no specific standard except "reasonable" distance*
- Texas
    - PCP: 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: 75 miles
    - General Acute hospital: 30 miles in non-rural areas; 60 miles in rural areas. Rural means county with < 50,000 or areas designated by the Commissioner.
    - Specialty hospital: 75 miles
    - Network adequacy must be assessed using TX's standards via Annual Report to TX to identify and address gaps.
- Vermont
    - PCP: 30 minutes
    - Outpatient MH/SA services: 30 minutes
    - Lab/x-ray, Rx, optometry, inpt psych, MRI, inpt rehab: 60 minutes
    - Cardiac cath, kidney transplant, trauma, NICU, open heart surgery: 90 minutes
    - Recognize centers of excellence outside of state
- 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 meets or exceeds the average ratio for Washington state for the prior plan year;
        - The network includes such numbers and distribution that eighty percent of customers within the service area are within thirty miles of a sufficient number of primary care providers in an urban area and within sixty miles of a sufficient number of primary care providers in a rural area from either their residence or work; and
    - Mental Health Services: The insurer must measure the adequacy of the mental health network against this standard at least twice a year, and submit an action plan with the commissioner if the standard is not met.
        - Emergency mental health services, including crisis intervention and crisis stabilization services must be included in an insurer's provider network.

- An insurer must include a sufficient number and type of mental health and substance use disorder treatment providers and facilities within a service area based on normal utilization patterns.
- An insurer must ensure that a customer can identify information about mental health services and substance use disorder treatment including benefits, providers, coverage, and other relevant information by calling a customer service representative during normal business hours.

o 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 and behavioral health services provided by Indian health care providers.
- At a minimum, an insurer's provider network must adequately provide for mental health and substance use disorder treatment, including behavioral health therapy.

States with Requirements that are Less Stringent than Cigna Standard:

- Connecticut
  - By-county network coverage reported annually to DOI; NCQA network adequacy requirements or URAC's provider network access and availability standards
- Florida
  - 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
- Maine
  - Must analyze performance against the standards at least annually using methodology selected that allows direct measurement against standards for PCPs, SCPs and Behavioral Health Care Providers.
  - 1 PCP per 2,000 enrollees
- 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
  - Specialty/tertiary hospitals: no specific standards, but required to have standards
  - 1 PCP per 1,500 enrollees

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, 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, Florida, Hawaii, Iowa, Louisiana, Massachusetts, Minnesota, New Jersey, New Mexico, Oregon (if specializes in Women's Health), Rhode Island, Texas, 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: Vermont