Network Adequacy Talking Points for Oversight Committee

December 12, 2017

1. Network Access Plans

   - Health Maintenance Organizations (HMOs) are required to file access plans with the Department of Insurance, Financial Institutions and Professional Registration (DIFP) by March 1 of every year pursuant to 20 CSR 400-7.095 and 354.603, RSMo.
   - The health plans contracted with the state to deliver services through the Managed Care Program are HMOs so must comply with this requirement.
   - Access plans describe and measure the adequacy of the health plans' provider networks to provide services to their members.
     - Provider types include primary care providers, specialty providers, hospitals (emergent and non-emergent), behavioral health and dentists.

2. Network adequacy must be documented:
   - With bid proposal during RPF evaluation
   - Prior to delivering services under a new contract (readiness reviews)
   - Annually by March 1 according to 20 CSR 400-7.095 under DIFP

3. Measurement of adequacy includes:
   - Analysis of travel distance standards
   - Administrative measures including those that ensure adherence with appointment standards

4. MO HealthNet Division (MHD) role in analysis of network adequacy access plans
   - Following the submission of the health plan annual network access plan with DIFP in accordance with RSMo 354.603 and pursuant to the specific instructions per 20 CSR 400-7.095:
     - Health plan network access plans are reviewed by MHD staff based upon an MOU between the two agencies and Managed Care contract requirements
     - Geo Networks software is used to analyze distance standards of provider and participant data
     - Health plans submit exception requests for areas with insufficient access. Requests are approved or denied based on the nearest available provider
     - Final approval of access plan is agreed upon by both agencies

5. Health plans are required to regularly monitor their networks to ensure:

- Service accessibility standards are met
- Provider listing of panel status are accurate
- Members have and use PCPs
- Emergency rooms are not being used unnecessarily
- Providers report on number of members they will accept and limitations
- Providers report to the health plan when they reach 85% capacity

6. Health plans must report to MHD any network changes that materially affect their ability to provide services in a timely manner, for example:
    - Loss of a hospital
    - Decrease of primary care providers
    - Providers reaching 85% capacity

7. MO HealthNet Division compliance activities
    - Annual analysis of networks
    - Readiness reviews and other focused reviews of policies and procedures
    - Secret Shopper Survey of provider directory accuracy, new patient acceptance rates, and appointment wait times
    - Monitoring health plan when they have significant network changes to ensure compliance