MIKE CHANEY
Commissioner of Insurance
State Fire Marshal

MARK HAIRE
Deputy Commissioner of Insurance

RICKY DAVIS
State Chief Deputy Fire Marshal

MISSISSIPPI INSURANCE DEPARTMENT

501 N. WEST STREET, SUITE 1001
WOOLFOLK BUILDING
JACKSON, MISSISSIPPI 39201
www.mid.ms.gov

MAILING ADDRESS
Post Office Box 79
Jackson, Mississippi 39205-0079
TELEPHONE: (601) 359-3569
FAX: (601) 359-2474

MISSISSIPPI INSURANCE DEPARTMENT BULLETIN NO. 2015-4

NETWORK ADEQUACY REVIEW OF HEALTH CARRIERS OFFERING MANAGED CARE PLANS IN THE STATE

July 20, 2015

I. Purpose

The purpose of this Bulletin is to advise all health carriers offering a managed care plan in Mississippi of the requirement to submit for review to the Mississippi Insurance Department ("MID") an access plan for each managed care plan pursuant to the State's Managed Care Plan Network Adequacy Regulation (the "Regulation"). *Code Miss. R. 19-3:14.05.*

Pursuant to the Regulation's network adequacy provision, health carriers offering managed care plans in Mississippi must maintain networks that are sufficient in numbers and types of providers to assure that all services to covered persons are accessible without unreasonable delay. MID conducts an annual network review to ensure compliance with the Regulation. Health carriers are required to file an access plan by August 1 each year for each managed care plan the carrier offers in this State. Should the filing deadline fall on a weekend, submissions received on the next business day will be accepted.

II. Guidance

All access plans should be filed through the System for Electronic Rate and Form Filing ("SERFF"). To be satisfactory, an access plan must address the criteria set forth in Section 14.05B of the Regulation. A carrier's response to each criterion should include both an answer statement and a reference to attached supporting documents. Additional guidance is provided below.

14.05B(1) The health carrier's network;

The carrier's response should contain a brief description of the carrier's network. In addition, the response should reference and attach supporting documentation.

For example: "The network includes [#] total physicians in [#] specialties. The provider-to-member ratio is [#:#] for primary care and [#:#] for specialty care. *See* list of providers, covered services and provider-to-member ratios attached as Exhibit [#]."

14.05B(2) The health carrier's procedures for making referrals within and outside its network;

The response should provide a step-by-step explanation of the carrier's procedures for making referrals within and outside of its network. The response should also include information on any relevant referral policies, continuity and coordination of care policies, discharge planning policies, planning needs policies, etc.

Policies and/or procedures should be referenced and attached for verification.

14.05B(3) The health carrier's process for monitoring and assuring on an ongoing basis the sufficiency of the network to meet the health care needs of populations that enroll in managed care plans;

The response should describe how the carrier monitors its network and measures accessibility to care, such as through the use of GEO Access software.

The response may describe grievance procedures and how the carrier addresses a complaint filed by a member based on access to care, how the carrier handles recruitment requests and/or the carrier's recruitment procedures in the event additional providers are needed to meet the needs of members, how the carrier evaluates provider relations, etc.

The response may also discuss the carrier's policies related to practitioner availability, availability of services, and/or monitoring.

Supporting documentation should be referenced and attached for verification.

14.05B(4) The health carrier's efforts to address the needs of covered persons with limited English proficiency and illiteracy, with diverse cultural and ethnic backgrounds, and with physical and mental disabilities;

First, the response should explain the carrier's efforts to address the needs of covered persons with limited English proficiency and illiteracy. For example, the carrier may require providers to ensure that members have access to medical interpreters and signers to facilitate communication without cost to them and/or require providers to ensure that office staff responsible for data collection makes reasonable attempts to collect language-specific member information.

Second, the response should explain the carrier's efforts to address the needs of covered persons with diverse cultural and ethnic backgrounds. The carrier may do so by requiring providers to ensure that office staff that routinely interact with members participate in cultural competency

training and development, by requiring providers to ensure that treatment plans are developed and clinical guidelines are followed with consideration of a member's race, country of origin, social class, and other characteristics that may result in a different perspective or decision-making process, and/or by requiring providers to ensure that medical care is provided with consideration of the member's race/ethnicity as well as its impact/influence on the member's health or illness.

Third, the response should explain the carrier's efforts to address the needs of covered persons with physical and mental disabilities. For example, the carrier may require its providers to maintain medical office space in accordance with the ADA and/or require providers to ensure that treatment plans are developed and clinical guidelines are followed with consideration of a member's mental or physical disabilities.

The response may also describe specific policies and procedures relative to language, culture/ethnicity, and/or disabilities. Examples may include translation policies, quality of care investigation policies, cultural competency policies, member satisfaction policies, etc.

Supporting documentation should be referenced and attached.

14.05B(5) The health carrier's methods for assessing the health care needs of covered persons and their satisfaction with services;

The response should describe the carrier's health care assessment process and any other measures indicative of member satisfaction. For example, the carrier may describe case management programs, grievance and appeals trends, annual member satisfaction surveys, member services hotlines, etc. In addition, the carrier may describe any relevant policies and procedures, including its grievance and complaint process and policies related to member rights and responsibilities.

Supporting documentation should be referenced and attached.

14.05B(6) The health carrier's method of informing covered persons of the plan's services and features, including but not limited to, the plan's grievance procedures, its process for choosing and changing providers, and its procedures for providing and approving emergency and specialty care;

At a minimum, a carrier's response must describe how members are informed of grievance procedures, processes for choosing and changing providers, and procedures for providing and approving emergency and specialty care. For example, a member handbook and/or website, call center hours, and/or a discussion of specific policies regarding enrollee information requirements, orientation information, grievances and complaints, etc.

Supporting documentation should be referenced and attached.

14.05B(7) The health carrier's system for ensuring the coordination and continuity of care for covered persons referred to specialty physicians, for covered persons using

ancillary services including social services and other community resources, and for ensuring appropriate discharge planning;

The response should address how the carrier ensures coordination and continuity of care for persons referred to specialty physicians and for persons using ancillary services, as well as how the carrier ensures appropriate discharge planning for its plan members.

For example, the carrier may discuss its policies related to continuity and coordination of services, utilization management programs, case management programs, discharge planning needs, etc.

Supporting documentation should be referenced and attached.

14.05B(8) The health carrier's process for enabling covered persons to change primary care professionals;

The response should explain the steps a member must take to change primary care professionals and indicate where that process is outlined for members (for example, in a member handbook). The response may also include information regarding specific policies with regard to changing primary care professionals.

Supporting documentation should be referenced and attached.

14.05B(9) The health carrier's proposed plan for providing continuity of care in the event of contract termination between the health carrier and any of its participating providers, or in the event of the health carrier's insolvency or other inability to continue operations. The description shall explain how covered persons will be notified of the contract termination, or the health carrier's insolvency or other cessation of operations, and transferred to other providers in a timely manner;

The response must explain the carrier's proposed plan for providing continuity of care in the event of contract termination with any of its participating providers, indicate how covered persons will be notified of the contract termination, and describe how covered persons will be transferred to other providers in a timely manner. This may be accomplished through a description of the carrier's policies in place to ensure continuity of care as well as how continuity of care will be preserved. The response may describe contractual provisions between the carrier and its participating providers requiring that providers continue to treat members that are receiving care until the point at which the carrier arranges coordination of that care with another provider, etc.

The response must also explain the carrier's proposed plan for providing continuity of care in the event of insolvency or other cessation of operations. The explanation must describe how the carrier will notify covered persons of the insolvency or other cessation of operations, as well as how covered persons will be transferred to other providers in a timely manner.

Supporting documentation should be referenced and attached.

14.05B(10) Any other information required by the Commissioner to determine compliance with the provisions of this Regulation.

Should the Commissioner determine that additional information is needed to complete the network adequacy review, health carriers will be contacted at that time.

III. Contact

This Bulletin along with any future guidance or other information regarding the submission of access plans pursuant to section 14.05B of Mississippi's Managed Care Plan Network Adequacy Regulation will be posted on MID's website: www.mid.ms.gov.

Should you have any questions or concerns, please do not hesitate to contact us.

Issued this the 20th day of July, 2015.

MIKE CHANEY
COMMISSIONER OF INSURANCE