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MISSISSIPPI DEPARTMENT OF INSURANCE
BULLETIN 2025-3

NETWORK ADEQUACY FILING INSTRUCTIONS AND GUIDANCE
April 15, 2025

I. Purpose and Scope.

The Mississippi Managed Care Plan Network Adequacy Regulation, ("Network Adequacy Regulation"), was adopted by the Mississippi Insurance Department ("MID") in order to establish standards for the creation and maintenance of networks by health insurance carriers to assure the adequacy, accessibility and quality of health care services offered under a managed care plan. 19 Miss. Admin. Code, Pt. 3, Ch.14. As part of the requirements under the Network Adequacy Regulation, health insurance carriers are to submit an access plan for each managed care plan that the carrier offers in this state by June 1 of each year for review. 19 Miss. Admin. Code Pt. 3, R.14.05. This Bulletin has been promulgated to give health insurance carriers instruction and guidance in filing their access plan with MID.

This Bulletin shall apply to all health insurance carriers that offer managed care plans in Mississippi. This Bulletin does not apply to the Mississippi State Employee Health Plan, any managed care plan regulated by the Mississippi Division of Medicaid, or to any self-insured health plans.

II. Filing of Access Plans

Rule 14.05(E) of the Network Adequacy Regulation requires a health insurance carrier to have an access plan for each managed care plan that the carrier offers in the State of Mississippi. As part of its regulatory authority, MID directs health insurance carriers offering managed care plans in the State to submit their access plans through the System for Electronic Rate and Form Filing (SERFF) by June 1 of each year for review.

III. Access Plan Required Contents

To be deemed satisfactory, an access plan must address each of the following ten (10) standards as set forth in Rule 14.05(E) of the Network Adequacy Regulation, along with any additional guidance as provided herein.

1. The health insurance carrier's network;

The access plan should give a concise, general overview of the health insurance carrier's network. The carrier should submit and may reference supporting documentation as needed to verify statements contained within the access plan. The carrier may reference the information submitted pursuant to Rule 18.05 of the Network Adequacy Regulation as part of their verification.

2. The health insurance carrier's procedures for making referrals within and outside its network;

The access plan should include a description of the referral process and have policies and/or referral procedures attached and referenced in its response. If the carrier does not require its members to obtain referrals, the access plan should include a statement to that effect must be included.

3. The health insurance 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 access plan should address the process the carrier uses to monitor the population's needs on an ongoing basis and to ensure that those needs are met.

The access plan must confirm that the carrier has an ongoing monitoring process in place, whether it is its own process or geoaccess software, and the access plan must refer to written policies and/or GEO Access reports, which should be attached.

4. The health insurance 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;

This subsection should be broken down into the following categories:

A. The carrier's efforts to address the needs of covered persons with limited English proficiency;
B. The carrier's efforts to address the needs of covered persons with diverse cultural and ethnic backgrounds; and,
C. The carrier's efforts to address the needs of covered persons with physical and mental disabilities.

To be sufficient, an access plan must explain the carrier's efforts to address each category of barriers. A plan that addresses categories (A) and (B) but fails to address category (C) will be considered inadequate.

Furthermore, within each category the access plan should list the steps taken by the

carrier to ensure that network providers are making efforts to overcome barriers resulting from each category of special needs. A response that fails to address one or more of the categories will be deemed inadequate.

5. The health insurance carrier's methods for assessing the health care needs of covered persons and their satisfaction with services;

The access plan must describe the methods the carrier uses to assess needs and satisfaction with services.

6. The health insurance 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;

The access plan should state how the carrier informs its enrollees of the plan services and features. The response should be broken down into the following categories:

A. How the carrier informs enrollees of the plan's grievance procedures;
B. How the plan informs enrollees of the process for choosing/changing providers; and,
C. How the carrier informs enrollees of its procedures for providing/approving emergency and specialty care.

7. The health insurance 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;

This subsection should be broken down into the following categories:

A. The carrier's system for ensuring coordination and continuity of care for covered persons referred to specialty physicians;
B. The carrier's system for ensuring coordination and continuity of care for covered persons using ancillary services; and,
C. The carrier's system for ensuring appropriate discharge planning.

8. The health insurance carrier's process for enabling covered persons to change primary care professionals;

The access plan must describe the carrier's process for enabling covered persons to change primary care professionals, if such a process exists. If a carrier allows their members to choose and/or change providers on their own at any time, then a statement to that effect must be included.

9. The health insurance 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;

This subsection has three parts:

A. The carrier's proposed plan for providing continuity of care in the event of contract termination between the carrier and one of its providers;
B. The carrier's proposed plan for providing continuity of care in the event of the carrier's insolvency or other cessation of operations; and
C. A description of how the carrier will notify; covered persons of the occurrence of (A) and/or (B).

An access plan that provides a response to parts (A) and (C) but fails to answer part (B) will be deemed inadequate.

10. Any other information required by the Commissioner to determine compliance with the provisions of the Regulation.

Currently, the Commissioner is not requesting any additional information.

IV. Information Required to be Submitted

All health insurance carriers offering covered managed care plans must obtain certification by the MID pursuant to Section 18.06 of the Network Adequacy Regulation. This certification is subject to reconsideration at any time. Consistent with the requirements of Rule 18.05, along with the access plan referenced above, health carriers must submit a package containing the following materials:

1. Sample contract forms proposed for use with its participating providers and intermediaries.

Health carriers shall submit a contract form for each regulated managed care plan they offer in the State.

2. A complete list of its participating providers and information about them. The information must include:

A. Each network provider's most-closely affiliated provider type as provided for in Rule 14.05 of the Network Adequacy Regulation;

Rule 14.05 explicitly incorporates by reference the network adequacy standards in 45 C.F.R. § 156.230. CMS' guidance on 45 C.F.R. § 156.230 includes the 2023 Final Letter to Issuers in the Federally-facilitated Exchanges, and Tables 3.1, 3.2, and 3.3 list the common provider types that CMS uses to measure network adequacy. The health carrier's provider types should coincide with the provider types as established by CMS.

B. The complete practice location(s) for each of its network providers;

The submission should include the address, not just city and state.

C. Contact information for each network provider.

A telephone number and email address are sufficient to meet this standard.

3. A sufficient geoaccess report.

Health insurance carriers may submit geoaccess reports prepared by any of the major software programs or third parties that prepare them. If CMS accepts a particular type of geoaccess report, the carrier may submit that report.

4. An attestation by a person with authority for the health insurance carrier that the carrier has complied with the Network Adequacy and Certification Regulations, and if the carrier is unable to comply, an explanation as to why. Such explanation must address the carriers efforts to secure health care providers and the relative availability of health care providers in the geographic area under consideration.

5. A report detailing the health insurance carrier's terms and conditions of coverage under its covered managed care plan(s), including detailed descriptions of:

A. Provisions delineating health coverage;

B. Provisions delineating plan benefits;

C. Provisions delineating limitations on coverage and benefits;

D. Exclusions and restrictions on the use of any providers;

E. Its utilization review and quality assurance policies;

F. Its members' responsibility for copays, deductions, and payment responsibility for out-of-plan services and supplies;

G. Its policies for compliance with Rule 14.05(c);

H. Its credentialing criteria and policies and processes for credentialing criteria;

I. Its procedure for allowing a provider to request its individual profile if economic or practice profiles are used in the credentialing process;

J. Its procedure for informing providers of reasons for contract termination or denial of a provider's network application;

K. Its procedures for maintaining confidentiality of members' medical records; and,

L. Its procedures for encouraging interested providers to apply for network participation.

V. Certification

Upon review, MID will advise the health insurance carrier in writing if a submitted access plan is deemed satisfactory. If an access plan is deemed insufficient, the carrier will be notified in writing and will be given the opportunity to submit supplemental information before the access plan is denied.

If MID determines that a health insurance carrier's network does not adequately assure reasonable access to covered benefits for all covered persons, or fails to meet the Certification Regulation, MID may institute a corrective action or use any of its other enforcement powers to obtain the health carrier's compliance with the Regulations. 19 Miss. Admin. Code, Pt. 3, R.14.10 and 19 Miss. Admin. Code, Pt. 3, R.18.06.

VI. Violations.

Failure to comply with the provisions contained within this Bulletin shall be considered a violation of the Network Adequacy Regulation and shall be subject to the penalty provisions set forth in *Miss. Code Ann.* § 83-5-17, as well as other penalty provisions under applicable law, including 19 Miss. Admin. Code, Pt. 3, R.14.11 and 19 Miss. Admin. Code, Pt. 3, R.18.09.

VII. Effective Date.

The provisions contained within this Bulletin are effective as of this date.

Any health insurance carrier that has questions regarding the provisions contained within this Bulletin may contact the Life and Health Actuarial Division at 601-359-3657.

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