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Network Management

Values

Accountability ● Integrity ● Service Excellence ● Innovation ● Collaboration

Abstract Purpose:

To determine the network adequacy, Network Health (NH) will assess member/participant populations, practitioner and provider availability, and appointment access.

Policy Detail:

I. Network Adequacy
   A. NH follows methodology defined by the health plan and CMS as quantifiable and measurable to monitor the availability and geographic distribution of practitioners and providers in relation to the membership:
      1. County Type designation (Large Metro, Metro, Micro, Rural, or CEAC) is determined by CMS. The county type affects both the minimum number of providers and the maximum time/distance criteria.
      2. Population / Density Parameters are established by CMS, for the purpose of CMS determining County Type.
      3. Specialty Codes are defined by CMS annually. For reporting purposes NH recognized specialty codes are cross walked, as necessary, to the CMS defined specialty codes.
      4. Time and Distance requirements are established by CMS on an annual basis. Maximum travel distance and time to provider sites is based upon member/beneficiary residence. 90% of members/beneficiaries in a given county must have access to at least one provider/facility, for each specialty type, within NH and CMS established time and distance requirements. Maximum travel time and distance criteria vary by county type and specialty type. Practice locations of contracted providers are not limited to the boundaries of the county or counties in question. If providers are within the time and distance requirements, contracted providers located outside of the requested service area/county may be included.
      5. Population Assessment assesses the plan's membership based upon claims data, local, state and national organization supplied demographic data, and member eligibility data to determine the characteristics and needs of the membership population and subpopulations.

II. Appointment Access
   A. NH will maintain and monitor a network of providers to provide adequate access to covered services in a number sufficient to meet the needs of the

population served. NH assesses access through annual member/participant surveys and continuous monitoring of member/participant complaints to all types of services and modifies the network arrangements as necessary. In addition, on an annual basis, NH conducts an outbound call campaign using an external vendor to contact provider offices regarding access and availability standards. NH identifies opportunities and takes corrective action for observed deficiencies and performs follow-up to determine the effectiveness of the corrective action. See the attached standards and process for monitoring appointment access. Services assessed include access to:

1. Primary Care Practitioners:
    a. Regular and routine care
    b. Urgent
    c. After-hours care
2. Behavioral Healthcare
    a. Non-life threating emergency care within 6 hours
    b. Urgent care within 48 hours
    c. Routine care within 10 business days
    d. Follow-Up Routine Care within 30 business days
3. Specialty and OB/GYN

Definitions:

Access (Accessibility): is the extent to which a patient/member can obtain available services when needed. “Services” refer to both telephone access and ease of scheduling an appointment, if applicable. Appointment Access related to the amount of time which can be measured in hours, days, etc. between scheduling an appointment with a practitioner and the actual practitioner visit.

Adequacy: measures whether the practitioner and provider availability standards, as defined by the health plan and CMS, are being met.

Availability: is the extent to which the health plan geographically distributes the appropriate types and numbers of practitioners and providers to meet the needs of its members within the plan’s defined geographical area.

Behavioral Health Specialists: include Psychiatrists/APNPs (those who prescribe and monitor medications), Behavioral Health Clinicians (those psychologists and masters-prepared therapists who provide mental health assessments and counseling), and AODA counselors (those whose specialty is treating substance abuse).

High Volume Specialists: are a type of specialist who treats a significant portion of the organization’s membership.

High Impact Specialists: are a type of specialist who treats specials specific conditions that have serious consequences for the member and require significant resources.

High Volume Behavioral Health Specialists: are defined as those behavioral health practitioners who treated at least 50% of the members receiving behavioral health services of the following defined specialties: Psychiatrists/APNPs (those who prescribe and monitor medications), Behavioral Health Clinicians (those psychologists and masters-prepared therapists who provide mental health assessments and counseling), and AODA counselors (those whose specialty is treating substance abuse).

Behavioral Health Facilities: include inpatient, residential and ambulatory behavioral health services.

Medical Health Specialists: include practitioners who provide for necessary specialty care. Women enrollees have the option of direct access to a women's health specialist within the network for women's routine preventive health care services provided as basic benefits.

Key High-Volume Specialists: are defined as the top 5 medical specialties with the greatest number of member encounters per year.

Primary Care Practitioners (PCPs): include Physicians, Advanced Practice Nurse Prescribers, NHIC approved Certified Nurse Practitioners and NHIC approved certified Physician Assistants. All of the practitioner's work in the specialties of Family Practice, General Practice, and Internal Medicine. Members are encouraged to choose a Primary Care Practitioner (PCP). OB-GYNs may provide women's routine and preventive health care. In some instances, it is appropriate for the medical specialist to function as a PCP. Refer to NHIC Medicare Advantage Physician Care Model Health care (Policy N03613).

Employment Status is defined as:
Full-time includes a minimum of 4.5 days per week devoted generally to patient care activities in the office setting, with no fewer than 36 hours of face- to-face patient contact (e.g. 8 hours of face-to-face patient contact, 4 days per week).

Regular part-time includes a minimum of 3.5 days per week devoted generally to patient care activities in the office setting, with no fewer than 14 hours of face-to-face patient contact (e.g. 4 hours of face-to-face patient contact, 3 days per week).

Regulatory Citations:

NCQA - NET1, NET 2, NET3

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