Texas Department of Insurance

SN-019 Major Medical Access Plan Instructions Guide

General instructions

Adhering to the following key points will increase user experience when completing the Major Medical Access Plan template.

Copy/Paste

To ensure data integrity, the following areas are restricted and cannot be edited or pasted into:

- Column headings
- TIC/TAC references
- Cells with a dark blue background

Drop down lists

- Drop-down lists have been provided in specific cells as suggestions. However, they are not restrictive, and copy/paste is still available for use.

Workbook tabs

- Under Texas Administration Code §11.1607 when a network does not meet specified distance requirements prescribed in §11.1607 (h) and accessibility times in §11.1607 (b), an insurer must provide an access plan to operate within its service area with the identified network gaps.

- The Access Plan contains five worksheet tabs.

Overview

1. Complete the overview portion by filling in applicable information in the Insurer/HMO Name and Network Name cell.
    a. This tab may also be replaced with the company's access plan for addressing deficiencies.

Overview
When contracted providers are not available within the TDI mileage access and/or availability standards outlined in Texas Administrative Code, Title 28, Section 11.1607
Insurer or HMO Name and Network Name
, will utilize procedures that will assist enrollees in obtaining medically necessary services when no network physician or provider is available, including procedures to coordinate care to eliminate or limit the likelihood of balance billing.
Insurer or HMO Name and Network Name
ensures that enrollees will be held harmless from any amounts beyond the copayment, deductible, coinsurance percentage and other out-of-pocket amounts in accordance with Texas Administrative Code, Title 28, Section 11.1611(d) (HMO).

See detailed worksheets for access plan information by county and by specialty.

Insurer/HMO Name and Network Name: Insurer or HMO Name and Network Name

2. Fill in the form name box in the left-hand bottom corner.

Form Name:

Counties

1. Service area designation
    A. Individually select counties within the network's approved service area.
        a. To select all counties, select the first county. Then drag the corner of corresponding cell all the way down.

*** The counties selected will be summated into the "Counties in Service Area" box to the right.

    B. Individually select counties requiring an access plan.
        a. To select all counties, select the first county. Then drag the corner of corresponding cell all the way down.

*** The counties selected for having an access plan will be summated into the "Counties with Access Plan" box to the right.

Counties in Service Area:	0
Counties with Access Plan:	0

Major Medical

Information in this tab will identify deficiencies in the service area, the reason why providers are not available, and the corresponding access plan summary.

1. The following columns will need to be filled:
    *Copy/Paste can be utilized, or drop-downs have been provided for each column accordingly

- County
    - Each deficient county will need to be listed.
- Provider/Facility Type/Services
    - For each county, the corresponding deficiency in specialty will need to be listed.
    - One specialty per row. (i.e. a county has 30 deficiencies, that same county will be listed 30 different times)
- Reason Network Providers Not Available
    - From the drop-down list, choose a reason why preferred providers are not available to insureds.

The drop-down list provides the following reasons for network providers not available:

Reason	Explanation
Insufficient number of available providers	Not enough qualified healthcare professionals are available to meet adequacy requirements.
Research and outreach to available providers are in progress	The company is actively gathering information and proposals; contacting available providers; evaluating provider qualifications; or identifying potential providers.
Unable to agree on reimbursement rate	An agreement cannot be made on the amount of money that will be paid for a particular service.
Available provider(s) do not contract with commercial insurance companies	The available healthcare provider(s) have chosen not to participate in commercial insurance. They may only accept government funded insurance or they may be self-pay providers who require payment upfront.
Unable to contact provider/Provider did not respond to outreach attempts	The company is unable to contact the provider due to communication barriers, such as high call volume, provider availability, technical difficulties, or incorrect contact information.
In active contract negotiations	Currently in ongoing discussions to modify or amend certain terms and conditions within an existing contract.
Providers or physicians participate in an exclusivity arrangement	The provider is contractually prohibited from contracting with another company.
No other retail pharmacies are available for contracting	Not enough retail pharmacies are available to meet adequacy requirements.
A contracted provider has been identified. Once record is updated, the deficiency will be resolved.	Providers are in the process of verifying their qualifications, licenses, and other credentials to ensure necessary standards are met for them to practice. Information regarding providers is being entered into the company's system.
Other- see comments	None of the drop-down options apply for this

	situation. An explanation is required to be given in the "Comments" column.

- Access Plan
    - Choose an access plan summary from the drop-down list below. You may also copy/paste your own access plan summary language

Reason	Explanation
Insufficient number of providers are currently practicing within the applicable network adequacy standards. Procedures are in place to comply with the access plan requirements in 28 TAC §11.1607 and balance billing protections in 28 TAC §11.1611(d).	An access plan is in place for enrollees due to the lack of physicians or healthcare providers in the affected county. A waiver is requested as there are no uncontracted physicians or healthcare providers in the area to meet the specific standard.
Not Applicable-No enrollees currently reside in the county. For any new enrollees residing within the county, insurer will comply with the access plan requirements in 28 TAC §11.1607 and balance billing protections in 28 TAC §11.1611(d).	An access plan is available in the event a new enrollee lives in this deficient county, or an existing enrollee relocates to this deficient county. In this situation, a waiver is being requested.
Unable to contract with available providers. Procedures are in place for HMO to comply with the access plan requirements in 28 TAC §11.1607 and balance billing protections in 28 TAC §11.1611(d).	An access plan is available for enrollees due to the company's failure to contract with available physicians or providers. The company is required to demonstrate good cause and good faith to receive an approved waiver.

Hospital Based Providers

Information in this tab will identify deficiencies for in-network hospital-based providers, the reason why providers are not available, and the corresponding access plan summary.

1. The following columns will need to be filled:
   *Copy/Paste can be utilized, or drop-downs have been provided for each column accordingly
    - Name of Hospital, Address, City, County
        - Each deficient hospital will need to be listed.
    - Services
        - For each facility, the corresponding deficiency in specialty will need to be listed.
        - Multiple deficient specialties can be listed in one row for the same facility. (i.e. a facility is deficient in anesthesia and general surgery, both deficiencies can be reported in one row).

Anesthesia 28 TAC § 11.1607(j)(1)	Emergency Medicine 28 TAC § 11.1607(j)(1)
X	X

- Reason Network Providers Not Available
    - From the drop-down list, choose a reason why preferred providers are not available

to insureds.

The drop-down list provides the following reasons for network providers not available:

Reason	Explanation
Service(s) will be paid at the in-network benefit level at the nearest facility or through telemedicine when contracted providers are not available within the TDI mileage access and/or availability standards outlined by the Texas Administrative Code. Enrollees will be held harmless from balance billing. In accordance with 28 TAC 11.1607, the Company requests an access plan for the county listed.	When there are no contracted in-network providers, services will be available to enrollees for no additional expense at the nearest facility or through telemedicine.
Research and outreach to available providers are in progress.	The company is actively gathering information and proposals; contacting available providers; evaluating provider qualifications; or identifying potential providers.
Services are not rendered at this facility.	The facility does not offer these services.
Unable to agree on reimbursement rate.	An agreement cannot be made on the amount of money that will be paid for a particular service.
Insufficient number of available providers/facility staffed by a single provider.	Not enough qualified healthcare professionals are available to meet adequacy requirements.
In active contract negotiations.	Currently in ongoing discussions to modify or amend certain terms and conditions within an existing contract.
Unable to contact provider/Provider did not respond to outreach attempts.	The company is unable to contact the provider due to communication barriers, such as high call volume, provider availability, technical difficulties, or incorrect contact information.
A contracted provider/facility-based group has been identified. Once record is updated, the deficiency will be resolved.	Providers are in the process of verifying their qualifications, licenses, and other credentials to ensure necessary standards are met for them to practice. Information regarding providers is being entered into the company's system.
Other- see comments.	None of the drop-down options apply for this situation. An explanation is required to be given in the “Comments” column.

- Access Plan
  - Choose an access plan summary from the drop-down list below. You may also copy/paste your own access plan summary language

Reason	Explanation
Insufficient number of providers are currently practicing within the applicable network adequacy standards. Procedures are in place to comply with the access plan requirements in 28 TAC §11.1607 and balance billing protections in 28 TAC §11.1611(d).	An access plan is in place for enrollees due to the lack of physicians or healthcare providers in the affected county. A waiver is requested as there are no uncontracted physicians or healthcare providers in the area to meet the specific standard.
Not Applicable-No enrollees currently reside in the county. For any new enrollees residing within the county, insurer will comply with the access plan requirements in 28 TAC §11.1607 and balance billing protections in 28 TAC §11.1611(d).	An access plan is available in the event a new enrollee lives in this deficient county, or an existing enrollee relocates to this deficient county. In this situation, a waiver is being requested.
Unable to contract with available providers. Procedures are in place for HMO to comply with the access plan requirements in 28 TAC §11.1607 and balance billing protections in 28 TAC §11.1611(d).	An access plan is available for enrollees due to the company's failure to contract with available physicians or providers. The company is required to demonstrate good cause and good faith to receive an approved waiver.