Health Maintenance Organization
Network Access Plan Instructions

2021

(For health plans who submit network data files, please note highlighted sections at pages 4, 10, and 11).

Also for health plans who submit network data files, please note the addition of a "Row ID" requirement. See pages 9, 11, 12, and 13.

Life and Healthcare Section
Division of Market Regulation
Missouri Department of Commerce & Insurance

The Access Plan

Pursuant to §354.603, RSMo, HMOs licensed in the state of Missouri must file an Access Plan with the Missouri Department of Commerce & Insurance (DCI). The Access Plan must include the following information. Each of the items and sub-items listed below should be clearly labeled and should be presented in the order given to ensure full credit for everything submitted. Please submit all materials in 10 point font or greater:

1. A description of the health carrier's network (in a format that is described later in these instructions) or a completed affidavit per 20 CSR 400-7.095 Exhibit B. If an affidavit is submitted, a complete listing of currently used health plan form name(s) and numbers, the DCI File number(s) and/or SERFF filing number(s) and date of approval shall be included. The list of currently used health plan form name(s) and numbers etc. may be separate from the affidavit, but clearly referenced on the affidavit.
2. A description of the HMO's procedures for making referrals within and outside its network.
3. A description of the HMO's process for monitoring and assuring on an ongoing basis the sufficiency of the network to meet the health care needs of enrollees of the managed care plan.
4. A description of the HMO's method for assessing the health care needs of enrollees and their satisfaction with services.
5. A description of the HMO's method of informing enrollees 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.
6. A description of the HMO's system for ensuring the coordination and continuity of care for enrollees referred to specialty physicians, using ancillary services (including social services and other community resources) and for ensuring appropriate discharge planning. (§354.615 RSMo)
7. A description of the HMO's process for enabling enrollees to change primary care physicians.
8. A description of the HMO's proposed plan for providing continuity of care in the event of contract termination between the health carrier and any of its participating providers, a reduction in service area or the health carrier's insolvency or other inability to continue operations. The description shall explain how enrollees would be notified should any of these events occur, and how enrollees would be transferred to other providers in a timely manner. (§354.612 RSMo for provider contract termination)
9. Any other information required by the director to determine compliance with the provisions of §354.600-354.636 RSMo:

   A. For the **2021** filing, the Director requires that all HMOs include their most recent copies of all network provider directories with the access plan, pursuant to §354.603.2(9), RSMo. This includes any directories issued by sub-contractors, such as mental or behavioral health, pharmacy, dental, vision, etc. All the provider directories are to be attached to the "Provider Directories" section of the "Supporting Documents" tab in the SERFF file.

   B. Information as required by 20 CSR 400-7.095 (2)(A)3 demonstrating the following:

   1. Emergency Medical Services – a written triage, treatment and transfer protocol for all ambulance services and hospitals is in place. The protocol shall address post-emergency situations when members have received emergency care from a non-participating provider.
   2. Home Health Providers – Home health providers are contracted to serve enrollees in each county where enrollment is reported. A home health provider need not be physically located or headquartered in each county. However, there must be at least one (1) home health provider under contract to serve enrollees in each county of the HMO's service area.
   3. Administrative Measures for Timely Access to Appointments are in place for the medical providers listed in Exhibit A based on the following guidelines:
      (a) Routine care, without symptoms – within thirty (30) days from the time the enrollee contacts the provider;
      (b) Routine care, with symptoms – within five (5) business days from the time the enrollee contacts the provider;
      (c) Urgent care for illnesses/injuries which require care immediately, but which do not constitute emergencies as defined by §354.400 RSMo – within twenty-four (24) hours from the time the enrollee contacts the provider,

(d) Emergency care – a provider or emergency care facility shall be available twenty-four (24) hours per day, seven (7) days per week for enrollees who require emergency care as defined by §354.400 RSMo;
(e) Obstetrical care – within one (1) week for enrollees in the first or second trimester of pregnancy; within three (3) days for enrollees in the third trimester. Emergency obstetrical care is subject to the same standards as emergency care, except that an obstetrician must be available twenty-four (24) hours per day, seven (7) days per week for enrollees who require emergency obstetrical care; and
(f) Mental health care – telephone access to a licensed therapist shall be available twenty-four (24) hours per day, seven (7) days per week.

4. A section demonstrating or stating the entire network is available to all enrollees of a managed care plan, §354.603.1(4) RSMo, including describing any network management practices that affect enrollees' access to all participating providers. (20 CSR 400-7.095(2)(A)3.B.)
5. For employer specific networks, a section demonstrating that the contract holder agreed in writing to the different or reduced network. §354.603.1(4) RSMo An employer specific network is subject to the standards in this rule (20 CSR 400-7.095(2)(A)3.C.).
6. Written policies and procedures to assure that with regard to providers not addressed in Exhibit A of this regulation, 20 CSR 400-7.095, access to such providers is reasonable. For otherwise covered services, the policies and procedures must show that the HMO will provide out-of-network access at no greater cost to the enrollee than for access to in-network providers if access to in-network providers cannot be assured without unreasonable delay.

C. Information as follows regarding network hospitals which utilize non-network service providers, including but not limited to radiologists, anesthesiologists, pathologists, laboratories, emergency room physicians (or other hospital-based service providers):

1. Name(s) and address (es) of participating facilities where this occurs.
2. Identify which specific hospital-based service providers are not contracted at that hospital.
3. Method of payment for the non-network services and/or enrollee's financial obligation.
4. Copy of disclosure provided to all enrollees (including POS enrollees) regarding the hospital and the enrollee's possible financial obligation.

D. Information pursuant to §376.1199 RSMo regarding coverage of ~~contraception and~~ elective abortion under the company's health benefit plans. In your response please include the SERFF filing number(s) of approved policy forms, application forms, enrollment forms or other policy forms which demonstrate compliance with the subsections of 376.1199 that are not pre-empted by the Affordable Care Act.
(Subsections 1(4), 4, 5, 6(1), 6(2), and 6(3) of section 376.1199 are pre-empted by the federal Affordable Care Act and its implementing regulations. (*Missouri Insurance Coalition v. Huff, 947 F.Supp.2d 1014 (E.D.Mo))*.

E. Information pursuant to §376.1224 RSMo regarding licensed participating Applied Behavior Analyst (ABA) or assistant behavior analyst as licensed per Chapter 337. **Not required of MO HealthNet Plans.**

a. Name(s) and professional address(es) of participating or contracted Applied Behavior Analyst (ABA) or assistant behavior analyst. This listing is for only Applied Behavior Analyst (ABA) or assistant behavior analyst who are licensed by Missouri Department of Professional Registration or certified by Behavior Analyst Certification Board (BACB).
b. Indicate how the participating Applied Behavior Analyst (ABA) or assistant behavior analysts are listed in the provider directories, both print and electronic.
c. Copy of disclosure provided to all enrollees (including POS enrollees) regarding Applied Behavior Analyst (ABA) or assistant behavior analyst, services provided and any enrollee's financial obligation.
d. If there are not currently contracted participating Applied Behavior Analyst (ABA) or assistant behavior analyst, indicate how the enrolled member or dependent is aware benefits are available at no greater cost than if services were obtained by a participating provider, and obtains services and how the claims are processed, including any enrollee's financial obligation.

F. Information pursuant to §376.1900 RSMo regarding telehealth services: Provide any policies and procedures implemented to comply with section 376.1900 regarding coverage of telehealth services. Include a copy of

any health benefit plan language that has been approved describing this benefit, or any SERFF filing #'s your company has filed for approval to update health benefit plans to comply. Also include a reference to where telehealth providers are listed in provider directories, if listed therein. If telehealth providers are not listed in provider directories, please explain why.

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- Annual access plans must be submitted on or before **March 1**.
- A new access plan must be filed if the HMO experiences a significant change in its network or enrollment or approved service area before the annual filing date or at any time during the year after the Network Access Plan has been filed.
- A **checklist** is listed on the website which includes, at a minimum, the information to be submitted. http://insurance.mo.gov/industry/filings/mc/accessMain.php

Additional Instructions for MO HealthNet managed care networks

Pursuant to the most recent MO HealthNet Managed Care contract, MO HealthNet Managed Care health plans are encouraged to reflect any applicable Community Mental Health Centers, Federally Qualified Health Centers, Rural Health Clinics, Family Planning Providers, Local Public Health Agencies or School Based Clinics in the applicable network data file. For example, the location of a Local Public Health Agency contracted to provide primary care services should be reflected in the provider data file. If the medical professional rendering care at that location is unknown, it is acceptable to put the Local Public Health Agency's name in either the FRSTNAME or LASTNAME field of the provider data file. (Please see pages 10 thru 13 for additional information on the required data files).

HMOs in the MO HealthNet Managed Care Program are required to include data on participating dental care providers. See page 14 for the required specialty code for general dental providers. This data fulfills MO HealthNet Managed Care contract requirements and does not affect any HMO's enrollee access score.

HMO's in the MO HealthNet Managed Care Program are also required to include data on participating Chiropractic providers. See page 14 for the required specialty code for Chiropractic providers.

HMO's in the MO HealthNet Managed Care Program are not required to submit data files for Applied Behavior Analyst providers.

Standards for access to care for HMOs in the MO HealthNet Managed Care Program are more stringent in some cases than those required by DCI, for example appointment standards. HMOs in the MO HealthNet Managed Care Program will be evaluated according to the contract with the MO HealthNet Division.

As required, the MO HealthNet Plans have obtained national accreditation. These plans will need to submit data files for evaluation of the current Network Access to enrollees.

General Filing Information

20 CSR 400-7.095 sets forth specific criteria that DCI will use to evaluate each HMO's network. The regulation uses distance and wait-time standards set forth for specified medical professionals, facilities and ancillary service providers. These Instructions are intended as guidelines for preparation of the required information.

Filing fees:

Pursuant to §374.230 RSMo, DCI will collect a filing fee of $150.00 for each Network Access Plan filed. Companies must remit filing fees via EFT. To establish payment via EFT, please contact the SERFF helpdesk at 816-783-8990 or via email at serffhelp@naic.org.

Where to send the Network Access Plan(s):

Please submit the written portion of the Network Access Plan with the required items via SERFF on or before **March 1, 2021** at 5:00 CST**.** Please follow the Missouri SERFF Filing Guidelines with TOI code HOrg03 Health Organizations - Other. The "filing type" must be "Report" as stated in the SERFF filing instructions and Sub-TOI code: HOrg03.NET Network Access Plan. The submitted written portion shall be filed under the "Forms" tab in SERFF. Please bypass the "PPACA" and "variable text" requirements with N/A. All documentation shall be at a MINIMUM of 10 font, including any charts. When the correct SERFF TOI, Sub-TOI and filing type are indicated, the supporting documentation tab lists the correct headings to be used for the SERFF filing of the Network Access Plan.

The written access plan is to be attached under "Forms" tab. The following are the list of headings under "Supporting Documentation" to which the appropriate and applicable documents should be attached. Cover Letter; Network Description-Data Submission Guidelines; Accreditation Letter and Certificate; Affidavit; Internal Policies and Procedures; EOC or Certificates; Emergency Medical Services protocol; Home Health Providers by county; Administrative Measures for Timely Access to Appointments, Non-Network Hospital Based Providers (RAPLs); Applied Behavior Analyst and assistants; Recently passed legislation, Printed Provider Directory.

The response to any objections will be with the objections as set up in the SERFF system. Please DO NOT attach a separate letter in the Supporting Documents tab with responses to objections. When adding a "Note to Filer", please send a corresponding e-mail to the reviewer. This will result in quicker action taken by the reviewer.

The printed provider directories should be attached to the "Provider Directory" section of the "Supporting Document" tab in SERFF. Since SERFF has size limitations to each attached file, be prepared to divide the information into more than one section, if needed.

How to contact the Life and Healthcare Section:

Please direct inquiries regarding the Network Access Plan to Randy Rust at (573) 522-9177; via email at randy.rust@insurance.mo.gov; or via USPS at the following address:

Randy Rust
Life and Healthcare Section
Missouri Department of Commerce & Insurance
301 West High Street, Room 530
Jefferson City, MO 65102

The World Wide Web:

Copies of these instructions and other pertinent information can also be obtained on the DCI homepage at:
http://insurance.mo.gov/industry/filings/mc/accessMain.php

Reminders:

Networks that contain POS providers: When reporting a network, report only the regular HMO network. Do not include the POS providers and facilities. POS enrollees should continue to be included and reported in the appropriate enrollee file as done in the past.

The 2021 Network Access Plans should contain all changes and corrections noted in the 2020 Network Access Plans.

The Cover Letter

Please include a cover letter containing the following information:

1. All managed care plans (MCPs) offered by the HMO, including each product's name and type.

   NOTE: If separate MCPs have different networks, you must submit a separate set of data files or affidavit for each MCP.

2. A chart indicating the populations served by the HMO and the Missouri counties in which the HMO is currently serving those populations (see example below). Please include the entire approved service area for the Plan with notations as to which populations are served by the HMO.

Approved Service Area	Commercial Plan	Medicaid Plan	Medicare Plan
ADAIR	X		
ANDREW	X	X	
ATCHISON	X	X	X
AUDRAIN	X	X	X
BARRY	X	X	X
BARTON	X		X

'X' indicates that the HMO serves that population in the corresponding county listed in the first column.

Network Description - Data Submission Guidelines

For each MCP, four distinct data files for each network should be submitted to DCI for analysis.

Data files that are infected with any form of virus will be destroyed, and must be resubmitted free of viruses.

Quest Analytics™ software is used to analyze each network.

The required files are as follows:

1. The **enrollee file** must contain a count by ZIP code of the number of enrollees accessing the network. **DO NOT INCLUDE ADMINISTRATIVE SERVICES ONLY (ASO) MEMBERS IN THE ENROLLEE FILE.** Include only information for members employed or residing in the state of Missouri.
2. The **provider file** must contain information about medical professionals that are available to the members listed in the enrollee file, and with whom the carrier has an agreement or other contractual arrangement.
   - **The file must include all subcontracted professionals.**
   - **Providers without license numbers will not be included in the analysis and this may cause an HMO network to appear inadequate.**
3. The **facility file** must contain information about the facilities that are available to the members listed in the enrollee file, and with whom the carrier has an agreement or other contractual arrangement.
   - **The file must include all subcontracted facilities.**
   - **Facilities without taxid numbers will not be included in the analysis and this may cause an HMO network to appear inadequate.**
4. The **ancillary file** must contain information about the ancillary service providers (both individuals and facility providers) that are available to the members listed in the enrollee file, and with whom the carrier has an agreement or other contractual arrangement.
   - **The file must include all subcontracted ancillary service providers.**
   - **Ancillary providers without taxid or license numbers will not be included in the analysis and this may cause an HMO network to appear inadequate.**

All files should contain data as of **January 1st** for the year being reported. Specific formatting guidelines for these files begin on page 9 of these instructions.

If the MCP is covered by accreditation, then an affidavit may be submitted instead of data files, except for the MO HealthNet Plans. All MO HealthNet Plans are required to submit data files as described herein.

I. Enrollee File(s) Instructions

The enrollee file must contain a count by Zip code of the number of enrollees accessing each MCP submitted as of **January 1st**. These files should be submitted in ASCII (*.txt or .txts) or Excel (*.xls or .xlsx) formats. File names, field names/column headings, and the required contents of each data file are listed below. The formatting recommendations for submission of ASCII fixed-record length, non-delimited text format are also listed below should the HMO elect to use this format. The number of enrollee files required will depend on what products the HMO offers. **Do not include Administrative Services Only (ASO) members in any file.**

Commercial Plan enrollee file (COMENR.txt or .txts or COMENR.xls or .xlsx)
(Including commercial HMO and POS members, combined group and individual, EXCLUDING Medicaid, Medicare and ASO members)
Field 1: ROWID (Row number)
Field 2: ZIPCODE (5-digit Zip code)
Field 3: COUNTCM (Commercial HMO plan enrollee count)
Field 4: NAIC (Reporting HMO's 5-digit NAIC number)

Medicaid Plan enrollee file (MDCDENR.txt or .txts or MDCDENR.xls or .xlsx)
Field 1: ROWID (Row number)
Field 2: ZIPCODE (5-digit Zip code)
Field 3: COUNTMCD (Medicaid plan enrollee count)
Field 4: NAIC (Reporting HMO's 5-digit NAIC number)

Enrollee File ASCII Parameters: If an ASCII fixed-width file format is used there should be a separate record of fixed-length 24 for each applicable Zip code. All numeric fields should be right justified (left zero filled) and all text fields left justified. Please do not include decimals, commas or carriage control characters in the data file.

Enrollee File ASCII Parameters:

Field Name/Column Heading	Field Length	Field Position	Field Type
ROWID ZIPCODE	6 5	01-06 07-11	Numeric Text
COUNTCM* or COUNTMCD*	8	12-19	Numeric
NAIC	5	20-24	Text

*COUNTCM for commercial enrollees, or COUNTMCD for MO HealthNet managed care enrollees.

II. Provider File Instructions

Please submit only ONE provider file per MCP. Each provider file must contain medical professionals of the types listed on page 14. This file must contain all subcontracted medical professionals. **Failure to include subcontracted medical professionals may cause an HMO network to appear inadequate.**

NOTE: Report all medical professionals that would provide services to Missouri enrollees.

NOTE: Report a Primary Care Physician as a Specialist ONLY if he/she is licensed, practicing and contracted to provide that specialty. If a physician serves as both a PCP and a Specialist, place a "1" in both the **PRIMCARE** and **SPCILST** Fields.

NOTE: Addresses should indicate the street, city, state and Zip code where medical professionals practice their specialty. Please use the actual street address. **Do not use PO Box numbers.** DCI will inform each HMO if their provider file(s) contain address information that cannot be used.

NOTE: If a medical professional practices at multiple locations, please provide a separate record for each address. **Do not put extra practice locations in an "Address 2" field or any variation of supplying that information through additional fields.** Any fields beyond what are required in these instructions are eliminated from the data files prior to analysis. DCI will inform any HMO that is affected if extra address fields were eliminated. DCI does not have the resources to inform HMOs exactly which addresses would be lost if extra address fields are eliminated.

NOTE: License Numbers are those assigned by DCI, Division of Professional Registration. License numbers are collected on the state mandated credentialing form (CAQH Form UCDS) for every contracted medical professional. **Do not use ID numbers assigned by the HMO.** Any medical professionals in the provider file that do not have a valid license number may be excluded from the network analysis. DCI will inform any HMO affected if medical professionals were eliminated due to lack of valid license numbers.

NOTE: Some of the medical professional codes begin with zero. **Failure to format SPEC1, SPEC2 and SPEC3 as text fields will result in the loss of leading zeros.** DCI will require the provider file to be resubmitted with the appropriate formatting and intact medical professional codes.

NOTE: For MO HealthNet managed care plans, any of the agencies listed in Attachment 5 of the most recent MO HealthNet managed care contract that are providing primary care or specialty care services should be listed in the provider data file. (An agency or clinic that does not provide the full range of primary care services specified in the MO HealthNet managed care contract cannot be reported as a PCP, but may be reported as any applicable specialty care provider, such as vision care.) If the medical professional rendering care at the applicable location is unknown, it is acceptable to put the applicable agency's name in either the **FRSTNAME** or **LASTNAME** field of the provider data file.

NOTE: Please be aware that this information may be subject to verification by our Market Conduct examiners at any time.

This file is to be prepared based on health care providers in the applicable network as of **January 1st** for the year being reported.

Provider File ASCII Parameters: If an ASCII fixed-width file format is used, there should be a separate record of fixed-length 152 for each contracted and subcontracted medical professional. All fields should be left justified text fields. Please do not include decimals, commas or carriage control characters in the data file.

Field Name/ Column Heading	Field Description	Field Length	Field Position	Field Type
ROWID	Row number	6	01-06	Numeric
LICNUM	Medical Professional's license number (See CAQH Form UCDS[1])	15	07-21	Text
LASTNAME	Medical Professional's last name	25	22-46	Text
FRSTNAME	Medical Professional's first name	18	47-64	Text
MIDINIT	Medical Professional's middle initial	1	65	Text
PROVADD	Medical Professional's **practice** address **Not a PO Box**	40	66-105	Text
PROVCITY	Medical Professional's **practice** city	20	106-125	Text
PROVST	Medical Professional's **practice** state	2	126-127	Text
ZIPCODE	Medical Professional's **practice** ZIP code.	5	128-132	Text
PRIMCARE	Is the Medical Professional a Primary Care Physician? 1=yes 0=no	1	133	Text
SPCILST	Is the Medical Professional a specialist? 1=yes 0=no	1	134	Text
HMOCOMM	Does the Medical Professional see commercial enrollees? 1=yes 0=no	1	135	Text
HMOMDCD	Does the Medical Professional see Medicaid enrollees? 1=yes 0=no	1	136	Text
PRIMEYE	Does Medical Professional's contract include provision of primary medical eye care? 1=yes 0=no	1	137	Text
SPEC1	Medical Professional's most frequently practiced specialty (See CAQH Form UCDS[1] and choose from the list of codes on page 14 of these instructions.)	3	138-140	**Text**[2]
SPEC2	Medical Professional's second most frequently practiced specialty, if any (See CAQH Form UCDS[1] and choose from list of codes on page 14 of these instructions.)	3	141-143	**Text**[2]
SPEC3	Medical Professional's third most frequently practiced specialty, if any (See CAQH Form UCDS[1] and choose from list of codes on page 14 of these instructions.)	3	144-146	**Text**[2]
CLOSPRAC	Is the Medical Professional closed to new patients? 1=yes 0=no (See p. 8 of CAQH Form UCDS[1])	1	147	Text
PROVNAIC	Reporting HMO's 5-digit NAIC number	5	148-152	Text

[1]CAQH Form UCDS, per 20 CSR 400-7.180.

[2]Some of the medical professional codes begin with zero. Failure to format SPEC1, SPEC2 and SPEC3 as text fields will result in the loss of leading zeros. DCI will require the provider file to be resubmitted with the appropriate formatting and intact medical professional codes.

III. Facility File Instructions

Please submit only ONE facility file per MCP. Each facility file must contain the facilities listed on page 15, including hospitals, ambulatory, residential and inpatient mental health facilities and pharmacies. This file must contain all subcontracted facilities (i.e. third party pharmacy vendors). **Failure to report subcontracted facilities may cause an HMO network to appear inadequate.**

NOTE: Addresses should indicate the street, city, state and Zip code where medical professionals practice their specialty. Please use the actual street address. **Do not use PO Box numbers**. DCI will inform each HMO if their provider file(s) contain address information that cannot be used.

NOTE: In order to correctly reflect all services provided by a facility, it may need to be listed more than once in the facility file. For example, a particular hospital could be listed between one and eleven separate times according to the services it provides. See page 15 for the complete list of all facility codes.

NOTE: For MO HealthNet managed care plans, any of the agencies listed in Attachment 5 of the most recent MO HealthNet managed care contract that are providing mental health services should be listed in the facility data file.

NOTE: It is permissible to use the NABP# for pharmacies rather than a tax ID number.

NOTE: Please be aware that this information may be subject to verification by our Market Conduct examiners at any time.

This file is to be prepared based on health care facilities in the applicable network as of **January 1st** for the year being reported.

Facility File ASCII Parameters: If an ASCII fixed-width format is used there should be a separate record of fixed-length 238 for each contracted and subcontracted health care facility. All fields should be left justified text fields. Please do not include decimals, commas or carriage control characters in the facility file.

Facility File ASCII Parameters:

Field Name/ Column Heading	Field Description	Field Length	Field Position	Field Type
ROWID	Row number	6	01-06	Numeric
TAXID	Facility's tax ID number or NABP# for pharmacy	15	07-21	Text
FACTYPE	Type of facility (See list of applicable codes on page 15)	3	22-24	Text
FACNAME	Facility's name	100	25-124	Text
FACSTRT	Facility's street address **Not a PO Box**	80	125-204	Text
FACCITY	Facility's city	20	205-224	Text
FACSTATE	Facility's state	2	225-226	Text
ZIPCODE	Facility's ZIP code	5	227-231	Text
FACCOMM	Does the facility see commercial enrollees? 1=yes 0=no	1	232	Text
FACMDCD	Does the facility see Medicaid enrollees? 1=yes 0=no	1	233	Text
FACNAIC	Reporting HMO's 5-digit NAIC number	5	234-238	Text

IV. Ancillary Provider File Instructions

Please submit only ONE ancillary file per MCP. Each ancillary file must contain the ancillary service providers listed on page 15, including physical, speech and occupational therapists, and audiologists. This file must contain all subcontracted ancillary service providers, individuals, groups and facilities. **Failure to include subcontracted ancillary service providers may cause an HMO network to appear inadequate.**

NOTE: Addresses should indicate the street, city, state and Zip code where medical professionals practice their specialty. Please use the actual street address. **Do not use PO Box numbers**. DCI will inform each HMO if their provider file(s) contain address information that cannot be used.

NOTE: It may be necessary to list an ancillary service provider more than once in order to accurately reflect all services that they may provide. **Ancillary service providers may be individuals or facilities**. For example, a hospital previously reported in the facility file may provide certain therapy or nursing services, and should be reported in the ancillary file with the appropriate ancillary service code(s).

NOTE: For MO HealthNet managed care plans, any of the agencies listed in Attachment 5 of the most recent MO HealthNet managed care contract that are providing ancillary services should be listed in the ancillary data file.

NOTE: Do not include Home Health Providers in the Ancillary Data File. Home Health Providers are reported in chart form in the written portion of the Network Access Plan, per 20 CSR 400-7.095(2)(A)3.A. Please see page 2 of these instructions. Please be aware that this information may be subject to verification by our Market Conduct examiners at any time.

This file is to be prepared based on health care providers in the applicable network as of **January 1st** for the year being reported.

Ancillary Services File ASCII Parameters: If an ASCII fixed-width format is used there should be a separate record of fixed-length 240 for each contracted and subcontracted ancillary service provider. All fields should be left justified text fields. Do not include decimals, commas or carriage control characters in data file.

Ancillary Services File ASCII Parameters:

Field Name/ Column Heading	Field Description	Field Length	Field Position	Field Type
ROWID	Row number	6	01-06	Numeric
TAXID	Ancillary service provider's tax ID number	15	07-21	Text
ANCTYPE	Type of ancillary service provider (See list of applicable codes on page 15)	3	22-24	Text
ANCNAME	Ancillary service provider's name, individual or facility	100	25-124	Text
ANCSTRT	Ancillary service provider's street address **Not a PO Box**	80	125-204	Text
ANCCITY	Ancillary service provider's city	20	205-224	Text
ANCSTATE	Ancillary service provider's state	2	225-226	Text
ZIPCODE	Ancillary service provider's ZIP code	5	227-231	Text
ANCCOMM	Does the ancillary service provider see commercial enrollees? 1=yes 0=no	1	232	Text
ANCMDCD	Does the ancillary service provider see Medicaid enrollees? 1=yes 0=no	1	233	Text
ANCHOME	Does the ancillary service provider offer home-based services to enrollees? 1=yes 0=no	1	234	Text
ANCFACIL	Does the ancillary service provider offer facility-based services to enrollees? 1=yes 0=no	1	235	Text
ANCNAIC	Reporting HMO's 5-digit NAIC number	5	236-240	Text

MEDICAL PROFESSIONAL CODES

Primary Care Providers

General Medicine	087	†Obstetrics	029
Family Medicine	010	†Gynecology	015
Internal Medicine	019	†Obstetrics/Gynecology	030
Pediatrics	038	†Advanced Nurse Practitioners	ANP

†These providers are primary care providers only if the HMO permits this pursuant to the benefits contract and the provider contract. HMOs wanting to use the services of an Advanced Nurse Practitioners as a PCP in their commercial network must request an exception per 20 CSR 400-7.095(3)(A)1.B.(V).

Specialists

Obstetrics/Gynecology	030	Physical Medicine/Rehab	042
Neurology	024	Podiatry	200
Dermatology	006	‡Vision Care/Primary Eye Care	201 or 032

‡ (Ophthalmologists providing primary eye care-report as 032 with 1 in PRIMEYE field. Optometrists providing primary eye care-report as 201 with 1 in PRIMEYE field).

Medical Subspecialties:

Allergy	002	Orthopedics	202
Cardiology	106	Otolaryngology	094
Endocrinology	009	Pediatric	038
Gastroenterology	011	Pulmonary Disease	048
Hematology/Oncology	110	Rheumatology	053
Infectious Disease	018	Urology	125
Nephrology	023	General Surgery	059
Ophthalmology	032		

Mental Health Providers:

Psychiatrist-Adult/General	043	Psychologists/Other Therapists	PSY
Psychiatrist-Child/Adolescent	044	(Not including psychiatry)	

Chiropractic Care:
Chiropractor CDO

Dental Care:**
General Dentist GDE

**(Dental Care is required for MO HealthNet managed care networks only).

Facility Codes

Hospitals

Basic Hospital	HBA
Secondary Hospital	HSE
Level I or Level II Trauma Unit	HT1
Neonatal Intensive Care Unit	HT2
Perinatology Services	HT3
Comprehensive Cancer Services	HT4
Comprehensive Cardiac Services	HT5
Pediatric Subspecialty Care	HT6

Pharmacies

Pharmacy	PHA

Mental Health Facilities

Ambulatory Mental Health Treatment Providers	AMH
Inpatient Mental Health Treatment Facility	IMH
Residential Mental Health Treatment Providers	RMH

Ancillary Health Care Service Codes

Audiology	ATA
Occupational Therapy	OTA
Physical Therapy	PTA
Speech Therapy	STA

Affidavit Submission Guidelines

1. The affidavit set forth in Exhibit B of 20 CSR 400-7.095 may be submitted for each managed care plan the HMO operates in lieu of submission of the data files described in these instructions.

2. If an affidavit is submitted, each managed care plan must fall into at least one of the following categories:
   A. Medicare Advantage
   B. NCQA Accreditation at a level of "accredited" or better, currently effective
   C. URAC Accreditation at a level of full URAC Health Plan accreditation, currently effective.
   D. Accreditation by any other nationally recognized managed care accrediting organization which has been received by the department of insurance by October 15 of the year prior to the year the access plan is filed and approved by the department of insurance.

3. In each case, accreditation must be in effect on **March 1, 2021.**
4. The affidavit must specify the product name(s) of the managed care plan for which accreditation has been awarded.

5. The form name(s) and number(s) of the health benefit plan for the managed care plan(s) must be listed on the affidavit along with the DCI approval numbers or SERFF tracking number and date of approval. (A separate but attached listing is acceptable.)

6. The affidavit must be signed and notarized.

7. Information required by §354.603.2(2) through (9) RSMo and by 20 CSR 400-7.095(2)(A)3 must also accompany the affidavit.

8. Please attach a copy of the accreditation certificate to the affidavit, or proof of accreditation identifying the accredited entity.

PLEASE REFER TO THE INSTRUCTIONS, STATUTES & REGULATIONS FOR ALL REQUIREMENTS.

Requesting Exceptions

1. Quality of Care Exception:
   HMO must submit a request which demonstrates the quality of care to enrollees is enhanced and that it imposes no greater cost to enrollees than they would have incurred if they had access to providers as otherwise required by 20 CSR 400-7.095. If the exception is granted, a score of 90% will then be applied for the provider type in that requested county.

2. Noncompetitive Market Exception for PCP's and Pharmacies:
   HMO must submit a request for consideration of an exception that would double the distance standard for counties that are believed to be lacking available primary care physicians and/or pharmacies that meet the HMO's credentialing standards. The county requested should be listed along with the provider type. A determination will be made by DCI taking into consideration available providers who are practicing in the proximity of the requested county. If no provider of that type is available for contracting, the distance standard set for that county type will be doubled. The recalculated score will then be applied to reflect the access for that county.

3. Noncompetitive Market Exception for other provider types:
   HMO must submit a request for consideration of an exception which would demonstrate that the HMO's nearest contracted provider is practicing at a location which is not more than 25 miles further than the distance to the nearest available provider of that type for that county, or that they have contracted with the nearest available provider for that county. A determination will be made by DCI by taking a measurement to the nearest available provider. If the nearest contracted provider is located no more than 25 miles further than the nearest available provider, an exception will be granted. A score of 90% will then be applied for the provider type in that requested county.

4. Staff or IPA Model Exception:
   HMO must submit documentation that all or substantially all of the health care services provided to enrollees are provided by qualified full-time employees of the HMO and that enrollees have adequate access to the services described in 20 CSR 400-7.095(2)(A)3.A. Documentation must also be provided which demonstrates the contract holder was made aware of the circumstances under which such services were to be provided prior to the decision to contract with the HMO.

5. Use of Physician Extenders in Medically Underserved Areas:
   HMO must request consideration for the addition of physician extenders to meet access obligations in counties that are lacking in available physicians. Along with the request, the HMO must submit a database of the physician extenders that will be available for access. The database should follow the guidelines set forth for providers on pages 10 and 11 of the Network Access Plan Instructions. The HMO should also submit copies of the contract pages which demonstrate that the provider contract and health benefit plan permit the selection and use of physician extenders. Upon approval of the exception, the database will be merged with the provider file, and the score recalculated for that particular county. The recalculated score will then be applied to reflect access using physician extenders for that county.

PLEASE REFER TO THE INSTRUCTIONS, STATUTES & REGULATIONS FOR ALL REQUIREMENTS.