**ACCESS PLAN TEMPLATE**

Nebraska’s Managed Care Plan Network Adequacy Act, Neb. Rev. Stat. §§ 44-7101 to 44-7112, and specifically § 44-7105(2), requires insurers to prepare an access plan prior to offering a new managed care plan, made available to the Director or any interested party upon request. The Director is making this request as part of the filing review for ACA products.

Insurers are allowed to request that sections of the access plan be deemed proprietary or competitive and not made public. Section 44-7105(2) provides, “For purposes of this section, information is proprietary or competitive if revealing the information would cause the health carrier’s competitors to obtain valuable business information.”

The access plan must describe or contain at least the following, according to § 44-7105(2)(a)-(j). If insurers have access plan documents that are already in use, providing those documents and listing the page(s) on which each of the following is located is preferred. Insurers can use this list to create an access plan if one is not already developed.

1. The health carrier's network.

Please provide maps for each of the following: hospitals, primary care providers, specialists, behavioral health inpatient, and behavioral health outpatient.

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

(c) 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;

(d) 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;

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

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

(g) 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;

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

(i) 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; and

(j) Any other information required by the director to determine compliance with the provisions of the act.

The only additional information required is the maps under item (a) above.