Tuesday, July 8, 2008

Health Access Networks

I. Eligible Providers

For purposes of the Health Access Network Payments, a **HAN** is:

An entity representing a collection of providers which may including hospitals, community health centers, public health departments, physicians, rural health clinics (RHCs), federally qualified health centers (FQHCs), or other recognized safety net providers, that--

- is organized for the purpose of restructuring and improving the access, quality, and continuity of care to SoonerCare members, the uninsured and the underinsured; and
- offers patients access to all levels of care, including primary, outpatient, specialty, certain ancillary services, and acute inpatient care, within a community or across a broad spectrum of providers across a service region or State.

RHCs and FQHCs that receive federally designated prospective payments are not eligible to be an independent HAN but could be part of another network to improve access to care.

Networks must provide documentation that they meet at least two of the following:

1. **have a formal affiliation agreement/partnership at the community-level with traditional and non-traditional providers;**
2. **have a formal program to promote public health principles, community development, and local educational programs to address the challenges of rural and underserved populations.**
3. ***have 501 (c) 3 status.***

II. Performance and Reporting Requirements

Qualifying networks must submit a development plan to the OHCA or designated entity that details how the network plans to:

- Reduce costs associated with the provision of health care services to SoonerCare, uninsured and underinsured individuals;
- Improve access to, and the availability of, health care services provided to individuals served by the health access network;
- Enhance the quality and coordination of health care services provided to such individuals;
- Improve the health status of communities served by the health access network; and
- Reduce health disparities in such communities.

Once the plan has been approved, HANs must identify and submit measurable performance targets and demonstrate progress in order to qualify for payment on an ongoing basis.

OHCA will monitor networks to ensure that all requirements are met.

III. Reimbursement

The PCPs of the network will receive a case management payment based on the type of panel that they see. The network will receive the network fee as a supplemental payment.

Quarterly (monthly) payments will be made to the network. The network will identify to the OHCA the PCPs associated with their network. The OHCA will determine the number of MMs paid to those PCPs and multiply by the network fee. Network must document the contractual relationship between the PCP and the network if PCP is not employed by the network.

The network payment will be subject to recoupment and / or termination of this component for failure to properly meet the reporting requirements.

IV. Funding

HANs may be required to use local funds as state match in Year 1 of the Medical Home. Health access networks will be required to identify measurable performance targets and demonstrate progress in order to qualify for future year funding. This will be subject to annual limits on payment.