# Network Adequacy Survey

**Regular mail:** Connecticut Insurance Department, Life & Health Division, PO Box 816, Hartford, CT 06142-0816

**Overnight mail or hand delivery:** Connecticut Insurance Department, 153 Market St., 7th Floor, Hartford, CT 06103

Please provide a contact person should there be any questions or requests for additional information.

**Name of Company:** _____

**Address:** _____

_____

**Contact Person:** _____ **Direct Phone #:** _____

**Title:** _____ **e-mail address:** _____

Please note that all responses, letters, and data provided must be Connecticut specific for Fully Insured plans. Responses that include processes, letters or data for jurisdictions outside of Connecticut or for Self-Funded plans will be rejected.

Carriers are responsible for addressing all the questions, regardless of whether they own or lease their network(s).

1. Does the health carrier utilize its own or lease its network(s)?

   - ○ Own network(s)
   - ○ Lease network(s)
   - ○ Combination of owned and leased network(s)

   a. If the health carrier leases network(s), please provide the name(s) of network(s) leased:

2. Is the health carrier accredited by NCQA for meeting network adequacy requirements or by URAC for meeting URAC's provider network access and availability standards?

   - ○ Yes
   - ○ No. If not, provide information on the corrective actions taken to address this.

3. How many providers (as defined in §38a-478) does the health plan have per 1,200 covered persons? If the health plan does not have at least one provider, provide information on what corrective actions will be taken to address this and the date you expect to be compliant.

4. How many primary care physicians (if applicable) does the health plan have per 2,000 covered persons? If the health plan does not have at least one primary care physician, provide information on what corrective actions will be taken to address this and the date you expect to be compliant.

5. What percentage of in network providers accept new patients? If applicable, provide the answer by specialty. How frequently is this measure assessed and monitored?

6. Please see the below maximum time and distance requirements for each specialty by population size. Fill out the actual time and distance measures met for 90% of your members for each specialty by population size. If a requirement is not met, provide information on the corrective actions taken to address it and the date you expect to be compliant.

| Specialty Area | Maximum Time and Distance Standards (Minutes/Miles) | | |
|---|---|---|---|
| | ***Metro Requirement*** Population 50,000 + | ***Micro Requirement*** Population 10,000-50,000 | ***Rural Requirement*** Population under 10,000 |
| Primary Care, including Pediatrics routine/primary | *15/10* | *30/20* | *40/30* |
| Dental | *45/30* | *80/60* | *90/75* |
| Vision | 45/30 | 80/60 | 90/75 |
| Endocrinology | *60/40* | *100/75* | 110/90 |
| Infectious Diseases | *60/40* | *100/75* | *110/90* |
| Cardiovascular Disease | *45/30* | *60/45* | *75/60* |
| Oncology – Medical/Surgery | *45/30* | *60/45* | *75/60* |
| Oncology – Radiation/Radiology | *60/40* | *100/75* | *110/90* |
| Mental Health – Psychiatry/Psychology | *45/30* | *60/45* | *75/60* |
| Mental Health – Child & Adolescent Psychiatry/Psychology | *45/30* | *60/45* | *75/60* |
| Substance Use Disorder Treatment | *45/30* | *60/45* | *75/60* |
| Child & Adolescent Substance Use Disorder Treatment | *45/30* | *60/45* | *75/60* |
| Licensed Clinical Social Worker | *45/30* | *60/45* | *75/60* |
| Rheumatology | *60/40* | *100/75* | 110/90 |
| Hospitals – Inpatient & Outpatient Services | *45/30* | *80/60* | *90/75* |
| Outpatient Dialysis | *45/30* | *80/60* | *90/75* |

7. Please see the below timeframe requirements for scheduling in-network appointments. Fill out the actual measures that are achieved 90% of the time within your network. If a requirement is not met, provide information on the corrective actions taken to address it and the date you expect to be compliant.

| Type of Appointment | Timeframe Requirement |
|---|---|
| Urgent care | *within 48 hours* |
| Non-Urgent appointments for primary care | *within 10 business days* |
| Non-Urgent appointments for specialist care | *within 15 business days* |
| Non-Urgent for non-physical mental health | *within 10 business days* |
| Non-Urgent for ancillary services | *within 15 business days* |

8. Describe the health plan's capacity to provide medically necessary organ, tissue, and stem cell transplant surgery, if applicable.

9. How frequently is provider information updated in the network directory and what is the process for ensuring that the directories are accurate?

    a. Provide a link to the online directory:

    b. Verify that the below requirements are met. If a requirement is not met, provide information on the corrective actions taken to address it and the date you expect to be complaint.

        ☐ The directory accessible to non-members

        ☐ The directory clearly states when it was last updated

        ☐ The directory clearly indicates whether a provider accepts new patients

        ☐ The directory clearly indicates what other languages are spoken in the provider's office

        ☐ The directory clearly indicates whether the provider's office is handicap accessible

☐ A paper version of the directory is provided upon request

10. Specify the average length of a provider contract. Do contracts vary by specialty? Do the contracts renew automatically?

11. Describe the process in place to notify participating providers of their responsibilities to the health carrier's applicable administrative policies and programs, including, but not limited to the below. If there is no process in place, provide information on the corrective actions taken to address each requirement and the date you expect to be compliant.

    a. Payment terms
    b. Utilization review
    c. Quality assessment and improvement programs
    d. Credentialing
    e. Grievance and appeals processes
    f. Data reporting requirements
    g. Reporting requirements for timely notice of changes in practice such as discontinuance of accepting new patients
    h. Confidentiality requirements
    i. Any applicable federal or state programs
    j. Obtaining necessary approval of referrals to nonparticipating providers
    k. Collecting applicable coinsurance, deductibles or copayments from covered persons pursuant to a covered person's health benefit plan
    l. Notifying covered persons, prior to delivery of health care services, if possible, of such covered persons' financial obligations for non-covered benefits

12. Describe how the health carrier and participating providers are meeting the requirement to provide at least sixty days' written notice to each other before the health carrier removes or the participating provider leaves the network. If this requirement is not currently met, provide information on the date you expect to be compliant.

    a. Describe the process in place to ensure that each participating provider who receives a notice of removal or issues a departure notice provides the health carrier a list of covered persons that are covered under the health plan and are being treated on a regular basis. If this requirement is not currently met, provide information on the date you expect to be compliant.

b. Describe how the health carrier is meeting the requirement of sending a written notice to all covered persons being treated on a regular basis, notifying them that their provider is leaving or is being removed from the network. Confirm that the written notice is sent no later than 30 days after the health carrier issues or receives a written termination notice. If this requirement is not currently met, provide information on the date you expect to be compliant.

13. Describe the processes in place to enable covered persons to change their primary care provider or primary dentist designation. Provide an explanation if you do not have such processes in place.

14. Describe and provide a copy of the current policies and procedures in place for informing covered persons of the network plan's covered benefits, including but not limited to the below. If there are no current policies in place, provide information on the date you expect to have each policy implemented.

    a. The network plan's grievance and appeals processes.

    b. The network plan's process for covered persons to choose or change participating providers in the network plan.

    c. A statement of the health care services offered by the network plan, including those health care services offered through the preventive care benefit, if applicable.

    d. The network plan's procedures for covering and approving emergency, urgent and specialty care.

15. Describe and provide a copy of the current policies and procedures in place for the below requirements. If there are no current policies in place, provide information on the date you expect to have each policy implemented.

    a. Maintaining adequate arrangements to assure that covered persons have reasonable access to participating providers located near such covered persons' places of residence or employment.

    b. Approving and covering an out-of-network provider at an in-network level should there be no in-network providers within a reasonable driving distance, reasonable appointment scheduling timeframe, or accepting new members. Confirm that the timeframe for approving such requests falls within Connecticut’s Utilization Review standards?

c. Monitoring on an ongoing basis the ability, clinical capacity and legal authority of participating providers to provide all covered benefits to its covered persons. Also, address your credentialing and re-credentialing process, including frequency.

d. Notifying participating providers on an ongoing basis of the specific covered health care services for which such participating provider will be responsible, including any limitations on or conditions of such services.

e. Enabling participating providers to determine, in a timely manner at the time benefits are provided, whether an individual is a covered person or is within a grace period for payment of premium.

f. Establishing and maintaining procedures for the resolution of administrative, payment or other disputes between the health carrier and a participating provider.

g. Making and authorizing referrals within and outside of the network.

h. Addressing the health carrier's and providers' ability to meet the needs of covered persons, including, but not limited to children and adults, with (address each category below):
   - limited English proficiency or illiteracy
   - diverse cultural or ethnic backgrounds
   - physical or mental disabilities
   - serious chronic or complex conditions
   - visual or hearing impairments

i. When appropriate, including various types of essential community providers in its network?

j. Assessing the health care needs of covered persons and covered persons' satisfaction with the health care services provided. Describe how frequently these assessments are conducted and what corrective measures may be taken, when necessary.

k. Monitoring access to specialist services in emergency room care, anesthesiology, radiology, hospitalist care, pathology and laboratory services at participating hospitals, if applicable.

l. Ensuring that participating providers meet available and appropriate quality of care standards and health outcomes for network plans and that the included health care providers and facilities provide high quality of care and health outcomes.

16. Describe the factors and standards used to build a network, including a description of the network and the criteria used to select and tier health care providers and facilities, if applicable).

a. Provide a link to the company website where these standards are posted in plain language.

17. Describe the process for providing continuity of care to covered persons 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.

    a. Explain how covered persons will be notified of such contract termination, insolvency or other cessation of operations and transitioned to other participating providers in a timely manner.

18. Verify that all provider contracts include a hold-harmless clause?

19. Describe the process for ensuring the coordination and continuity of care for covered persons that are referred to specialty physicians or those that are using ancillary services, including but not limited to, social services and other community resources and for ensuring appropriate discharge planning for covered persons using such ancillary services.

## ATTACHMENT

**THE FOLLOWING CERTIFICATION MUST BE COMPLETED AND SIGNED BY AN OFFICER OF THE COMPANY TO CERTIFY THAT THE INFORMATION PROVIDED IS CORRECT**

I, _____, _____
(PRINTED NAME) (TITLE)

of _____, hereby acknowledge that I have read the
(COMPANY)

foregoing request and attached materials, that the information provided is true, accurate and offered in support of this request. I understand that any material changes in the information contained in this application must be filed with the Commissioner, as an amendment hereto, within thirty days of such change.