

## 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., 7<sup>th</sup> Floor,  
Hartford, CT 06103

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

<p><b>Name of Company:</b> _____</p> <p><b>Address:</b> _____ _____</p> <p><b>Contact Person:</b> _____ <b>Direct Phone #:</b> _____</p> <p><b>E-mail address:</b> _____</p>
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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.

1. 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? If these standards were not met, provide a copy of the corrective actions to address these concerns.  
 Yes  
 No
2. Does the health plan have at least 1 physician / 1,200 covered persons AND at least 1 primary care physician / 2,000 covered persons? If not, provide information on how this is being addressed.  
 Yes  
 No

3. Does the health plan have adequate primary care and specialist providers in the network accepting new patients to accommodate anticipated enrollment growth? If not, provide information on how this is being addressed.
- Yes  
 No
4. Does the health plan provide access to at least one provider in each of the below-listed provider types for at least 90% of covered persons? If not, provide information on how this is being addressed.
- Yes  
 No

Specialty Area	Maximum Time and Distance Standards (Minutes/Miles)		
	Metro Population 50,000 +	Micro Population 10,000-50,000	Rural Population under 10,000
Primary Care, including Pediatrics routine/primary	15/10	30/20	40/30
Dental	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 and Outpatient Services	45/30	80/60	75/60
Outpatient Dialysis	45/30	80/60	90/75

5. Does the health plan have sufficient number of providers to meet the below time frames for scheduling in-network care? If not, provide an explanation.

Urgent care:	within 48 hrs
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

- Yes  
 No

6. Does the health plan have the capacity to provide medically necessary organ, tissue, and stem cell transplant surgery? If not, provide an explanation and a proposed process to meet this requirement.

- Yes  
 No

7. Specify the process and frequency of assessing network adequacy. What procedures are followed in an effort to increase network adequacy?

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

- a. How far in advance and by what venue(s) are covered persons notified of changes to the directory?

9. Specify the average length of a provider contract. Does it vary by specialty?

10. Is there a process in place to timely notify a participating health care provider or facility of such health care provider's or facility's network participation status? If not, provide an explanation.

- Yes  
 No

11. Is there a process in place to notify participating providers of responsibilities to the health carrier's applicable administrative policies and programs, including, but not limited to, payment terms, utilization review, quality assessment and improvement programs, credentialing, grievance and appeals processes, data reporting requirements, reporting requirements for timely notice of changes in practice such as discontinuance of accepting new

patients, confidentiality requirements, any applicable federal or state programs and obtaining necessary approval of referrals to nonparticipating providers? If not, provide an explanation.

- Yes
- No

12. Is there a process in place to notify participating providers of their obligations, listed below? If not, provide an explanation.

a. Collect applicable coinsurance, deductibles or copayments from covered persons pursuant to a covered person's health benefit plan.

- Yes
- No

b. Notify covered persons, prior to delivery of health care services, if possible, of such covered persons' financial obligations for non-covered benefits.

- Yes
- No

c. Provide at least sixty days' written notice to the health carrier before leaving the participating network and provide the health carrier with a list of patients who are covered under the health carrier's network plan.

- Yes
- No

13. Does the health carrier provide at least a sixty days' written notice before removing a participating provider from the network? If not, provide an explanation.

- Yes
- No

a. Does the health carrier make it clear that each participating provider that receives a notice of removal shall provide the health carrier with a list of patients who are covered under the health carrier's network plan? If not, provide an explanation.

14. Are there processes in place to enable covered persons to change their designation of a primary care provider? If not, provide an explanation.

- Yes
- No

15. Are there processes in place for informing covered persons of the network plan's covered benefits, including but not limited to the below? If not, provide an explanation.

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

- Yes
- No

- b. The network plan's process for covered persons to choose or change participating providers in the network plan.
  - Yes
  - No
  
- c. The health carrier's process for updating its participating provider directories for each of its network plans.
  - Yes
  - No
  
- d. 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.
  - Yes
  - No
  
- e. The network plan's procedures for covering and approving emergency, urgent and specialty care.
  - Yes
  - No

16. Describe the current policies and procedures in place for:

- 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. Monitoring on an ongoing basis the ability, clinical capacity and legal authority of participating providers to provide all covered benefits to its covered persons.
  
- c. Notifying a participating provider 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.
  
- d. 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.
  
- e. Establishing and maintaining procedures for the resolution of administrative, payment or other disputes between the health carrier and a participating provider.
  
- f. Making and authorizing referrals within and outside the network.

- g. Addressing the needs of covered persons, including, but not limited to, children and adults, including those with limited English proficiency or illiteracy, diverse cultural or ethnic backgrounds, physical or mental disabilities and serious, chronic or complex conditions. Such description shall include the health carrier's efforts, when appropriate, to include various types of essential community providers in its network.
  - h. Assessing the health care needs of covered persons and covered persons' satisfaction with the health care services provided.
  - i. Monitoring access to specialist services in emergency room care, anesthesiology, radiology, hospitalist care, pathology and laboratory services at participating hospitals.
  - j. 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.
17. 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. Are these standards posted on the health carrier's Internet website in plain language? Provide a link to the website page.
    - Yes
    - No
18. 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.
19. Describe your process for ensuring the coordination and continuity of care:
- a. 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.
  - b. For ensuring appropriate discharge planning for covered persons using such ancillary services.