**The State of New Hampshire Insurance Department**

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Public Network Adequacy Working Group Kickoff Meeting: April 23, 2014  
Brown Building, 129 Pleasant St., Concord, NH  
9am-11am

**Goal:** The Insurance Department has convened this organizational meeting to launch the review of its network adequacy rules. This is the first step of a process intended to gather information and feedback on New Hampshire’s current rules defining network adequacy for health insurance companies, and what changes might be made through the formal rulemaking process.

**Agenda:**

- Opening comments

- Overview of the administrative rulemaking process & timeline

- History and policy issues related to network adequacy

- Discussion of comments submitted by participants

- Wrap up & next steps

- Questions & answers
Discussion Points for Stakeholder Engagement

In order to capture the comments received in advance of this meeting, we categorized the suggested areas for reform and comments on current state network adequacy regulation into high-level topics of particular interest and consideration for the stakeholder engagement process.

Below, you will find key considerations for the stakeholder discussion, with comments received from interested parties bulleted below the main headings:

1. **Healthcare priorities of the State:** Do state laws and regulations regarding provider networks align with these priorities?
   - i. **Access issues:**
     - Ensure access to mental health services
     - Address access to out-of-network providers
     - Require adequate access for all enrollees (not just 90%)
     - Strengthen time and distance standards and base these on actual driving routes
     - Improve access during non-business hours
     - Improve access to all required services (dental, pediatric)
     - Strengthen access for all populations, regardless of benefit design, with consideration for geography
     - Ensure low-income populations have access to local hospital services
   - ii. **Continuity of care:**
     - Strengthen continuity-of-care requirements
     - Align requirements with Medicaid managed care, for example:
       - Preventive care office visits available within 30 days
       - Transitional home care within 2 days of discharge

2. **How will changes affect large and small providers?** For example, how would any changes affect large hospitals and small community providers, including Federally Qualified Health Centers and rural health centers?
   - Apply any willing provider contract requirements for FQHC
   - Improve access to ECPs

3. **Additional considerations for special needs populations:** How would any changes affect the significant population of rural, minority, or special-needs consumers? Would changes disrupt existing relationships?
   - Improve access for “gap” or border communities
   - Protect vulnerable populations
   - Access for people with disabilities
   - Protect under-served counties, and all patients
   - Consider using regional economic statistics as one way to better recognize and define NH's regional needs.
Agenda & Comments
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For Discussion Only

- **Access for those living in medically underserved areas who are less affluent, create presumptions for medically underserved areas either identified by HHS or served by an FQHC that the network should include all primary care providers willing to accept rates offered and accepted by any provider in the service area. If an insurer's network does not include primary care providers in such areas, it ought to be required to identify those excluded and certify that the excluded were offered the same rates accepted by others and declined.**

- **An ECP hospital should be included in every New Hampshire market**

- **Hillsborough Country should be considered two distinct geographic areas**

- **Prospective Payment System Disproportionate Share Hospitals should be considered Essential Community Provider's**

- **For purposes of determining geographic proximity for hospital services, hospitals should be divided into general services and at-risk services (for example; inpatient behavioral health, full-scope women's services, inpatient pediatric services, neonatal intensive care.)**

4. **Provider capacity:** Would limited networks in combination with a large newly-insured population further intensify the issue?

- **Establish maximum wait times in addition to NCQA/URAC standards**

- **Ensure access to inpatient behavioral health, partial hospitalization for behavioral health, and sterilization procedures**

- **Wait time standards**

5. **Payment and delivery reforms:** Do laws and regulations support issuers and providers in attempts to improve quality and lower costs through healthcare reform?

- **Allow competition based on premiums and networks**

- **Structure requirements so that networks can focus on high value providers, telemedicine, use of urgent care centers, and value-based purchasing**

6. **Balancing priorities:** How can the State balance access and cost in order to ensure that consumers receive plans that offer the best value?

- **Ensure that people can choose insurance that is best for them**

- **“Best” is highly variable**

- **Encourage more carriers to participate in NH**

- **Allow both broad and narrow networks**

- **Do not allow providers to determine the network**

- **Establish NH network adequacy requirements using carrier accreditation and federal Qualified Health Plan requirements**

7. **Transparency:** How can increased transparency mitigate the potentially adverse effects of limited network arrangements?

- **Improve transparency of networks**

- **Insurers should identify the providers in their networks who have open panels. In addition, I suggest there be some affirmative representation of the wait time for new patient and non-urgent appointments. For example: Vermont’s standard is 2 weeks**
In addition to the above recommendations, a key consideration for the stakeholder engagement meeting should be potential additional regulatory oversight of network adequacy by Center for Medicaid Services implied in recent regulations. For 2015, CMS intends to collect plan provider lists and review them to determine whether providers are available without unreasonable delay, set forth above in Section II. Network Adequacy. The focus will be access to hospital systems, mental health providers, oncology providers, and primary care providers.

This is similar to the NH certification requirements set forth in the NHID 2015 QHP Certification Bulletin: http://www.nh.gov/insurance/media/bulletins/2014/documents/14-010-ab.pdf. CMS has indicated it intends to use its review to develop time and distance or other standards for future network review, and thus this should be part of the discussion with stakeholders.