

New Hampshire Network Adequacy Process

Per Ins 2701.07 each health carrier has a reporting requirement to prepare an annual healthcare certification of compliance report for each managed care health plan the carrier offers in New Hampshire. The purpose of the certification of compliance report is to notify the Insurance Department that they comply with the requirements of rule Ins 2700 and signed by an authorized representative of the insurance company. The report is to specifically state that the carrier has prepared a network adequacy report. If the report prepared by the carrier identifies any noncompliance to Ins 2700, the carrier shall identify the noncompliance in its certification of compliance report and not certify compliance until the noncompliance is corrected. These reports are due to the Department by March 1st of each year. In addition, the carriers are to make the network adequacy report accessible on their website.

- When reports are received, review the annual health care certification of compliance reports. Reports shall state that the issuer has prepared a network adequacy report and either met the requirements of Ins 2700 or was not compliant and identify their noncompliance
- Review the network adequacy report for verification if provided, or request a copy of the report for review
- If report is for a QHP plan, confirm an attestation was provided that the network is in compliance with the Essential Community Provider requirements. During the 1st year of the marketplace the issuers must demonstrate one of the following:
 - General Standard/Safe Harbor Standard: The issuer achieved at least 20% ECP participation in network in the service area, agreed to offer contracts to at least 1 ECP in each category in each county in the service area, where an ECP in that category is available; and offers contracts during the coverage year to all available Indian providers in the service area. If they do not meet both conditions, an ECP Supplemental Response Form Section 1 questions 1 or 2, whichever may apply should be completed.
 - Minimum Expectations Standard: The issuer achieved at least 10% ECP participation in the network service area and submits a satisfactory narrative justification as part of its issuer application by using the ECP Supplemental Response Form completing Section 2, Questions 3 - 5; or
 - If the issuer failed to achieve either standard they should submit a satisfactory narrative justification as part of its issuer application using the ECP Supplemental Response Form by answering Section 2, Questions 3 - 5.

OR

- Alternate Standard:
- If an issuer provides a majority of covered professional services through physicians employed by the issuer or through a single contracted medical group must have a sufficient number and geographic distribution of employed providers and hospital

facilities, to ensure reasonable and timely access for low income, medically underserved individuals in the QHP's service area, in accordance with the Exchange's network adequacy standards.

- To comply with the alternate ECP standard, the issuer must verify one of the following:
 - That the issuer has at least the same number of providers located in designated low income areas as the equivalent of at least 20% of available ECPs in the service area;
 - That the issuer has at least the same number of providers located in designated low income areas as the equivalent of at least 10% of available ECPs in the service area, and submits a satisfactory narrative justification as part of its issuer application using the ECP Supplemental Response Form completing Section 3, Questions 6 - 9; or
 - If the issuer failed either standard above but submitted a satisfactory narrative justification using the ECP Supplemental Response Form completing Section 3, Questions 6 – 9 as part of its issuer application.
- If report is for a QHP plan, download the Master Review and ECP Tool provided by CMS to confirm ECP requirements are being met
- If report is for a QHP plan, verify they are accredited with NCQA or URAC. If so, verify they provided their accreditation survey data and official accreditation correspondence. If not accredited with NCQA or URAC, the QHP issuer must provide attestation that they will become accredited prior to recertification
- If QHP issuer does not meet Ins 2700 or is not accredited with NCQA or URAC, confirm Access Plan was submitted
- If report is for a QHP stand alone dental plan, confirm report demonstrates their network has sufficient numbers and types of providers to assure services will be accessible without unreasonable delay
- Verify issuer has made their provider directory available online and in print as requested
- Prepare Department letter for signature highlighting any deficiencies and whether the report was approved by the department with or without exceptions