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NETWORK ADEQUACY STANDARDS
FOR
STANDALONE DENTAL PLANS
IN THE
SILVER STATE HEALTH INSURANCE EXCHANGE

PURPOSE

This document is intended to provide network adequacy standards for standalone dental plans offered through the Silver State Health Insurance Exchange.

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SECTION I – GENERAL REQUIREMENTS

A dental carrier that is participating in the Silver State Health Insurance Exchange (Exchange) by offering a network plan shall use best efforts to maintain each product provider network in a manner that is sufficient in numbers and types of oral health care providers to assure that all oral health care services to covered persons will be accessible without unreasonable delay. Each

covered person shall have adequate choice of oral health care providers. Provider directories shall be updated on-line no less than every 90 days and filed with the Division of Insurance in SERFF.

SECTION II – SUBMISSION AND UPDATED PROCESSES

Each carrier shall complete the "Network Access Plan Cover Sheet Template" in SERFF and include it in the Binder submission. Additionally, each carrier shall attest that its network(s) will meet these requirements by January 1, 2014, and at all times thereafter. An attestation form of compliance with network adequacy standards will be required to be signed by an officer of the company and submitted to the Exchange via SERFF on or before January 1st of each subsequent year. *An attestation form can be obtained on the Division of Insurance website.* A carrier shall use best efforts to provide notice of any significant change in the network to the Exchange within 60 days of the change taking affect. If the significant change results in a deficiency in the network, the notification must include a corrective action plan by the carrier to resolve the deficiency. Failure to provide such notification may lead to the suspension or termination of participation in the Exchange. The carrier shall have the right to appeal the decision and submit a corrective action plan to the Exchange for consideration.

SECTION III – REFERRALS AND REIMBURSEMENT

In any case where the carrier has an absence of or an insufficient number or type of participating providers or facilities to provide a covered oral health care service, the carrier shall use best efforts to ensure through referral by the primary care provider or otherwise that the covered person obtains the covered service from a provider or facility within reasonable proximity of the covered person at no greater cost to the covered person than if the service were obtained from network providers and facilities, or shall make other arrangements acceptable to the Exchange.

SECTION IV – REASONABLE EFFORT AND RELATIVE AVAILABILITY

Each carrier shall use best efforts to establish and maintain adequate arrangements to ensure reasonable proximity of network providers and facilities to the business or personal residence of covered persons. Carriers shall make reasonable efforts to include providers and facilities in networks in a manner that limits the amount of travel required to obtain covered benefits. In determining whether a carrier has complied with this provision, the Exchange will give due consideration to the relative availability of health care providers or facilities in each geographic area using standards that are realistic for the community, the delivery system and clinical safety. Relative availability includes the willingness of providers or facilities in the geographic area to contract with the carrier under reasonable terms and conditions.

SECTION V – DISCLOSURE OF NETWORK LIMITATIONS

The carrier shall disclose to all covered persons that limitations or restrictions to access of participating providers and facilities may arise from the oral health care service referral and authorization practices of participating providers and facilities. The carrier shall provide

instructions to covered persons as to how they can receive details about such practices from their primary care provider or through other formally established processes.

SECTION VI – COVERAGE OF FACILITIES WITHIN THE INDIAN HEALTH CARE SYSTEM

A carrier that is participating in the Exchange shall use best efforts to maintain arrangements that ensure that American Indians and Native Alaskans who are covered persons have access to Indian health care services and facilities that are part of the Indian Health Care System (IHS). Carriers shall ensure that such covered persons may obtain covered services from the Indian health care system at no greater cost to the covered person than if the service were obtained from network providers and facilities. Carriers are not responsible for credentialing providers and facilities that are part of the Indian health care system. Nothing in this subsection prohibits a carrier from limiting coverage to those health care services that meet the standards for medical necessity, care management, and claims administration, or from limiting payment to that amount payable if the oral health care service were obtained from a network provider or facility.

SECTION VII – ESSENTIAL COMMUNITY PROVIDERS

A carrier that is participating in the Exchange shall use best efforts to have a sufficient number and geographic distribution of Essential Community Providers (ECPs), where available, to ensure reasonable and timely access to such providers for low-income, medically underserved individuals in the geographic area. Sufficient number and geographic distribution is defined as "at least 20 percent of available ECPs in the plan's geographic area participating in the applicant's provider network; or at least 10 percent of available ECPs in the plan's geographic area participating in the applicant's provider network(s)". A narrative justification must be included as part of the Qualified Health Plan application. You can find a list of ECPs for Nevada at: https://data.cms.gov/dataset/Non-Exhaustive-List-of-Essential-Community-Provide/ibqy-mswq

SECTION VIII – ESTABLISHMENT OF REASONABLE CRITERIA

Adequacy of choice may be established by the carrier with reference to any reasonable criteria used by the carrier, including but not limited to: provider-to-covered-person ratios by specialty, primary-care-provider-to-covered-person ratios, geographic accessibility, waiting times for appointments with participating providers, hours of operation, and the volume of specialty services available to serve the needs of covered persons requiring specialty care. Any exceptions or deviations from the standards identified below (ratios and geographic accessibility) must be approved by Exchange.

SECTION IX – PARTICIPATING PROVIDER AVAILABILITY AND ACCESSIBILITY STANDARDS

Accessibility standards have been developed to address the fact that population density in the carrier's geographic area varies from one defined market region to another. One set of standards for each type of geographic area (urban, rural, or frontier) will be addressed separately for general dentist and dental specialty. Each carrier must demonstrate that its network meets the

established time and distance requirements. Carriers will be held accountable for meeting the standards described below.

The standalone dental network must have one (1) **general dentist**, one (1) **pediadontist**, one (1) **oral surgeon**, and one (1) **orthodontist** within the travel standards established below[1].

Geographic Areas by County	Maximum Travel Distance or Time
Urban Counties Carson City Clark Washoe	45 miles or 45 minutes
Rural Counties Douglas Lyon Storey	60 miles or 1 hour
Frontier Counties Churchill Elko Esmeralda Eureka Humboldt Lander Lincoln Mineral Nye Pershing White Pine	100 miles or 2 hours

SECTION X – PROVIDER NETWORK ADEQUACY GOALS

- To offer an adequate number and type of contracted or participating providers to meet the oral health care needs of the covered persons.
- To offer a network of participating providers that is geographically accessible to covered persons.
- The number of network providers of different specialties will vary from one geographic area/county to another. The Carrier will contract with sufficient providers of all types necessary to provide a full range of covered services using standards that are realistic for the community, the delivery system and clinical safety.

[1] Availability of certain provider types may be limited within each county. Additionally, the availability of certain provider types may also be limited within certain cities/communities within a specific county. Every consideration, including established community patterns of care, will be given by the Exchange to the relative availability of oral health care providers or facilities in the geographic area when determining if a carrier meets the above established network adequacy travel standards as measured in distance or time as outlined above.

- Compliance with the distance standards will be achieved if 80 percent of the population of the geographic service area or existing membership is within the distance standards of the providers with whom the Carrier contracts.

SECTION XI – PROVIDER NETWORK REQUIREMENTS

- Be adequate in numbers and types of providers to meet the full range of health care service needs of the enrolled population.
- Comply with the Essential Community Provider requirement.
- A provider directory must be available for publication online and to potential enrollees in hard copy upon request. A provider directory must identify general dentists that are not accepting new patients.