**DENTAL NETWORK ADEQUACY SURVEY**

**Carriers should complete the Network Adequacy Survey and file electronically no later than April 1, 2020. Surveys and applicable documents should be sent to:** **LHCompliance@ct.gov**

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

**Name of Company:** Click here to enter text.

**Name of Network (as marketed):** Click here to enter text.

**Address:** Click here to enter text.

**Contact Person:** Click here to enter text.

**Title:** Click here to enter text.

**Direct Phone #:** Click here to enter text.

**E-mail Address:** Click here to enter text.

**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.

**A separate filing needs to be filed for each network offering. If you are using multiple leased networks together to create one network offering, you should file it together under one filing and include appropriate documentation for each leased network(s).**

**Carriers are responsible for addressing all the questions, regardless of whether they own or lease their network(s). Any response with an attachment (document / policy / procedure) should clearly indicate where in the document the specific response is addressed (including page number and section). If changes were made to any document(s) since the last approved network adequacy filing, a redline version of the updated document(s) should be submitted with the filing.**

**Questions answered as “N/A” will not be accepted. No response to a question or policy will not be accepted.**

**Please submit the surveys in word format, not PDF.**

**GENERAL INFORMATION**

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| **QUESTIONS** | **RESPONSES** |
| 1. | Does the health carrier utilize its own, leased, or a combination of owned and leased network(s)? | Click here to enter text. |
| 1a. | If the health carrier leases network(s), please provide the name(s) of network(s) leased: | Click here to enter text. |

**STANDARDS & RESPONSIBILITIES TO THE PROVIDER**

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| **QUESTIONS** | **RESPONSES** | **NAME OF THE ATTACHED POLICY/PROCEDURE & PAGE NUMBER(S) WHERE THE INFORMATION CAN BE FOUND** |
| 1. | Specify the average term of a provider contract. Do contracts vary by specialty? Do the contracts renew automatically? | Click here to enter text. | N/A |
| 2. | Confirm that all provider contracts include a clause that hold covered persons harmless from balance billing beyond any contractual cost sharing amounts. | Click here to enter text. | Click here to enter text. |
| 3. | Confirm that all provider contracts include a clause that prohibits ophthalmologists and dentists from charging more than the usual and customary rate for services, procedures, or products not covered by an insurance policy. | Click here to enter text. | Click here to enter text.  |
| 4. | Describe how the health carrier and participating providers are meeting the requirement to provide at least ninety days’ written notice to each other before the health carrier removes or the participating provider leaves the network. | Click here to enter text. | Click here to enter text. |
| 5. | Describe the process in place to ensure that each participating provider provides the health carrier, no later than 30 days after receiving a notice of removal or issuing a departure notice, a list of covered persons that are covered under the health plan and are being treated on a regular basis (receiving treatment at least once during the previous 12 months). | Click here to enter text. | Click here to enter text. |
| 6. | Describe the process in place to notify participating providers of their detailed responsibilities to the health carrier’s applicable administrative policies and programs in regard to payment terms, such as submission of claims and reimbursement terms. | Click here to enter text. | Click here to enter text. |
| 7. | Describe the process in place to notify participating providers of their detailed responsibilities to the health carrier’s applicable administrative policies and programs in regard to utilization review. | Click here to enter text. | Click here to enter text. |
| 8. | Describe the process in place to notify participating providers of their detailed responsibilities to the health carrier’s applicable administrative policies and programs in regard to quality assessment and improvement programs. | Click here to enter text. | Click here to enter text. |
| 9. | Describe the process in place to notify participating providers of their detailed responsibilities to the health carrier’s applicable administrative policies and programs in regard to credentialing and re-credentialing. | Click here to enter text. | Click here to enter text. |
| 10. | Describe the process in place to notify participating providers of their detailed responsibilities to the health carrier’s applicable administrative policies and programs in regard to data reporting requirements. | Click here to enter text. | Click here to enter text. |
| 11. | Describe the process in place to notify participating providers of their detailed responsibilities to the health carrier’s applicable administrative policies and programs in regard to reporting requirements for timely notice of changes in practice, including but not limited to discontinuance of accepting new patients. | Click here to enter text. | Click here to enter text. |
| 12. | Describe the process in place to notify participating providers of their responsibilities to the health carrier’s applicable administrative policies and programs in regard to confidentiality requirements. | Click here to enter text. | Click here to enter text. |
| 13. | Describe the process in place to notify participating providers of their responsibilities to the health carrier’s applicable administrative policies and programs in regard to any applicable federal or state programs. | Click here to enter text. | Click here to enter text. |
| 14. | Describe the process in place to notify participating providers of their responsibilities to the health carrier’s applicable administrative policies and programs in regard to collecting applicable coinsurance, deductibles or copayments from covered persons pursuant to a covered person’s health benefit plan. | Click here to enter text. | Click here to enter text. |
| 15. | Describe the process in place to notify participating providers of their responsibilities to the health carrier’s applicable administrative policies and programs in regard to notifying covered persons, prior to delivery of health care services, if possible, of such covered person’s financial obligations for non-covered benefits. | Click here to enter text. | Click here to enter text. |
| 16. | Describe the procedures in place for the resolution of administrative, payment or other disputes between the health carrier and a participating provider. | Click here to enter text. | Click here to enter text. |
| 17. | Describe how providers are notified of any referral process, both for referrals within and outside the network. If referrals are not required, how are providers informed of this? | Click here to enter text. | Click here to enter text. |
| 18. | Describe the process in place (including newsletters, emails, etc.) for 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. | Click here to enter text. | N/A |
| 19. | Describe the process in place for 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. How are providers informed of this process? | Click here to enter text. | N/A |
| 20. | Indicate which, if any, new or revised procedures or policies (since the last approved filing) are attached to address questions #2-17 above. (Make sure that a redline version of these documents is attached.) | Click here to enter text. | N/A |

**STANDARDS & RESPONSIBILITIES TO COVERED PERSONS**

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| **QUESTIONS** | **RESPONSES** | **NAME OF THE ATTACHED POLICY/PROCEDURE & PAGE NUMBER(S) WHERE THE INFORMATION CAN BE FOUND** |
| 1. | Describe how the health carrier is meeting the requirement of sending a written notice to all covered persons being treated on a regular basis (receiving treatment at least once during the previous 12 months), notifying them that their provider is leaving or is being removed from the network. Attach a policy that describes the internal process and confirm that the written notice is sent to covered persons no later than 30 days after the health carrier issues or receives a written termination notice. | Click here to enter text. | Click here to enter text. |
| 2. | Attach a sample letter sent to covered persons notifying them that their provider is leaving or is being removed from the network. | N/A | Click here to enter text. |
| 3. | Confirm that all insurance contracts include information to inform covered persons of the network plan's grievance and appeals process. | Click here to enter text. | N/A |
| 4. | Confirm that all insurance contracts include information to inform covered persons of the network plan's process for covered persons to choose or change participating providers in the network plan, if applicable. | Click here to enter text. | N/A |
| 5. | Confirm that all insurance contracts include information to inform covered persons of health care services offered by the network plan, including those health care services offered through the preventive care benefit, if applicable. | Click here to enter text. | N/A |
| 6. | Confirm that all insurance contracts include information to inform covered persons of the network plan's procedures for covering and approving urgent and specialty care. | Click here to enter text. | N/A |
| 7. | Describe how covered persons are informed of the process to cover an out-of-network provider at an in-network level of cost share to the member should there be no in-network providers within a reasonable driving distance, reasonable appointment scheduling timeframe, or accepting new members. | Click here to enter text. | Click here to enter text. |
| 8. | Describe the internal process in place to approve coverage for an out-of-network provider at an in-network level of cost share should there be no in-network providers within reasonable driving distance, reasonable appointment scheduling timeframe, or accepting new members. Confirm that the time/distance and appointment wait time measures comply with Connecticut's standards. | Click here to enter text. | Click here to enter text. |
| 9. | Confirm that the timeframe for approving out of network requests, including for instances where there is network inadequacy, falls within Connecticut’s Utilization Review standards. | Click here to enter text. | N/A |
| 10. | Describe the policies in place for addressing the health carrier’s and providers’ ability to meet the needs of covered persons, including, but not limited to children and adults, with limited English proficiency or illiteracy. Attach both the internal policy as well as the member notification. | Click here to enter text. | Click here to enter text. |
| 11. | Describe the policies in place for addressing the health carrier’s and providers’ ability to meet the needs of covered persons, including, but not limited to children and adults, with diverse cultural or ethnic backgrounds. Attach both the internal policy as well as the member notification. | Click here to enter text. | Click here to enter text. |
| 12. | Describe the policies in place for addressing the health carrier’s and providers’ ability to meet the needs of covered persons, including, but not limited to children and adults, with serious chronic or complex conditions, including vision or hearing impaired. Attach both the internal policy as well as the member notification. | Click here to enter text. | Click here to enter text. |
| 13. | Describe the process in place for 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. Confirm that there is a process in place to take corrective measures, when necessary. | Click here to enter text. | N/A |
| 14. | Where applicable, indicate which, if any, new or revised procedures or policies (since the last approved filing) are attached to address questions #1-14 above. (Make sure that a redline version of these documents is attached.) | Click here to enter text. | N/A |

**NETWORK ADEQUACY STANDARDS**

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| **QUESTIONS** | **RESPONSES** | **NAME OF THE ATTACHED POLICY/PROCEDURE & PAGE NUMBER(S) WHERE THE INFORMATION CAN BE FOUND** |
| 1. | How many dental 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 per 1,200 covered persons, provide information on what corrective actions are being taken to address this and the date you expect to be compliant. (If you do not have any enrollment in the plan, indicate the total number of providers in your network.) | Click here to enter text. | N/A |
| 2. | How many general dentists does the health plan have per 2,000 covered persons? If the health plan does not have at least one general dentist per 2,000 covered persons, provide information on what corrective actions will be taken to address this and the date you expect to be compliant. (If you do not have any enrollment in the plan, indicate the total number of general dentists in your network.) | Click here to enter text. | N/A |
| 3. | Verify that at least 70% of in-network providers accept new patients. Provide the actual percentage of providers in your network who accept new patients. If applicable, provide the answer by specialty. Describe how frequently this is measured, assessed and monitored. | Click here to enter text. | N/A |
| 4. | Describe the process in place for maintaining adequate arrangements to assure that covered persons have reasonable access to participating providers located near such covered persons' places of residence or employment. (If any documents or policies were revised since the prior approved filing, please attach a redline version.) | Click here to enter text. | Click here to enter text. |
| 5. | Please fill out the actual maximum time and distance measures met for 90% of your members by county. Note: When measuring this data, include Connecticut-only members who reside in the state. Include all providers used for Connecticut service areas. | SEE “TIME & DISTANCE” standards on page 12 (Please provide the TIME & DISTANCE measures achieved for 90% of your members on page 11). |

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| 6. | Please see the timeframe requirements (*in italics*) for scheduling in-network appointments. Fill out the actual measure (in terms of hours for Urgent Care and days for everything else) that is achieved 90% of the time within your network for each provider type. If you are not compliant with the standards (*in italics*), indicate what measures have been taken to comply and when you expect to be compliant. | **APPOINTMENT WAIT TIMES** |
| TYPE OF APPOINTMENT | TIMEFRAME REQUIREMENT | TIMEFRAME ACHIEVED |
| Urgent care | *Within 48 hours* | Click here to enter text. |
| Non-Urgent appointments for general dentist | *Within 10 business days* | Click here to enter text. |
| Non-Urgent appointments for specialist care | *Within 15 business days* | Click here to enter text. |
| 7. | Confirm that a valid sample size, as defined by NAIC (95% confidence level with a 5% margin of error), was used to collect the appointment wait times reported. | Click here to enter text. | N/A |
| 8. | Describe the process in place to collect information regarding the average appointment wait times. How frequently is this information collected? | Click here to enter text. | N/A |
| 9. | Describe the health plans’ efforts to ensure that covered persons have access to emergency dental services 24 hours a day, seven days a week. | Click here to enter text. | N/A |
| 10. | Describe the process in place for monitoring on an ongoing basis the ability, clinical capacity and legal authority of participating providers to provide all covered benefits to covered persons. | Click here to enter text. | N/A |
| 11. | Describe the process in place for ensuring that participating providers and facilities meet available and appropriate quality of care standards and provide high quality of care and health outcomes. | Click here to enter text. | N/A |
| 12. | Describe the factors and standards used to build a network. Include a description of the network and the criteria used to select and tier health care providers and facilities, if applicable. | Click here to enter text. | N/A |
| 13. | Provide a link to the carrier website where the standards used to build a network are posted in plain language. | Click here to enter text. | N/A |
| 14. | Explain how covered persons will be notified of contract termination, insolvency or other cessation of operations and transitioned to other participating providers in a timely manner. | Click here to enter text. | N/A |
| 15. | 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. | Click here to enter text. | N/A |

**TIME (T) & DISTANCES (D) STANDARDS**

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| **SPECIALTY AREA** | **FAIFIELD COUNTY****(Large Metro)** | **ALL OTHER COUNTIES****(Metro)** |
| Dental | 30/15 | 45/30 |

**TIME (T) & DISTANCES (D) TABLE**

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| **NETWORK ADEQUACY QUESTION #5: TIME (minutes) / DISTANCE (miles)** |
| **FAIFIELD COUNTY** | **HARTFORD COUNTY** | **LITCHFIELD COUNTY** | **MIDDLESEX COUNTY** | **NEW HAVEN COUNTY** | **NEW LONDON COUNTY** | **TOLLAND COUNTY** | **WINDHAM COUNTY** |
| Enter T/D | Enter T/D | Enter T/D | Enter T/D | Enter T/D | Enter T/D | Enter T/D | Enter T/D |

**PROVIDER DIRECTORY**

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| **QUESTIONS** | **RESPONSES** |
| 1. | Verify that a hard copy of the provider directory is updated at least annually and is available upon request. Provide the actual frequency of the hard copy directory updates. | Click here to enter text. |
| 2. | Verify that the online provider directory is updated at least monthly. Provide the actual frequency of the online directory updates. | Click here to enter text. |
| 3. | Describe and provide a copy of the process in place to audit a reasonable sample size of the provider directory for accuracy. Indicate the frequency of such audits. | Click here to enter text. |
| 4. | Provide a link to the online directory: | Click here to enter text. |
| 5. | Verify that the below requirements are met for both the online and the hard copy of the provider directory. Include a screen shot of an online and paper directory and indicate where each requirement is addressed. |
| a. | The directory accessible to non-members. | Click here to enter text. |
| b. | The directory clearly indicates the plan/network name(s). | Click here to enter text. |
| c. | The directory clearly states when it was last updated. | Click here to enter text. |
| d. | The directory clearly indicates whether a provider accepts new patients. | Click here to enter text. |
| e. | The directory clearly indicates what other languages are spoken in the provider’s office. | Click here to enter text. |
| f. | The directory clearly indicates whether the provider’s office is handicap accessible. | Click here to enter text. |
| g. | The directory includes a description of the criteria the health carrier used to build its network. | Click here to enter text. |
| h. | If applicable, the directory includes a description of how the health carrier designates the different provider tiers in the network and clearly indicates the providers for each different tier of benefits. | Click here to enter text. |
| i. | If applicable, the directory includes a statement that authorization or referral may be required to access some participating providers. | Click here to enter text. |
| j. | The directory provides an e-mail address and a telephone number to report inaccurate information. | Click here to enter text. |

**ATTESTATION FORM**

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

I, Click here to enter text. , Click here to enter text.
 (PRINTED NAME) (TITLE)

of Click here to enter text. , hereby acknowledge that:

(COMPANY)

1. I have read the foregoing request and attached materials and that the information provided is true, accurate and offered in support of this request.

1. I certify that the network submitted is fully compliant with the requirements of C.G.S. 38a-472f, C.G.S. 38a-477g, C.G.S. 38a-477h, and Regulations of Connecticut State Agencies, Sect. 38a-472f-1 to Sect. 38a-472f-6.
2. 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.

Click here to enter text.

(SIGNATURE)

Click here to enter text.

(DATE)