

Davis Vision, Inc.
Geographic Network Access Plan – Colorado

Introduction

Davis Vision, Inc. maintains an extensive provider panel throughout the State of Colorado in order to meet the applicable Geographic Network Standards established for Vision Plans in 3 CCR 702-4. The vision care services provided by Davis Vision include a routine (non-medical) vision examination and corrective eyewear. The licensed providers (optometrists, ophthalmologists) contracted with Davis Vision provide access to these services within the required standards.

Davis Vision's network accessibility analysis contains the following information:

Quest Analytics report on the accessibility of the Davis Vision provider network for the commercial members enrolled through the Davis Vision commercial group vision plan.

Accessibility summary and detail – Commercial members access to participating providers

Provider Listing – Davis Vision provider list

Following initial development of its provider network, Davis Vision has continuously evaluated the need to enhance network access in specific areas as Davis Vision contracts with new clients and existing clients experience membership growth and/or service area expansion.

Davis Vision also monitors the impact of provider additions and terminations on the adequacy of the network overall, and in specific geographic areas.

<https://www.davisvision.com/>

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Network Adequacy and Corrective Action Processes

Davis Vision meets the Provider Network Adequacy requirements with 99.58% of current Colorado members having access to an optometrist and an ophthalmologist within standards.

Overall access (MD/DO & OD combined):

Large Metro – 100%

Metro – 99.2%

Micro – 99.9%

Rural – 100%

CEAC – 98.8%

Because Davis Vision's provider network is comprised of more than 197,000 private practitioners across the U.S., it generally meets the access requirements of new clients. However, Davis vision analyzes its network for each new client and recruits additional providers when a deficiency is identified. (When a client does not specify an access standard, Davis Vision's corporate access standard is that, whenever possible, members do not have to travel more than 30 miles to receive services.)

Davis Vision maintains a ratio of approximately 1,000 members per provider. The ratio may vary due to benefit design or group-specific requirements. We utilize geographical access analysis software to monitor our current membership and network on an ongoing basis. If the analysis identifies a particular service area in which the membership is above this threshold, additional doctors will be recruited to maintain our service commitments.

Davis Vision's benefit plans are customized for each client, and the geographical access requirement is group-specific. When Davis Vision contracts with a new client, staff generates reports of network adequacy based on the increased membership. Davis Vision's standard formula for network adequacy is that, whenever possible, members do not have to travel more than 30 miles to access qualified providers for services. The ratio of providers to members average 1:1000. This ration ensures ease of access for all members, whether in urban or rural areas.

When reports identify a deficiency caused by increased membership, recruiting efforts may be initiated either nationally or targeted to a specific geographic area. (Consideration is also given to financial resources, client contract and Davis Vision's ability to guarantee quality care to members.) Recruiting efforts may include mailing Provider Applications and recruitment materials with telephone or email communication.

Client groups may receive requests from their employees to add specific practitioners or providers to the Davis Vision network. These requests are evaluated based on the geographic adequacy of the network. Whenever possible, David Vision includes these recommended practitioners or providers to ensure continuity of care and enhance member satisfaction.

Any practitioner can contact Davis Vision directly for information regarding the company, its vision plans or network participation. These inquiries are evaluated based on the geographic adequacy of the network.

Recruitment decisions are made solely on the basis of a practitioner's qualifications, quality of care and the geographic need of the network. Over-saturation is avoided to ensure each practitioner an adequate share of the market.

Recruitment decisions are not based upon race, ethnicity, gender, age or sexual orientation. Davis Vision does not charge practitioner any membership or administrative fees, nor is any portion of schedule payment withheld. Davis Vision does not discriminate against providers that serve high-risk populations or specialize in conditions that require costly treatment.

Recruitment decisions are made solely on the basis of a practitioner's qualifications, quality of care and the geographic need of the network. Over-saturation is avoided to ensure each practitioner an adequate share of the market.

When over-saturation in a specific market segment exists within the Davis Vision network, or when other circumstances dictate that no new providers should be added to a network within a geographic area, the network may be closed to new practitioners until such time as appropriate market ratios of providers to members is re-attained. Davis Vision defines network over-saturation as a ratio consisting of less than 1000 members per provider. The ratio may vary due to benefit design or group-specific requirements.

In the event there is a member who does not have access to a participating provider within the established access standards, such member is offered the opportunity of choosing the nearest participating providers or the non-participating provider from whom the member wishes to receive covered vision care services.

Davis Vision will continue to attempt to develop its delivery network in the counties without complete coverage through its identification of licensed providers with whom it can seek to contract.

When advised by a member that there is no participating practitioner in his/her geographic area (member would have to travel more than 30 miles from his/her residence) OR there is no participating provider with appropriate training and experience to meet the member's particular vision care needs, Davis Vision will allow the member to access a non-participating provider. Davis Vision shall pay for the cost of the services in the treatment plan provided by the Non-Participating Provider. There will be no additional cost to the member beyond what the member would otherwise pay for services received within the network.

Utilizing geographic analysis software, Davis Vision measures network adequacy on a quarterly basis to identify counties with an inadequate network and to address network development needs if there are vision providers available to contract in those areas. This ensures ease of access for all members whether in urban or rural areas. All participating providers have arrangements for emergency care that are available 24 hours a day, 7 days a week. Davis Vision's members can expect to see a provider for urgent care matters within 24-48 hours after calling. Typically, members will be seen within 10 calendar days from the date of their request for an appointment and members should not have to wait in the office more than 1 hour from their scheduled appointment time.

Davis Vision monitors compliance with these standards through member satisfaction survey responses related to office locations, convenience of office hours and the ability to obtain an appointment within a reasonable period of time.

- 1) Davis Vision collects and evaluates member complaints related to provider availability. The results are analyzed to identify trends and/or opportunities for improvement.
- 2) Annually, Davis Vision collects member satisfaction data regarding provider availability. Survey statements related to office locations, office hours and the ability to obtain an appointment within 10 calendar days of the member's request are analyzed. If member satisfaction for any metric falls below 95%, detailed analysis is conducted and improvements are identified for implementation.

Network Access Plan Procedures for Referrals

Demographic changes such as change of address, name, tax identification, etc are processed within 30 business days from the time the demographic change request is received, updates are made to the CVII provider system by Network Operations. Once a provider record is updated in CVII, the Provider Update Process (PUP) updates the data to the CV1 mainframe in real time. The system picks up the changes made and loads/updates all changes to the Davis Vision Provider Directory every night at 3 a.m. Monday through Saturday.

Davis Vision Provider Directories conform to a variety of State and Federal guidelines. In order to maintain compliance and up to date provider data, Davis Vision performs a combination of activities to capture and validate provider data. Provider online directory is machine readable and is written to a fourth and sixth grade level in at least ten point print. Davis Vision ensures that all data elements displayed in the Provider Directory are accurate and up-to-date. At a minimum, Davis Vision conducts verification of current Provider Directory information including the following elements: Provider Name, Practice Physical Address, Phone Number, Web site URL, if available, Office Hours, Days of Operation, Practice Limitations, Language spoken and offered, Provider Type, Provider Specialty, Board Certification, if applicable, NPI, number, Handicap Accessibility, Cultural Competence Training completed (Training consists of cross-cultural strategies, and notice of communication and language assistance services), Provider accepting new patients.

Davis Vision performs quarterly calls to the Provider Network. These calls are intended to connect with Network Providers to inquire if they have made changes to their office and/or providers within the last quarter. Should a provider indicate they have made a change within the previous quarter and not notified Davis Vision of their change, Davis Vision will contact the office to educate the provider on the need to notify Davis Vision and on the notification process.

Davis Vision utilizes CAQH (Council for Affordable Quality Healthcare) Direct Assure to capture provider directory data. On a quarterly basis, CAQH requests providers review and re-attest to their CAQH Application and associated documents and there is a second Provider Directory Data attestation specific to directory elements. In addition to the quarterly provider re-attestation requests, any time a provider updates their CAQH Application and/or associated documents, the Provider is prompted to also review and re-attest to their directory elements data. CAQH Direct Assure makes the Provider Directory data available on a daily basis and Davis Vision utilizes new Provider Directory Data on a weekly basis.

In addition to the rob-calls and CAQH Direct Assure, Providers are educated and advised to notify Davis Vision timely on changes and updates to their Providers and Office(s). This requirement is outlined in the Davis Vision Provider Manual, Provider Portal, and on Explanation of Payments (EOP).

Davis Vision does not require a referral for a member to access any provider under the routine vision plan.

Davis Vision providers bill and collect all Copayments, Coinsurances and Deductibles from members, which are specifically permitted and/or applicable to Members' benefit plan. Providers bill and collect all charges from a Member for those non-covered services provided to a member. Davis Vision providers only bill the member when Davis Vision has denied confirmation of eligibility for the services and when the following conditions are met:

- (a) The Member has been notified by the Davis Vision provider of the financial liability in advance of the service delivery;
- (b) The notification by the Davis Vision provider is in writing, specific to the service being rendered, and clearly states that the member is financially responsible for the specific service. A general patient liability statement which is signed by all patients is not sufficient for this purpose;
- (c) The notification is dated and signed by the member.

All financial information, including copayments, coinsurance, deductibles, and discounts are listed on Davis Vision Member Portal. Log in is required to view plan specific information.

When advised by a member that there is no participating practitioner in his/her geographic area (member would have to travel more than 30 miles from his/her residence) or there is no participating provider with appropriate training and experience to meet the member's particular vision care needs, Davis Vision will allow the member to access a non-participating provider. Davis Vision shall pay for the cost of the services in the treatment plan provided by the Non-Participating Provider. There will be no additional cost to the member beyond what the member would otherwise pay for services received within the network.

Network Access Plan Disclosures and Notices

Davis Vision provides each of its clients with a list of participating providers for such client at the inception of the contract and, thereafter, in accordance with the client's desired schedule. Davis Vision's provider directory is also available on its website or in printed form if requested.

Davis Vision provides each of its clients with a summary of benefits at the time of enrollment, which describes covered services, material allowances, frequency, and copayments.

Davis Vision Member Portal offers plan specific information for each member enrolled with Davis Vision. Log in is required to view plan specific information.

Davis Vision provides routine vision care services to beneficiaries located in all fifty states, the District of Columbia, Puerto Rico, and Guam. The generic complaint, grievance, and appeal processes described below may not include state-specific requirements. For more complete information and guidance, call Davis Vision's Complaints and Appeals Department at 1-888-343-3470.

If Davis Vision denies a request for services, a written adverse determination will be issued explaining the reason(s) for the denial along with the appeal rights. If the patient asks that an appeal should be initiated on his or her behalf, the provider should contact Davis Vision immediately to obtain details on timeframes and requirements for appeal submission.

Adverse determinations or denials of services are divided into two categories:

A. Benefit denials – a denial decision based on whether the member has a benefit for the service or product at the time the service or product is received. Routine vision and eye care services are limited to a frequency chosen by a client. Therefore, administrative adverse determinations are based solely on whether or not the member has an available benefit. No clinical review is conducted to determine medical necessity.

B. Medical necessity denials – an adverse determination based on whether the product or service meets established medical necessity criteria. Plans include enhanced coverage for contact lenses. For plans offering enhanced coverage, Davis Vision reviews these requests to determine visually required/medical necessity and appropriateness based on the guidelines of the American Optometric Association and the American Academy of Ophthalmology.

Davis Vision allows a member, a member's designee or healthcare provider one hundred and eighty (180) calendar days to appeal an initial adverse determination.

All appeal requests are processed by Davis Vision's Complaints and Appeals (C&A) department and a C&A associate will document the substance of the appeal request as well as any actions taken in the course of the appeal process. During the discovery period of the appeal process, full investigation of the substance of the appeal, including any aspects of clinical care are developed. Review of the facts will be conducted without deference to the initial denial decision.

Written acknowledgement of the filing of the appeal after initial receipt of the appeal request is provided, at which time the member, member's designee or healthcare provider is informed of the ability to submit written comments, documents or other information relating to the appeal. The acknowledgement notice will also provide direction as to how the member can designate a representative to act on their behalf. In the event of a medical necessity appeal request, the affected individuals will also be provided information regarding an external review process if Davis Vision does not complete its appeal review within specified timeframes.

Appeal review and determination is conducted by an associate that was not involved in the prior adverse determination or a subordinate of such person. With respect to medically necessary appeals, a clinical peer reviewer, other than the reviewer who made the initial determination, will review the appeal. At no instance will the healthcare professional providing healthcare services to the member be permitted to serve as the clinical peer reviewer for such member in connection with the health services being provided to the member.

Davis Vision ensures that all appeals requiring review for clinical issues involving denials pertaining to any aspect of investigational, experimental or medically necessary or appropriate care will be reviewed by a healthcare professional who is appropriately trained in Davis Vision's principles, procedures, and standards and has similar credentials and licensure as those who would typically treat the condition or health problem in question in the appeal. This same-or-similar expertise review will be applied in the event of both a first and second level appeal.

In regard to an appeal of an adverse concurrent care decision, Davis Vision will allow for continued coverage pending the outcome of the appeal.

Appeal determinations will be made in writing or via electronic notification within the following time frames:

Pre-service Appeals – 30 calendar days from the initial receipt of the request by Davis Vision

Post-service Appeals – 60 calendar days from the initial receipt of the request by Davis Vision

Extension of the above time frames can only be extended if the member voluntarily agrees to extend the appeal time frame.

If a decision is overturned upon appeal, the notification will state that decision and the date.

Davis Vision provides and expedited appeal process for pre-service appeal requests when a member, the member's representative or a healthcare provider acting on the member's behalf indicates that a delay in the appeal process would seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function.

In the event of an expedited appeal, Davis Vision will make a decision and notify members and providers as expeditiously as the medical condition requires, but no later than 72 hours after the request for an expedited appeal. Oral notification will be made within 72 hours, followed by written notification to both the member and provider with 3 calendar days of the initial oral notification of determination.

Davis Vision offers a second level of appeal to a member, the member's representative or a healthcare provider on the member's behalf if such appeal is requested within one hundred and eighty (180) calendars of the first level appeal determination. Second level determination timeframes will follow the same timeframes outlined in the first level appeal process.

A member, member's representative or healthcare provider may request for an external review within one hundred and eighty (180) days after a final internal adverse determination for medically necessity has been made; however, with the member's permission, Davis Vision reserves the right to refer an appeal, regardless of level, directly to an independent review organization (IRO) without conducting an internal review. Davis Vision will comply with state or federal requirements as applicable.

Davis Vision provides routine vision and eye care services including routine eye examinations, eyeglasses, contact lenses, value-added discounts and accessories. Davis Vision does not provide or manufacture life-saving equipment, nor does Davis Vision authorize or provide medical eye care treatment (urgent, emergency or routine).

When a member is out of the area and an urgent or emergency issue arises, if the member believes that an urgent/emergency medical condition exists or that a delay in services might compromise their health, they are permitted to seek urgent/ emergency care from a licensed health care practitioner or provider without obtaining prior approval from Davis Vision. Because Davis Vision provides routine vision and eye care services, reimbursement for urgent/emergency services will be solely dependent upon whether the member has appropriate coverage and is eligible for the benefit.

All Davis Vision providers must provide documentation stating that their offices have adequate hours of operation, minimally 12 hours per week, appropriate examination room and equipment, arrangements for medical specialty care and arrangements for emergency care that are available 24 hours a day, 7 days a week.

By signing Davis Vision's Participating Provider Agreement, providers agree to:

- a) Make an appointment for routine services available within 10 calendar days of the date of the request by the member
- b) Ensure members should not have to wait in the office more than 1 hour from their scheduled appointment time for routine services

- c) Be available to provide covered services taking into account the urgency of the need for services
- d) Provide covered services for medically appropriate urgent or emergent care, as appropriate, according to their scope of licensure
- e) Provide members with access to an answering machine or pager number 24 hours a day, 7 days a week for members to obtain information about a provider's office hours, leave a message for the provider and to receive pre-recorded instructions about handling an emergency

The primary reasons Davis Vision solicits application from vision care practitioners are:

- To include additional providers to improve access to care for eligible members.
- To satisfy the need for additional providers in specific geographic regions as determined by internal surveys or patient needs assessments.
- To include providers specifically recommended by client groups.
- To include providers specifically recommended by patients.
- To include providers who have expressed an interest in participating in the network.
- To replace practitioners who have left the network (retirement, death, termination, etc.)

Recruitment decisions are not based upon race, ethnicity, gender, age or sexual orientation. Davis Vision does not charge practitioner any membership or administrative fees, nor is any portion of schedule payment withheld. Davis Vision does not discriminate against providers that serve high-risk populations or specialize in conditions that require costly treatment.

Recruitment decisions are made solely on the basis of a practitioner's qualifications, quality of care and the geographic need of the network. Over-saturation is avoided to ensure each practitioner an adequate share of the market.

When over-saturation in a specific market segment exists within the Davis Vision network, or when other circumstances dictate that no new providers should be added to a network within a geographic area, the network may be closed to new practitioners until such time as appropriate market ratios of providers to members is re-attained. Davis Vision defines network over-saturation as a ratio consisting of less than 1000 members per provider. The ratio may vary due to benefit design or group-specific requirements.

Telehealth is not used to meet healthcare needs and network adequacy standards.

Davis Vision's Customer Service staff has access to provider and member zip code locating software that is utilized to identify those providers in the closest proximity to the member. Members who do not have the required access are offered the choice of utilizing the services of either a participating or a non-participating provider. Customer Service has access to translation services, TTY for deaf or hearing impaired members. The Davis Vision website is also available 24 hours a day and is ADA compliant.

As established by the Participating Provider Agreement, providers must provide covered services in a culturally competent and sensitive manner to all Davis Vision patients, including those with limited English proficiency and diverse cultural and ethnic backgrounds. Providers will only be able to provide culturally competent services if cultural knowledge and sensitivity is incorporated into the office policies, procedures and service manuals.

The U.S. Department of Health and Human Services, Office of Minority Health has established fifteen (15) standards to advance health equity, improve quality, and eliminate health care disparities. These standards may be reviewed by going to www.minorityhealth.hhs.gov and reviewing the Office of Minority Health's Cultural Competency information.

Translation services at no cost to the patient during the provision of services are available through Davis Vision for members requiring communication in a language other than the languages available at the participating Davis Vision office. As a best practice, Providers should contact Davis Vision provider services at 1-800-77DAVIS at least seven (7) business days prior to the patient's appointment to request translation services. The patient's language preference should be documented in the patient's clinical files. Refusal by a patient to accept access to language assistance through Davis Vision at no cost to the member should also be documented in the clinical files.

All decisions regarding treatment will be determined solely on medical necessity and not on financial cost. Davis Vision members are to inform Davis Vision of any physical, mental, or emotional impairment that may impede their ability to provide appropriate patient care or to meet contractual obligations with Davis Vision.

Patients' attitudes and perceptions are the fundamental component of quality improvement that is why Davis Vision members have the right to access and express their opinions and concerns. Patients obtaining services have the opportunity to complete a patient satisfaction survey to express their views concerning the quality of services rendered. This survey instrument is designed to elicit the patient's opinion on access to care, treatment by the professional staff and satisfaction with the examination and prescriptive eyewear.

Survey responses are evaluated and, if necessary, follow-up action is taken promptly.

Davis Vision conducts and reports statistical analysis on patient satisfaction aggregate results.

The purpose of Davis Vision's comprehensive patient satisfaction program is to:

- Determine overall member perception of the vision care plan.
- Identify aspects of the program in which members would recommend a change.
- Identify practitioners on the panel who are not providing courteous and high quality services to members.
- Identify elements of the system which may be causing delays in the provision of care.
- Provide members with the opportunity to offer both positive and critical feedback
- Offer members the opportunity to ask questions regarding the program.
- Provide feedback to the practitioners on their patients' opinions about their care.

- Provide feedback to the laboratory on the patients' opinions about their services and materials.
- Provide feedback to the program's sponsor group on the assessment of the benefit by their constituents.

Annually, Davis Vision collects member satisfaction data regarding provider availability. Survey statements related to office locations, office hours and the ability to obtain an appointment within 10 calendar days of the member's request are analyzed. If member satisfaction for any metric falls below 95%, detailed analysis is conducted and improvements are identified for implementation.

Plans for Coordination and Continuity of Care

Davis Vision, Inc. is a stand-alone vision plan. Davis Vision does not offer Preferred Care Provider services; therefore, Continuity of Care does not apply to Davis Vision routine service benefit. However, in the event that a Davis Vision provider agreement is terminated (other than for loss of licensure or failure to comply with legal requirements), Davis Vision providers are required to continue to provide covered services to a member who is receiving covered services from provider on the effective termination date of Davis Vision Provider Agreement for a minimum transitional period of sixty (60) days from the date the member is notified of the termination or pending termination, or until the covered services being rendered to the member by provider are completed.

Davis Vision Provider agrees that Davis Visions' payment hereunder constitutes payment in full and except as otherwise provided for in a Member's benefit program, Providers look only to Davis Vision for compensation for Covered Services provided to Members and shall at no time seek compensation, remuneration or reimbursement from members, persons acting on members' behalf, from the MCO, the plan, or MAP for covered services even if Davis Vision for any reason, including insolvency or breach of provider agreement, fails to pay Davis Vision provider.

Conclusion

Each year the number of provider points of access has grown significantly. Davis Vision's efforts to continuously expand its provider panel, coupled with its willingness to pay a non-participating provider when a participating provider is not available within the established access standards, assures members access to covered vision care services.