PROPOSED RULE MAKING

CR-102 (June 2012)
(Implements RCW 34.05.320)
Do **NOT** use for expedited rule making

Agency: Office of the Insurance Commissioner

☒ **Preproposal Statement of Inquiry was filed as WSR** 13-19-092; **or**
☐ **Expedited Rule Making--Proposed notice was filed as WSR _____; or**
☐ **Proposal is exempt under RCW 34.05.310(4) or 34.05.330(1).**

☒ **Original Notice**
☐ **Supplemental Notice to WSR _____**
☐ **Continuance of WSR _____**

Title of rule and other identifying information: Health coverage issuer provider network formation, adequacy, and filing and approval standards

Insurance Commissioner Matter No. R 2013-22

Hearing location(s):
Office of the Insurance Commissioner
Training Room (TR-120)
5000 Capitol Blvd SE
Tumwater, WA

Date: April 22, 2014 Time: 9:00 am

Date of intended adoption: April 23, 2014
(Note: This is **NOT** the **effective** date)

Submit written comments to:
Name: Kate Reynolds
Address: PO Box 40258
Olympia, WA 98504-0258
e-mail rulescoordinator@oic.wa.gov
Fax: 360-586-3109 by (date) April 21, 2014

Assistance for persons with disabilities:
Contact: Lori Villaflores by April 21, 2014

TTY (360) 586-0241 or (360) 725-7087

Purpose of the proposal and its anticipated effects, including any changes in existing rules:
Based on the significant changes in health care delivery and access to care that will occur after January 1, 2014 due to health care reform, the commissioner determined that updating regulations is reasonable and necessary. Both qualified health plans and health plans offered outside of the Exchange must have networks that at a minimum ensure access to covered services without unreasonable delay and address the specific needs of the populations served. Clarification of the provider network criteria in these areas is needed to support issuer filings. Issuers will benefit from written guidance regarding the commissioner's review standards for provider networks in general and the inclusion of essential community providers in networks for qualified health plans. The proposed rule also includes requirements for provider directories and creates a more transparent process for the building and maintenance of provider networks.

Reasons supporting proposal: The current provider network regulations were adopted prior to the passage of the Affordable Care Act.

Statutory authority for adoption: RCW 48.02.060, 48.18.120, 48.20.460, 48.43.505, 48.43.510, 48.43.515, 48.43.530, 48.43.535, 48.44.050, 48.46.200

Statute being implemented: RCW 48.20.450, RCW 48.44.020, RCW 48.44.080, RCW 48.46.030, 45 CFR 156.230, 45 CFR 156.235, 45 CFR 156.245

Is rule necessary because of a:

Federal Law?		
Federal Court Decision?	☒ Yes	☐ No
State Court Decision?	☐ Yes	☒ No
If yes, CITATION:	☐ Yes	☒ No

45 CFR 156.230, 45 CFR 156.235, 45 CFR 156.245

DATE
March 19, 2014

NAME (type or print)
Mike Kreidler

SIGNATURE

TITLE
Insurance Commissioner

CODE REVISER USE ONLY

OFFICE OF THE CODE REVISER
STATE OF WASHINGTON
FILED

DATE: March 19, 2014
TIME: 7:19 AM

WSR 14-07-102

(COMPLETE REVERSE SIDE)

Agency comments or recommendations, if any, as to statutory language, implementation, enforcement, and fiscal matters:
None.

Name of proponent: Mike Kreidler, Insurance Commissioner

☐ Private
☐ Public
☒ Governmental

Name of agency personnel responsible for:

	Name	Office Location	Phone
Drafting.....	Kate Reynolds	PO Box 40258, Olympia, WA 98504-0258	(360) 725-7170
Implementation....	Molly Nollette	PO Box 40255, Olympia, WA 98504-0255	(360) 725-7117
Enforcement.....	AnnaLisa Gellermann	PO Box 40255, Olympia, WA 98504-0255	(360) 725-7050

Has a small business economic impact statement been prepared under chapter 19.85 RCW or has a school district fiscal impact statement been prepared under section 1, chapter 210, Laws of 2012?

☐ Yes. Attach copy of small business economic impact statement or school district fiscal impact statement.

A copy of the statement may be obtained by contacting:
Name:
Address:

phone ( ) _____
fax ( )_____
e-mail _____

☒ No. Explain why no statement was prepared.

The entities that must comply with the proposed rule are not small businesses, pursuant to chapter 19.85 RCW.

Is a cost-benefit analysis required under RCW 34.05.328?

☒ Yes A preliminary cost-benefit analysis may be obtained by contacting:
Name: Kate Reynolds
Address: PO Box 40258
Olympia, WA 98504-0258
phone (360) 725-7170
fax (360)586-3535
e-mail rulescoordinator@oic.wa.gov

☐ No: Please explain:

AMENDATORY SECTION (Amending WSR 12-23-005, filed 11/7/12, effective 11/20/12)

WAC 284-43-130 Definitions. Except as defined in other subchapters and unless the context requires otherwise, the following definitions shall apply throughout this chapter.

(1) "Adverse determination" has the same meaning as the definition of adverse benefit determination in RCW 48.43.005, and includes:

(a) The determination includes any decision by a health carrier's designee utilization review organization that a request for a benefit under the health carrier's health benefit plan does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness or is determined to be experimental or investigational and the requested benefit is therefore denied, reduced, or terminated or payment is not provided or made, in whole or in part for the benefit;

(b) The denial, reduction, termination, or failure to provide or make payment, in whole or in part, for a benefit based on a determination by a health carrier or its designee utilization review organization of a covered person's eligibility to participate in the health carrier's health benefit plan;

(c) Any prospective review or retrospective review determination that denies, reduces, or terminates or fails to provide or make payment in whole or in part for a benefit;

(d) A rescission of coverage determination; or

(e) A carrier's denial of an application for coverage.

(2) "Authorization" or "certification" means a determination by the carrier that an admission, extension of stay, or other health care service has been reviewed and, based on the information provided, meets the clinical requirements for medical necessity, appropriateness, level of care, or effectiveness in relation to the applicable health plan.

(3) "Clinical review criteria" means the written screens, decision rules, medical protocols, or guidelines used by the carrier as an element in the evaluation of medical necessity and appropriateness of requested admissions, procedures, and services under the auspices of the applicable health plan.

(4) "Covered health condition" means any disease, illness, injury or condition of health risk covered according to the terms of any health plan.

(5) "Covered person" or "enrollee" means an individual covered by a health plan including ((~~an enrollee,~~)) a subscriber, policyholder, or beneficiary of a group plan.

(6) "Emergency medical condition" means the emergent and acute onset of a symptom or symptoms, including severe pain, that would lead a prudent layperson acting reasonably to believe that a health condition exists that requires immediate medical attention, if failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy.

(7) "Emergency services" has the meaning set forth in RCW 48.43.005.

(8) "Enrollee point-of-service cost-sharing" or "cost-sharing" means amounts paid to health carriers directly providing services, health care providers, or health care facilities by enrollees and may include copayments, coinsurance, or deductibles.

(9) "Facility" means an institution providing health care services, including but not limited to hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory, and imaging centers, and rehabilitation and other therapeutic settings, and as defined in RCW 48.43.005.

(10) "Formulary" means a listing of drugs used within a health plan.

(11) "Grievance" has the meaning set forth in RCW 48.43.005.

(12) "Health care provider" or "provider" means:

(a) A person regulated under Title 18 RCW or chapter 70.127 RCW, to practice health or health-related services or otherwise practicing health care services in this state consistent with state law; or

(b) An employee or agent of a person described in (a) of this subsection, acting in the course and scope of his or her employment.

(13) "Health care service" or "health service" means that service offered or provided by health care facilities and health care providers relating to the prevention, cure, or treatment of illness, injury, or disease.

(14) "Health carrier" or "carrier" means a disability insurance company regulated under chapter 48.20 or 48.21 RCW, a health care service contractor as defined in RCW 48.44.010, and a health maintenance organization as defined in RCW 48.46.020((~~, and includes "issuers" as that term is used in the Patient Protection and Affordable Care Act (P.L. 111-148, as amended (2010))~~)).

(15) "Issuer" means a disability insurance company regulated under chapter 48.20 or 48.21 RCW, a health care service contractor as defined in RCW 48.44.010, and a health maintenance organization as defined in RCW 48.46.020, and as that term is used in the Patient Protection and Affordable Care Act (P.L. 111-148, as amended (2010)).

(16) "Health plan" or "plan" means any individual or group policy, contract, or agreement offered by a health carrier to provide, arrange, reimburse, or pay for health care service except the following:

(a) Long-term care insurance governed by chapter 48.84 RCW;

(b) Medicare supplemental health insurance governed by chapter 48.66 RCW;

(c) Limited health care service offered by limited health care service contractors in accordance with RCW 48.44.035;

(d) Disability income;

(e) Coverage incidental to a property/casualty liability insurance policy such as automobile personal injury protection coverage and homeowner guest medical;

(f) Workers' compensation coverage;

(g) Accident only coverage;

(h) Specified disease and hospital confinement indemnity when marketed solely as a supplement to a health plan;

(i) Employer-sponsored self-funded health plans;

(j) Dental only and vision only coverage; and

(k) Plans deemed by the insurance commissioner to have a short-term limited purpose or duration, or to be a student-only plan that is guaranteed renewable while the covered person is enrolled as a regular full-time undergraduate or graduate student at an accredited higher education institution, after a written request for such classification by the carrier and subsequent written approval by the insurance commissioner.

((~~(16)~~)) (17) "Indian health care provider" means:

(a) The Indian Health Service, an agency operated by the U.S. Department of Health and Human Services established by the Indian Health Care Improvement Act, Section 601, 25 U.S.C. §1661;

(b) An Indian tribe, as defined in the Indian Health Care Improvement Act, Section 4(14), 25 U.S.C. §1603(14), that operates a health program under a contract or compact to carry out programs of the Indian Health Service pursuant to the Indian Self-Determination and Education Assistance Act (ISDEAA), 25 U.S.C. §450 et seq.;

(c) A tribal organization, as defined in the Indian Health Care Improvement Act, Section 4(26), 25 U.S.C. §1603(26), that operates a health program under a contract or compact to carry out programs of the Indian Health Service pursuant to the ISDEAA, 25 U.S.C. §450 et seq.;

(d) An Indian tribe, as defined in the Indian Health Care Improvement Act, Section 4(14), 25 U.S.C. §1603(14), or tribal organization, as defined in the Indian Health Care Improvement Act, Section 4(26), 25 U.S.C. §1603(26), that operates a health program with funding provided in whole or part pursuant to 25 U.S.C. §47 (commonly known as the Buy Indian Act); or

(e) An urban Indian organization that operates a health program with funds in whole or part provided by Indian Health Service under a grant or contract awarded pursuant to Title V of the Indian Health Care Improvement Act, Section 4(29), 25 U.S.C. §1603(29).

(18) "Managed care plan" means a health plan that coordinates the provision of covered health care services to a covered person through the use of a primary care provider and a network.

((~~(17)~~)) (19) "Medically necessary" or "medical necessity" in regard to mental health services and pharmacy services is a carrier determination as to whether a health service is a covered benefit because the service is consistent with generally recognized standards within a relevant health profession.

((~~(18)~~)) (20) "Mental health provider" means a health care provider or a health care facility authorized by state law to provide mental health services.

((~~(19)~~)) (21) "Mental health services" means in-patient or out-patient treatment, partial hospitalization or out-patient treatment to manage or ameliorate the effects of a mental disorder listed in the *Diagnostic and Statistical Manual (DSM) IV* published by the American Psychiatric Association, excluding diagnoses and treatments for substance abuse, 291.0 through 292.9 and 303.0 through 305.9.

((~~(20)~~)) (22) "Network" means the group of participating providers and facilities providing health care services to a particular health plan or line of business (individual, small, or large group). A health plan network for ((~~carriers~~)) issuers offering more than one health plan may be smaller in number than the total number of participating providers and facilities for all plans offered by the carrier.

((~~(21)~~)) (23) "Out-patient therapeutic visit" or "out-patient visit" means a clinical treatment session with a mental health provider of a duration consistent with relevant professional standards used by the carrier to determine medical necessity for the particular service being rendered, as defined in *Physicians Current Procedural Terminology,* published by the American Medical Association.

((~~(22)~~)) (24) "Participating provider" and "participating facility" means a facility or provider who, under a contract with the health carrier or with the carrier's contractor or subcontractor, has agreed to provide health care services to covered persons with an expectation

of receiving payment, other than coinsurance, copayments, or deductibles, from the health carrier rather than from the covered person.

((~~(23)~~)) (25) "Person" means an individual, a corporation, a partnership, an association, a joint venture, a joint stock company, a trust, an unincorporated organization, any similar entity, or any combination of the foregoing.

((~~(24)~~)) (26) "Pharmacy services" means the practice of pharmacy as defined in chapter 18.64 RCW and includes any drugs or devices as defined in chapter 18.64 RCW.

((~~(25)~~)) (27) "Primary care provider" means a participating provider who supervises, coordinates, or provides initial care or continuing care to a covered person, and who may be required by the health carrier to initiate a referral for specialty care and maintain supervision of health care services rendered to the covered person.

((~~(26)~~)) (28) "Preexisting condition" means any medical condition, illness, or injury that existed any time prior to the effective date of coverage.

((~~(27)~~)) (29) "Premium" means all sums charged, received, or deposited by a health carrier as consideration for a health plan or the continuance of a health plan. Any assessment or any "membership," "policy," "contract," "service," or similar fee or charge made by a health carrier in consideration for a health plan is deemed part of the premium. "Premium" shall not include amounts paid as enrollee point-of-service cost-sharing.

((~~(28)~~)) (30) "Service area" means the geographic area or areas within the state where a specific health plan is issued, accepts members or enrollees, and covers provided services. A service area must be defined by the county or counties included unless, for good cause, the commissioner permits limitation of a service area by zip code. Good cause includes geographic barriers within a service area, or other conditions that make offering coverage throughout an entire county unreasonable.

(31) "Small group plan" means a health plan issued to a small employer as defined under RCW 48.43.005 (33) comprising from one to fifty eligible employees.

((~~(29)~~)) (32) "Substitute drug" means a therapeutically equivalent substance as defined in chapter 69.41 RCW.

((~~(30)~~)) (33) "Supplementary pharmacy services" or "other pharmacy services" means pharmacy services involving the provision of drug therapy management and other services not required under state and federal law but that may be rendered in connection with dispensing, or that may be used in disease prevention or disease management.

AMENDATORY SECTION (Amending WSR 01-03-033, filed 1/9/01, effective 7/1/01)

WAC 284-43-200 Network ((~~adequacy~~)) access—General standards. (1) ((~~A health carrier shall~~)) An issuer must maintain each ((~~plan~~)) provider network for each health plan in a manner that is sufficient in numbers and types of providers and facilities to assure that, to the extent feasible based on the number and type of providers and facilities in the service area, all health plan services provided to ((~~covered persons~~)) enrollees will be accessible in a timely manner appropriate for the enrollee's condition. An issuer must demonstrate

that for each health plan's defined service area, a comprehensive range of primary, specialty, institutional, and ancillary services are readily available without unreasonable delay to all enrollees and that emergency services are accessible twenty-four hours per day, seven days per week without unreasonable delay.

(2) Each ((~~covered person shall~~)) enrollee must have adequate choice among ((~~each type of~~)) health care providers, including those ((~~types of providers who~~)) providers which must be included in the network under WAC 284-43-205, and for qualified health plans and qualified stand-alone dental plans, under WAC 284-43-222. ((~~In the case of emergency services, covered persons shall have access twenty-four hours per day, seven days per week. The carrier's~~))

(3) An issuer's service area ((~~shall~~)) must not be created in a manner designed to discriminate or that results in discrimination against persons because of age, gender, gender identity, sexual orientation, disability, national origin, sex, family structure, ethnicity, race, health condition, employment status, or socioeconomic status((~~. Each carrier shall ensure that its networks will meet these requirements by the end of the first year of initial operation of the network and at all times thereafter~~)).

((~~(2)~~)) (4) An issuer must establish sufficiency and 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-covered person ratios by specialty, primary care provider-covered person ratios, geographic accessibility, waiting times for appointments with participating providers, hours of operation, and the volume of technological and specialty services available to serve the needs of covered persons requiring technologically advanced or specialty care. Evidence of carrier compliance with network adequacy standards that are substantially similar to those standards established by state agency health care purchasers (e.g., the state health care authority and the department of social and health services) and by private managed care accreditation organizations may be used to demonstrate sufficiency. At a minimum, a carrier will be held accountable for meeting those standards described under WAC 284-43-220.~~

~~(3) In any case where the health carrier has an absence of or an insufficient number or type of participating providers or facilities to provide a particular covered health care service, the carrier shall 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 commissioner.~~

~~(4) The health carrier shall~~)) of providers based on the number and type of providers and facilities necessary within the service area for the plan to meet the access requirements set forth in this subchapter. Where an issuer establishes medical necessity or other prior authorization procedures, the issuer must ensure sufficient qualified staff is available to provide timely prior authorization decisions on an appropriate basis, without delays detrimental to the health of enrollees.

(5) In any case where the issuer has an absence of or an insufficient number or type of participating providers or facilities to provide a particular covered health care service, the issuer must ensure through referral by the primary care provider or otherwise that the enrollee obtains the covered service from a provider or facility with-

in reasonable proximity of the enrollee at no greater cost to the enrollee than if the service were obtained from network providers and facilities. An issuer must satisfy this obligation even if an alternate access delivery request is filed and pending commissioner approval.

An issuer may use facilities in neighboring service areas to satisfy a network access standard if one of the following types of facilities is not in the service area, or if the issuer can provide substantial evidence of good faith efforts on its part to contract with the facilities in the service area. Such evidence of good faith efforts to contract will include documentation about the efforts to contract but not the substantive contract terms offered by either the issuer or the facility. This applies to the following types of facilities:

(a) Tertiary hospitals;

(b) Pediatric community hospitals;

(c) Specialty or limited hospitals, such as burn units, rehabilitative hospitals, orthopedic hospitals, and cancer care hospitals;

(d) Neonatal intensive care units; and

(e) Facilities providing transplant services, including those that provide solid organ, bone marrow, and stem cell transplants.

(6) An issuer must establish and maintain adequate arrangements to ensure reasonable proximity of network providers and facilities to the business or personal residence of ((~~covered persons. Health carriers shall~~)) enrollees, and located so as to not result in unreasonable barriers to accessibility. Issuers must make reasonable efforts to include providers and facilities in networks in a manner that limits the amount of travel required to obtain covered benefits. ((~~For example, a carrier should not require travel of thirty miles or more when a provider who meets carrier standards is available for inclusion in the network and practices within five miles of enrollees.~~

~~In determining whether a health carrier has complied with this provision, the commissioner will give due consideration to the relative availability of health care providers or facilities in the service area under consideration and to the standards established by state agency health care purchasers. Relative availability includes the willingness of providers or facilities in the service area to contract with the carrier under reasonable terms and conditions.~~

~~(5) A health carrier shall monitor, on an ongoing basis, the ability and clinical capacity of its network providers and facilities to furnish health plan services to covered persons.~~

~~(6) Beginning July 1, 2000, the health carrier shall disclose to covered persons~~))

(7) A single case provider reimbursement agreement must be used only to address unique situations that typically occur out-of-network and out-of-service area, where an enrollee requires services that extend beyond stabilization or one time urgent care. Single case provider reimbursement agreements must not be used to fill holes or gaps in the network and do not support a determination of network access.

(8) An issuer must disclose to enrollees that limitations or restrictions on access to participating providers and facilities may arise from the health 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. For example, a covered person relying on such instructions or processes could discover if the choice of a~~

~~particular primary care provider would result in the covered person's inability to obtain a referral to certain other participating providers.~~

~~(7)~~)) the issuer. A description of the health plan's referral and authorization practices, including information about how to contact customer service for guidance, must be set forth as an introduction or preamble to the provider directory for a health plan. In the alternative, the description of referral and authorization practices may be included in the summary of benefits and explanation of coverage for the health plan.

(9) To provide adequate choice to ((~~covered persons~~)) enrollees who are American Indians/Alaska Natives, each health ((~~carrier shall~~)) issuer must maintain arrangements that ensure that American Indians/Alaska Natives who are ((~~covered persons~~)) enrollees have access to covered medical and behavioral health services provided by Indian health care ((~~services and facilities that are part of the Indian health system~~)) providers.

((~~Carriers shall~~)) Issuers must ensure that such ((~~covered persons~~)) enrollees may obtain covered medical and behavioral health services from the Indian health ((~~system~~)) care provider at no greater cost to the ((~~covered person~~)) enrollee than if the service were obtained from network providers and facilities, even if the Indian health care provider is not a contracted provider. ((~~Carriers~~)) Issuers are not responsible for credentialing providers and facilities that are part of the Indian health system. Nothing in this subsection prohibits ((~~a carrier~~)) an issuer from limiting coverage to those health services that meet ((~~carrier~~)) issuer standards for medical necessity, care management, and claims administration or from limiting payment to that amount payable if the health service were obtained from a network provider or facility.

(10) An issuer must have a demonstrable method and contracting strategy to ensure that contracting hospitals in a plan's service area have the capacity to serve the entire enrollee population based on normal utilization.

(11) At a minimum, an issuer's provider network must adequately provide for mental health and substance use disorder treatment, including behavioral health therapy.

(a) Adequate networks include crisis intervention and stabilization, psychiatric inpatient hospital services, including voluntary psychiatric inpatient services, and services from mental health providers. There must be mental health providers of sufficient number and type to provide diagnosis and medically necessary treatment of conditions covered by the plan through providers acting within their scope of license and scope of competence established by education, training, and experience to diagnose and treat conditions found in the most recent version of the *Diagnostic and Statistical Manual of Medical Disorders* or other recognized diagnostic manual or standard.

(b) An issuer must establish a reasonable standard for the number and geographic distribution of mental health providers who can treat serious mental illness of an adult and serious emotional disturbances of a child, taking into account the various types of mental health practitioners acting within the scope of their licensure.

The issuer must measure the adequacy of the mental health network against this standard at least twice a year, and file an action plan with the commissioner if the standard is not met.

(c) Emergency mental health services, including crisis intervention and crisis stabilization services, must be included in an issuer's provider network.

(d) An issuer must include a sufficient number and type of mental health and substance use disorder treatment providers and facilities within a service area based on normal utilization patterns.

(e) An issuer must ensure that an enrollee can identify information about mental health services and substance use disorder treatment including benefits, providers, coverage, and other relevant information by calling a customer service representative during normal business hours.

(12) The provider network must include preventative and wellness services, including chronic disease management and smoking cessation services as defined in RCW 48.43.005(37) and WAC 284-43-878(9). If these services are provided through a quit-line or help-line, the issuer must ensure that when follow-up services are medically necessary, the enrollee will have access to sufficient information to access those services within the service area. Contracts with quit-line or help-line services are subject to the same conditions and terms as other provider contracts under this section.

(13) For the essential health benefits category of ambulatory patient services, as defined in WAC 284-43-878(1), an issuer's network is adequate if:

(a) The issuer establishes a network that affords enrollee access to urgent appointments without prior authorization within forty-eight hours, or with prior authorization, within ninety-six hours of the referring provider's referral.

(b) For primary care providers the following must be demonstrated:

(i) The ratio of enrollee to primary care provider within the issuer's service area as a whole meets or exceeds the average ratio for Washington state for the prior plan year;

(ii) The network includes such numbers and distribution that eighty percent of enrollees within the service area are within thirty miles of a sufficient number of primary care providers in an urban area and within sixty miles of a sufficient number of primary care providers in a rural area from either their residence or work; and

(iii) Enrollees have access to an appointment, for other than preventive services, with their primary care provider within ten business days of requesting one.

(c) For specialists:

(i) The issuer documents the distribution of specialists in the network for the service area in relation to the population distribution within the service area; and

(ii) The issuer establishes that when an enrollee is referred to a specialist, the enrollee has access to an appointment with such a specialist within fifteen business days for nonurgent services.

(d) For preventive care services, and periodic follow-up care including, but not limited to, standing referrals to specialists for chronic conditions, periodic office visits to monitor and treat pregnancy, cardiac or mental health conditions, and laboratory and radiological or imaging monitoring for recurrence of disease, the issuer permits scheduling such services in advance, consistent with professionally recognized standards of practice as determined by the treating licensed health care provider acting within the scope of his or her practice.

(14) The network access requirements in this subchapter apply to stand-alone dental plans offered through the exchange or where a stand-alone dental plan is offered outside of the exchange for the purpose of providing the essential health benefit category of pediatric oral benefits. All such stand-alone dental plans must ensure that all covered services to enrollees will be accessible in a timely manner appropriate for the enrollee's conditions.

(a) An issuer of such stand-alone dental plans must demonstrate that, for the dental plan's defined service area, all services required under WAC 284-43-879(3) are available to all enrollees without unreasonable delay.

(b) Dental networks for pediatric oral services must be sufficient for the enrollee population in the service area based on expected utilization.

(15) Issuers must meet all requirements of this subsection for all provider networks. An alternate access delivery request under WAC 284-43-201 may be proposed only if:

(a) There are sufficient numbers and types of providers or facilities in the service area to meet the standards under this subchapter but the issuer is unable to contract with sufficient providers or facilities to meet the network standards in this subchapter; or

(b) An issuer's provider network has been previously approved under this section, and a provider or facility type subsequently becomes unavailable within a health plan's service area; or

(c) A county has a population that is fifty thousand or fewer, and the county is the sole service area for the plan, and the issuer chooses to propose an alternative access delivery system for that county; or

(d) A qualified health plan issuer is unable to meet the standards for inclusion of essential community providers, as provided under WAC 284-43-222 (3)(d) and (4).

(16) This section is effective for all plans, whether new or renewed, with effective dates on or after January 1, 2015.

NEW SECTION

WAC 284-43-201 Alternate access delivery request. (1) Where an issuer's network meets one or more of the criteria in WAC 284-43-200 (15)(a) through (d), the issuer may submit an alternate access delivery request for the commissioner's review and approval. The alternate access delivery request must be made using the Alternate Access Delivery Request Form C, as provided in WAC 284-43-220 (3)(d).

(a) An alternate access delivery system must provide enrollees with access to medically necessary care on a reasonable basis without detriment to their health.

(b) The issuer must ensure that the enrollee obtains all covered services in the alternate access delivery system at no greater cost to the enrollee than if the service was obtained from network providers or facilities or must make other arrangements acceptable to the commissioner.

(i) Copayments and deductible requirements must apply to alternate access delivery systems at the same level they are applied to in-network services.

(ii) The alternate access delivery system may result in issuer payment of billed charges to ensure network access.

(c) An issuer must demonstrate in its alternate access delivery request a reasonable basis for not meeting a standard as part of its filing for approval of an alternate access delivery system, and include an explanation of why the alternate access delivery system provides a sufficient number or type of the provider or facility to which the standard applies to enrollees.

(d) An issuer must demonstrate a plan and practice to assist enrollees to locate providers and facilities in neighboring service areas in a manner that assures both availability and accessibility. Enrollees must be able to obtain health care services from a provider or facility within the closest reasonable proximity of the enrollee in a timely manner appropriate for the enrollee's health needs.

Alternate access delivery systems include, but are not limited to, such provider network strategies as use of out-of-state and out of county or service area providers, and exceptions to network standards based on rural locations in the service area.

(2) The commissioner will not approve an alternate access delivery system unless the issuer provides substantial evidence of good faith efforts on its part to contract with providers or facilities, and can demonstrate that there is not an available provider or facility with which the issuer can contract to meet provider network standards under WAC 284-43-200.

(a) Such evidence of good faith efforts to contract, where required, will be submitted as part of the issuer's Alternate Access Delivery Request Form C submission, as described in WAC 284-43-220 (3)(d).

(b) Evidence of good faith efforts to contract will include documentation about the efforts to contract but not the substantive contract terms offered by either the issuer or the provider.

(3) The practice of entering into a single case provider reimbursement agreement with a provider or facility in relation to a specific enrollee's condition or treatment requirements is not an alternate access delivery system for purposes of establishing an adequate provider network. A single case provider reimbursement agreement must be used only to address unique situations that typically occur out of network and out of service area, where an enrollee requires services that extend beyond stabilization or one time urgent care. Single case provider reimbursement agreements must not be used to fill holes or gaps in a network for the whole population of enrollees under a plan, and do not support a determination of network access.

(4) This section is effective for all plans, whether new or renewed, with effective dates on or after January 1, 2015.

NEW SECTION

WAC 284-43-203 Use of subcontracted networks. (1) The primary contractor with each provider and facility in an issuer's network must be specifically identified in network report filings with the commissioner. An issuer may use subcontracted networks as part of a provider network for a service area, subject to the following requirements:

(a) An issuer must not elect to use less than one hundred percent of the subcontracted network or networks in its service area.

(b) An issuer may use a combination of directly contracting with providers and use of a subcontracted network in the same service area.

(2) Upon request by the commissioner, an issuer must produce an executed copy of its agreement with a subcontracted network, and certify to the commissioner that there is reasonable assurance the providers listed as part of the subcontracted network are under enforceable contracts with the subcontractor. The contract with the subcontracted network's administrator must provide the issuer with the ability to require providers to conform to the requirements in chapter 284-43 WAC, subchapter B.

(3) If an issuer permits a facility or provider to delegate functions, the issuer must require the facility or provider to:

(a) Include the requirements of this subchapter in its contracting documents with the subcontractor, including providing the commissioner with access to any pertinent information related to the contract during the contract term, for up to ten years from the final date of the contract period, and in certain instances, where required by federal or state law, periods in excess of ten years;

(b) Provide the issuer with the right to approve, suspend or terminate any such arrangement.

(4) This section is effective for all plans, whether new or renewed, with effective dates on or after January 1, 2015.

NEW SECTION

WAC 284-43-204 Provider directories. (1) Provider directories must be updated at least monthly, and must be offered to accommodate individuals with limited-English proficiency or disabilities. An issuer must post the current provider directory for each health plan online, and must make printed copy of the current directory available to an enrollee upon request as required under RCW 48.43.510 (1)(g).

(2) For each health plan, the associated provider directory must include the following information for each provider:

(a) The specialty area or areas for which the provider is licensed to practice and included in the network;

(b) Any in-network institutional affiliation of the provider, such as hospitals where the provider has admitting privileges or provider groups with which a provider is a member;

(c) Whether the provider may be accessed without referral;

(d) Any languages, other than English, spoken by the provider.

(3) An issuer must include in its electronic posting of a health plan's provider directory a notation of any primary care, chiropractor, women's health care provider, or pediatrician whose practice is closed to new patients.

(4) If an issuer maintains more than one provider network, its posted provider directory or directories must make it reasonably clear to an enrollee which network applies to which health plan.

(5) Information about any available telemedicine services must be included and specifically described.

(6) Information about any available interpreter services, communication and language assistance services, and accessibility of the physical facility must be identified in the directory, and the mechanism by which an enrollee may access such services.

(7) An issuer must include information about the network status of emergency providers as required by WAC 284-43-252.

(8) This section is effective for all plans, whether new or renewed, with effective dates on or after January 1, 2015.

AMENDATORY SECTION (Amending WSR 99-16-036, filed 7/28/99, effective 8/28/99)

WAC 284-43-205 Every category of health care providers. (1) ((~~To effectuate the requirement of RCW 48.43.045 that health plans provide coverage for treatments and services by every category of provider, health carriers shall~~)) Issuers must not exclude any category of providers licensed by the state of Washington who provide health care services or care within the scope of their practice for ((~~conditions covered by basic health plan (BHP) services as defined by RCW 48.43.005(4). If the BHP covers the condition, the carrier may~~)) services covered as essential health benefits, as defined in WAC 284-43-878 and RCW 48.43.715, for individual and small group plans; and as covered by the basic health plan, as defined in RCW 48.43.005(4), for plans other than individual and small group.

For individual and small group plans, the issuer must not exclude a category of provider who is licensed to provide services for that condition, and is acting within the scope of practice, unless such services would not meet the ((~~carrier's~~)) issuer's standards pursuant to RCW 48.43.045 (1)((~~(b)~~)) (a). For example, ((~~if the BHP provides coverage for~~)) if the issuer covers outpatient treatment of lower back pain as part of the essential health benefits, any category of provider that provides cost-effective and clinically efficacious outpatient treatment for lower back pain within its scope of practice and otherwise abides by standards pursuant to RCW 48.43.045 (1)((~~(b) may~~)) (a) must not be excluded from the network.

(2) RCW 48.43.045 (1)((~~(b)~~)) (a) permits ((~~health carriers~~)) issuers to require providers to abide by certain standards. These standards may not be used in a manner designed to exclude categories of providers unreasonably. For example, ((~~health carriers may~~)) issuers must not decide that a particular category of provider can never render any cost-effective or clinically efficacious services and thereby exclude that category of provider completely from health plans on that basis. ((~~However, health carriers may determine that particular services for particular conditions by particular categories of providers are not cost-effective or clinically efficacious, and may exclude such services from coverage or reimbursement under a health plan. Any such determinations must be supported by relevant information or evidence of the type usually considered and relied upon in making determinations of cost-effectiveness or clinical efficacy.~~))

(3) Health plans are not prohibited by this section from placing reasonable limits on individual services rendered by specific categories of providers based on relevant information or evidence of the type usually considered and relied upon in making determinations of cost-effectiveness or clinical efficacy. However, health plans ((~~may~~)) must not contain unreasonable limits, and ((~~may~~)) must not include limits on the type of provider permitted to render the covered service unless such limits comply with RCW 48.43.045 (1)((~~(b)~~)) (a).

(4) This section does not prohibit health plans from using restricted networks. ((~~Health carriers~~)) Issuers offering plans with restricted networks may select the individual providers in any category of provider with whom they will contract or whom they will reimburse. ((~~A health carrier~~)) An issuer is not required by RCW 48.43.045 or this section to accede to a request by any individual provider for inclusion in any network for any health plan.

(a) Health plan((~~s~~)) networks that use "gatekeepers" or "medical homes" for access to specialist providers may use them for access to specified categories of providers.

(b) For purposes of this section:

(i) "Gatekeeper" means requiring a referral from a primary care or direct access provider or practitioner to access specialty or inpatient services.

(ii) "Medical home" means a team based health care delivery model for patient centered primary care that provides comprehensive and continuous medical care to patients with the goal of obtaining maximized health outcomes as modified and updated by the Agency for Healthcare Research and Quality, the U.S. Department of Health and Human Services (HRSA), and other state and federal agencies.

(5) ((~~Health carriers may~~)) Issuers must not offer coverage for health services for certain categories of providers solely as a separately priced optional benefit.

(6) The insurance commissioner may grant reasonable temporary extensions of time for implementation of RCW 48.43.045 or this section, or any part thereof, for good cause shown.

((~~(7) All health carriers and their plans, provider contracts, networks and operations shall conform to the provisions of this section WAC 284-43-205, by January 1, 2000.~~))

AMENDATORY SECTION (Amending WSR 11-07-015, filed 3/8/11, effective 4/8/11)

WAC 284-43-220 Network reports—Format. ((~~Each health carrier must file with the commissioner a Provider Network Form A and a Network Enrollment Form B.~~)) (1) An issuer must submit its provider network materials to the commissioner for approval prior to or at the time it files a newly offered health plan.

(a) For individual and small groups, the submission must occur when the issuer files its plan under WAC 284-170-870. For groups other than individual and small, the submission must occur when the issuer files a new health plan and as required in this section.

(b) The commissioner may extend the time for filing for good cause shown.

(c) For plan year 2015 only, the commissioner will permit a safe harbor standard. An issuer, who can not meet the submission requirements in (e) and (f) of this subsection, will be determined to meet the requirements of those subsections even if the submissions are incomplete, provided that the issuer:

(i) Identifies specifically each map required under subsection (3)(e)(i) of this section, or Access Plan component required under subsection (3)(f) of this section which has not been included in whole or part;

(ii) Explains the specific reason each map or component has not been included; and

(iii) Sets forth the issuer's plan to complete the filing, including the date(s) by which each incomplete map and component will be completed and filed.

(2) Unless indicated otherwise, the issuer's reports must be submitted electronically and completed consistent with the posted submission instructions on the commissioner's web site, using the required formats.

(3) For plan years beginning January 1, 2015, an issuer must submit the following specific documents and data to the commissioner to document network access:

(a) **Provider Network Form A.** ((~~A carrier~~)) An issuer must file ((~~an electronic~~)) a report of all participating providers by network.

((~~This report must contain all data items shown in Provider Network Form A prescribed by and available from the commissioner. Updated reports must be filed each month.~~))

(i) The Provider Network Form A must be submitted for each network being reviewed for network access. A network may be used by more than one plan.

(ii) An issuer must indicate whether a provider is an essential community provider as instructed in the commissioner's Provider Network Form A instructions.

(iii) An issuer must submit an updated, accurate Provider Network Form A on a monthly basis by the 5th of each month for each network and when a material change in the network occurs as described in subchapter B.

(iv) Filing of this data satisfies the reporting requirements of RCW 48.44.080 and the requirements of RCW 48.46.030 relating to filing of notices that describe((~~s~~)) changes in the provider network.

((~~(2)~~)) (b) **Provider directory certification.** An issuer must submit at the time of each Provider Network Form A submission a certification that the provider directory posted on the issuer's web site is specific to each plan, accurate as of the last date of the prior month. A certification signed by an officer of the issuer must confirm that the provider directory contains only providers and facilities with which the issuer has a signed contract that is in effect on the date of the certification.

(c) **Network Enrollment Form B.** ((~~By March 31, 2004, and every year thereafter, a carrier must prepare an electronic report showing the total number of covered persons who were entitled to health care services during each month of the year, excluding nonresidents. A separate~~)) The Network Enrollment Form B report provides the commissioner with an issuer's count of total covered lives for the prior year, during each month of the year, for each health plan by county.

(i) The report must be ((~~filed~~)) submitted for each network ((~~by line of business~~)) as a separate report. The report must contain all data items shown in and conform to the format of Network Enrollment Form B prescribed by and available from the commissioner.

((~~(3)~~)) (ii) An issuer must file this report by March 31st of each year.

(d) **Alternate Access Delivery Request Form C.** For plan years that begin on or after January 1, 2015, alternate access delivery requests must be submitted when an issuer's network meets one or more of the criteria in WAC 284-43-200 (15)(a) through (d). Alternate access delivery requests must be submitted to the commissioner using the Alternate Access Delivery Request Form C.

(i) The Alternate Access Delivery Request Form C submission must address the following areas, and may include other additional information as requested by the commissioner:

(A) A description of the specific issues the alternate access delivery system is intended to address, accompanied by supporting data describing how the alternate access delivery system ensures that enrollees have reasonable access to sufficient providers, by number and type, for covered services;

(B) A description and schedule of cost-sharing requirements for providers that fall under the alternate access delivery system;

(C) The issuer's proposed method of noting on its provider directory how an enrollee can access provider types under the alternate access delivery system;

(D) The issuer's marketing plan to accommodate the time period that the alternate access delivery system is in effect, and specifically describe how it impacts current and future enrollment and for what period of time;

(ii) Provider Network Form A and Network Enrollment Form B submissions are required in relation to an alternate access delivery system on the basis described in subsections (1) and (2) of this section.

(iii) If a network becomes unable to meet the network access standards after approval but prior to the health product's effective date, an alternate access delivery request must include a timeline to bring the network into full compliance with this subchapter.

(e) **Geographic Network Reports.**

(i) The geographic mapping criteria outlined below are minimum requirements and will be considered in conjunction with the standards set forth in WAC 284-43-200 and 284-43-222. One map for each of the following provider types must be submitted:

(A) Hospital and emergency services. Map must identify provider locations, and demonstrate that each enrollee in the service area has access within thirty minutes in an urban area and sixty minutes in a rural area from either their residence or workplace to general hospital facilities including emergency services.

(B) Primary care providers. Map must demonstrate that eighty percent of the enrollees in the service area have access within thirty miles in an urban area and sixty miles in a rural area from either their residence or workplace to a primary care provider with an open practice. The provider type selected must have a license under Title 18 RCW that includes primary care services in the scope of license.

(C) Mental health providers. For general mental health providers, such as licensed psychiatrists, psychologists, social workers, and mental health nurse practitioners, the map must demonstrate that eighty percent of the enrollees in the service area have access to a mental health provider within thirty miles in an urban area and sixty miles in a rural area from either their residence or workplace. For specialty mental health providers, the map must demonstrate that eighty percent of the enrollees have access to the following types of service provider or facility: Evaluation and treatment, voluntary and involuntary inpatient mental health and substance use disorder treatment, outpatient mental health and substance use disorder treatment, and behavioral therapy. If one of the types of specialty providers is not available as required above, the issuer must propose an alternate access delivery system to meet this requirement.

(D) Pediatric services. For general pediatric services, the map must demonstrate that eighty percent of the covered children in the service area have access to a pediatrician or other provider whose li-

cense under Title 18 RCW includes pediatric services in the scope of license. This access must be within thirty miles in an urban area and sixty miles in a rural area of their family or placement residence. For specialty pediatric services, the map must demonstrate that eighty percent of covered children in the service area have access to pediatric specialty care within sixty miles in an urban area and ninety miles in a rural area of their family or placement residence. The pediatric specialty types include, but are not limited to, nephrology, pulmonology, rheumatology, hematology-oncology, perinatal medicine, neurodevelopmental disabilities, cardiology, endocrinology, and gastroenterology.

(E) Specialty services. An issuer must provide one map for the service area for each area of specialty found on the American Board of Medical Specialties list of approved medical specialty boards. The map must demonstrate that eighty percent of the enrollees in the service area have access to an adequate number of providers and facilities in each specialty. Subspecialties are subsumed on each map.

(F) Therapy services. An issuer must provide one map that demonstrates that eighty percent of the enrollees have access to the following types of providers within thirty miles in an urban area and sixty miles in a rural area of their residence or workplace: Chiropractor, rehabilitative service providers and habilitative service providers.

(G) Home health, hospice, vision, and dental providers. An issuer must provide one map that identifies each provider or facility to which an enrollee has access in the service area for home health care, hospice, vision, and pediatric oral coverage, including allied dental professionals, dental therapist, dentists, and orthodontists.

(H) Covered pharmacy dispensing services. An issuer must provide one map that demonstrates the geographic distribution of the pharmacy dispensing service within the service area. If a pharmacy benefit manager is used by the issuer, the issuer must establish that the specifically contracted pharmacy locations within the service area are available to enrollees through the pharmacy benefit manager.

(I) Essential community providers. An issuer must provide one map that demonstrates the geographic distribution of essential community providers, by type of provider or facility, within the service area. This requirement applies only to qualified health plans as certified in RCW 43.71.065.

(ii) Each report must include the provider data points on each map, title the map as to the provider type or facility type it represents, include the network identification number the map applies to, and the name of each county included on the report.

(iii) For plan years beginning January 1, 2015, and every year thereafter, an issuer must submit reports as required in this subsection (1) to the commissioner for review and approval, or when an alternate access delivery request is submitted.

(f) Access Plan. An issuer must establish an access plan specific to each health plan that describes the issuer's strategy, policies, and procedures necessary to establishing, maintaining, and administering an adequate network.

(i) At a minimum, the issuer's policies and procedures referenced in the access plan must address:

(A) Referral of enrollees out-of-network, including criteria for determining when an out-of-network referral is required or appropriate;

(B) Copayment and coinsurance determination standards for enrollees accessing care out-of-network;

(C) Standards of accessibility expressed in terms of objectives and minimum levels below which corrective action will be taken, including the proximity of specialists and hospitals to primary care sources, and a method and process for documentation confirming that access will not result in delay detrimental to health of enrollees;

(D) Monitoring policies and procedures for compliance, including tracking and documenting network capacity and availability;

(E) Standard hours of operation, and after-hours, for prior authorization, consumer and provider assistance, and claims adjudication;

(F) Triage and screening arrangements for prior authorization requests;

(G) Prior authorization processes that enrollees must follow, including the responsibilities and scope of use of nonlicensed staff to handle enrollee calls about prior authorization;

(H) Specific procedures and materials used to address the needs of enrollees with limited-English proficiency and literacy, with diverse cultural and ethnic backgrounds, and with physical and mental disabilities;

(I) Assessment of the health status of the population of enrollees or prospective enrollees, including incorporation of the findings of local public health community assessments, and standardized outcome measures, and use of the assessment data and findings to develop network or networks in the service area;

(J) Notification to enrollees regarding personal health information privacy rights and restrictions, termination of a provider from the network, and maintaining continuity of care for enrollees when there is a material change in the provider network, insolvency of the issuer, or other cessation of operations;

(K) Processes for corrective action for providers related to the provider's licensure, prior authorization, referral and access compliance. The process must include remedies to address insufficient access to appointments or services.

(ii) An access plan applicable to each product, must be filed with every Geographic Network Report, when the issuer seeks initial certification of the network, submits its annual rate filing to the commissioner for review and approval, or when an alternative access delivery request is required due to a material change in the network.

(iii) The current access plan, with all associated data sets, policies and procedures, must be made available to the commissioner upon request, and a summary of the access plan's associated procedures must be made available to the public upon request.

(4) For purposes of this section((~~: (a) "Line of business" means either individual, small group or large group coverage;~~

~~(b) "Network" means the group of participating providers and facilities providing health care services to a particular line of business.~~)), "urban area" means:

(a) A county with a density of ninety persons per square mile; or

(b) An area with a twenty-five mile radius around an incorporated city with a population of more than thirty thousand.

NEW SECTION

WAC 284-43-221 Essential community providers for exchange plans—Definition. "Essential community provider" means providers listed on the Centers for Medicare and Medicaid Services Non-Exhaustive List of Essential Community Providers. This list includes providers and facilities that have demonstrated service to medicaid, low-income, and medically underserved populations in addition to those that meet the federal minimum standard, which includes:

(1) Hospitals and providers who participate in the federal 340B Drug Pricing Program;

(2) Disproportionate share hospitals, as designated annually;

(3) Those eligible for Section 1927 Nominal Drug Pricing;

(4) Those whose patient mix is at least thirty percent medicaid or medicaid expansion patients who have approved applications for the Electronic Medical Record Incentive Program;

(5) State licensed community clinics or health centers or community clinics exempt from licensure;

(6) Indian health care providers as defined in WAC 284-43-130(17);

(7) Long-term care facilities in which the average residency rate is fifty percent or more eligible for medicaid during the preceding calendar year;

(8) School-based health centers as referenced for funding in Sec. 4101 of Title IV of ACA;

(9) Providers identified as essential community providers by the U.S. Department of Health and Human Services through subregulatory guidance or bulletins;

(10) Facilities or providers who waive charges or charge for services on a sliding scale based on income and that do not restrict access or services because of a client's financial limitations;

(11) Title X Family Planning Clinics and Title X look-alike Family Planning Clinics;

(12) Rural based or free health centers as identified on the Rural Health Clinic and the Washington Free Clinic Association web sites; and

(13) Federal qualified health centers (FQHC) or FQHC look-alikes.

NEW SECTION

WAC 284-43-222 Essential community providers for exchange plans—Network access. (1) An issuer must include essential community providers in its provider network for qualified health plans and qualified stand-alone dental plans in compliance with this section and as defined in WAC 284-43-221.

(2) An issuer must include a sufficient number and type of essential community providers in its provider network to provide reasonable access to the medically underserved or low-income in the service area, unless the issuer can provide substantial evidence of good faith efforts on its part to contract with the providers or facilities in the service area. Such evidence of good faith efforts to contract will include documentation about the efforts to contract but not the substantive contract terms offered by either the issuer or the provider.

(3) The following minimum standards apply to establish adequate qualified health plan inclusion of essential community providers:

(a) Each issuer must demonstrate that at least thirty percent of available primary care providers, pediatricians, and hospitals that meet the definition of an essential community provider in each plan's service area participate in the provider network;

(b) The issuer's provider network must include access to one hundred percent of Indian health care providers in a service area, as defined in WAC 284-43-130(17), such that qualified enrollees obtain all covered services at no greater cost than if the service was obtained from network providers or facilities;

(c) Within a service area, fifty percent of rural health clinics located outside an area defined as urban by the 2010 Census must be included in the issuer's provider network;

(d) For essential community provider categories of which only one or two exist in the state, an issuer must demonstrate a good faith effort to contract with that provider or providers for inclusion in its network, which will include documentation about the efforts to contract but not the substantive contract terms offered by either the issuer or the provider;

(e) For qualified health plans that include pediatric oral services or qualified dental plans, thirty percent of essential community providers in the service area for pediatric oral services must be included in each issuer's provider network;

(f) Ninety percent of all federally qualified health centers and FQHC look-alike facilities in the service area must be included in each issuer's provider network;

(g) At least one essential community provider hospital per county in the service area must be included in each issuer's provider network;

(h) At least fifteen percent of all providers participating in the 340B program in the service area, balanced between hospital and nonhospital entities, must be included in the issuer's provider network;

(i) By 2016, at least seventy-five percent of all school-based health centers in the service area must be included in the issuer's network.

(4) An issuer must, at the request of a school-based health center or group of school-based health centers, offer to contract with such a center or centers to reimburse covered health care services delivered to enrollees under an issuer's health plan.

(a) If a contract is not entered into, the issuer must provide substantial evidence of good faith efforts on its part to contract with a school-based health center or group of school-based health centers. Such evidence of good faith efforts to contract will include documentation about the efforts to contract but not the substantive contract terms offered by either the issuer or the provider.

(b) "School-based health center" means a school-based location for the delivery of health services, often operated as a partnership of schools and community health organizations, which can include issuers, which provide on-site medical and mental health services through a team of medical and mental health professionals to school-aged children and adolescents.

(5) An issuer must, at the request of an Indian health care provider, offer to contract with such a provider to reimburse covered health care services delivered to qualified enrollees under an issuer's health plan.

(a) Issuers are encouraged to use the current version of the Washington State Indian Health Plan Addendum, as posted on http://www.aihc-wa.com, to supplement the existing provider contracts when contracting with an Indian health care provider.

(b) If an Indian health care provider requests a contract and a contract is not entered into, the issuer must provide substantial evidence of good faith efforts on its part to contract with the Indian health care provider. Such evidence of good faith efforts to contract will include documentation about the efforts to contract but not the substantive contract terms offered by either the issuer or the provider.

(6) These requirements do not apply to integrated delivery systems pursuant to RCW 43.71.065.

NEW SECTION

WAC 284-43-229 Tiered provider networks. (1) "Tiered provider network" means a network that identifies and groups providers and facilities into specific groups to which different provider reimbursement, enrollee cost-sharing, or provider access requirements, or any combination thereof, apply as a means to manage cost, utilization, quality, or to otherwise incentivize enrollee or provider behavior.

(a) An issuer may use a term other than tiered network as long as the term is not misleading or susceptible to confusion with a specific licensee designation, such as accountable care organization.

(b) An issuer must not use tiered networks to limit access to certain categories of providers or facilities.

(2) When an issuer's contracts include the placement of providers or facilities in tiers, and the network design results in cost differentials for enrollees, the issuer must disclose to enrollees at the time of enrollment the cost difference and the basis for the issuer's placement of providers or facilities in one tier or another.

(3) The lowest cost-sharing tier of a tiered network must provide enrollees with adequate access and choice among health care providers and facilities for essential health benefits as set forth in WAC 284-43-878, 284-43-879, and 284-43-880.

(4) Cost-sharing differentials between tiers must not be imposed on an enrollee if the sole provider or facility type or category required to deliver a covered service is not available to the enrollee in the lowest cost tier of the network.

(a) All enrollees must have reasonable access to providers and facilities at the lowest cost tier of cost-sharing.

(b) Variations in cost-sharing between tiers must be reasonable in relation to the premium rate charged.

(5) An issuer must include with the Provider Compensation Agreement the metrics and methodology used to assign participating providers and facilities to tiers. An issuer must be able to demonstrate to the commissioner's satisfaction that its assignment of providers and facilities to tiers, when based on a rating system, is consistent with the issuer's placement methodology.

(a) When an issuer revises or amends a quality, cost-efficiency or tiering program related to its provider network, it must provide notice to affected providers and facilities of the proposed change sixty days before notifying the public of the program. The notice must

explain the methodology and data, if any, used for particular providers and facilities and include information on provider appeal rights as stated in the provider agreement.

(b) An issuer must make its physician cost profile available to providers and facilities under a tiered network, including the written criteria by which the provider's performance is measured.

(6) An issuer's provider and facility ranking program, and the criteria used to assign providers and facilities to different tiers, must not be described in advertising or plan documents so as to deceive consumers as to issuer rating practices and their affect on available benefits. When a tiered network is used, an issuer must provide detailed information on its web site and if requested, make available in paper form information about the tiered network including, but not limited to:

(a) The providers and facilities participating in the tiered network;

(b) The selection criteria, if any, used to place the providers and facilities, but not including the results of applying those selection criteria to a particular provider or facility;

(c) The potential for providers and facilities to move from one tier to another at any time; and

(d) The tier in which each participating provider or facility is assigned.

(7) For any health plan in effect on a tiered network's reassignment date, an issuer must make a good faith effort to provide information to affected enrollees at least sixty days before the reassignment takes effect. This information includes, but is not limited to, the procedure the enrollee must follow to choose an alternate provider or facility to obtain treatment at the same cost-sharing level. The specific classes of enrollees to whom notice must be sent are:

(a) Patients of a reassigned primary care provider if their primary care provider is reassigned to a higher cost-sharing level;

(b) A patient in the second or third trimester of pregnancy if a care provider or facility in connection with her pregnancy is reassigned to a higher cost-sharing level;

(c) A terminally ill patient if a provider or facility in connection with the illness is reassigned to a higher cost-sharing level; and

(d) Patients under active treatment for cancer or hematologic disorders, if the provider or facility that is delivering the care is reassigned to a higher cost-sharing level.

NEW SECTION

WAC 284-43-230 Assessment of access. (1) The commissioner will assess whether an issuer's provider network access meets the requirements of WAC 284-43-200, 284-43-201, and 284-43-205 such that all health plan services to enrollees will be accessible in a timely manner appropriate for the enrollee's condition. Factors considered by the commissioner will include the following:

(a) The location of the participating providers and facilities;

(b) The location of employers or enrollees in the health plan;

(c) The range of services offered by providers and facilities for the health plan;

(d) Health plan provisions that recognize and provide for extraordinary medical needs of enrollees that cannot be adequately treated by the network's participating providers and facilities;

(e) The number of enrollees within each service area living in certain types of institutions or who have chronic, severe, or disabling medical conditions, as determined by the population the issuer is covering and the benefits provided;

(f) The availability of specific types of providers who deliver medically necessary services to enrollees under the supervision of a provider licensed under Title 18 RCW;

(g) The availability within the service area of facilities under Titles 70 and 71 RCW;

(h) Accreditation as to network access by a national accreditation organization including, but not limited to, the National Committee for Quality Assurance (NCQA), the Joint Commission, Accreditation Association of Ambulatory Health Care (AAAHC), or URAC.

(2) In determining whether an issuer has complied with the provisions of WAC 284-43-200, the commissioner will give due consideration to the relative availability of health care providers or facilities in the service area under consideration and to the standards established by state agency health care purchasers. Relative availability includes the willingness of providers or facilities in the service area to contract with the issuer under reasonable terms and conditions.

(3) If the commissioner determines that an issuer's proposed or current network for a health plan is not adequate, the commissioner may, for good cause shown, permit the issuer to propose changes sufficient to make the network adequate within a sixty-day period of time. The proposal must include a mechanism to ensure that new enrollees have access to an open primary care provider within ten business days of enrolling in the plan while the proposed changes are being implemented. This requirement is in addition to such enforcement action as is otherwise permitted under Title 48 RCW.

AMENDATORY SECTION (Amending WSR 00-04-034, filed 1/24/00, effective 2/24/00)

WAC 284-43-250 ((~~Health carrier~~)) Issuer standards for women's right to directly access certain health care practitioners for women's health care services. (1)(a) "Women's health care services" ((~~is defined to~~)) means organized services to provide health care to women, inclusive of the women's preventive services required by the Health Resources and Services Administration of the U.S. Department of Health and Human Services. The services include, but ((~~need~~)) are not ((~~be~~)) limited to, maternity care, reproductive health services, gynecological care, general examination, and preventive care as medically appropriate, and medically appropriate follow-up visits for these services. ((~~General examinations, preventive care, and medically appropriate follow-up care are limited to services related to maternity, reproductive health services, gynecological care, or other health services that are particular to women, such as breast examinations.~~)) Women's health care services also include any appropriate health care service for other health problems, discovered and treated during the course of a visit to a women's health care practitioner for a women's health care service, which is within the practitioner's scope of practice.

For purposes of determining a woman's right to directly access health services covered by the plan, maternity care, reproductive health, and preventive services include((~~,~~)): Contraceptive services, testing and treatment for sexually transmitted diseases, pregnancy termination, breast-feeding, and complications of pregnancy.

(b) ((~~A carrier may~~)) An issuer must not exclude or limit access to covered women's health care services offered by a particular type of women's health care provider, practitioner, or facility in a manner that would unreasonably restrict access to that type of provider, practitioner, or facility or covered service. For example, ((~~a carrier may~~)) an issuer must not impose a limitation on maternity services that would require all child birth to occur in a hospital attended by a physician, thus((~~,~~)) preventing a woman from choosing between and using the birthing services of an advanced registered nurse practitioner ((~~specialist in midwifery~~)), a certified midwife, or a licensed midwife.

(c) ((~~A carrier may~~)) An issuer must not impose notification or prior authorization requirements upon women's health care practitioners, providers, and facilities who render women's health care services or upon women who directly access such services unless such requirements are imposed upon other providers offering similar types of service. For example, ((~~a carrier may~~)) an issuer must not require a directly accessed women's health care practitioner to notify the plan within seven days of providing direct women's health care services if a primary care provider would not also be required to provide seven-day notice to the ((~~carrier~~)) issuer for the same or similar service.

(2) ((~~A health carrier shall~~)) An issuer must not deny coverage for medically appropriate laboratory services, imaging services, diagnostic services, or prescriptions for pharmaceutical or medical supplies, which are ordered by a directly accessed women's health care practitioner, and which are within the practitioner's scope of practice, if such services would be covered when provided by another type of health care practitioner. ((~~A health carrier shall~~)) An issuer must not require authorization by another type of health care practitioner for these services. For example, if the ((~~carrier~~)) issuer would cover a prescription if the prescription had been written by the primary care provider, the ((~~carrier shall~~)) issuer must cover the prescription written by the directly accessed women's health care practitioner.

(3)(a) All ((~~health carriers shall~~)) issuers must permit each female ((~~policyholder, subscriber, enrolled participant, or beneficiary of carrier policies, plans, and programs written, amended, or renewed after July 23, 1995,~~)) enrollee of a health plan to directly access ((~~the types of women's health care practitioners identified in RCW 48.42.100(2),~~)) providers or practitioners for appropriate covered women's health care services without prior referral from another health care practitioner.

(b) ((~~Beginning July 1, 2000,~~)) An issuer may limit direct access ((~~may be limited~~)) to those women's health care practitioners who have signed participating provider agreements with the ((~~carrier~~)) issuer for a specific ((~~benefit~~)) health plan network. Irrespective of the financial arrangements ((~~a carrier~~)) an issuer may have with participating providers, ((~~a carrier~~)) an issuer may not limit and ((~~shall~~)) must not permit a network provider to limit access to a subset of participating women's health care practitioners within the network. Such an impermissible limitation might arise when a primary care provider's group practice receives a capitation payment for comprehensive care to

((~~a covered person~~)) an enrollee and then represents to the ((~~covered person~~)) enrollee that only those gynecologists in the primary care provider's clinic are available for direct access. Nothing in this subsection ((~~shall~~)) must be interpreted to prohibit ((~~a carrier~~)) an issuer from contracting with a provider to render limited health care services.

(c) Every ((~~carrier shall~~)) issuer must include in each provider network((~~,~~)) a sufficient number of each type of practitioner included in the definition of women's health care practitioners in RCW 48.42.100(2). A "sufficient number" means enough to reasonably ensure that enrollees can exercise their right of direct access within their service area, based on the number of providers with women's health care service in the scope of their license, and the number of enrollees. An issuer must demonstrate the basis on which it determined the sufficiency of the number and type of providers under this section.

(d) ((~~Beginning July 1, 2000,~~)) A woman's right to directly access practitioners for health care services, as provided under RCW 48.42.100, includes the right to obtain appropriate women's health care services ordered by the practitioner from a participating facility used by the practitioner.

(4) To inform enrollees of their rights under RCW 48.42.100, all ((~~health carriers shall~~)) issuers must include in enrollee handbooks a written explanation of a woman's right to directly access ((~~women's health care practitioners for~~)) covered women's health care services. Enrollee handbooks ((~~shall~~)) must include information regarding any limitations to direct access, including, but not limited to:

(a) Limited direct access based on a benefit plan's closed network of practitioners, if appropriate; and

(b) The ((~~carrier's~~)) issuer's right to limit coverage to medically necessary and appropriate women's health care services.

(5) No ((~~carrier~~)) issuer shall impose cost-sharing, such as copayments or deductibles, for directly accessed women's health care services, that are not required for access to health care practitioners acting as primary care providers.

NEW SECTION

WAC 284-43-252 Hospital emergency service departments and practice groups. Enrollees must have access to emergency services twenty-four hours per day, seven days per week. An issuer must make good faith attempts to contract with provider groups offering services within hospital emergency departments, if the hospital is included in its network. Such evidence of good faith efforts to contract will include documentation about the efforts to contract but not the substantive contract terms offered by either the issuer or the provider groups. If the issuer is unsuccessful in contracting with provider groups offering services within contracted hospital emergency departments, the issuer's provider directory must prominently note that while the hospital's emergency department is contracted, the providers within the department are not.

AMENDATORY SECTION (Amending WSR 99-21-016, filed 10/11/99, effective 11/11/99)

WAC 284-43-331 Effective date. (1) All participating provider and facility contracts entered into after the effective date of these rules ((~~shall~~)) must comply with these rules no later than ((~~July 1, 2000~~)) January 1, 2015.

(2) Participating provider and facility contracts entered into prior to the effective date of these rules ((~~shall~~)) must be amended upon renewal to comply with these rules, and all such contracts ((~~shall~~)) must conform to these provisions no later than January 1, ((~~2001~~)) 2015. The commissioner may extend the January 1, ((~~2001~~)) 2015, deadline for ((~~a health carrier~~)) an issuer for an additional ((~~six months~~)) one year, if the ((~~health carrier~~)) issuer makes a written request. That request must explain how a good faith effort at compliance has been made, provide the specific reasons the deadline cannot be met, and state the date the ((~~health carrier~~)) issuer expects to be in compliance (no more than ((~~six months~~)) one year beyond January 1, ((~~2001~~)) 2015).

REPEALER

The following section of the Washington Administrative Code is repealed:

WAC 284-43-340 Effective date.