

Chapter 284-170 WAC

HEALTH BENEFIT PLAN MANAGEMENT

WAC

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- 050, 48.46.200, 45 C.F.R. §§ 147.104, 147.106, 155.420, and 155.725. WSR 14-01-042 (Matter No. R 2013-02), § 284-170-435, filed 12/11/13, effective 1/1/14.] Decodified by WSR 16-01-081, filed 12/14/15, effective 12/14/15. Recodified as § 284-43-1140.
- 284-170-800 Purpose and scope—Pediatric dental benefits for health benefit plans sold outside of the health benefit exchange. [Statutory Authority: RCW 48.02.060 and 48.43.715. WSR 14-09-080 (Matter No. R 2013-19), § 284-170-800, filed 4/18/14, effective 5/19/14.] Decodified by WSR 16-01-081, filed 12/14/15, effective 12/14/15. Recodified as § 284-43-5720.
- 284-170-805 Definitions. [Statutory Authority: RCW 48.02.060 and 48.43.715. WSR 14-09-080 (Matter No. R 2013-19), § 284-170-805, filed 4/18/14, effective 5/19/14.] Decodified by WSR 16-01-081, filed 12/14/15, effective 12/14/15. Recodified as § 284-43-5740.
- 284-170-810 Pediatric dental benefits design—Methods of satisfying requirements. [Statutory Authority: RCW 48.02.060 and 48.43.715. WSR 14-09-080 (Matter No. R 2013-19), § 284-170-810, filed 4/18/14, effective 5/19/14.] Decodified by WSR 16-01-081, filed 12/14/15, effective 12/14/15. Recodified as § 284-43-5760.
- 284-170-870 Deadline for filing individual health plans, small group health plans, and stand-alone dental plans. [Statutory Authority: RCW 48.02.060, 48.18.100, 48.43.340, 48.43.715, 48.44.050, and 48.46.200. WSR 14-07-047 (Matter No. R 2013-27), § 284-170-870, filed 3/13/14, effective 4/13/14.] Decodified by WSR 16-01-081, filed 12/14/15, effective 12/14/15. Recodified as § 284-43-0200.
- 284-170-950 Grandfathered health plan status. [Statutory Authority: RCW 48.02.060, 48.43.700, 48.43.715, 48.44.050, 48.46.200, and 45 C.F.R. 150.101(2). WSR 14-01-039 (Matter No. R 2013-13), § 284-170-950, filed 12/11/13, effective 1/11/14.] Decodified by WSR 16-01-081, filed 12/14/15, effective 12/14/15. Recodified as § 284-43-0250.
- 284-170-952 Market conduct requirements related to grandfathered status. [Statutory Authority: RCW 48.02.060, 48.43.700, 48.43.715, 48.44.050, 48.46.200, and 45 C.F.R. 150.101(2). WSR 14-01-039 (Matter No. R 2013-13), § 284-170-952, filed 12/11/13, effective 1/11/14.] Decodified by WSR 16-01-081, filed 12/14/15, effective 12/14/15. Recodified as § 284-43-0270.
- 284-170-954 Small group coverage market transition requirements. [Statutory Authority: RCW 48.02.060, 48.43.700, 48.43.715, 48.44.050, 48.46.200, and 45 C.F.R. 150.101(2). WSR 14-01-039 (Matter No. R 2013-13), § 284-170-954, filed 12/11/13, effective 1/11/14.] Decodified by WSR 16-01-081, filed 12/14/15, effective 12/14/15. Recodified as § 284-43-0290.
- 284-170-955 Association health plan compliance with statutory or regulatory changes. [Statutory Authority: RCW 48.02.060, 48.43.700, 48.43.715, 48.44.050, 48.46.200, and 45 C.F.R. 150.101(2). WSR 14-01-039 (Matter No. R 2013-13), § 284-170-955, filed 12/11/13, effective 1/11/14.] Decodified by WSR 16-01-081, filed 12/14/15, effective 12/14/15. Recodified as § 284-43-0310.
- 284-170-958 Transition of plans purchased by association members. [Statutory Authority: RCW 48.02.060, 48.43.700, 48.43.715, 48.44.050, 48.46.200, and 45 C.F.R. 150.101(2). WSR 14-01-039 (Matter No. R 2013-13), § 284-170-958, filed 12/11/13, effective 1/11/14.] Decodified by WSR 16-01-081, filed 12/14/15, effective 12/14/15. Recodified as § 284-43-0330.
- 284-170-959 Individual coverage market transition requirements. [Statutory Authority: RCW 48.02.060, 48.43.700, 48.43.715, 48.44.050, 48.46.200, and 45 C.F.R. 150.101(2). WSR 14-01-039 (Matter No. R 2013-13), § 284-170-959, filed 12/11/13, effective 1/11/14.] Decodified by WSR 16-01-081, filed 12/14/15, effective 12/14/15. Recodified as § 284-43-0350.

SUBCHAPTER A

GENERAL PROVISIONS

WAC 284-170-110 Purpose. The purpose of this chapter is to establish uniform regulatory standards for health car-

riers and to create minimum standards for health plans that ensure consumer access to the health care services promised in these health plans.

[Statutory Authority: RCW 48.02.060. WSR 16-07-144 (Matter No. R 2016-01), § 284-170-110, filed 3/23/16, effective 4/23/16.]

WAC 284-170-120 Applicability and scope. This chapter shall apply to all health plans and all health carriers subject to the jurisdiction of the state of Washington except as otherwise expressly provided in this chapter. Health carriers are responsible for compliance with the provisions of this chapter and are responsible for the compliance of any person or organization acting on behalf of or at the direction of the carrier, or acting pursuant to carrier standards or requirements concerning the coverage of, payment for, or provision of health care services. A carrier may not offer as a defense to a violation of any provision of this chapter that the violation arose from the act or omission of a participating provider or facility, network administrator, claims administrator, or other person acting on behalf of or at the direction of the carrier, or acting pursuant to carrier standards or requirements under a contract with the carrier rather than from the direct act or omission of the carrier. Nothing in this chapter shall be construed to permit the direct regulation of health care providers or facilities by the office of the insurance commissioner.

[Statutory Authority: RCW 48.02.060. WSR 16-07-144 (Matter No. R 2016-01), as § 284-170-120, filed 3/23/16, effective 4/23/16.]

WAC 284-170-125 Compliance with state and federal laws. Health carriers shall comply with all Washington state and federal laws relating to the acts and practices of carriers and laws relating to health plan benefits.

[Statutory Authority: RCW 48.02.060. WSR 16-07-144 (Matter No. R 2016-01), as § 284-170-125, filed 3/23/16, effective 4/23/16.]

WAC 284-170-130 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 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) "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) "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. Sec. 1661;

(b) An Indian tribe, as defined in the Indian Health Care Improvement Act, Section 4(14), 25 U.S.C. Sec. 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. Sec. 450 et seq.;

(c) A tribal organization, as defined in the Indian Health Care Improvement Act, Section 4(26), 25 U.S.C. Sec. 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. Sec. 450 et seq.;

(d) An Indian tribe, as defined in the Indian Health Care Improvement Act, Section 4(14), 25 U.S.C. Sec. 1603(14), or tribal organization, as defined in the Indian Health Care Improvement Act, Section 4(26), 25 U.S.C. Sec. 1603(26), that operates a health program with funding provided in whole or part pursuant to 25 U.S.C. Sec. 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. Sec. 1603(29).

(17) "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.

(18) "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.

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

(20) "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.

(21) "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 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.

(22) "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.

(23) "Participating provider" and "participating facility" mean 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.

(24) "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.

(25) "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.

(26) "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.

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

(28) "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.

(29) "Service area" means the geographic area or areas where a specific product 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.

(30) "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.

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

(32) "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.

[Statutory Authority: RCW 48.02.060. WSR 16-07-144 (Matter No. R 2016-01), § 284-170-130, filed 3/23/16, effective 4/23/16.]

SUBCHAPTER B

HEALTH CARE NETWORKS

WAC 284-170-200 Network access—General standards. (1) An issuer must maintain each 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 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 enrollee must have adequate choice among health care providers, including those providers which must be included in the network under WAC 284-170-270, and for qualified health plans and qualified stand-alone dental plans, under WAC 284-170-310.

(3) An issuer's service area 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.

(4) An issuer must establish sufficiency and adequacy of choice 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 within 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 has been submitted and is 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 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.

(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 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 enrollees who are American Indians/Alaska Natives, each health issuer must maintain arrangements that ensure that American Indians/Alaska Natives who are enrollees have access to covered medical and behavioral health services provided by Indian health care providers.

Issuers must ensure that such enrollees may obtain covered medical and behavioral health services from the Indian health care provider at no greater cost to the enrollee than if the service were obtained from network providers and facilities, even if the Indian health care provider is not a contracted provider. Issuers are not responsible for credentialing providers and facilities that are part of the Indian health system. Nothing in this subsection prohibits an issuer from limiting coverage to those health services that meet 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 Mental 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 submit 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 preventive and wellness services, including chronic disease management and smoking cessation services as defined in RCW 48.43.005(37) and WAC 284-43-5640(9) and 284-43-5642(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 284-43-5640(1) and 284-43-5642(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 primary care providers to enrollees 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 a 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 284-43-5700(3) and 284-43-5702(4), as appropriate, 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 284-170-210 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 284-170-310(3).

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

[Statutory Authority: RCW 48.02.060. WSR 16-14-106 (Matter No. R 2016-11), § 284-170-200, filed 7/6/16, effective 8/6/16; WSR 16-07-144 (Matter No. R 2016-01), recodified as § 284-170-200, filed 3/23/16, effective 4/23/16. WSR 16-01-081, recodified as § 284-43-9970, filed 12/14/15, effective 12/14/15. Statutory Authority: 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, 48.20.450, 48.44.020, 48.44.080, 48.46.030, 45 C.F.R. §§ 156.230, 156.235, and 156.245. WSR 14-10-017 (Matter No. R 2013-22), § 284-43-200, filed 4/25/14, effective 5/26/14. Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.30.010, 48.44.050, 48.46.100, 48.46.200, 48.43.505, 48.43.510, 48.43.515, 48.43.520, 48.43.525, 48.43.530, 48.43.535. WSR 01-03-033 (Matter No. R 2000-02), § 284-43-200, filed 1/9/01, effective 7/1/01. Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.30.010, 48.44.050, 48.46.030, 48.46.200. WSR 00-04-034 (Matter No. R 99-2), § 284-43-200, filed 1/24/00, effective 3/1/00. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.30.010, 48.44.020, 48.44.050, 48.44.080, 48.46.030, 48.46.060(2), 48.46.200 and 48.46.243. WSR 98-04-005 (Matter No. R 97-3), § 284-43-200, filed 1/22/98, effective 2/22/98.]

WAC 284-170-210 Alternate access delivery request.

(1) Where an issuer's network meets one or more of the criteria in WAC 284-170-200 (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 284-170-280 (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 284-170-200.

(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 284-170-280 (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.

[Statutory Authority: RCW 48.02.060, WSR 16-14-106 (Matter No. R 2016-11), § 284-170-210, filed 7/6/16, effective 8/6/16; WSR 16-07-144 (Matter No. R 2016-01), recodified as § 284-170-210, filed 3/23/16, effective 4/23/16. WSR 16-01-081, recodified as § 284-43-9971, filed 12/14/15, effective 12/14/15. Statutory Authority: 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, 48.20.450, 48.44.020, 48.44.080, 48.46.030, 45 C.F.R. §§ 156.230, 156.235, and 156.245. WSR 14-10-017 (Matter No. R 2013-22), § 284-43-201, filed 4/25/14, effective 5/26/14.]

WAC 284-170-230 Maintenance of sufficient provider networks. (1) An issuer must maintain and monitor its provider networks on an ongoing basis for compliance with the network access standards set forth in WAC 284-170-200. This includes an issuer of a stand-alone dental plan offered through the exchange or a stand-alone dental plan offered

outside the exchange for the purpose of providing the essential health benefit category of pediatric oral benefits, which must maintain and monitor its networks for compliance with WAC 284-170-200(14). An issuer must report to the commissioner, within the time frames stated in this section, any changes affecting the ability of its network providers and facilities to furnish covered services to enrollees.

(2) An issuer must notify the OIC in writing within five business days of either receiving or issuing a written notice of potential contract termination that would affect the network's ability to meet the standards set forth in WAC 284-170-200. Notice of potential termination must include an issuer's preliminary determination of whether an alternate access delivery request must be filed and the documentation supporting that determination. The issuer's notice must be submitted electronically following the submission instructions on the commissioner's web site.

(a) If the issuer determines that an alternate access delivery request must be submitted to comply with WAC 284-170-200(15), the issuer has ten business days to submit the request and supporting documentation for the alternate access delivery request in accordance with WAC 284-170-280 (3)(d).

(b) If, after reviewing the issuer's preliminary determination that an alternate access delivery request is not necessary, the OIC determines that an alternate access delivery request is required to comply with WAC 284-170-200(15), the issuer has five business days to submit the request and supporting documentation for the alternate access delivery request in accordance with WAC 284-170-280 (3)(d).

(c) If the OIC determines that a network is out of compliance with WAC 284-170-200 and the issuer has failed to report this change to the OIC, the issuer must, within one business day of notification by the OIC, submit an alternate access delivery request in accordance with WAC 284-170-200(15) and supporting documentation for the alternate access delivery request in accordance with WAC 284-170-280 (3)(d).

(3) An issuer of a health plan must maintain and monitor, on an ongoing basis, the ability and clinical capacity of its network providers and facilities to furnish covered health plan services to enrollees. An issuer must notify the commissioner in writing within fifteen days of a change in its network as described below:

(a) A reduction, by termination or otherwise, of ten percent or more in the number of either specialty providers, mental health providers, or facilities participating in the network;

(i) The initial time frame for measuring this reduction is from the network's initial approval date until the January 1st following the initial approval date.

(ii) After the January 1st following the network's initial approval date, the time frame for measuring this reduction is from January 1st to the following January 1st.

(b) Termination or reduction of a specific type of specialty provider on the American Board of Medical Specialties list of specialty and subspecialty certificates, where there are fewer than two of the specialists in a service area;

(c) An increase or reduction of twenty-five percent or more in the number of enrollees in the service area since the annual approval date;

(d) A reduction of five percent or more in the number of primary care providers in the service area who are accepting new patients;

(e) The termination or expiration of a contract with a hospital or any associated hospital-based medical group within a service area;

(f) A fifteen percent reduction in the number of providers or facilities for a specific chronic condition or disease participating in the network where the chronic condition or disease affects more than five percent of the issuer's enrollees in the service area. For purposes of monitoring, chronic illnesses are those conditions identified (or recognized) by the Centers for Medicare and Medicaid Services within the most current version of the Centers for Medicare and Medicaid Chronic Conditions Data Warehouse (CCW) database available on the CMS.gov web site; or

(g) Written notice to the commissioner must include the issuer's preliminary determination whether the identified changes in the network require an alternate access delivery request in accordance with WAC 284-170-280 (3)(d).

(i) If the issuer determines that an alternate access delivery request must be submitted, the issuer has ten business days to submit the request and supporting documentation for the alternate access delivery request in accordance with WAC 284-170-280 (3)(d).

(ii) If, after reviewing the issuer's preliminary determination that an alternate access delivery request is not required, the OIC determines that an alternate access delivery request is required, the issuer has five business days to submit the request and supporting documentation for the alternate access delivery request in accordance with WAC 284-170-280 (3)(d).

(iii) If the OIC determines that a network is out of compliance with these standards and the issuer has failed to report this change to the OIC, the issuer must, within one business day of notification by the OIC, submit an alternate access delivery request in accordance with WAC 284-170-200(15) and supporting documentation for the alternate access delivery request in accordance with WAC 284-170-280 (3)(d).

(4) An issuer of a stand-alone dental plan offered through the exchange or of a stand-alone dental plan offered outside the exchange for the purpose of providing the essential health benefit category of pediatric oral benefits must maintain and monitor, on an ongoing basis, the ability and clinical capacity of its network providers and facilities to furnish covered services to enrollees. An issuer must notify the commissioner in writing within fifteen days of the change in its network as described below:

(a) A reduction, by termination or otherwise, of ten percent or more in the number of specialty providers in the network since the initial approval date;

(b) An increase or reduction of twenty-five percent or more in the number of enrollees in the service area since the annual approval date;

(c) A reduction of five percent or more in the number of providers of preventive and general dentistry accepting new patients in the service area;

(d) Notice to the commissioner must include the issuer's preliminary determination whether an alternate access delivery request must be submitted with supporting documentation in accordance with WAC 284-170-280 (3)(d).

(i) If the issuer determines that an alternate access delivery request must be submitted, the issuer has ten business days to submit the request and supporting documentation in accordance with WAC 284-170-280 (3)(d).

(ii) If after reviewing the issuer's preliminary determination that an alternate access delivery request is not required, the OIC determines that an alternate access delivery request is required, the issuer has five business days to submit the request and supporting documentation for the request in accordance with WAC 284-170-280 (3)(d).

(iii) If the OIC determines that a network is not in compliance with these standards and the issuer has failed to report this change to the OIC, the issuer must, within one business day of notification by the OIC, submit an alternate access delivery request in accordance with WAC 284-170-200(15) and supporting documentation for the request in accordance with WAC 284-170-280 (3)(d).

(5) The following network access standards must be met on an ongoing basis:

(a) The actuarial projections of health care costs submitted as part of a premium rate filing must continue to be based on the actual network the issuer proposes for the health plan's service areas.

(b) A practice that is not currently accepting new patients may be included in a provider network for purposes of reporting network access, but must not be used to justify network access for anticipated enrollment growth.

(c) An issuer must have and maintain in its network a sufficient number and type of providers to whom direct access is required under RCW 48.43.515 (2) and (5) and 48.42.100 to accommodate all new and existing enrollees in the service areas.

(d) Issuers that use the following network models must maintain and monitor the continuity and coordination of care that enrollees receive: Networks that include medical home or medical management services in lieu of providing access to specialty or ancillary services through primary care provider referral, and networks where the issuer requires providers to whom an enrollee has direct access to notify the enrollee's primary care provider of treatment plans and services delivered. For these models, an issuer must perform continuity and coordination of care in a manner consistent with professionally recognized evidence-based standards of practice, across the health plan network. The baseline for such coordination is maintenance and monitoring as often as is necessary, but not less than once a year:

(i) The systems or processes for integration of health care services by medical and mental health providers;

(ii) The exchange of information between primary and specialty providers;

(iii) Appropriate diagnosis, treatment, and referral practices;

(iv) Access to treatment and follow-up for enrollees with coexisting conditions including, but not limited to, a mental health condition coexisting with a chronic health condition.

(6) This section is effective for all plans, whether new or renewed, with effective dates on or after January 1, 2016.

[Statutory Authority: RCW 48.02.060. WSR 16-14-106 (Matter No. R 2016-11), § 284-170-230, filed 7/6/16, effective 8/6/16; WSR 16-07-144 (Matter No. R 2016-01), recodified as § 284-170-230, filed 3/23/16, effective 4/23/16. WSR 16-01-074, recodified as § 284-43-9972, filed 12/14/15,

effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.-450, 48.20.460, 48.43.055, 48.43.505, 48.43.510, 48.43.515, 48.43.530, 48.43.535, 48.43.730, 48.44.020, 48.44.050, 48.44.080, 48.46.030, 48.46.200. WSR 16-01-074 (Matter No. R 2014-08), § 284-43-202, filed 12/14/15, effective 1/14/16.]

WAC 284-170-240 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 284-170 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.

[Statutory Authority: RCW 48.02.060. WSR 16-14-106 (Matter No. R 2016-11), § 284-170-240, filed 7/6/16, effective 8/6/16; WSR 16-07-144 (Matter No. R 2016-01), recodified as § 284-170-240, filed 3/23/16, effective 4/23/16. WSR 16-01-081, recodified as § 284-43-9973, filed 12/14/15, effective 12/14/15. Statutory Authority: 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, 48.20.450, 48.44.020, 48.44.080, 48.46.030, 45 C.F.R. §§ 156.230, 156.235, and 156.245. WSR 14-10-017 (Matter No. R 2013-22), § 284-43-203, filed 4/25/14, effective 5/26/14.]

WAC 284-170-260 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 a 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;

(9/20/16)

(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 284-170-370.

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

[Statutory Authority: RCW 48.02.060. WSR 16-14-106 (Matter No. R 2016-11), § 284-170-260, filed 7/6/16, effective 8/6/16; WSR 16-07-144 (Matter No. R 2016-01), recodified as § 284-170-260, filed 3/23/16, effective 4/23/16. WSR 16-01-081, recodified as § 284-43-9974, filed 12/14/15, effective 12/14/15. Statutory Authority: 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, 48.20.450, 48.44.020, 48.44.080, 48.46.030, 45 C.F.R. §§ 156.230, 156.235, and 156.245. WSR 14-10-017 (Matter No. R 2013-22), § 284-43-204, filed 4/25/14, effective 5/26/14.]

WAC 284-170-270 Every category of health care providers. (1) 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 services covered as essential health benefits, as defined in WAC 284-43-5640 and 284-43-5642 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 a covered condition, and is acting within the scope of practice, unless such services would not meet the issuer's standards pursuant to RCW 48.43.045 (1)(a). For example, 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)(a) must not be excluded from the network.

(2) RCW 48.43.045 (1)(a) permits 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, 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.

(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 must not contain unreasonable limits, and 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)(a).

(4) This section does not prohibit health plans from using restricted networks. 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. 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 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 in-patient 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) 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.

[Statutory Authority: RCW 48.02.060, WSR 16-14-106 (Matter No. R 2016-11), § 284-170-270, filed 7/6/16, effective 8/6/16; WSR 16-07-144 (Matter No. R 2016-01), recodified as § 284-170-270, filed 3/23/16, effective 4/23/16. WSR 16-01-081, recodified as § 284-43-9975, filed 12/14/15, effective 12/14/15. Statutory Authority: 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, 48.20.450, 48.44.020, 48.44.080, 48.46.030, 45 C.F.R. §§ 156.230, 156.235, and 156.245. WSR 14-10-017 (Matter No. R 2013-22), § 284-43-205, filed 4/25/14, effective 5/26/14. Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.30.010, 48.44.050 and 48.46.200. WSR 99-16-036 (Matter No. R 98-20), § 284-43-205, filed 7/28/99, effective 8/28/99.]

WAC 284-170-280 Network reports—Format. (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 submits its plan under WAC 284-43-0200. For groups other than individual and small, the submission must occur when the issuer submits 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 submission, including the date(s) by which each incomplete map and component will be completed and submitted.

(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.** An issuer must submit a report of all participating providers by network.

(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 changes in the provider network.

(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.** 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 submitted for each network 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.

(ii) An issuer must submit 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 284-170-200 (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 and facilities, 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 284-170-200 and 284-170-310. 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 and substance use disorder 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 and substance use disorder providers, the map must demonstrate that eighty per-

cent 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 license 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 specialties 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 the 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 therapists, dentists, and orthodontists.

(H) Covered pharmacy dispensing services. An issuer must provide one map that demonstrates the geographic distribution of the pharmacy dispensing services 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 subsection (1) of this section 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 product 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 non-licensed 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) Issuer's process 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 submitted 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.

(ii) 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, "urban area" means:

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

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

[Statutory Authority: RCW 48.02.060. WSR 16-14-106 (Matter No. R 2016-11), § 284-170-280, filed 7/6/16, effective 8/6/16; WSR 16-07-144 (Matter No. R 2016-01), recodified as § 284-170-280, filed 3/23/16, effective 4/23/16. WSR 16-01-081, recodified as § 284-43-9976, filed 12/14/15, effective 12/14/15. Statutory Authority: 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, 48.20.450, 48.44.020, 48.44.080, 48.46.030, 45 C.F.R. §§ 156.230, 156.235, and 156.245. WSR 14-10-017 (Matter No. R 2013-22), § 284-43-220, filed 4/25/14, effective 5/26/14. Statutory Authority: RCW 48.02.060, 48.43.510 and 48.43.515. WSR 11-07-015 (Matter No. R 2011-01), § 284-43-220, filed 3/8/11, effective 4/8/11. Statutory Authority: RCW 48.02.060. WSR 08-17-037 (Matter No. R 2008-17), § 284-43-220, filed 8/13/08, effective 9/13/08. Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.43.515, 48.44.050, 48.46.030, 48.46.200, 48.42.100, 48.43.515, 48.46.030. WSR 03-09-142 (Matter No. R 2003-01), § 284-43-220, filed 4/23/03, effective 5/24/03. Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.30.010, 48.44.050, 48.46.030, 48.46.200. WSR 00-04-034 (Matter No. R 99-2), § 284-43-220, filed 1/24/00, effective 1/1/01. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.30.010, 48.44.020, 48.44.050, 48.44.080, 48.46.030, 48.46.060(2), 48.46.200 and 48.46.243. WSR 98-04-005 (Matter No. R 97-3), § 284-43-220, filed 1/22/98, effective 2/22/98.]

WAC 284-170-300 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 284-170-130(16);

(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.

[Statutory Authority: RCW 48.02.060. WSR 16-14-106 (Matter No. R 2016-11), § 284-170-300, filed 7/6/16, effective 8/6/16; WSR 16-07-144 (Matter No. R 2016-01), recodified as § 284-170-300, filed 3/23/16, effective 4/23/16. WSR 16-01-081, recodified as § 284-43-9977, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.-200, 48.20.450, 48.43.515, 48.44.020, 48.44.080, 48.46.030, 45 C.F.R. 156.230, 156.235, and 156.245. WSR 14-22-007, § 284-43-221, filed 10/23/14, effective 11/23/14. Statutory Authority: 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, 48.20.450, 48.44.020, 48.44.080, 48.46.030, 45 C.F.R. §§ 156.230, 156.235, and 156.245. WSR 14-10-017 (Matter No. R 2013-22), § 284-43-221, filed 4/25/14, effective 5/26/14.]

WAC 284-170-310 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 284-170-300.

(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 284-170-130(16), 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;

(9/20/16)

(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 Care Provider 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.

[Statutory Authority: RCW 48.02.060. WSR 16-14-106 (Matter No. R 2016-11), § 284-170-310, filed 7/6/16, effective 8/6/16; WSR 16-07-144 (Matter No. R 2016-01), recodified as § 284-170-310, filed 3/23/16, effective 4/23/16. WSR 16-01-081, recodified as § 284-43-9977, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.-200, 48.20.450, 48.43.515, 48.44.020, 48.44.080, 48.46.030, 45 C.F.R. 156.230, 156.235, and 156.245. WSR 14-22-007, § 284-43-222, filed 10/23/14, effective 11/23/14. Statutory Authority: 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,

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48.44.050, 48.46.200, 48.20.450, 48.44.020, 48.44.080, 48.46.030, 45 C.F.R. §§ 156.230, 156.235, and 156.245. WSR 14-10-017 (Matter No. R 2013-22), § 284-43-222, filed 4/25/14, effective 5/26/14.]

WAC 284-170-320 Issuer recordkeeping—Provider networks. (1) An issuer must make available to the commissioner upon request its records, contracts, and agreements related to its provider networks.

(a) Records to support proof of good faith contracting efforts must be retained for seven years.

(b) Signed contracts, reimbursement agreements, and associated accounting records must be retained for ten years after the contract is terminated.

(2) Beginning January 1, 2016, an issuer must be able to provide to the commissioner upon request the following information for a time period specified by the commissioner. These records must be retained for a period of ten years:

(a) The number of requests submitted for prior authorization for services by all providers and facilities;

(b) The total number of such requests processed; and

(c) The total number of such requests denied.

[Statutory Authority: RCW 48.02.060. WSR 16-07-144 (Matter No. R 2016-01), recodified as § 284-170-320, filed 3/23/16, effective 4/23/16. WSR 16-01-074, recodified as § 284-43-9979, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.43.055, 48.43.505, 48.43.510, 48.43.515, 48.43.530, 48.43.535, 48.43-730, 48.44.020, 48.44.050, 48.44.080, 48.46.030, 48.46.200. WSR 16-01-074 (Matter No. R 2014-08), § 284-43-225, filed 12/14/15, effective 1/14/16.]

WAC 284-170-330 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 284-43-5640 and 284-43-5642, 284-43-5700 and 284-43-5702, and 284-43-5780 and 284-43-5782.

(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-sharing 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.

[Statutory Authority: RCW 48.02.060. WSR 16-14-106 (Matter No. R 2016-11), § 284-170-330, filed 7/6/16, effective 8/6/16; WSR 16-07-144 (Matter

No. R 2016-01), recodified as § 284-170-330, filed 3/23/16, effective 4/23/16. WSR 16-01-081, recodified as § 284-43-9980, filed 12/14/15, effective 12/14/15. Statutory Authority: 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, 48.20.450, 48.44.020, 48.44.080, 48.46.030, 45 C.F.R. §§ 156.230, 156.235, and 156.245. WSR 14-10-017 (Matter No. R 2013-22), § 284-43-229, filed 4/25/14, effective 5/26/14.]

WAC 284-170-340 Assessment of access. (1) The commissioner will assess whether an issuer's provider network access meets the requirements of WAC 284-170-200, 284-170-210, and 284-170-270 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 284-170-200, 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.

[Statutory Authority: RCW 48.02.060. WSR 16-14-106 (Matter No. R 2016-11), § 284-170-340, filed 7/6/16, effective 8/6/16; WSR 16-07-144 (Matter No. R 2016-01), recodified as § 284-170-340, filed 3/23/16, effective 4/23/16. WSR 16-01-081, recodified as § 284-43-9981, filed 12/14/15, effective 12/14/15. Statutory Authority: 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, 48.20.450, 48.44.020, 48.44.080, 48.46.030, 45 C.F.R. §§ 156.230, 156.235, and 156.245. WSR 14-10-017 (Matter No. R 2013-22), § 284-43-230, filed 4/25/14, effective 5/26/14.]

WAC 284-170-350 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" 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 are not 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. 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) 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, 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, a certified midwife, or a licensed midwife.

(c) 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, 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 issuer for the same or similar service.

(2) 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. An issuer must not require authorization by another type of health care practitioner for these services. For example, if the issuer would cover a prescription if the prescription had been written by the primary care provider, the issuer must cover the prescription written by the directly accessed women's health care practitioner.

(3)(a) All issuers must permit each female enrollee of a health plan to directly access providers or practitioners for appropriate covered women's health care services without prior referral from another health care practitioner.

(b) An issuer may limit direct access to those women's health care practitioners who have signed participating provider agreements with the issuer for a specific health plan network. Irrespective of the financial arrangements an issuer may have with participating providers, an issuer may not limit and 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 an enrollee and then represents to the enrollee that only those gynecologists in the primary care provider's clinic are available for direct access. Nothing in this subsection must be interpreted to prohibit an issuer from contracting with a provider to render limited health care services.

(c) Every 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) 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 issuers must include in enrollee handbooks a written explanation of a woman's right to directly access covered women's health care services. Enrollee handbooks 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 issuer's right to limit coverage to medically necessary and appropriate women's health care services.

(5) No 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.

[Statutory Authority: RCW 48.02.060. WSR 16-07-144 (Matter No. R 2016-01), recodified as § 284-170-350, filed 3/23/16, effective 4/23/16. WSR 16-01-081, recodified as § 284-43-9982, filed 12/14/15, effective 12/14/15. Statutory Authority: 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, 48.20-450, 48.44.020, 48.44.080, 48.46.030, 45 C.F.R. §§ 156.230, 156.235, and 156.245. WSR 14-10-017 (Matter No. R 2013-22), § 284-43-250, filed 4/25/14, effective 5/26/14. Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.30.010, 48.44.050, 48.46.030, 48.46.200. WSR 00-04-034 (Matter No. R 99-2), § 284-43-250, filed 1/24/00, effective 2/24/00. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.30.010, 48.44.020, 48.44.050, 48.44.080, 48.46.030, 48.46.060(2), 48.46.200 and 48.46.243. WSR 98-04-005 (Matter No. R 97-3), § 284-43-250, filed 1/22/98, effective 2/22/98.]

WAC 284-170-360 Enrollee's access to providers. (1)

Each issuer must allow an enrollee to choose a primary care provider who is accepting new patients from a list of participating providers.

(a) Enrollees also must be permitted to change primary care providers at any time with the change becoming effective not later than the beginning of the month following the enrollee's request for the change.

(b) The issuer must ensure at all times that there are a sufficient number of primary care providers in the service area accepting new patients to accommodate new enrollees if the plan is open to new enrollment, and to ensure that existing enrollees have the ability to change primary care providers.

(2) Each issuer must allow an enrolled child direct access to a pediatrician from a list of participating pediatricians within their network who are accepting new patients.

(a) Enrollees must be permitted to change pediatricians at any time, with the change becoming effective not later than the beginning of the month following the enrollee's request for the change.

(b) Each issuer must ensure at all times that there are a sufficient number of pediatricians in the service area accepting new patients to accommodate new enrollees if the plan is open to new enrollment, and to ensure that existing enrolled children have the ability to change pediatricians.

(3) Each issuer must have a process whereby an enrollee with a complex or serious medical condition or mental health or substance use disorder, including behavioral health condition, may receive a standing referral to a participating specialist for an extended period of time. The standing referral must be consistent with the enrollee's medical or mental health needs and plan benefits. For example, a one-month standing referral would not satisfy this requirement when the expected course of treatment was indefinite. However, a referral does not preclude issuer performance of utilization review functions.

(4) Each issuer must provide enrollees with direct access to the participating chiropractor of the enrollee's choice for covered chiropractic health care without the necessity of prior referral. Nothing in this subsection prevents issuers from restricting enrollees to seeing only chiropractors who have signed participating provider agreements or from utilizing other managed care and cost containment techniques and processes such as prior authorization for services. For purposes of this subsection, "covered chiropractic health care" means covered benefits and limitations related to chiropractic health services as stated in the plan's medical coverage agreement, with the exception of any provisions related to prior referral for services.

(5) Each issuer must provide, upon the request of an enrollee, access by the enrollee to a second opinion regarding any medical diagnosis or treatment plan from a qualified participating provider of the enrollee's choice. The issuer may not impose any charge or cost upon the enrollee for such second opinion other than the charge or cost imposed for the same service in otherwise similar circumstances.

(6) Each issuer must cover services of a primary care provider whose contract with the plan or whose contract with a subcontractor is being terminated by the plan or subcontractor without cause under the terms of that contract:

(a) For at least sixty days following notice of termination to the enrollees; or

(b) In group coverage arrangements involving periods of open enrollment, only until the end of the next open enrollment period.

(i) Notice to enrollees must include information of the enrollee's right of access to the terminating provider for an additional sixty days.

(ii) The provider's relationship with the issuer or subcontractor must be continued on the same terms and conditions as those of the contract the plan or subcontractor is terminating, except for any provision requiring that the issuer assign new enrollees to the terminated provider.

(7) Each issuer must make a good faith effort to assure that written notice of a termination is provided at least thirty days prior to the effective date of the termination to all enrollees who are patients seen on a regular basis by the provider or facility whose contract is terminating, irrespective of whether the termination was for cause or without cause. When a termination for cause provides less than thirty days notice to the carrier or provider, an issuer must make a good faith effort to assure that written notice of termination is provided immediately to all enrollees.

[Statutory Authority: RCW 48.02.060, WSR 16-07-144 (Matter No. R 2016-01), recodified as § 284-170-360, filed 3/23/16, effective 4/23/16. WSR 16-01-074, recodified as § 284-43-9983, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.43.055, 48.43.505, 48.43.510, 48.43.515, 48.43.530, 48.43.535, 48.43-730, 48.44.020, 48.44.050, 48.44.080, 48.46.030, 48.46.200. WSR 16-01-074 (Matter No. R 2014-08), § 284-43-251, filed 12/14/15, effective 1/14/16. Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.30.010, 48.44.050, 48.46.100, 48.46.200, 48.43.505, 48.43.510, 48.43.515, 48.43.520, 48.43.525, 48.43.530, 48.43.535. WSR 01-03-033 (Matter No. R 2000-02), § 284-43-251, filed 1/9/01, effective 7/1/01.]

WAC 284-170-370 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.

[Statutory Authority: RCW 48.02.060, WSR 16-07-144 (Matter No. R 2016-01), recodified as § 284-170-370, filed 3/23/16, effective 4/23/16. WSR 16-01-081, recodified as § 284-43-9984, filed 12/14/15, effective 12/14/15. Statutory Authority: 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, 48.20-450, 48.44.020, 48.44.080, 48.46.030, 45 C.F.R. §§ 156.230, 156.235, and 156.245. WSR 14-10-017 (Matter No. R 2013-22), § 284-43-252, filed 4/25/14, effective 5/26/14.]

WAC 284-170-380 Standards for temporary substitution of contracted network providers—"Locum tenens" providers. It is a longstanding and widespread practice for contracted network providers to retain substitute providers to take over their professional practices when the con-

tracted network providers are absent for reasons such as illness, pregnancy, vacation, or continuing medical education, and for contracted network providers to bill and receive payment for the substitute providers' services as though they were provided by the contracted network provider. The contracted network provider generally pays the substitute provider based on an agreement between the contracted network provider and the substitute provider, and the substitute provider has the status of an independent contractor rather than an employee of the contracted network provider. These substitute providers are commonly called "locum tenens" providers.

In order to protect patients and ensure that they benefit from seamless quality care when contractual network providers are away from their practices, and that patients receive quality care from qualified substitute providers, carriers may require substitute providers to provide the information required in subsection (1) of this section.

The following are minimum standards for temporary provider substitution and do not prevent a carrier from entering into other agreed arrangements with its contracted network providers for terms that are less restrictive or more favorable to providers.

Carriers must permit the following categories of contracted network provider to arrange for temporary substitution by a substitute provider: Doctor of medicine, doctor of osteopathic medicine, doctor of dental surgery or dental medicine, doctor of chiropractic, podiatric physician and surgeon, doctor of optometry, doctor of naturopathic medicine and advanced registered nurse practitioner.

(1) At the time of substitution, the substitute provider:

(a) Must have a current Washington license and be legally authorized to practice in this state;

(b) Must provide services under the same scope of practice as the contracted network provider;

(c) Must not be suspended or excluded from any state or federal health care program;

(d) Must have professional liability insurance coverage; and

(e) Must have a current drug enforcement certificate, if applicable.

(2)(a) Carriers must allow a contracted network provider to arrange for a substitute provider for at least sixty days during any calendar year.

(b) A carrier must grant an extension if a contracted network provider demonstrates that exceptional circumstances require additional time away from his or her practice.

(3) A carrier may require that the contracted network provider agree to bill for services rendered by the substitute provider using the carrier's billing guidelines, including use of HIPAA compliant code sets, commonly known as the Q-6 modifier, or any other code or modifier that the Centers for Medicare and Medicaid Services (CMS) adopts in the future.

(4) Nothing in this section is intended to prevent the carrier from requiring:

(a) That the contracted network provider require acceptance by the substitute provider of the carrier's fee schedule; or

(b) Acceptance by the substitute provider of the carrier's usual and customary charge as payment in full.

(5) This rule does not apply to Medicare Advantage or other health plans administered by the federal government that require precredentialing of all providers.

[Statutory Authority: RCW 48.02.060, WSR 16-07-144 (Matter No. R 2016-01), recodified as § 284-170-380, filed 3/23/16, effective 4/23/16. WSR 16-01-081, recodified as § 284-43-9985, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060 and 48.43.515. WSR 08-01-025 (Matter No. R 2005-04), § 284-43-260, filed 12/10/07, effective 1/10/08.]

WAC 284-170-390 Rule concerning contracted network providers called to active duty military service. In lieu of substitution of a provider during a period of active duty military service longer than sixty continuous days, carriers must provide contracted network providers with the opportunity to return to the carrier's network after the provider's active duty military service is completed.

(1)(a) A carrier must allow the provider a period of at least one hundred twenty days to request a return to contracted network provider status after the provider returns to civilian status.

(b) The one hundred twenty-day period must begin no earlier than the date the provider's period of active duty ends.

(2)(a) As a condition for return to the carrier's network, the carrier may require that the provider provide evidence that he or she meets the carrier's then-current standards for credentialing.

(b) If the provider meets or exceeds the credentialing standards of the carrier and timely requests a return to contracted network provider status, the carrier must grant the request whether or not the carrier's network is otherwise closed.

[Statutory Authority: RCW 48.02.060, WSR 16-07-144 (Matter No. R 2016-01), recodified as § 284-170-390, filed 3/23/16, effective 4/23/16. WSR 16-01-081, recodified as § 284-43-9986, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060 and 48.43.515. WSR 08-01-025 (Matter No. R 2005-04), § 284-43-262, filed 12/10/07, effective 1/10/08.]

SUBCHAPTER C

PROVIDER CONTRACTS AND PAYMENT

WAC 284-170-401 Provider and facility contracts with issuers—Generally. (1) An issuer contracting with providers or facilities for health care service delivery to enrollees must satisfy all the requirements contained in this subchapter.

(2) An issuer must ensure that subcontractors of its contracted providers and facilities comply with the requirements of this subchapter. An issuer's obligation to comply with these requirements is nondelegable; the issuer is not exempt from these requirements because it relied upon a third-party vendor or subcontracting arrangement.

[Statutory Authority: RCW 48.02.060, WSR 16-07-144 (Matter No. R 2016-01), recodified as § 284-170-401, filed 3/23/16, effective 4/23/16. WSR 16-01-074, recodified as § 284-43-9990, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.43.055, 48.43.505, 48.43.510, 48.43.515, 48.43.530, 48.43.535, 48.43.730, 48.44.020, 48.44.050, 48.44.080, 48.46.030, 48.46.200. WSR 16-01-074 (Matter No. R 2014-08), § 284-43-300, filed 12/14/15, effective 1/14/16. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.30.010, 48.44.020, 48.44.050, 48.44.080, 48.46.030, 48.46.060(2), 48.46.200 and 48.46.243. WSR 98-04-005 (Matter No. R 97-3), § 284-43-300, filed 1/22/98, effective 2/22/98.]

[Ch. 284-170 WAC p. 18]

WAC 284-170-411 Selection of participating providers—Credentialing and unfair discrimination. (1) An issuer must develop standards for selecting participating providers, for primary care providers, and for each health care provider or facility license and professional specialty. The standards must be used in determining the selection of health care providers and facilities by the issuer. The standards must be consistent with rules or standards established by the state department of health or other regulatory authority established in Title 18 RCW for health care providers specified in RCW 18.130.040. Selection criteria must not be established in a manner that would:

(a) Allow an issuer to avoid risk by excluding providers or facilities because they are located in geographic areas that contain populations presenting a risk of higher than average claims, losses, or health services utilization;

(b) Exclude providers or facilities because they treat or specialize in treating persons presenting a risk of higher than average claims, losses, or health services utilization or because they treat or specialize in treating minority or special populations; or

(c) Discriminate regarding participation in the network solely based on the provider or facility type or category if the provider is acting within the scope of their license.

(2) The provisions of subsection (1) of this section must not be construed to prohibit an issuer from declining to select a provider or facility who fails to meet other legitimate selection criteria of the issuer. The purpose of these provisions is to prevent prohibited health risk avoidance or prohibited discrimination through network creation and provider or facility selection.

(3) The provisions of this subchapter do not require an issuer to employ, to contract with, or retain more providers or facilities than are necessary to comply with the network access standards of this chapter.

(4) An issuer must make its selection standards for participating providers and facilities available for review upon request by the commissioner.

[Statutory Authority: RCW 48.02.060, WSR 16-07-144 (Matter No. R 2016-01), recodified as § 284-170-411, filed 3/23/16, effective 4/23/16. WSR 16-01-074, recodified as § 284-43-9991, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.43.055, 48.43.505, 48.43.510, 48.43.515, 48.43.530, 48.43.535, 48.43.730, 48.44.020, 48.44.050, 48.44.080, 48.46.030, 48.46.200. WSR 16-01-074 (Matter No. R 2014-08), § 284-43-310, filed 12/14/15, effective 1/14/16. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.30.010, 48.44.020, 48.44.050, 48.44.080, 48.46.030, 48.46.060(2), 48.46.200 and 48.46.243. WSR 98-04-005 (Matter No. R 97-3), § 284-43-310, filed 1/22/98, effective 2/22/98.]

WAC 284-170-421 Provider contracts—Standards—Hold harmless provisions. The execution of a contract by an issuer does not relieve the issuer of its obligations to any enrollee for the provision of health care services, nor of its responsibility for compliance with statutes or regulations. In addition to the contract form filing requirements of this subchapter, all individual provider and facility contracts must be in writing and available for review upon request by the commissioner.

(1) An issuer must establish a mechanism by which its participating providers and facilities can obtain timely information on patient eligibility for health care services and

health plan benefits, including any limitations or conditions on services or benefits.

(2) Nothing contained in a participating provider or a participating facility contract may have the effect of modifying benefits, terms, or conditions contained in the health plan. In the event of any conflict between the contract and a health plan, the benefits, terms, and conditions of the health plan must govern with respect to coverage provided to enrollees.

(3) Each participating provider and participating facility contract must contain the following provisions:

"(a) {Name of provider or facility} hereby agrees that in no event, including, but not limited to nonpayment by {name of issuer}, {name of issuer's} insolvency, or breach of this contract will {name of provider or facility} bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against an enrollee or person acting on their behalf, other than {name of issuer}, for services provided pursuant to this contract. This provision does not prohibit collection of {deductibles, copayments, coinsurance, and/or payment for noncovered services}, which have not otherwise been paid by a primary or secondary issuer in accordance with regulatory standards for coordination of benefits, from enrollees in accordance with the terms of the enrollee's health plan.

(b) {Name of provider or facility} agrees, in the event of {name of issuer's} insolvency, to continue to provide the services promised in this contract to enrollees of {name of issuer} for the duration of the period for which premiums on behalf of the enrollee were paid to {Name of issuer} or until the enrollee's discharge from inpatient facilities, whichever time is greater.

(c) Notwithstanding any other provision of this contract, nothing in this contract shall be construed to modify the rights and benefits contained in the enrollee's health plan.

(d) {Name of provider or facility} may not bill the enrollee for covered services (except for deductibles, copayments, or coinsurance) where {name of issuer} denies payments because the provider or facility has failed to comply with the terms or conditions of this contract.

(e) {Name of provider or facility} further agrees (i) that the provisions of (a), (b), (c), and (d) of this subsection shall survive termination of this contract regardless of the cause giving rise to termination and shall be construed to be for the benefit of {name of issuer's} enrollees, and (ii) that this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between {name of provider or facility} and enrollees or persons acting on their behalf.

(f) If {name of provider or facility} contracts with other providers or facilities who agree to provide covered services to enrollees of {name of issuer} with the expectation of receiving payment directly or indirectly from {name of issuer}, such providers or facilities must agree to abide by the provisions of (a), (b), (c), (d), and (e) of this subsection."

(4) The contract must inform participating providers and facilities that willfully collecting or attempting to collect an amount from an enrollee knowing that collection to be in violation of the participating provider or facility contract constitutes a class C felony under RCW 48.80.030(5).

(5) An issuer must notify participating providers and facilities of their responsibilities with respect to the health issuer's applicable administrative policies and programs,

including but not limited to payment terms, utilization review, quality assessment and improvement programs, credentialing, grievance, appeal and adverse benefit determination procedures, data reporting requirements, pharmacy benefit substitution processes, confidentiality requirements and any applicable federal or state requirements.

(6) An issuer must make all documents, procedures, and other administrative policies and programs referenced in the contract available for review by the provider or facility prior to contracting. An issuer may comply with this subsection by providing electronic access.

(a) Participating providers and facilities must be given reasonable notice of not less than sixty days of changes that affect provider or facility compensation or that affect health care service delivery unless changes to federal or state law or regulations make such advance notice impossible, in which case notice must be provided as soon as possible.

(b)(i) Subject to any termination and continuity of care provisions of the contract, a provider or facility may terminate the contract without penalty if the provider or facility does not agree with the changes, subject to the requirements in subsection (9) of this section.

(ii) A material amendment to a contract may be rejected by a provider or facility. The rejection will not affect the terms of the existing contract. A material amendment has the same meaning as in RCW 48.39.005.

(c) No change to the contract may be made retroactive without the express written consent of the provider or facility.

(d) An issuer must give a provider or facility full access to the coverage and service terms of the applicable health plan for an enrolled patient.

(7) Each participating provider and participating facility contract must contain the following provisions:

(a) "No health carrier subject to the jurisdiction of the state of Washington may in any way preclude or discourage their providers from informing patients of the care they require, including various treatment options, and whether in their view such care is consistent with medical necessity, medical appropriateness, or otherwise covered by the patient's service agreement with the health carrier. No health carrier may prohibit, discourage, or penalize a provider otherwise practicing in compliance with the law from advocating on behalf of a patient with a health carrier. Nothing in this section shall be construed to authorize providers to bind health carriers to pay for any service."

(b) "No health carrier may preclude or discourage patients or those paying for their coverage from discussing the comparative merits of different health carriers with their providers. This prohibition specifically includes prohibiting or limiting providers participating in those discussions even if critical of a carrier."

(8) Subject to applicable state and federal laws related to the confidentiality of medical or health records, an issuer must require participating providers and facilities to make health records available to appropriate state and federal authorities involved in assessing the quality of care or investigating complaints, grievances, appeals, or review of any adverse benefit determinations of enrollees. An issuer must require providers and facilities to cooperate with audit reviews of encounter data in relation to the administration of health plan risk adjustment and reinsurance programs.

(9) An issuer and participating provider and facility must provide at least sixty days' written notice to each other before terminating the contract without cause.

(10) Whether the termination was for cause, or without cause, the issuer must make a good faith effort to ensure written notice of a termination is provided at least thirty days prior to the effective date of the termination or immediately for a termination for cause that results in less than thirty days notice to a provider or carrier to all enrollees who are patients seen:

- (a) On a regular basis by a specialist;
- (b) By a provider for whom they have a standing referral;

or

- (c) By a primary care provider.

(11) An issuer is responsible for ensuring that participating providers and facilities furnish covered services to each enrollee without regard to the enrollee's enrollment in the plan as a private purchaser of the plan or as a participant in publicly financed programs of health care services. This requirement does not apply to circumstances when the provider should not render services due to limitations arising from lack of training, experience, skill, or licensing restrictions.

(12) An issuer must not penalize a provider because the provider, in good faith, reports to state or federal authorities any act or practice by the issuer that jeopardizes patient health or welfare or that may violate state or federal law.

(13) Every participating provider contract must contain procedures for the fair resolution of disputes arising out of the contract.

(14) Participating provider and facility contracts entered into prior to the effective date of these rules must be amended upon renewal to comply with these rules, and all such contracts must conform to these provisions no later than July 1, 2016. The commissioner may extend the July 1, 2016, deadline for an issuer for an additional one year, if the 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 issuer expects to be in compliance (no more than one year beyond July 1, 2016).

[Statutory Authority: RCW 48.02.060, WSR 16-07-144 (Matter No. R 2016-01), recodified as § 284-170-421, filed 3/23/16, effective 4/23/16. WSR 16-01-074, recodified as § 284-43-9992, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.450, 48.20.460, 48.43.055, 48.43.505, 48.43.510, 48.43.515, 48.43.530, 48.43.535, 48.43.730, 48.44.020, 48.44.050, 48.44.080, 48.46.030, 48.46.200. WSR 16-01-074 (Matter No. R 2014-08), § 284-43-320, filed 12/14/15, effective 1/14/16. Statutory Authority: RCW 48.02.060, 48.30.010, 48.43.055, 48.44.050, 48.44.070, 48.46.030, 48.46.200 and 48.46.243. WSR 99-21-016 (Matter No. R 98-21), § 284-43-320, filed 10/11/99, effective 11/11/99. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.30.010, 48.44.020, 48.44.050, 48.44.080, 48.46.030, 48.46.060(2), 48.46.200 and 48.46.243. WSR 98-04-005 (Matter No. R 97-3), § 284-43-320, filed 1/22/98, effective 2/22/98.]

WAC 284-170-431 Provider contracts—Terms and conditions of payment. (1) Every participating provider and facility contract shall set forth a schedule for the prompt payment of amounts owed by the carrier to the provider or facility and shall include penalties for carrier failure to abide by that schedule. At a minimum, these contract provisions shall conform to the standards of this section.

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(2)(a) For health services provided to covered persons, a carrier shall pay providers and facilities as soon as practical but subject to the following minimum standards:

(i) Ninety-five percent of the monthly volume of clean claims shall be paid within thirty days of receipt by the responsible carrier or agent of the carrier; and

(ii) Ninety-five percent of the monthly volume of all claims shall be paid or denied within sixty days of receipt by the responsible carrier or agent of the carrier, except as agreed to in writing by the parties on a claim-by-claim basis.

(b) The receipt date of a claim is the date the responsible carrier or its agent receives either written or electronic notice of the claim.

(c) The carrier shall establish a reasonable method for confirming receipt of claims and responding to provider and facility inquiries about claims.

(d) Any carrier failing to pay claims within the standard established under subsection (2) of this section shall pay interest on undenied and unpaid clean claims more than sixty-one days old until the carrier meets the standard under subsection (2) of this section. Interest shall be assessed at the rate of one percent per month, and shall be calculated monthly as simple interest prorated for any portion of a month. The carrier shall add the interest payable to the amount of the unpaid claim without the necessity of the provider or facility submitting an additional claim. Any interest paid under this section shall not be applied by the carrier to a covered person's deductible, copayment, coinsurance, or any similar obligation of the covered person.

(e) When the carrier issues payment in either the provider or facility and the covered person names, the carrier shall make claim checks payable in the name of the provider or facility first and the covered person second.

(3) For purposes of this section, "clean claim" means a claim that has no defect or impropriety, including any lack of any required substantiating documentation, or particular circumstances requiring special treatment that prevents timely payments from being made on the claim under this section.

(4) Denial of a claim must be communicated to the provider or facility and must include the specific reason why the claim was denied. If the denial is based upon medical necessity or similar grounds, then the carrier upon request of the provider or facility must also promptly disclose the supporting basis for the decision. For example, the carrier must describe how the claim failed to meet medical necessity guidelines.

(5) Every carrier shall be responsible for ensuring that any person acting on behalf of or at the direction of the carrier or acting pursuant to carrier standards or requirements complies with these billing and claim payment standards.

(6) These standards do not apply to claims about which there is substantial evidence of fraud or misrepresentation by providers, facilities or covered persons, or instances where the carrier has not been granted reasonable access to information under the provider's or facility's control.

(7) Providers, facilities, and carriers are not required to comply with these contract provisions if the failure to comply is occasioned by any act of God, bankruptcy, act of a governmental authority responding to an act of God or other emergency, or the result of a strike, lockout, or other labor dispute.

(9/20/16)

[Statutory Authority: RCW 48.02.060. WSR 16-07-144 (Matter No. R 2016-01), recodified as § 284-170-431, filed 3/23/16, effective 4/23/16. WSR 16-01-081, recodified as § 284-43-9993, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.30.010, 48.43.055, 48.44.050, 48.44.070, 48.46.030, 48.46.200 and 48.46.243. WSR 99-21-016 (Matter No. R 98-21), § 284-43-321, filed 10/11/99, effective 11/11/99.]

WAC 284-170-440 Provider contracts—Dispute resolution process. Except as otherwise required by a specific federal or state statute or regulation governing dispute resolution, no process for the resolution of disputes arising out of a participating provider or facility contract shall be considered fair under RCW 48.43.055 unless the process meets all the provisions of this section.

(1) A dispute resolution process may include an initial informal process but must include a formal process for resolution of all contract disputes.

(2) A carrier may have different types of dispute resolution processes as necessary for specialized concerns such as provider credentialing or as otherwise required by law. For example, disputes over health plan coverage of health care services are subject to the grievance procedures established for covered persons.

(3) Carriers must allow not less than thirty days after the action giving rise to a dispute for providers and facilities to complain and initiate the dispute resolution process.

(4) Carriers may not require alternative dispute resolution to the exclusion of judicial remedies; however, carriers may require alternative dispute resolution prior to judicial remedies.

(5) Carriers must render a decision on provider or facility complaints within a reasonable time for the type of dispute. In the case of billing disputes, the carrier must render a decision within sixty days of the complaint.

[Statutory Authority: RCW 48.02.060. WSR 16-07-144 (Matter No. R 2016-01), recodified as § 284-43-9994, filed 3/23/16, effective 4/23/16. WSR 16-01-081, recodified as § 284-43-9994, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.30.010, 48.43.055, 48.44.050, 48.44.070, 48.46.030, 48.46.200 and 48.46.243. WSR 99-21-016 (Matter No. R 98-21), § 284-43-322, filed 10/11/99, effective 11/11/99.]

WAC 284-170-450 Pharmacy identification cards.

(1) This rule outlines the minimum standards for prescription claims processing as directed by RCW 48.43.023.

(2) The pharmacy identification card or other technology must include the data element consistent with the "BIN number," "IIN/BIN number" or "RxBIN" which is the ANSI assigned international identification number, identified in the *National Council for Prescription Drug Programs (NCPDP) Pharmacy ID Card Implementation Guide*. Other data elements of the *NCPDP Guide* must be included on the card only if they are required for the processing of claims.

(3) This rule does not compel the issuance of a separate pharmacy identification card provided that the enrollee health plan identification card contains the required data elements.

(4) All plans that use a card or other technology for prescription claims processing that are delivered, issued for delivery or renewed on or after July 1, 2003, must comply with the requirements of this rule.

[Statutory Authority: RCW 48.02.060. WSR 16-07-144 (Matter No. R 2016-01), recodified as § 284-170-450, filed 3/23/16, effective 4/23/16. WSR 16-01-081, recodified as § 284-43-9995, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.43.023, 48.44.050, 48.46.200.

(9/20/16)

WSR 03-07-006 (Matter No. R 2002-04), § 284-43-323, filed 3/6/03, effective 4/6/03.]

WAC 284-170-460 Provider contracts—Audit guidelines. (1) Provider and facility contracts may not contain provisions that grant the carrier access to health information and other similar records unrelated to covered persons. This provision shall not limit the carrier's right to ask for and receive information relating to the ability of the provider or facility to deliver health care services that meet the accepted standards of medical care prevalent in the community.

(2) Provider and facility contract provisions granting the carrier access to medical records for audit purposes must be limited to only that necessary to perform the audit.

(3) Provider and facility contracts may not contain billing audit standards that are not mutual. For example, if the carrier grants itself the right to audit hospital billing records, then the hospital has the right to audit carrier denials of the hospital's claims.

[Statutory Authority: RCW 48.02.060. WSR 16-07-144 (Matter No. R 2016-01), recodified as § 284-170-460, filed 3/23/16, effective 4/23/16. WSR 16-01-081, recodified as § 284-43-9996, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.30.010, 48.43.055, 48.44.050, 48.44.070, 48.46.030, 48.46.200 and 48.46.243. WSR 99-21-016 (Matter No. R 98-21), § 284-43-324, filed 10/11/99, effective 11/11/99.]

WAC 284-170-470 Pharmacy claims—Rejections, notifications and disclosures. Issuers must provide to billing pharmacies sufficient information about transactions initiated by the pharmacy so that pharmacy claims can be processed in a timely manner.

(1) For purposes of this section "claim rejection" is an administrative step in the claim process where a claim is neither paid nor denied, but is held awaiting a defined action from the pharmacist, prescriber, or member.

(2) An issuer must notify the billing pharmacy of a claim rejection electronically and make available to the pharmacy, utilizing the National Council for Prescription Drug Programs (NCPDP) Telecommunications Standard transaction, all required data elements, as well as the following information, to the extent supported by the transaction:

(a) Rejection reasons such as prior authorization, quantity level limit, and exclusion;

(b) Other medications to consider that would not require a preauthorization (if applicable);

(c) Other medications to consider that would require a preauthorization (if applicable);

(d) Instructions for further processing of claim or for more specific contact information which may include a reference to a specific location on a web site;

(e) Contact phone number of a person or department to contact who can provide additional information.

(3) Every issuer must notify its participating pharmacies of its claim process in its contracts.

(4) Every issuer must be responsible for ensuring that any person acting on behalf of or at the direction of the issuer or acting pursuant to carrier standards or requirements complies with these transaction standards.

(5) In every pharmacy provider agreement, the issuer must:

(a) Disclose if the provider or pharmacy has the right to make a prior authorization request; and

(b) Provide that if the issuer requires the authorization number to be transmitted on a pharmaceutical claim, the issuer will provide the authorization number to the billing pharmacy. The authorization number will be communicated to the billing pharmacy after approval of a prior authorization request and upon receipt of a claim for that authorized medication.

(6) The prior authorization determination must be transmitted to the requesting party and must include the following:

(a) Information about whether a request was approved.

(b) If the request was made by the pharmacy, notification will additionally be made to the prescriber.

(7) In every pharmacy provider agreement, every issuer will state that an issuer will authorize an emergency fill by the dispensing pharmacist and approve the claim payment. An emergency fill is only applicable when:

(a) The dispensing pharmacy cannot reach the issuer's prior authorization department by phone as it is outside of that department's business hours; or

(b) An issuer is available to respond to phone calls from a dispensing pharmacy regarding a covered benefit, but the issuer cannot reach the prescriber for full consultation.

(8) The issuer's emergency fill policy must include the following:

(a) The inclusionary and exclusionary list of medications provided for emergency fill by issuers. This list must be posted online on the issuer's web site; this can be accomplished by linking to a common web site dedicated to administrative simplification and available to the public, such as OneHealthPort.

(b) The authorized amount of the emergency fill will be no more than the prescribed amount up to a seven day supply or the minimum packaging size available at the time the emergency fill is dispensed.

(c) An emergency fill is a covered benefit. However, determination as to whether the subsequent fill is a covered health service under the patient benefit will be made as part of the prior authorization processing.

(9) Pharmacies and issuers are not required to comply with these contract provisions if the failure to comply is occasioned by any act of God, bankruptcy, act of a governmental authority responding to an act of God or other emergency, or the result of a strike, lockout, or other labor dispute.

[Statutory Authority: RCW 48.02.060, 48.43.510. WSR 16-19-086 (Matter No. R 2016-08), § 284-170-470, filed 9/20/16, effective 10/21/16. Statutory Authority: RCW 48.02.060. WSR 16-07-144 (Matter No. R 2016-01), recodified as § 284-170-470, filed 3/23/16, effective 4/23/16. WSR 16-01-081, recodified as § 284-43-9997, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.165.0301, 48.43.525, 48.43.530, 48.44.020, 48.44.050, 48.46.060(2), and 48.46.200. WSR 15-24-074 (Matter No. R 2014-13), § 284-43-325, filed 11/25/15, effective 7/1/16.]

WAC 284-170-480 Participating provider—Filing and approval. (1) An issuer must file for prior approval all participating provider agreements and facility agreements thirty calendar days prior to use. If a carrier negotiates a provider or facility contract or a compensation agreement that deviates from an approved agreement, then the issuer must file that negotiated contract or agreement with the commissioner for approval thirty days before use. The commissioner must receive the filings electronically in accordance with chapters 284-44A, 284-46A, and 284-58 WAC.

(2)(a) An issuer may file a provider or facility contract template with the commissioner. A "contract template" is a sample contract and compensation agreement form that the issuer will use to contract with multiple providers or facilities. A contract template must be issued exactly as approved.

(i) When an issuer modifies the contract template, an issuer must refile the modified contract template for approval. All changes to the contract template must be indicated through strike outs for deletions and underlines for new material. The modified template must be issued to providers and facilities upon approval.

(ii) Alternatively, issuers may file the modified contract template for prospective contracting and a contract addendum or amendment that would be issued to currently contracted providers or facilities for prior approval. The filing must include any correspondence that will be sent to a provider or facility that explains the amendment or addendum. The correspondence must provide sufficient information to clearly inform the provider or facility what the changes to the contract will be. All changes to the contract template must be indicated through strike outs for deletions and underlines for new material.

(iii) Changes to a previously filed and approved provider compensation agreement modifying the compensation amount or terms related to compensation must be filed and are deemed approved upon filing if there are no other changes to the previously approved provider contract or compensation agreement.

(b)(i) All negotiated contracts and compensation agreements must be filed with the commissioner for approval thirty calendar days prior to use and include all contract documents between the parties.

(ii) If the only negotiated change is to the compensation amount or terms related to compensation, it must be filed and is deemed approved upon filing.

(3) If the commissioner takes no action within thirty calendar days after submission, the form is deemed approved except that the commissioner may extend the approval period an additional fifteen calendar days upon giving notice before the expiration of the initial thirty-day period. Approval may be subsequently withdrawn for cause.

(4) The issuer must maintain provider and facility contracts at its principal place of business in the state, or the issuer must have access to all contracts and provide copies to facilitate regulatory review upon twenty days prior written notice from the commissioner.

(5) Nothing in this section relieves the issuer of the responsibility detailed in WAC 284-170-280 (3)(b) to ensure that all provider and facility contracts are current and signed if the provider or facility is listed in the network filed for approval with the commissioner.

(6) If an issuer enters into a reimbursement agreement that is tied to health outcomes, utilization of specific services, patient volume within a specific period of time, or other performance standards, the issuer must file the reimbursement agreement with the commissioner thirty days prior to the effective date of the agreement, and identify the number of enrollees in the service area in which the reimbursement agreement applies. Such reimbursement agreements must not cause or be determined by the commissioner to result in discrimination against or rationing of medically necessary ser-

vices for enrollees with a specific covered condition or disease. If the commissioner fails to notify the issuer that the agreement is disapproved within thirty days of receipt, the agreement is deemed approved. The commissioner may subsequently withdraw such approval for cause.

[Statutory Authority: RCW 48.02.060, WSR 16-14-106 (Matter No. R 2016-11), § 284-170-480, filed 7/6/16, effective 8/6/16; WSR 16-07-144 (Matter No. R 2016-01), recodified as § 284-170-480, filed 3/23/16, effective 4/23/16. WSR 16-01-074, recodified as § 284-43-9998, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.-450, 48.20.460, 48.43.055, 48.43.505, 48.43.510, 48.43.515, 48.43.530, 48.43.535, 48.43.730, 48.44.020, 48.44.050, 48.44.080, 48.46.030, 48.46.-200. WSR 16-01-074 (Matter No. R 2014-08), § 284-43-330, filed 12/14/15, effective 1/14/16. Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.030, 48.46.200, and 2013 c 277 § 1. WSR 13-16-045 (Matter No. R 2012-24), § 284-43-330, filed 7/31/13, effective 8/31/13. Statutory Authority: RCW 48.02.060, 48.30.010, 48.43.055, 48.44.050, 48.44.070, 48.46.030, 48.46.200 and 48.46.243. WSR 99-21-016 (Matter No. R 98-21), § 284-43-330, filed 10/11/99, effective 11/11/99. Statutory Authority: RCW 48.02.060, 48.20.450, 48.20.460, 48.30.010, 48.44.020, 48.44.050, 48.44.080, 48.46.030, 48.46.060(2), 48.46.200 and 48.46.243. WSR 98-04-005 (Matter No. R 97-3), § 284-43-330, filed 1/22/98, effective 2/22/98.]

WAC 284-170-490 Effective date. (1) All participating provider and facility contracts entered into after the effective date of these rules must comply with these rules no later than January 1, 2015.

(2) Participating provider and facility contracts entered into prior to the effective date of these rules must be amended upon renewal to comply with these rules, and all such contracts must conform to these provisions no later than January 1, 2015. The commissioner may extend the January 1, 2015, deadline for an issuer for an additional one year, if the 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 issuer expects to be in compliance (no more than one year beyond January 1, 2015).

[Statutory Authority: RCW 48.02.060, WSR 16-07-144 (Matter No. R 2016-01), recodified as § 284-170-490, filed 3/23/16, effective 4/23/16. WSR 16-01-081, recodified as § 284-43-9999, filed 12/14/15, effective 12/14/15. Statutory Authority: 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, 48.20.-450, 48.44.020, 48.44.080, 48.46.030, 45 C.F.R. §§ 156.230, 156.235, and 156.245. WSR 14-10-017 (Matter No. R 2013-22), § 284-43-331, filed 4/25/14, effective 5/26/14. Statutory Authority: RCW 48.02.060, 48.30.010, 48.43.055, 48.44.050, 48.44.070, 48.46.030, 48.46.200 and 48.46.243. WSR 99-21-016 (Matter No. R 98-21), § 284-43-331, filed 10/11/99, effective 11/11/99.]