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 website.

(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 website; 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.]