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). Amended alternate access delivery requests for services subject to the Balance Billing Protection Act are governed by WAC 284-170-220 and are distinct from alternative access delivery system requests under this section.

(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. Documentation of good faith efforts to contract may include, but is not limited to:

(i) Written requests to the provider to enter into contract negotiations for a new or extended contract, with the date each request was made and confirmation by the issuer that staff or a designated

person that has been authorized to negotiate or sign a contract on behalf of the provider has been contacted;

(ii) Records of communications and meetings between the issuer and provider, including dates, locations and communication format;

(iii) Written contract offers made to the provider, but not substantiative contract terms offered by either the issuer or the provider, including the date each offer was made and confirmation by the issuer that the appropriate staff of the provider was contacted.

(c) Except to the extent provided otherwise in subsection (5) of this section, an alternate access delivery request for services not subject to RCW 48.49.020 may include a request to be approved for up to one health plan year, one calendar year, or until the issuer executes a provider contract to address the network access issue in the alternate access delivery request, whichever occurs earlier. An issuer that needs to submit an alternate access delivery request for the same service and geographic location as a previously approved request must submit a new alternate access delivery request for approval.

(d) For services for which balance billing is prohibited under RCW 48.49.020, the issuer must notify out-of-network or nonparticipating providers or facilities that deliver the services referenced in the alternate access delivery request within five days of submitting the request to the commissioner. Any notification provided under this subsection must include contact information for issuer staff who can provide detailed information to the affected provider or facility regarding the submitted alternate access delivery request.

(3) The effective date of an alternate access delivery system is the date that the commissioner notifies the issuer that the alternate access delivery system has been approved. The commissioner will notify the carrier in writing that the alternate access delivery system has been approved, and will include the effective date of the approval.

(4) With respect to services for which balance billing is prohibited under RCW 48.49.020, the issuer may not treat payment to an out-of-network or nonparticipating provider or facility for a service addressed in an approved alternate access delivery request as a participating provider or as a means to satisfy network access standards in WAC 284-170-200.

(5) An approved alternate access delivery request for services subject to RCW 48.49.020 expires on December 31st of the year that the request was approved or the effective date of a contract executed by the issuer and a provider who can deliver the service in the geographic location referenced in the alternate access delivery request, whichever occurs earlier.

(6)(a) An alternate access delivery request may propose to use single case provider reimbursement agreements in limited situations if the issuer can demonstrate to the commissioner that the single case provider reimbursement agreement includes hold harmless language that complies with WAC 284-170-421 to protect the enrollee from being balanced billed.

(b) 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 and cannot be used in lieu of an alternate access delivery request to establish 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 reimburse-

ment 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.

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

[Statutory Authority: RCW 48.43.820, 48.49.180, 48.49.110, and 48.02.060. WSR 23-01-110 (Matter R 2022-02), § 284-170-210, filed 12/19/22, effective 1/19/23. 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.]