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

WAC 284-43-200 Network adequacy—General standards. (1) A health ((~~carrier shall~~)) issuer must maintain each ((~~plan~~)) provider network for each health plan in a manner that is sufficient in numbers and types of providers, practitioners, and facilities to assure that, to the extent feasible based on the number and type of providers, practitioners and facilities in the service area, all health plan services to ((~~covered persons~~)) enrollees will be accessible in a timely manner appropriate for the enrollee's condition. An issuer must demonstrate that for each health benefit plan's defined service area, a comprehensive range of primary, specialty, institutional, and ancillary services are readily available at reasonable times to all enrollees and that emergency services are accessible twenty-four hours per day, seven days per week without unreasonable delay.

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

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

((~~(2)~~)) (4) An issuer must establish sufficiency and adequacy of choice ((~~may be established by the carrier with reference to any reasonable criteria used by the carrier, including but not limited to: Provider-covered person ratios by specialty, primary care provider-covered person ratios, geographic accessibility, waiting times for appointments with participating providers, hours of operation, and the volume of technological and specialty services available to serve the needs of covered persons requiring technologically advanced or specialty care. Evidence of carrier compliance with network adequacy standards that are substantially similar to those standards established by state agency health care purchasers (e.g., the state health care authority and the department of social and health services) and by private managed care accreditation organizations may be used to~~

~~demonstrate sufficiency. At a minimum, a carrier will be held account-able for meeting those standards described under WAC 284-43-220.~~

~~(3) In any case where the health carrier has an absence of or an insufficient number or type of participating providers or facilities to provide a particular covered health care service, the carrier shall ensure through referral by the primary care provider or otherwise that the covered person obtains the covered service from a provider or facility within reasonable proximity of the covered person at no greater cost to the covered person than if the service were obtained from network providers and facilities, or shall make other arrangements acceptable to the commissioner.~~

~~(4) The health carrier shall~~)) of provider based on the number and type of provider, practitioner, and facility 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) An issuer must establish and maintain adequate arrangements to ensure reasonable proximity of network providers and facilities to

the business or personal residence of ((~~covered persons. Health carriers shall~~)) enrollees, and located so as to not result in unreasonable barriers to accessibility. Issuers must make reasonable efforts to include providers and facilities in networks in a manner that limits the amount of travel required to obtain covered benefits. For example, ((~~a carrier~~)) an issuer should not require travel of thirty miles or more when a provider who meets ((~~carrier~~)) issuer standards is available for inclusion in the network and practices within five miles of enrollees. In determining whether ((~~a health carrier~~)) an issuer has complied with this provision, the commissioner will give due consideration to the relative availability of health care providers or facilities in the service area under consideration and to the standards established by state agency health care purchasers. Relative availability includes the willingness of providers or facilities in the service area to contract with the ((~~carrier~~)) issuer under reasonable terms and conditions.

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

(6) ((~~Beginning July 1, 2000, the health carrier shall disclose to covered persons~~)) An issuer must disclose to enrollees that limita-

tions or restrictions on access to participating providers and facilities may arise from the health service referral and authorization practices of ((~~participating providers and facilities. The carrier shall provide instructions to covered persons as to how they can receive details about such practices from their primary care provider or through other formally established processes. For example, a covered person relying on such instructions or processes could discover if the choice of a particular primary care provider would result in the covered person's inability to obtain a referral to certain other participating providers.~~)) 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.

(7) To provide adequate choice to ((~~covered persons~~)) enrollees who are American Indians, each health ((~~carrier shall~~)) issuer must maintain arrangements that ensure that American Indians who are ((~~covered persons~~)) enrollees have access to Indian and tribal health care services and facilities that are part of the Indian health system.

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

(8) Where a provider type or facility is not available within a health benefit plan's service area, the issuer must propose to the commissioner an alternate network standard to provide enrollees with access to medically necessary care on a reasonable basis without detriment to their health.

(9) The network adequacy requirements in this subchapter apply to stand-alone dental plans offered through the exchange or where a stand-alone dental plan is offered off the exchange for the purpose of

providing the essential health benefit category of pediatric oral benefits.

(10) This section is effective for plans offered and issued on or after January 1, 2015.

[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.]

NEW SECTION

WAC 284-43-201 Alternate network standards. (1) An issuer may propose a network adequacy standard as an alternate to the requirements of this subchapter for the commissioner's review and approval.

(a) Copayments and deductible requirements must apply to alternate network standards at the same level they are applied to in-network services. This means that the alternate network standard may result in issuer payment of billed charges to ensure network adequacy. Alternate network adequacy standards, or alternate network standards, address such provider network strategies as use of out-of-state and out of county or service area providers, agreements to pay billed charges when a critical provider is not part of the network, exceptions to network standards based on rural locations in the service area, or limitations on authority to refer enrollees to specialty care.

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

(c) An issuer must demonstrate a plan and practice to assist enrollees to locate available and accessible contracted providers in neighboring service areas consistent with patterns of practice for obtaining health care services in a timely manner appropriate for the enrollee's health needs.

(d) An issuer must arrange for the provision of specialty services from specialists outside the contracted network if such specialists are not available within the network and the services are medically necessary for the enrollee's condition.

(2) If a county has a population that is fifty thousand or fewer, and the county is the sole service area for the plan, an issuer may propose an alternative network standard for that portion of its service area for a plan.

(3) If an issuer cannot meet the network adequacy standards of this subchapter due to the absence of or an insufficient number or type of participating providers or facilities to provide a particular covered health care service, the issuer must propose and receive the commissioner's approval of an alternative standard for the service area.

(4) If there are a sufficient number of provider or facility types in the service area to meet the standards under this subchapter, but the issuer is unable to contract with the provider or facility to meet the network standards in this subchapter, the issuer may propose an alternate network standard. The commissioner will not approve an alternate network standard on this basis unless the issuer provides clear and convincing evidence of good faith efforts on its part to

contract with the provider or facility, and can demonstrate that there is not an available commercial network provider with which the issuer can contract to meet provider network standards under this subcontract.

(5) An alternate network standard must ensure through referral by the primary care provider or otherwise that the covered person obtains the covered service from a provider or facility within the closest reasonable proximity of the covered person at no greater cost to the covered person than if the service were obtained from network providers and facilities.

(6) The practice of entering into a single case rate agreement with a provider, practitioner, or facility in relation to a specific enrollee's condition or treatment requirements is not an alternate network standard for purposes of establishing an adequate provider network. A single case rate 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 rate agreements must not be used to fill holes or gaps in network for the complete universe of enrollees under a plan, and does not support a determination of network adequacy.

(7) This section is effective for plans offered or issued on or after January 1, 2015.

[]

NEW SECTION

WAC 284-43-202 Maintenance of sufficient networks. (1) An issuer must monitor, on an ongoing basis, the ability and clinical capacity of its network providers and facilities to furnish health plan services to enrollees. Within thirty days of the change in its network as described below, an issuer must notify the commissioner and provide an action plan to restore network adequacy:

(a) A change of ten percent or more in the number of specialty providers participating in the network since the initial approval date;

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

(c) A change of twenty-five percent or more in the number of covered persons in the service area since the annual approval date;

(d) A reduction of five percent or more in the number of primary care providers with open panels or hospitals in the service area within the prior sixty days;

(e) The termination or expiration of a contract with a hospital within a service area within the prior sixty days; or

(f) A fifteen percent reduction in the number of providers 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 within the prior sixty days.

(2) An issuer must base its actuarial projections of health care costs submitted as part of a premium rate filing on the actual network it proposes for the health benefit plan's service areas.

(3) A closed practice may be included in a provider network for purposes of determining adequacy but must not be used to justify adequacy for anticipated enrollment growth.

(4) An issuer must have a sufficient number and type of providers for whom direct access is required in its network to accommodate all new and existing enrollees in the service areas.

(5) An issuer must establish an access plan specific to each health benefit plan that describes the issuer’s strategy, policies and

procedures necessary to establishing, maintaining and administering an adequate network. The access plan must be filed with the commissioner prior to the offering of a new health benefit plan, and must be updated as applicable policies and procedures are amended or added. 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. At a minimum, the 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 did 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) Hours of operation, standard and after-hours, for prior authorization, consumer and provider assistance and claims adjudication;

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

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

(h) Specific procedures and materials used to address the needs of covered persons 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 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 in each service areas;

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

(k) Processes for corrective action plans for providers related to the issuer's licensure, prior authorization, referral and access compliance. The process must include remedies to address a deficient access to appointments or services as a result of a provider's conduct.

(6) For networks that include medical home or medical management services in lieu of a model where the primary care provider provides referrals to specialty or ancillary services, or 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, the issuer must monitor the continuity and coordination of care that enrollees receive. An issuer must act to assure continuity and coordination of care in a manner consistent with professionally recognized evidence-based standards of practice, across the health plan network. For mental health services and pediatric services, the baseline for such coordination is:

(a) Monitoring as often as is necessary, but not less than once a year, the level of collaboration between medical and mental health providers;

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

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

(d) Access to treatment and follow-up for enrollees with coexisting and mental health disorders or chronic medical conditions.

(7) This section is effective for plans offered or issued on or after January 1, 2016.

[]

NEW SECTION

WAC 284-43-203 Use of subcontracted networks. (1) The primary contractor with each provider 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 or areas, subject to the following requirements:

(a) An issuer must not elect to use less than one hundred percent of the subcontracted network in a particular 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 the agreement with the 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 WAC 284-43-202, 284-43-205, 284-43-229 and 284-43-230.

(3) If a carrier permits a facility or provider to delegate functions, the carrier 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 carrier with the right to approve, suspend or terminate any such arrangement.

(4) This section is effective for plans offered or issued on or after January 1, 2015.

[]

NEW SECTION

WAC 284-43-204 Provider directories. (1) Provider directories must be updated at regular intervals, and must be offered to accommodate individuals with limited-English proficiency or disabilities. An issuer must post the provider directory for each health benefit plan online, and must make a printed copy of the directory available to an enrollee upon request.

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

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

(b) Any relevant institutional affiliation of the provider, such as hospitals where the provider has admitting privileges;

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

(3) An issuer must include in its electronic posting of a health benefit 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 directories or directory must make it reasonably clear to an enrollee which network applies to which health benefit plan.

(5) Telemedicine services must be included and specifically described in each provider directory as to which provider may use them and with what facility or provider.

(6) Interpreter services made available for specific providers or facilities must be identified in relation to the provider in the directory, and the mechanism by which an enrollee may access such services must be posted with the directory on the issuer's web site.

(7) This section is effective for plans offered or issued on or after January 1, 2015.

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

WAC 284-43-205 Every category of health care providers. (1) To effectuate the requirement of RCW 48.43.045 that health plans provide coverage for treatments and services by every category of provider, health ((~~carriers shall~~)) issuers must not exclude any category of

providers licensed by the state of Washington who provide health care services or care within the scope of their practice for conditions covered by ((~~basic health plan (BHP) services as defined by RCW 48.43.005(4)~~)) the essential health benefits package, as defined in WAC 284-43-878 and RCW 48.43.715. If the ((~~BHP~~)) essential health benefits package covers the condition, the ((~~carrier may~~)) issuer must not exclude a category of provider who is licensed to provide services for that condition, and is acting within the scope of practice, unless such services would not meet the ((~~carrier's~~)) issuer's standards pursuant to RCW 48.43.045 (1)(b). For example, if the ((~~BHP~~)) essential health benefits package provides coverage for outpatient treatment of lower back pain, any category of provider that provides cost-effective and clinically efficacious outpatient treatment for lower back pain within its scope practice and otherwise abides by standards pursuant to RCW 48.43.045 (1)(b) ((~~may~~)) must not be excluded from the network.

(2) RCW 48.43.045 (1)(b) permits ((~~health carriers~~)) issuers to require providers to abide by certain standards. These standards may not be used in a manner designed to exclude categories of providers unreasonably. For example, ((~~health carriers may~~)) issuers must not decide that a particular category of provider can never render any cost-effective or clinically efficacious services and thereby exclude

that category of provider completely from health plans on that basis. ((~~However, health carriers may determine that particular services for particular conditions by particular categories of providers are not cost-effective or clinically efficacious, and may exclude such services from coverage or reimbursement under a health plan. Any such determinations must be supported by relevant information or evidence of the type usually considered and relied upon in making determinations of cost-effectiveness or clinical efficacy.~~))

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

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

this section to accede to a request by any individual provider for inclusion in any network for any health plan. Health plan((~~s~~)) networks that use "gatekeepers" or "medical homes" for access to specialist providers may use them for access to specified categories of providers. "Gatekeeper" means requiring a referral from a primary care or direct access provider or practitioner to access specialty or in-patient services. "Medical home" means establishing a consortium or group of providers or practitioners who must participate in decisions about referring an enrollee for specialty or in-patient services.

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

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

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

[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.]

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

WAC 284-43-220 Network reports—Format. ((~~Each health carrier must file with the commissioner a Provider Network Form A and a Network Enrollment Form B.~~)) (1) An issuer must file its provider network materials with the commissioner for approval for a newly offered health plan prior to or at the time it files its initial premium rate filing for approval or review. The issuer's filing must be submitted electronically on the form posted on the commissioner's web site, and completed consistent with the posted filing instructions for the time frame of the filing.

(2) For benefit years beginning January 1, 2015, an issuer must annually file with the commissioner the provider network data and documentation specified by the commissioner in instructions on the commissioner's web site, using the required templates. The annual filing must occur at the time an issuer files its premium rate filing. The commissioner may extend the time for filing for good cause shown. The issuer's filing must be submitted electronically and completed consistent with the posted filing instructions for the time frame of the filing.

(3) An issuer must file the following specific documents and data with the commissioner to document network adequacy:

(a) **Provider Network Report Form A.** ((~~A carrier~~)) An issuer must file an electronic report of all participating providers for each plan by network. This report must contain all data items shown in Provider Network Form A prescribed by and available from the commissioner. Updated reports must be filed ((~~each month~~)) quarterly for each network by line of business, by market and by health plan in the market. 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 describes changes in the provider network.

((~~(2)~~)) (i) The Provider Network Report Form A must be submitted for each network being reviewed for network adequacy. A network may be used by more than one plan, and the issuer must include the name of each health plan in the health plan name field on the document. For the 2015 benefit year filing, this notation must be made manually.

(ii) Beginning with filings for the 2016 benefit year, if a provider or facility has more than one provider type or specialty, a separate row for each type or specialty must be used for that provider or facility.

(iii) Beginning with filings for the 2016 benefit year, the form A filing must indicate if a provider is an essential community provider using the specific data element in the file template on the provider row. An issuer must file an updated, accurate Form A each three months after the annual filing is received by the commissioner, or when a material change in the network occurs as described in WAC 284-43-202.

(b) **Network Enrollment Form B.** ((~~By March 31, 2004, and every year thereafter, a carrier must prepare an electronic report showing the total number of covered persons who were entitled to health care services during each month of the year, excluding nonresidents. A separate~~)) The Network Enrollment Form B document 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. The report data must include the aggregate number of covered lives, and also report the data by sex, month, and the age brackets used for rating, organized by line of business (individual market, including conversion plans, small group, and large group).

An issuer must file this electronic report by March 31st, of each year, beginning in 2015 for issuers offering and issuing plans in a market as of January 1, 2014, and 2016 for new market participants.

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

((~~(3)~~)) (c) **Form C Alternate Network Standards:** For plan years that begin on or after January 1, 2016, alternate network standards plans must be filed when a network for a plan does not or cannot meet network adequacy requirements as set forth in this subchapter. Alternate network standards must be filed with the commissioner using the Network Sufficiency Form C.

(i) The format for Form C filings is text.

(ii) The Form C filing must address the following areas, and may include other additional information as requested by the commissioner:

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

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

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

(D) The issuer's marketing plan to accommodate the time period that the alternate network standard is in effect, and specifically proposing management of enrollment on a continuing or closed basis, and for what period of time;

(E) Form A and Form B filings are required in relation to alternate network standards on the basis described in subsections (1) and (2) of this section.

(iii) If an issuer is a new entrant to a market, an alternate network standard proposal must include a timeline to bring the network into full compliance with this subchapter.

(d) **Provider directory certification:** At the time of filing each Form A, an issuer must certify 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, and correctly denotes closed practices and essential community providers. The certification must confirm that the provider directory contains providers with which the issuer has a signed contract that is in effect on the date of the certification.

(e) **Geo-Access® Reports:** For plan years beginning January 1, 2015, and every year thereafter, an issuer must submit Geo-Access® map reports with a filing when the issuer seeks initial certification of the network, submits its annual rate filing to the commissioner for review and approval, or when corrective action plans are required due to material changes.

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

(ii) One map for each of the following provider types must be submitted:

(A) The hospital and emergency services map must identify provider locations, and demonstrate that each enrollee in the service area has a thirty-mile access from either their residence or workplace to general hospital facilities including emergency services.

(B) Primary care providers must be mapped, demonstrating that each enrollee in the service area has a thirty-mile access from either their residence or workplace to a primary care provider with an open practice. The provider type selected must have a license under Title 18 RCW that includes primary care services in the scope of license.

(C) Mental health providers. For general mental health providers, such as licensed psychiatrists, psychologists, social workers, and mental health nurse practitioners, the map must demonstrate that each enrollee in the service area has a thirty-mile access from either their residence or workplace to a mental health provider. For specialty mental health providers, the map must demonstrate that each enrollee has access to the following types of service provider or facility: Residential treatment facilities, chemical dependency facilities and service providers in-patient treatment, and behavioral therapy. If one of the types of specialty provider is not within ninety miles of each enrollee in the service area, the issuer must propose an alternate network standard to meet this requirement.

(D) Pediatric services. For general pediatric services, the map must demonstrate that each child in the service area has access to a pediatrician or other provider whose license under Title 18 RCW includes pediatric services in the scope of license, within thirty miles of their family or placement residence. For specialty pediatric services, the map must demonstrate that each child in the service area has access to pediatric specialty care within sixty miles of their family or placement residence. The anticipated specialty types include nephrology, pulmonology, rheumatology, hematology-oncology, perinatal

medicine, neurodevelopmental disabilities, cardiology, endocrinology, and gastroenterology.

(E) Specialty services. For specialty services, the issuer must provide one map for the service area for each area of specialty found on the American Board of Medical Specialties list of approved medical specialty boards. Subspecialties are subsumed on each map.

(F) Therapy services. For therapy services, the issuer must provide one map that demonstrates that each enrollee has access to the following types of providers within sixty miles of their residence or workplace: Chiropractor, rehabilitative service providers and habilitative service providers.

(G) Home health, 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, vision, and pediatric dental coverage, including allied dental professionals, dental therapies, dentists, and orthodontists.

(H) Pharmacy dispensing services. An issuer must provide one map that identifies each pharmacy dispensing service within the service area to which an enrollee has access within thirty miles of their residence or workplace. If a pharmacy benefit manager is used by the issuer, the issuer must establish that the specifically contracted phar-

macy locations within the service area available to enrollees through the pharmacy benefit manager meet this standard.

(I) Essential community providers. An issuer must provide one map that demonstrates that the geographic distribution of essential community providers within the service area in relation to the number predominantly low income, and medically underserved individuals in the service area meets the standards of WAC 284-43-222.

(f) An **Access plan** applicable to each health plan, as described in WAC 284-43-202(5). The Access Plan must be filed with the commissioner for a new product or plan offering prior to use, and must be provided to the commissioner upon request electronically.

(4) For purposes of this section:

(a) "Line of business" means either individual, small group or large group coverage;

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

[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.]

NEW SECTION

WAC 284-43-221 Essential community providers—Definition. "Essential community provider" means physicians, clinics, and hospitals that have demonstrated service to medicaid, low-income, and medically underserved populations in addition to 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) Federally designated 638 Tribal Health programs, and Title V Urban Indian Health programs;

(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, where grant recipients are prioritized based on serving underserved communities that have shown barriers to primary care and mental health;

(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) Rural based, free or federally qualified health centers as identified on the Washington Association of Community and Migrant Health Centers, the Rural Health Clinic and the Washington Free Clinic Association web sites.

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NEW SECTION

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

(2) For each service area, an issuer must include a sufficient number and type of essential community provider in its provider network to provide reasonable access to the medically underserved or low-income in the service area, unless the issuer demonstrates that the provider or facility refuses to contract at the same or reasonably proximate reimbursement rates to those negotiated with other providers in the service area.

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

(a) Primary care providers, pediatricians, and hospitals that meet the definition of an essential community provider must comprise not less than thirty percent of the provider network if the service area is in a county determined by the state department of health to include a medically underserved population;

(b) One hundred percent of urban tribal health centers and Indian health centers in a service area must be included in the issuer's provider network, on a basis that satisfies RCW 43.71.065 and WAC 284-43-200(7);

(c) Fifty percent of rural health clinics within a service area 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 types of which only one or two exist in the state, an issuer must demonstrate a good faith effort to contract with that provider for inclusion in its network;

(e) Twenty percent of each essential community provider in the service area for pediatric dental services must be included in each issuer's provider network;

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

(g) At least one essential community provider hospital per 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) If an issuer's qualified health plan provider network does not meet the minimum adequacy standard for essential community providers set forth in subsection (2) of this section, the issuer must file an alternate network standard for providing adequate levels of services to low-income and medically underserved enrollees in each service area for each health benefit plan. The alternate network standard may concentrate the overall number and type of essential community providers for a health plan's targeted health outcomes for a service

area's population, based on documented health concerns for the service area, with prior approval of the commissioner.

(5) Beginning October 1, 2015, the commissioner will publish a list of approved essential community providers and the county in which they are located on an annual basis. A provider may seek inclusion in the list pursuant to instructions posted on the commissioner's web site.

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NEW SECTION

WAC 284-43-225 Issuer recordkeeping—Provider networks. (1) An issuer must make its records, contracts, and agreements available to the commissioner on request to support its provider network filing reports. Records to support proof of good faith contracting efforts must be retained for six years. Signed contracts and reimbursement agreements and associated accounting records must be retained for ten years.

(2) Beginning January 1, 2016, an issuer must be able to identify for the commissioner upon request the number of prior authorization requests for services by medical service providers and by mental

health or substance use disorder treatment providers that were made, and that were denied, by benefit year.

(3) Beginning January 1, 2016, an issuer must be able to identify for the commissioner upon request the number of provider requests for inclusion in its network that were denied by provider type and service area, and the reason for the denial.

[]

NEW SECTION

WAC 284-43-226 Service areas. "Service area" means the geographic area or areas within the state where a specific health benefit plan is issued, accepts members or enrollees and covers provided services. For purposes of this definition, a service area must be defined by the county 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.

[]

NEW SECTION

WAC 284-43-229 Tiered provider networks. (1) "Tiered provider network" means a network that identifies and groups providers and facilities into specific groups to which different provider reimbursement, enrollee cost-sharing or provider access requirements, or any combination thereof, apply as a means to control cost, utilization, quality, or to otherwise incentivize enrollee or provider behavior. An issuer may refer to a tiered provider network as an exclusive provider network, focused network, or use another term as long as the term is not misleading or susceptible to confusion with a specific licensee designation, such as accountable care organization.

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

(3) The lowest cost-sharing tier of a tiered network must provide enrollees with adequate access or adequate choice among health care providers as set forth in WAC 284-43-860, and required by RCW 48.43.515.

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

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

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

(5) An issuer must disclose to the commissioner upon request the metrics and methodology used to assign participating providers to tiers. An issuer must be able to demonstrate to the commissioner's satisfaction that its assignment of providers to tiers, when based on a rating system, is conducted in relation to the issuer's placement methodology, reliable, and accurate.

(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 of the proposed change sixty days before notifying the public of the program. The notice must explain the methodology and data used for particular providers, and inform providers of their right to make corrections and appeal.

(b) An issuer must make their economic profile available to providers under a tiered network, including the written criteria by which the physician's performance is measured. Scores developed by the federal or state health benefit plan risk adjustment program may not be used as a basis for placing a participating provider in a particular tier.

(6) An issuer's provider ranking program, and the criteria used to assign providers to different tiers, must not be described in advertising or plan documents so as to deceive consumers as to carrier rating practices and their affect on available benefits. When a tiered network is used, a carrier 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 participating in the tiered network;

(b) The selection criteria used to place the providers;

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

(d) The tier in which each participating provider is classified.

(7) For any health benefit plan in effect on a tiered network's reclassification date, an issuer must make a good faith effort to provide information to specified enrollees at least thirty days before

the reclassification takes effect. This information includes, but is not limited to, the procedure the enrollee must follow to choose an alternate provider 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 reclassified primary care provider if their primary care provider is reclassified to a higher cost-sharing level;

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

(c) A terminally ill patient if a provider in connection with the illness is reclassified to a higher cost-sharing level.

[]

NEW SECTION

WAC 284-43-230 Assessment of adequacy. (1) Factors considered by the commissioner in making a provider network adequacy determination include, but are not limited to, the following:

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

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

(c) The range of services offered by providers for the health benefit 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;

(e) The number of enrollees within each service area living in certain types of institutions or who have chronic, severe, or disabling medical conditions;

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

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

(h) Accreditation as to network adequacy by a national accreditation organization such as the NCQA or JCAHO.

(2) For ambulatory patient services, including preventive services and ancillary services such as laboratory and pharmacy services, an issuer's network is adequate if:

(a) The ratio of enrollee to primary care provider within the service area as a whole meets or exceeds the average ratio for Washington state for the prior benefit year, and in such numbers and distribution that for eighty percent of enrollees within the service area, places the enrollee within thirty minutes of the primary care provider from either their residence or work. The issuer must document that an enrollee has access to an appointment with their primary care provider within ten business days of requesting one.

(b) The issuer documents the distribution of specialists in the network for each service area in relation to the population distribution within the service area, and establishes that for referrals to specialists, an enrollee has access to an appointment with that specialist within fifteen business days for nonurgent services, unless the issuer receives documentation from the referring or treating provider that a longer wait time is not detrimental to the enrollee's health.

(c) The issuer permits scheduling of 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 re-

currence of disease, 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.

(d) 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, unless the referring provider documents that a longer wait time is not detrimental to enrollee health.

(3) An issuer may use providers and facilities in neighboring service areas to satisfy a network adequacy standard if one of the following types of facilities is not in the service area, or if the hospital in the service area refuses to contract with the issuer at reasonably proximate reimbursement levels to those the issuer entered into in other service areas with similar provider or facility types:

(a) Tertiary hospitals;

(b) Pediatric community hospitals, LOOK UP FORMAL UNIVERSAL DEFINITIONS AND INSERT, meaning a community hospital with pediatric beds pursuant to DOH;

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

(d) Neonatal intensive care units;

(e) Transplant centers of excellence.

(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 benefit plan. Such an offer must be made on terms and conditions similar to contracts offered to other providers of health care services. "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 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 dependent enrollee population based on normal utilization.

(6) Dental networks for pediatric dental services must be sufficient for the dependent enrollee population in the service area based on normal utilization.

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

intervention and stabilization, psychiatric inpatient hospital services, including voluntary psychiatric inpatient services, and services from licensed mental health providers including, but not limited to, psychiatrists and psychologists of sufficient number and type to provide for the coverage for the diagnosis and medically necessary treatment of conditions covered by the plan through providers acting within their scope of license and scope of competence established by education, training, and experience to diagnose and treat conditions found in the most recent version of the *Diagnostic and Statistical Manual of Medical Disorders* or other recognized diagnostic manual or standard.

(a) An issuer must establish a reasonable standard for the number and geographic distribution of mental health providers who can treat severe mental illness of a person of any age and serious emotional disturbances of a child, taking into account the various types of mental health practitioners acting within the scope of their licensure. The issuer must measure the adequacy of the mental health network against this standard at least twice a year, and file a corrective action plan with the commissioner if the standard is not met.

(b) An issuer must ensure that an enrollee can identify information about mental health services and substance use disorder treat-

ment, including benefits, providers, coverage and other relevant information by calling a customer service representative during normal business hours.

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

(d) An issuer must identify the sufficient number or type of mental health and substance use disorder treatment providers and facilities within a service area if the normal utilization pattern within that service area, particularly if the utilization pattern indicates that such a limitation would create an unreasonable restriction on access to care.

(8) Wellness and tobacco cessation services must be included in the provider network. 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.

(9) If the commissioner determines that an issuer's proposed or current network for a health benefit plan is not adequate, the commissioner may, for good cause shown, permit the issuer to propose a cor-

rective action plan to make the network adequate within a sixty-day period of time. The corrective action plan 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 corrective action plan is being implemented. The corrective action plan requirement is in addition to such enforcement action as is otherwise permitted under Title 48 RCW, including directing the issuer to cease and desist offering plans, pay penalties and fines, communicate with providers and enrollees the corrective action being undertaken.

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

WAC 284-43-250 ((~~Health carrier~~)) Issuer standards for women's right to directly access certain health care practitioners for women's health care services. (1)(a) "Women's health care services" ((~~is defined to~~)) means organized services to provide health care to women, inclusive of the women's preventive services required by the Health Resources and Services Administration of the U.S. Department of Health and Human Services. The services include, but ((~~need~~)) are not ((~~be~~))

limited to, maternity care, reproductive health services, gynecological care, general examination, and preventive care as medically appropriate, and medically appropriate follow-up visits for these services. ((~~General examinations, preventive care, and medically appropriate follow-up care are limited to services related to maternity, reproductive health services, gynecological care, or other health services that are particular to women, such as breast examinations.~~)) Women's health care services also include any appropriate health care service for other health problems, discovered and treated during the course of a visit to a women's health care practitioner for a women's health care service, which is within the practitioner's scope of practice. For purposes of determining a woman's right to directly access health services covered by the plan, maternity care, reproductive health, and preventive services include, contraceptive services, testing and treatment for sexually transmitted diseases, pregnancy termination, breast-feeding, and complications of pregnancy.

(b) ((~~A carrier may~~)) An issuer must not exclude or limit access to covered women's health care services offered by a particular type of women's health care provider, practitioner, or facility in a manner that would unreasonably restrict access to that type of provider, practitioner or facility or covered service. For example, ((~~a carrier~~

~~may~~)) an issuer must not impose a limitation on maternity services that would require all child birth to occur in a hospital attended by a physician thus, preventing a woman from choosing between and using the birthing services of an advanced registered nurse practitioner ((~~specialist in midwifery~~)), a certified midwife, or a licensed midwife.

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

(2) ((~~A health carrier shall~~)) An issuer must not deny coverage for medically appropriate laboratory services, imaging services, diagnostic services, or prescriptions for pharmaceutical or medical supplies, which are ordered by a directly accessed women's health care practitioner, and which are within the practitioner's scope of prac-

tice, if such services would be covered when provided by another type of health care practitioner. ((~~A health carrier shall~~)) An issuer must not require authorization by another type of health care practitioner for these services. For example, if the ((~~carrier~~)) issuer would cover a prescription if the prescription had been written by the primary care provider, the ((~~carrier~~)) issuer shall cover the prescription written by the directly accessed women's health care practitioner.

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

(b) ((~~Beginning July 1, 2000,~~)) An issuer may limit direct access ((~~may be limited~~)) to those women's health care practitioners who have signed participating provider agreements with the ((~~carrier~~)) issuer for a specific benefit plan network. Irrespective of the financial arrangements ((~~a carrier~~)) an issuer may have with participating providers, ((~~a carrier~~)) an issuer may not limit and ((~~shall~~)) must not permit a network provider to limit access to a subset of participating

women's health care practitioners within the network. Such an impermissible limitation might arise when a primary care provider's group practice receives a capitation payment for comprehensive care to ((~~a covered person~~)) an enrollee and then represents to the ((~~covered person~~)) enrollee that only those gynecologists in the primary care provider's clinic are available for direct access. Nothing in this subsection shall be interpreted to prohibit ((~~a carrier~~)) an issuer from contracting with a provider to render limited health care services.

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

(d) Beginning July 1, 2000, a woman's right to directly access practitioners for health care services as provided under RCW 48.42.100, includes the right to obtain appropriate women's health

care services ordered by the practitioner from a participating facility used by the practitioner.

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

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

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

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

[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.]

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

WAC 284-43-251 ((~~Covered person's~~)) Enrollee's access to providers. (1) Each ((~~carrier~~)) issuer must allow ((~~a covered person~~)) an enrollee to choose a primary care provider who is accepting new patients from a list of participating providers. ((~~Covered persons~~))

(a) Enrollees also must be permitted to change primary care providers at any time with the change becoming effective no later than the beginning of the month following the ((~~covered person's~~)) enrollee's request for the change.

((~~(2)~~)) (b) For a health plan that is open to new enrollment, the issuer must ensure at all times that there are a sufficient number of primary care physicians in the service accepting new patients.

(2) Each issuer must allow an enrolled child under the age of eighteen direct access to a pediatrician within their network, who is accepting new patients, from a list of participating providers.

(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) For a health plan that is open to new enrollment, the issuer must ensure at all times that there are a sufficient number of pediatricians in the service accepting new patients.

(3) Each ((~~carrier~~)) issuer must have a process whereby ((~~a covered person~~)) an enrollee with a complex or serious medical or ((~~psychiatric~~)) 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 ((~~covered person's~~)) 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 ((~~carrier~~)) issuer performance of utilization review functions.

((~~(3)~~)) (4) Each ((~~carrier shall~~)) issuer must provide ((~~covered persons~~)) enrollees with direct access to the participating chiropractor of the ((~~covered person's~~)) enrollee's choice for covered chiropractic health care without the necessity of prior referral. Nothing in this subsection shall prevent ((~~carriers~~)) issuers from restricting

((~~covered persons~~)) 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 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.

((~~(4)~~)) (5) Each ((~~carrier~~)) issuer must provide, upon the request of ((~~a covered person~~)) an enrollee, access by the ((~~covered person~~)) enrollee to a second opinion regarding any medical diagnosis or treatment plan from a qualified participating provider of the ((~~covered person's~~)) enrollee's choice. The ((~~carrier~~)) issuer may not impose any charge or cost upon the ((~~covered person~~)) enrollee for such second opinion other than a charge or cost imposed for the same service in otherwise similar circumstances.

((~~(5)~~)) (6) Each ((~~carrier~~)) 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 for at least sixty days following notice of termination to the ((~~covered persons~~)) enrollees

or, in group coverage arrangements involving periods of open enrollment, only until the end of the next open enrollment period. Notice to ((~~covered persons~~)) enrollees shall include information of the ((~~covered person's~~)) enrollee's right of access to the terminating provider for an additional sixty days. The provider's relationship with the ((~~carrier~~)) 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 ((~~carrier~~)) issuer assign new ((~~covered persons~~)) enrollees to the terminated provider.

((~~(6)~~)) (7) Each ((~~carrier~~)) issuer shall make a good faith effort to assure that written notice of a termination within fifteen working days of receipt or issuance of a notice of termination is provided to all ((~~covered persons~~)) enrollees who are patients seen on a regular basis by the provider whose contract is terminating, irrespective of whether the termination was for cause or without cause.

[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.]

NEW SECTION

WAC 284-43-252 Hospital emergency service departments and practice groups. In the case of emergency services, enrollees must have access 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. If the issuer is unsuccessful in contracting with provider groups offering services within contracted hospital emergency departments, the issuer's provider directory must prominently note that while the hospital's emergency department is contracted, the providers within the department are not.

[]

AMENDATORY SECTION (Amending WSR 98-04-005, filed 1/22/98, effective 2/22/98)

WAC 284-43-300 Provider and facility contracts with ((~~health carriers~~)) issuers—Generally. ((~~A health carrier~~)) An issuer contracting with providers or facilities for health care service delivery to ((~~covered persons shall~~)) enrollees must satisfy all the requirements

contained in this subchapter. ((~~The health carrier shall ensure that providers and facilities subcontracting with these providers and facilities under direct contract with the carrier also satisfy the requirements of this subchapter.~~)) An issuer must also ensure that subcontractors of its contracted providers and facilities comply with the requirements of this subchapter. Provider networks must include every provider category and type necessary to deliver covered services included in the essential health benefits package.

[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.]

AMENDATORY SECTION (Amending WSR 98-04-005, filed 1/22/98, effective 2/22/98)

WAC 284-43-310 Selection of participating providers—Credentialing and unfair discrimination. (1) ((~~Health carrier~~)) An issuer must develop selection standards for participating providers, practitioners, and facilities ((~~shall be developed by the carrier~~)) for primary care providers and each health care provider or facility license or profes-

sional specialty. The standards ((~~shall~~)) must be used in determining the selection of health care providers and facilities by the health ((~~carrier~~)) issuer. The standards ((~~shall~~)) 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 ((~~shall~~)) must not be established in a manner that would:

(a) ((~~That would allow a health carrier~~)) 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; or

(b) ((~~That would~~)) Exclude providers, practitioners, 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.

(2) Mental health and substance use disorder treatment provider and facility administration standards to participate in a network, including reimbursement rates, must be established, applied, and per-

formed in parity to the standards used for providers of medical and surgical services.

(3) A carrier's selection standards must not discriminate regarding participation in the network solely based on the provider type or category if the provider is acting within the scope of their license. An issuer may establish varying reimbursement rates based on quality or performance measures, consistent with WAC 284-43-330.

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

((~~(3)~~)) (5) The provisions of this subchapter do not require ((~~a health carrier~~)) an issuer to employ, to contract with, or retain more providers or facilities than are necessary to comply with the network adequacy standards of this chapter.

((~~(4) A health carrier shall~~)) (6) An issuer must make its selection standards for participating providers and facilities available for review upon request by the commissioner.

(7) Beginning October 1, 2014, an issuer must publish a list of the provider types or category that are open to request for participation in its network, and the provider types that are closed to participation in its network, and the reason or reasons the network is not open to further applications for participation by that type or category of provider. The provider type and category must be applied in a consistent manner, and be based on the list of provider types and categories identified in the commissioner's provider network filing instructions published on the commissioner's web site.

(a) The list may be published electronically, and must be accessible to the public.

(b) An issuer's reason for closing its network to participation by a specific provider type or category must be reasonable. Reasonable justification for closing a network to additional applicants for participation includes, but is not limited to:

(i) The network has a sufficient number of providers to ensure that covered services are available without reasonable delay to all covered persons; or

(ii) The network has a sufficient type of provider to assure that covered services are available without reasonable delay to all covered persons; and

(iii) Closing the network to further applicants for the provider type or category does not limit access to emergency services twenty-four hours a day, seven days a week.

(c) The list must identify any provider type or category for which there are insufficient numbers in the network either in aggregate, or in proximity to individuals living in specific areas of the state.

(d) An issuer must update the network open participation list required under this section quarterly.

[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.]

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

WAC 284-43-320 Provider contracts—Standards—Hold harmless provisions. The execution of a contract by a health ((~~carrier shall~~)) issuer does not relieve the health ((~~carrier~~)) issuer of its obligations to any ((~~covered person~~)) 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 ((~~shall~~)) must be in writing and available for review upon request by the commissioner.

(1) ((~~A health carrier shall~~)) 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. An issuer must ensure that plan and provider processes necessary to obtain authorization for or a referral for covered health care services are completed in a manner that assures the provision of covered health care services to enrollees in a timely manner appropriate for the enrollee's condition and in compliance with this chapter.

(a) An issuer must ensure that unlicensed staff handling enrollee calls do not make decisions or recommendations about treatment, nor assess, evaluate, advise or make a decision regarding the condition of an enrollee. The issuer must have training and procedures in place to ensure compliance with this requirement.

(b) If an issuer's documented procedures and requirements for prior authorization are not followed by the issuer, the issuer must provide for deemed approval of the requested service.

(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 ((~~shall~~)) must govern with respect to coverage provided to ((~~covered persons~~)) enrollees.

((~~(2)~~)) (3) Each participating provider and participating facility contract ((~~shall~~)) must contain the following provisions ((~~or variations approved by the commissioner~~)):

(a) "{Name of provider or facility} hereby agrees that in no event, including, but not limited to nonpayment by {name of ((~~carrier~~)) issuer}, {name of ((~~carrier's~~)) issuer's} insolvency, or breach of this contract ((~~shall~~)) must {name of provider or facility} bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against ((~~a covered person~~)) an enrollee or person acting on their behalf, other than {name of ((~~carrier~~)) issuer}, for services provided pursuant to this contract. This provision ((~~shall~~)) must not prohibit collection of {deductibles,

copayments, coinsurance, and/or noncovered services}, which have not otherwise been paid by a primary or secondary ((~~carrier~~)) issuer in accordance with regulatory standards for coordination of benefits, from ((~~covered persons~~)) enrollees in accordance with the terms of the ((~~covered person's~~)) enrollee's health plan."

(b) "{Name of provider or facility} agrees, in the event of {name of ((~~carrier's~~)) issuer's} insolvency, to continue to provide the services promised in this contract to ((~~covered persons~~)) enrollees of {name of ((~~carrier~~)) issuer} for the duration of the period for which premiums on behalf of the ((~~covered person~~)) enrollee were paid to {Name of ((~~carrier~~)) issuer} or until the ((~~covered person's~~)) 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 ((~~covered person's~~)) enrollee's health plan."

(d) "{Name of provider or facility} may not bill the ((~~covered person~~)) enrollee for covered services (except for deductibles, copayments, or coinsurance) where {name of ((~~carrier~~)) 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 {or identifying citations appropriate to the contract form} 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 ((~~carrier's} covered persons~~)) 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 ((~~covered persons~~)) 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 ((~~covered persons~~)) enrollees of {name of ((~~carrier~~)) issuer} with the expectation of receiving payment directly or indirectly from {name of ((~~carrier~~)) issuer}, such providers or facilities must agree to abide by the provisions of (a), (b), (c), (d), and (e) of this subsection {or identifying citations appropriate to the contract form}."

((~~(3)~~)) (4) The contract shall inform participating providers and facilities that willfully collecting or attempting to collect an amount from ((~~a covered person~~)) 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).

((~~(4) A health carrier shall~~)) (5) An issuer's contract may require compliance with provider procedure manuals associated with plan administration requirements established by the provider, but must notify participating providers and facilities of their responsibilities with respect to the health ((~~carrier's~~)) 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 documents, procedures, and other administrative policies and programs referenced in the contract must be 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 ((~~and~~)) 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 ((~~shall~~)) must be provided as soon as possible.

(b) 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 (8) of this section.

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

((~~(5) The following provision is a restatement of a statutory requirement found in RCW 48.43.075 included here for ease of reference:~~

~~(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 con-~~

~~strued 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."~~

~~(6) A health carrier shall~~)) (d) An issuer must give a provider or facility full access to the coverage and service terms of the applicable health benefit plan for an enrolled patient.

(7) 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 the grievances or complaints ((~~of covered persons~~)) or adverse benefit determinations of enrollees subject to applicable state and federal laws related to the confidentiality of medical or health records. 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.

((~~(7) A health carrier~~)) (8) An issuer and participating provider and facility ((~~shall~~)) must provide at least sixty days' written no-

tice to each other before terminating the contract without cause. ((~~The health carrier shall~~)) Whether the termination was for cause, or without cause, the issuer must make a good faith effort to assure that written notice of a termination within fifteen working days of receipt or issuance of a notice of termination is provided to all ((~~covered persons~~)) enrollees who are patients seen:

(a) On a regular basis by ((~~the provider~~)) a specialist for whom they have a standing referral, and whose contract is terminating((~~, irrespective of whether the termination was for cause or without cause. Where a contract termination involves~~)); and

(b) By a primary care provider((~~, that carrier shall make a good faith effort to assure that notice is provided to all covered persons who are patients of that primary care provider.~~

~~(8) A health carrier~~)).

(9) An issuer is responsible for ensuring that participating providers and facilities furnish covered services to ((~~covered persons~~)) enrollees without regard to the ((~~covered person's~~)) 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.

((~~(9) A health carrier shall~~)) (10) 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 health ((~~carrier~~)) issuer that jeopardizes patient health or welfare or that may violate state or federal law.

((~~(10) The following provision is a restatement of a statutory requirement found in RCW 48.43.085: "Notwithstanding any other provision of law, no health carrier subject to the jurisdiction of the state of Washington may prohibit directly or indirectly its enrollees from freely contracting at any time to obtain any health care services outside the health care plan on any terms or conditions the enrollees choose. Nothing in this section shall be construed to bind a carrier for any services delivered outside the health plan."~~))

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

[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. Statu-

tory 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.]

AMENDATORY SECTION (Amending WSR 13-16-045, filed 7/31/13, effective 8/31/13)

WAC 284-43-330 Participating provider—Filing and approval. (1) ((~~A health carrier must file with the commissioner thirty calendar days prior to use~~)) An issuer must file sample contract forms proposed for use with its participating providers and facilities prior to use. The commissioner must receive the filings electronically not later than thirty calendar days prior to the first date on which the contract form is proposed to providers for execution.

(2) ((~~A health carrier shall~~)) An issuer must submit material changes to a sample contract form to the commissioner thirty calendar days prior to use. ((~~Carriers shall~~)) Issuers must indicate in the filing whether any change affects a provision required by this chapter. All changes to contracts must be indicated through strike outs for deletions and underlines for new material. Alternatively, ((~~carri-~~

~~ers~~)) issuers may refile a sample contract that incorporates changes along with a copy of the contract addendum or amendment and any correspondence that will be sent to providers and facilities sufficient for a clear determination of contract changes. Changes not affecting a provision required by this chapter are deemed approved upon filing.

(3) If the commissioner takes no action within thirty calendar days after submission of a sample contract or a material change to a sample contract form by ((~~a health carrier~~)) an issuer, the change or 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 ((~~health carrier~~)) issuer shall maintain provider and facility contracts at its principal place of business in the state, or the health ((~~carrier shall~~)) 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 to ensure that all provider and facility contracts are current and signed if the provider is listed in the network is 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 be likely to result in discrimination against or rationing of medically necessary services 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.

(7) An issuer is not required to contract with an essential community provider, and may submit an alternate network standard proposal to address the needs of medically underserved or fragile individuals, or low-income persons in the service area for a qualified health plan, if the potential essential community provider refuses in writing to accept at a minimum the reimbursement rates offered by the issuer to similarly situated providers in the service area who are not essential community providers.

(8) If a carrier establishes a reimbursement structure pursuant to section 2717 of the Public Health Service Act (42 U.S.C. 300gg), the terms and conditions of that structure must be included in the contract with a participating provider either as an addendum or as a specific section or sections of the contract. The contract must identify the data source the carrier plans to use to make the determinations under the reimbursement structure, and establish a method that the provider or facility can use to validate the data and conclusions related to the reimbursement structure. If an issuer incorporates its reimbursement structure in a specific section or sections of a contract, and the contract is requested by a third party pursuant to a public disclosure request, the commissioner will produce the full contract unless the issuer also files a copy of the contract redacting the proprietary reimbursement information.

(a) An issuer may establish standards and requirements for repayment of overpayments within a timely period.

(b) An issuer must establish monitoring rights to confirm that providers and facilities have an effective compliance plan in place to address fraud and abuse.

(c) Each contract must identify any benefits a provider or facility receive as a result of agreeing to the contract, including any ad-

vertising that promotes a provider or facility's practice, and any incentives patients will be given to choose a provider or facility, including steerage of a member to a provider or facility based on whether in-network or out-of-network patient benefits apply.

(i) An issuer must not offer incentives to one type of provider delivering a service if the same incentive is not offered to a different type of provider licensed to provide the same service, unless there is a facially neutral reason for making a distinction between the two provider types that is not related to licensure, such as the quality of care or the provider's control of cost.

(ii) An issuer's method for calculating incentives, pay for performance or other care outcome related reimbursement approaches, must include a method to adjust data so that providers and facilities are not penalized for treating a high-risk, low compliance population.

[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.]

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

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

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

pliance (no more than ((~~six months~~)) one year beyond January 1, ((~~2001~~)) 2015).

[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.]

REPEALER

The following section of the Washington Administrative Code is repealed:

WAC 284-43-340 Effective date.