RULE 106
NETWORK ADEQUACY REQUIREMENTS FOR HEALTH BENEFIT PLANS

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Section 1. Authority

This Rule is issued pursuant to the authority granted the Arkansas Insurance Commissioner ("Commissioner") under Ark. Code Ann. § 23-61-108(a)(1) and by Ark. Code Ann. § 23-61-108(b)(1) to promulgate rules necessary for the effective regulation of the business of insurance and as required for this State to be in compliance with federal laws, namely Section 2702(c) of the Public Health Service Act and 45 CFR § 156.230 which require that Qualified Health Plans provide sufficiently accessible medical providers. In addition, this Rule is issued pursuant to the authority granted the Commissioner to issue regulations related to the provision of adequate health care services by health maintenance organizations under Ark. Code Ann. § 23-76-108(a).

Section 2. Purpose

The purpose of this Rule is to establish standards for the creation and maintenance of networks by Health Carriers and to assure the adequacy, accessibility and quality of Health Care Services offered under Health Benefit Plans.

Section 3. Definitions

For purposes of this Rule:

A. "Accredited Health Carrier" means a Health Carrier which has an adequate network as certified by an approved accrediting organization under the provisions of Section Five (5) (K) of this Rule.

B. "Commissioner" means the Arkansas Insurance Commissioner.

C. "Covered Benefits" or "benefits" means those Health Care Services to which a Covered Person is entitled under the terms of a Health Benefit Plan.

D. "Covered Person" means a policyholder, subscriber, enrollee or other individual participating in a Health Benefit Plan.

E. "Emergency Medical Condition" means the sudden and, at the time, unexpected onset of a health condition that requires immediate medical attention, where failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy.

F. "Emergency Services" means health care items and services furnished or required to evaluate and treat an emergency medical condition.

G. "Essential Community Provider" means a provider that serves predominantly low income, medically underserved individuals as defined in 45 CFR §156.235.

H. "Facility" means an institution providing Health Care Services or a health care setting, including but not limited to hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health settings.

I. "Health Benefit Plan" means any individual, blanket, or group plan, policy or contract for Health Care Services issued or renewed by a Health Carrier on or after January 1, 2015 which requires a Covered Person to use Health Care Providers managed, owned, under contract with or employed by the Health Carrier. "Health Benefit Plan" does not include a plan providing Health Care Services pursuant to the Arkansas Constitution, Article 5, § 32, the Workers' Compensation Law, § 11-9-101 et seq., and the Public Employee Workers' Compensation Act, § 21-5-601 et seq., nor include an accident-only, specified disease, hospital indemnity, long-term care, disability income, or limited-benefit health insurance policy. The provisions of this Rule also do not apply to Medicare Supplement or Medicare Advantage policies. This Rule does not apply to vision or dental only plans unless such plans are offered by Stand-alone Dental Carriers as defined in Section Three (3) (U) of this Rule.

J. "Health Care Professional" means a physician or other health care practitioner licensed, accredited or certified to perform physical, behavioral, mental health or substance use disorder and health services consistent with state law.

K. "Health Care Provider" or "provider" means a participating health care or dental professional or a facility.

L. "Health Care Services" means services for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease.

M. "Health Carrier" means an entity subject to the insurance laws and regulations of this State, or subject to the jurisdiction of the Commissioner, which contracts or offers to contract, or enters into an agreement to provide, deliver, arrange for, pay for or reimburse any of the costs of Health Care Services, including a health insurer, a health maintenance organization, a hospital and medical service corporation, or any other entity providing Health Benefit Plans. A Health Carrier does not include an automobile insurer paying medical or hospital benefits under Ark. Code Ann. § 23-89-202(1) nor shall it include a self-insured employer Health Benefits Plan. A Health Carrier does not include any person, company, or organization, licensed or registered to issue or who issues any insurance policy or insurance contract in this State providing medical or hospital benefits for accidental injury or accidental disability. A Health Carrier shall not include a vision or dental insurer unless it is a Stand-alone Dental Carrier as defined by Section Three (3) (U) of this Rule.

N. "Network" means the group of participating providers providing services to a Health Benefit Plan.

O. "Provider" means a provider who, under a contract with a Health Carrier or with its contractor or subcontractor, has agreed to provide Health Care Services to covered persons with an expectation of receiving payment, other than coinsurance, copayments or deductibles, directly or indirectly from the Health Carrier.

P. "Patient Centered Medical Home" ("PCMH") means a local point of access to care that proactively looks after patients' health on a "24-7" basis. A PCMH supports patients to connect with other Providers to form a health services team, customized for their patients' care needs with a focus on prevention and management of chronic disease through monitoring patient progress and coordination of care.

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

R. "Primary Care Professional" means a participating Health Care Professional practicing within their licensed scope of practice and designated by the Health Carrier to supervise, coordinate or provide initial care or continuing

care to a covered person, and who may be required by the Health Carrier to initiate a referral for specialty care and maintain supervision of Health Care Services rendered to the Covered Person.

S. "Qualified Health Plan" means an insurance policy that meets the requirements of 42 U.S.C. § 18021(a)(1).

T. "Specialty Care Professional" means a participating Health Care Professional that is specially qualified to practice by having attended an advanced program of study, passed an examination given by an organization of the members of the specialty, or gained experience through extensive practice in the specialty.

U. "Stand-alone Dental Carrier" means an entity subject to the insurance laws and regulations of this State, or subject to the jurisdiction of the Commissioner, which (i) offers plans through the ACA approved Marketplace and/or (ii) offers plans outside the ACA approved Marketplace for the purpose of providing the essential health benefits category of pediatric level oral benefits.

Section 4. Applicability and Scope

This Rule applies to all Health Carriers that offer Health Benefit Plans in this State which are issued or renewed on or after January 1, 2015.

Section 5. Network Adequacy

A. A Health Carrier providing a Health Benefit Plan shall maintain a network that is sufficient in numbers and types of providers to assure that all Health Care Services to Covered Persons will be accessible without unreasonable delay. Sufficiency may be established by reference to any reasonable criteria used by the Health Carrier, including but not limited to: provider to Covered Person ratios by specialty; Primary Care Professional to Covered Person ratios; typical referral patterns; provider's hospital admitting privileges; 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.

B. Every Health Carrier shall strive to meet the following guidelines related to geographic accessibility through geographical access maps or other information:

(1) In the case of Emergency Services, a covered person will have access to Emergency Services, twenty-four (24) hours per day, seven (7) days per week within a thirty (30) mile radius between the location of the Emergency Services and the residence of the Covered Person;

(2) In the case of a Primary Care Professional, a Covered Person will have access to at least one Primary Care Professional within a thirty (30) mile radius between the location of the Primary Care Professional and the residence of the Covered Person;

(3) In the case of a Specialty Care Professional, a Covered Person will have access to covered specialty care services within a sixty (60) mile radius between the location of the Specialty Care Professional and the residence of the Covered Person; and

(4) For Qualified Health Plans participating in the ACA approved Marketplace, in the case of Essential Community Providers, a Covered Person will have access to at least one Essential Community Provider within a thirty (30) mile radius between the location of the Essential Community Provider and the residence of the Covered Person.

C. In the event that a Health Carrier has an insufficient number or type of participating providers to provide a Covered Benefit, the Health Carrier shall ensure that the Covered Person obtains the Covered Benefit at no greater cost to the Covered Person than if the benefit were obtained from a participating provider.

D. In determining whether a Health Carrier has complied with the requirements in this Section, the Commissioner shall give due consideration to the relative availability of Health Care Providers in the service area under consideration.

E. A Health Carrier shall monitor, on an ongoing basis, the ability of its participating providers to furnish all contracted benefits to Covered Persons. A Health Carrier shall reasonably monitor:

(1) provider to Covered Person ratios by specialty;
(2) Primary Care Professional to Covered Person ratios;
(3) typical referral patterns;
(4) provider's hospital admitting privileges;
(5) geographic accessibility;
(6) waiting times for appointments with participating providers;
(7) general hours of operation, including part or full time status and weekend and after hour availability; and
(8) the volume of technological and specialty services available to serve the needs of Covered Persons requiring technologically advanced or specialty care.

F. Geographical access maps and compliance percentages must be submitted for each of the categories of care referenced in Section Five (5)(B)(1-4). A Health Carrier shall strive to meet a compliance percentage of eighty percent (80%) for each of the categories of care referenced in Section Five (5)(B)(1-4) . Requested maps may be submitted separately or combined and distinguished by color or other method.

The maps must indicate which providers are accepting new patients. The following are special requirements for each category of care:

(1) Health Carriers must provide geographical access maps for Primary Care Professionals that include each general/family practitioner, internal medicine provider, and family practitioner/pediatrician.

(2) Health carriers must provide geographical access maps for hospitals and Specialty Care Professionals according to the following categories:

(a) hospitals by Arkansas hospital licensure type;

(b) home health agencies;

(c) skilled nursing Facilities;

(d) all specialty care categories and sub-specialty categories covered under the Health Benefit Plan;

(3) Health Carriers must provide geographical access maps for mental health, behavioral health, and substance use disorder providers categorized between:

(a) psychiatric and state licensed clinical psychologists;

(b) substance use disorder providers; and

(c) other mental health, behavioral health, and substance use disorder providers with additional documentation describing the provider and facility types included within the other category.

(4) Health Carriers must provide geographical access maps for Essential Community Providers with the providers grouped within the following categories:

(a) federally qualified health centers;

(b) Ryan White provider;

(c) family planning provider;

(d) Indian provider;

(e) hospital; and

(f) other Essential community providers including but not limited to school based providers.

G. Performance Metrics: Non-accredited Health Carriers will be required to submit metrics demonstrating performance for each of the above standards for each county in the service area and overall service area. Accredited Health Carriers will be required to submit the following metrics for reporting purposes. These include:

(1) The number of members and percentage of total members meeting the geographical requirements under Section Five (5)(B) of this Rule.

(2) The average distance to first, second, and third closest provider for each provider type.

These figures should be provided overall (entire state) for each category as well as stratified by county for each category. For example, the percent of enrolled members that are within thirty (30) minutes or thirty (30) miles of a general/family practitioner will be submitted with percentages overall and for each county. The average distance to the first, second, and third closest provider will be

submitted overall and for each county. Health Carriers who do not yet have enrollees in the State of Arkansas will be exempt from this requirement and must attest to not currently having enrollees in Arkansas.

H. Essential Community Providers. Health Carriers issuing Qualified Health Plans are required to meet all federal requirements for inclusion of Essential Community Providers in the plan network. Qualifying Essential Community Providers include providers described in section 340B of the PHS Act and section 1927(c)(1)(D)(i)(IV) of the Social Security Act. In addition, the following State guidelines must be met regarding Essential Community Providers:

(1) Each Health Carrier issuing Qualified Health Plans will be required to meet conditions of the Heath Care Independence Program 1115 Waiver and offer at least one Qualified Health Plan that has at least one federally qualified health center or rural health center in each service area of the plan network.

(2) Each Health Carrier issuing Qualified Health Plans must submit a list of school-based providers included in the plan network.

(3) Each Health Carrier issuing Qualified Health Plans must offer a contract to at least one school-based provider in each county in the service area, where a school-based provider is identifiable and available and meets issuer certification and credentialing standards.

I. Access plans. A Health carrier shall file with the Commissioner an access plan meeting the requirements of Section Five (5)(I)(1)- (12) of this Rule for Health Benefit Plans issued or renewed in this State on or after January 1, 2015. The Health Carrier shall make the access plans, absent proprietary information, available to its insureds. The Health Carrier shall prepare an access plan prior to offering a new Health Benefit Plan, and shall update an existing access plan whenever it makes any material change to an existing Health Benefit Plan such as the loss of a material provider such as a hospital or multi-specialty clinic. The access plan shall describe or contain at least the following:

(1) The Health Carrier's network;

(2) The Health Carrier's procedures for making referrals within and outside its network and for notifying enrollees and potential enrollees regarding availability of network and out-of-network providers;

(3) The Health Carrier's process for monitoring and assuring on an ongoing basis the sufficiency of the network to meet the health care needs of populations that enroll in its health benefit plans;

(4) The Health Carrier's efforts to address the needs of covered persons with limited English proficiency and illiteracy, with diverse cultural and ethnic backgrounds, and with physical and mental disabilities;

(5) The Health Carrier's methods for assessing the health care needs of covered persons;

(6) The Health Carrier's method of informing Covered persons of the plan's services and features, including cost sharing, the plan's grievance procedures, its process for choosing and changing providers, and its procedures for providing and approving emergency and specialty care;

(7) The Health Carrier's method for assessing consumer satisfaction;

(8) The Health Carrier's method for using assessments of enrollee complaints and satisfaction to improve carrier performance;

(9) The Health Carrier's system for ensuring the coordination and continuity of care for covered persons referred to specialty providers, for covered persons using ancillary services, including social services and other community resources, and for ensuring appropriate discharge planning;

(10) The Health Carrier's process for enabling Covered Persons to change Primary Care Professionals;

(11) The Health Carrier's proposed plan for providing continuity of care in the event of contract termination between the Health Carrier and any of its participating providers, or in the event of the Health Carrier's insolvency or other inability to continue operations. The description shall explain how covered persons will be notified of the contract termination, or the health carrier's insolvency or other cessation of operations, and transferred to other providers in a timely manner; and

(12) Any other information required by the Commissioner to determine compliance with the provisions of this Rule.

J. Provider Directories. A health carrier shall make a provider directory available for online publication by the Commissioner and shall also make its provider directory accessible by a link to the Health Carrier's website and to potential enrollees in hardcopy upon request. The provider directory shall identify providers who are currently accepting new patients.

(1) Health Carriers shall update any changes to the provider directory within fourteen (14) days of that change becoming effective.

(2) If the provider directory must be taken off line for any reason for a period to exceed 48 hours, that carrier shall notify the Department at least two (2) weeks in advance of the provider directory going off line, or as soon as practically known. In the Department notification, Health Carriers shall state the reason for online unavailability, what steps are being taken to get the information back online, and expected online re-launch date.

(3) Online provider directories must be available in Spanish.

(4) The directory search must include the ability to filter by each category of ECP.

(5) The directory search must include an indication of hours of operation including part-time or full-time as well as after-hours availability as reported by providers.

(6) Providers who participate in the Patient-Centered Medical Home program must be indicated in the provider directory.

K. If a Health carrier has accreditation that includes an audit of the Health carrier's network adequacy, the Commissioner will accept that accreditation in lieu of the Health carrier demonstrating it has complied with the requirements under Section 5 (A) through (H) of this Rule, if the following conditions are met:

(1) A certificate of accreditation must be submitted by the certified accrediting entity that is recognized pursuant to 45 CFR § 156.275, or any other certified entity as recognized by the Arkansas Insurance Department;

(2) The certified accrediting entity has submitted information showing that its audit includes a review of all reasonable and/or necessary requirements of state and federal law; and

(3) The Health Carrier agrees to provide to the Arkansas Insurance Department any and all material and information submitted to the certified accrediting entity upon the Commissioner's request.

(4) The accredited Health Carrier has submitted annual geographical access maps and performance metrics as required in Section 5 of this Rule for reporting purposes only.

(5) Nothing in the above conditions shall supersede the federal accreditation requirements of Qualified Health Plans as described in 45 CFR § 156.275.

(6) The Commissioner reserves the right to re-verify compliance of network adequacy as a part of any quarterly audit or request for certification of a Qualified Health Plan.

L. The Commissioner will also accept an accreditation of a Health Carrier's access plan by a certified accrediting entity that a Health Carrier has an access plan meeting the requirements of Section Five (5) (I)(1)-(12) of this Rule although such plan must be filed with the Commissioner.

Section 6. Stand-alone Dental Plans

(A) For stand-alone dental plans offered through the ACA approved Marketplace or where a stand-alone dental plan is offered outside of the ACA approved marketplace for the purpose of providing the essential health benefit category of pediatric oral benefits, all such stand-alone dental plans must ensure that all covered services to enrollees will be accessible in a timely manner appropriate for the enrollee's conditions. Dental networks for oral services must be sufficient for the enrollee population in the service area based on potential utilization. Determination of whether a Stand-alone Dental Carrier's network is sufficient will be based on reasonable criteria used by the Stand-alone Dental Carrier, including, but not limited to: provider to covered ratios by general dentist; typical referral patterns; geographic accessibility; waiting times for appointments with Participating providers; hours of operation; and the volume of technologically advanced or specialty care. Stand-alone dental carriers shall strive to meet the following guidelines through geographical access maps or other information:

(1) In the case of a non-specialist oral care provider, a covered person will have access to at least one dentist within a thirty (30) mile radius between the location of the dentist and the residence of the covered person;

(2) In the case of a specialist oral care provider, a covered person will have access to at least one specialist dentist within a sixty (60) mile radius between the location of the Specialty Care Professional and the residence of the covered person; and

(3) If an Essential Community Provider that provides oral health services is located within a thirty (30) mile radius between the location of the Essential Community Provider and the residence of a covered person, a Stand-alone Dental Carrier must make reasonably best efforts to provide the covered person access to that Essential Community Provider.

For purposes of satisfying the requirements of Section 6(A) (1)-(3) of this Rule, a Stand-alone Dental Carrier may submit an accreditation that such requirements are met by a certified accredited entity abiding by the same conditions as described in Section Five (5)(K) of this Rule.

(B) Stand-alone Dental Carriers applying to the Commissioner to participate in the ACA approved Marketplace or offer a stand-alone dental plan outside of the ACA approved Marketplace for the purpose of providing the essential health benefit category of pediatric oral benefits are required to submit metrics demonstrating performance for each of the standards above for each county in the service area and overall service area. These figures should be provided overall (entire state) for each category as well as stratified by county for each category. For example, the percent of enrolled members that are within thirty (30) minutes or thirty (30) miles of a general dentist will be submitted with percentages overall and for each county. The average distance to the first, second, and third closest provider will be submitted overall and for each county. These include:

(1) The number of members and percentage of total members meeting the geographical requirements under Section 6 (A) of this Rule.

(2) The average distance to first, second, and third closest provider for each provider type.

(3) Stand alone dental carriers who do not yet have enrollees in the State of Arkansas will be exempt from this requirement and must attest to not currently having enrollees in Arkansas.

(C) In the event that a Stand-alone Dental Carrier has an insufficient number or type of participating providers to provide a covered benefit, the Health carrier shall ensure that the covered person obtains the covered benefit at no greater cost to the covered person than if the benefit were obtained from a participating provider, or shall make other arrangements acceptable to the Commissioner that shall include reasonable criteria utilized by the carrier including but not limited to:

(1) provider to covered person ratios by dental specialty;

(2) general dentist to covered person ratios;

(3) typical referral patterns;

(4) geographic accessibility;

(5) waiting times for appointments with participating providers;

(6) general hours of operation, including part or full time status and weekend and after hour availability; and

(D) In determining whether a health carrier has complied with the requirements in this Section, the Commissioner shall give due consideration to the relative availability of dental providers in the service area under consideration.

(E) A Stand-alone Dental Carrier shall monitor, on an ongoing basis, the ability of its participating providers to furnish all contracted benefits to Covered Persons.

(F) Access plans. A Stand alone Dental Carrier shall file with the Commissioner an access plan meeting the requirements of Section 6(F)(1)- (12) of this Rule for Stand-alone dental plans issued or renewed in this State on or after January 1, 2015. The Stand-alone dental carrier shall make the access plans, absent proprietary information, available to its insureds. The Stand-alone Dental Carrier shall prepare an access plan prior to offering a new stand-alone dental plan, and shall update an existing access plan whenever it makes any material change to an existing stand-alone dental plan such as the loss of a material provider. The access plan shall describe or contain at least the following:

(1) The Stand-alone Dental carrier's network;

(2) The Stand-alone Dental carrier's procedures for making referrals to the extent applicable within and outside its network and for notifying enrollees and potential enrollees regarding availability of network and out-of-network providers;

(3) The Stand-alone Dental carrier's process for monitoring and assuring on an ongoing basis the sufficiency of the network to meet the health care needs of populations that enroll in its health benefit plans;

(4) The Stand-alone Dental carrier's efforts to address the needs of covered persons with limited English proficiency and illiteracy, with diverse cultural and ethnic backgrounds, and with physical and mental disabilities;

(5) The Stand-alone Dental carrier's methods for assessing the health care needs of covered persons;

(6) The Stand-alone Dental carrier's method of informing covered persons of the plan's services and features, including cost sharing, the plan's grievance procedures, its process for choosing and changing providers, and its procedures for providing and approving emergency and specialty care;

(7) The Stand-alone Dental carrier's method for assessing consumer satisfaction;

(8) The Stand-alone Dental carrier's method for using assessments of enrollee complaints and satisfaction to improve carrier performance;

(9) The Stand-alone Dental carrier's system for ensuring the coordination and continuity of care for covered persons referred to specialty providers, for covered persons using ancillary services, including social services and other community resources, and for ensuring appropriate discharge planning;

(10) The Stand-alone Dental carrier's process for enabling covered persons to change non-specialist dental providers;

(11) The Stand-alone Dental carrier's proposed plan for providing continuity of care in the event of contract termination between the health carrier and any of its participating providers, or in the event of the health carrier's

insolvency or other inability to continue operations. The description shall explain how covered persons will be notified of the contract termination, or the health carrier's insolvency or other cessation of operations, and transferred to other providers in a timely manner; and

(12) Any other information required by the Commissioner to determine compliance with the provisions of this Rule.

(G) Provider Directories. A Stand-alone Dental Carrier shall make a provider directory available for online publication by the Commissioner and shall also make its provider directory accessible by a link to the Stand-alone dental carrier's website and to potential enrollees in hardcopy upon request. The provider directory shall identify providers who are currently accepting new patients.

(1) Stand-alone Dental Carriers shall update any changes to the provider directory within fourteen (14) days of that change becoming effective.

(2) If the provider directory must be taken off line for any reason for a period to exceed 48 hours, that carrier shall notify the Department at least two (2) weeks in advance of the provider directory going off line, or as soon as practically known. In the Department notification, Stand-alone Dental Carriers shall state the reason for online unavailability, what steps are being taken to get the information back online, and expected online re-launch date.

(3) Online provider directories must be available in Spanish.

(4) The directory search must include the ability to filter by ECP.

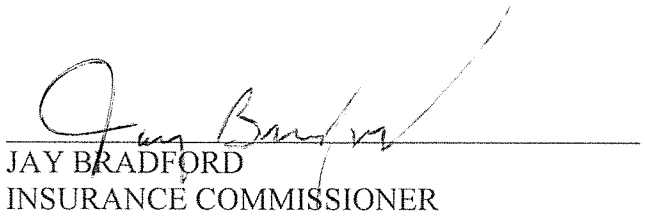
(5) The directory search must include an indication of hours of operation including part-time or full-time as well as after-hours availability as reported by providers.

Section 7. Enforcement

The penalties, license actions or orders as authorized under Ark. Code Ann. § 23-66-210 shall apply to violations of this Rule.

Section 8. Effective Date

The effective date of this Rule is January 1, 2015.



JAY BRADFORD
INSURANCE COMMISSIONER

11-17-2024

DATE