

## **Title 19, Part 3, Chapter 16: Managed Care Plan Network Adequacy**

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### **Section 16.01. Title**

This Regulation shall be known and may be cited as the Managed Care Plan Network Adequacy Regulation and is promulgated by the Commissioner of Insurance pursuant to the authority granted to him by Title 83, the Mississippi Insurance Code; the requirements of Mississippi Code Annotated, Section 25-43-1.101, et seq., in accordance with the Mississippi Administrative Procedures Law; and the requirements of Mississippi Code Annotated, Section 83-41-101, et seq., the Mississippi Patient Protection Act of 1995.

Source: Miss. Code Ann. §§ 25-43-1.101, et seq.; § 83-5-1; §§83-41-101, et seq. (Rev. 2011)

### **Section 16.02. Purpose**

The purpose and intent of this Regulation are 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 a managed care plan by establishing requirements for written agreements between health carriers offering managed care plans and participating providers regarding the standards, terms and provisions under which the participating provider will provide services to covered persons.

Source: Miss. Code Ann. § 83-41-405; §83-41-413 (Rev. 2011)

### **Section 16.03. Definitions**

For purposes of this Regulation:

- A. “Closed plan” means a managed care plan that requires covered persons to use participating providers under the terms of the managed care plan.

- B. “Commissioner” means the Commissioner of Insurance.
- 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. “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.
- H. “Health benefit plan” means a policy, contract, certificate or agreement entered into, offered or issued by a health carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services.
- I. “Health care professional” means a physician or other health care practitioner licensed, accredited or certified to perform specified health services consistent with state law.
- J. “Health care provider” or “provider” means a health care professional or a facility.
- K. “Health care services” means services for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease.
- L. “Health carrier” means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, that 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 sickness and accident insurance company, a health maintenance organization, a nonprofit hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits or health services.
- M. “Health indemnity plan” means a health benefit plan that is not a managed care plan.

- N. “Intermediary” means a person authorized to negotiate and execute provider contracts with health carriers on behalf of health care providers or on behalf of a network.
- O. “Managed care plan” means a plan as defined by Miss. Code Ann. § 83-41-403(b).
- P. “Network” means the group of participating providers providing services to a managed care plan.
- Q. “Open plan” means a managed care plan other than a closed plan that provides incentives, including financial incentives, for covered persons to use participating providers under the terms of the managed care plan.
- R. “Participating provider” means a provider as defined by Miss. Code Ann. § 83-41-403(e).
- S. “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.
- T. “Primary care professional” means a participating health care professional 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.

Source: Miss. Code Ann. § 83-41-403; § 83-41-405; § 83-41-413 (Rev. 2011)

**Section 16.04. Applicability and Scope**

This Regulation shall apply to all health carriers that offer managed care plans.

Source: Miss. Code Ann. § 83-41-405; § 83-41-413 (Rev. 2011)

**Section 16.05. Network Adequacy**

- A. A health carrier providing a managed care plan shall maintain a network that is sufficient in numbers and types of providers to assure that all services to covered persons will be accessible without unreasonable delay. In the case of emergency services, covered persons shall have access twenty-four (24) hours per day, seven (7) days per week. Sufficiency shall be determined in accordance with the requirements of this section, and may be established by 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.

(1) In any case where the health carrier has an insufficient number or type of

participating provider 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 participating providers, or shall make other arrangements acceptable to the commissioner.

(2) The health carrier shall establish and maintain adequate arrangements to ensure reasonable proximity of participating providers to the business or personal residence of covered persons. In determining whether a health carrier has complied with this provision, the commissioner shall give due consideration to the relative availability of health care providers in the service area under consideration.

(3) A health carrier shall monitor, on an ongoing basis, the ability, clinical capacity, financial capability and legal authority of its providers to furnish all contracted benefits to covered persons.

B. Beginning July 1, 2014, a health carrier shall file with the commissioner an access plan meeting the requirements of this Regulation for each of the managed care plans that the carrier offers in this state. The health carrier may request the commissioner to deem sections of the access plan as proprietary or competitive information that shall not be made public. For the purposes of this section, information is proprietary or competitive if revealing the information would cause the health carrier's competitors to obtain valuable business information. The health carrier shall make the access plans, absent proprietary information, available on its business premises and shall provide them to any interested party upon request. The carrier shall prepare an access plan prior to offering a new managed care plan, and shall update an existing access plan whenever it makes any material change to an existing managed care plan. 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;

(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 managed care 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 and their satisfaction with services;

(6) The health carrier's method of informing covered persons of the plan's services and features, including but not limited to, 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 system for ensuring the coordination and continuity of care for covered persons referred to specialty physicians, for covered persons using ancillary services, including social services and other community resources, and for ensuring appropriate discharge planning;

(8) The health carrier's process for enabling covered persons to change primary care professionals;

(9) 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

(10) Any other information required by the commissioner to determine compliance with the provisions of this Regulation.

Source: Miss. Code Ann. § 83-41-405; § 83-41-413 (Rev. 2011)

#### **Section 16.06. Requirements for Health Carriers and Participating Providers**

A health carrier offering a managed care plan shall include the following requirements contained in this section, in addition to any other requirements required under Mississippi law.

- A. A health carrier shall establish a mechanism by which the participating provider will be notified on an ongoing basis of the specific covered health services for which the provider will be responsible, including any limitations or conditions on services.
- B. Every contract between a health carrier and a participating provider shall set forth a hold harmless provision specifying protection for covered persons. This requirement shall be met by including a provision substantially similar to the following:

“Provider agrees that in no event, including but not limited to nonpayment by the health carrier or intermediary, insolvency of the health carrier or intermediary, or breach of this agreement, shall the provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a covered person or a person (other than the health carrier or intermediary) acting on behalf of the covered person for services provided pursuant to this agreement. This agreement does not prohibit the provider from collecting coinsurance, deductibles or copayments, as specifically provided in the evidence of coverage, or fees for uncovered services delivered on a fee-for-service basis to

covered persons. Nor does this agreement prohibit a provider (except for a health care professional who is employed full-time on the staff of a health carrier and has agreed to provide services exclusively to that health carrier's covered persons and no others) and a covered person from agreeing to continue services solely at the expense of the covered person, as long as the provider has clearly informed the covered person that the health carrier may not cover or continue to cover a specific service or services. Except as provided herein, this agreement does not prohibit the provider from pursuing any available legal remedy.”

- C. Every contract between a health carrier and a participating provider shall set forth that in the event of a health carrier or intermediary insolvency or other cessation of operations, covered services to covered persons will continue through the period for which a premium has been paid to the health carrier on behalf of the covered person or until the covered person's discharge from an inpatient facility, whichever time is greater. Covered benefits to covered persons confined in an inpatient facility on the date of insolvency or other cessation of operations will continue until their continued confinement in an inpatient facility is no longer medically necessary.
- D. The contract provisions that satisfy the requirements of Subsections B and C shall be construed in favor of the covered person, shall survive the termination of the contract regardless of the reason for termination, including the insolvency of the health carrier, and shall supersede any oral or written contrary agreement between a provider and a covered person or the representative of a covered person if the contrary agreement is inconsistent with the hold harmless and continuation of covered services provisions required by Subsections B and C of this section.
- E. In no event shall a participating provider collect or attempt to collect from a covered person any money owed to the provider by the health carrier.
- F. (1) Health carrier selection standards for participating providers shall be developed for primary care professionals and each health care professional specialty. The standards shall be used in determining the selection of health care professionals by the health carrier, its intermediaries and any provider networks with which it contracts. As to physicians, the standards shall meet the requirements of 19 Miss. Admin. Code, Part 3, Rule 11, “Health Care Professional Credentialing Verification”. Selection criteria shall not be established in a manner:
  - (a) That would allow a health carrier to avoid high-risk populations by excluding providers because they are located in geographic areas that contain populations or providers presenting a risk of higher than average claims, losses or health services utilization; or
  - (b) That would exclude providers because they treat or specialize in treating populations presenting a risk of higher than average claims, losses or health services utilization.

(2) Paragraphs (1)(a) and (1)(b) shall not be construed to prohibit a carrier from declining to select a provider who fails to meet the other legitimate selection criteria of the carrier developed in compliance with this Regulation.

(3) The provisions of this Regulation do not require a health carrier, its intermediaries or the provider networks with which they contract, to employ specific providers or types of providers that may meet their selection criteria, or to contract with or retain more providers or types of providers than are necessary to maintain an adequate network.

- G. A health carrier shall make its selection standards for participating providers available for review by the commissioner.
- H. A health carrier shall notify participating providers of the providers' responsibilities with respect to the health carrier's applicable administrative policies and programs, including but not limited to payment terms, utilization review, quality assessment and improvement programs, credentialing, grievance procedures, data reporting requirements, confidentiality requirements and any applicable federal or state programs.
- I. A health carrier shall not offer an inducement under the managed care plan to a provider to provide less than medically necessary services to a covered person.
- J. A health carrier shall not prohibit a participating provider from discussing treatment options with covered persons irrespective of the health carrier's position on the treatment options, or from advocating on behalf of covered persons within the utilization review or grievance processes established by the carrier or a person contracting with the carrier.
- K. A health carrier shall require a provider 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, and to comply with the applicable state and federal laws related to the confidentiality of medical or health records.
- L. A health carrier and participating provider shall provide at least sixty (60) days written notice to each other before terminating the contract without cause. The health carrier shall make a good faith effort to provide written notice of a termination within fifteen (15) working days of receipt or issuance of a notice of termination to all covered persons 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. Where a contract termination involves a primary care professional, all covered persons who are patients of that primary care professional shall also be notified. Within five (5) working days of the date that the provider either gives or receives notice of termination, the provider shall supply the health carrier with a list of those patients of the provider that are covered by a plan of the health carrier.

- M. The rights and responsibilities under a contract between a health carrier and a participating provider shall not be assigned or delegated by the provider without the prior written consent of the health carrier.
- N. A health carrier is responsible for ensuring that a participating provider furnishes covered benefits to all covered persons without regard to the covered person'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.
- O. A health carrier shall notify the participating providers of their obligations, if any, to collect applicable coinsurance, copayments or deductibles from covered persons pursuant to the evidence of coverage, or of the providers' obligations, if any, to notify covered persons of their personal financial obligations for non-covered services.
- P. A health carrier shall not penalize a provider because the provider, in good faith, reports to state or federal authorities any act or practice by the health carrier that jeopardizes patient health or welfare.
- Q. A health carrier shall establish a mechanism by which the participating providers may determine in a timely manner whether or not a person is covered by the carrier.
- R. A health carrier shall establish procedures for the resolution of administrative, payment or other disputes between providers and the health carrier.
- S. A contract between a health carrier and a provider shall include payment and reimbursement methodologies that are described in terms a reasonably prudent layperson could be expected to understand.
- T. A contract between a health carrier and a provider shall not contain definitions or other provisions that conflict with the definitions or provisions contained in the managed care plan or this Regulation.

Source: Miss. Code Ann. § 83-41-405; §83-41-411; and §83-41-413 (Rev. 2011)

**Section 16.07. Intermediaries**

A contract between a health carrier and an intermediary shall satisfy all the requirements contained in this section.

- A. Intermediaries and participating providers with whom they contract shall comply with all the applicable requirements of Section 16.06.



- B. A health carrier's statutory responsibility to monitor the offering of covered benefits to covered persons shall not be delegated or assigned to the intermediary.
- C. A health carrier shall have the right to approve or disapprove participation status of a subcontracted provider in its own or a contracted network for the purpose of delivering covered benefits to the carrier's covered persons.
- D. A health carrier shall maintain copies of all intermediary health care subcontracts at its principal place of business in the state, or ensure that it has access to all intermediary subcontracts, including the right to make copies to facilitate regulatory review, upon twenty (20) days prior written notice from the health carrier.
- E. If applicable, an intermediary shall transmit utilization documentation and claims paid documentation to the health carrier. The carrier shall monitor the timeliness and appropriateness of payments made to providers and health care services received by covered persons.
- F. If applicable, an intermediary shall maintain the books, records, financial information and documentation of services provided to covered persons at its principal place of business in the state and preserve them in a manner that facilitates regulatory review.
- G. An intermediary shall allow the commissioner access to the intermediary's books, records, financial information and any documentation of services provided to covered persons, as necessary to determine compliance with this Regulation.
- H. A health carrier shall have the right, in the event of the intermediary's insolvency, to require the assignment to the health carrier of the provisions of a provider's contract addressing the provider's obligation to furnish covered services.

Source: Miss. Code Ann. § 83-41-405; § 83-41-413 (Rev. 2011)

**Section 16.08. Filing Requirements and State Administration**

- A. Beginning July 1, 2014, a health carrier shall file with the commissioner sample contract forms proposed for use with its participating providers and intermediaries.
- B. A health carrier shall submit material changes to a contract that would affect a provision required by this regulation to the commissioner for approval prior to use. Changes in provider payment rates, coinsurance, copayments or deductibles, or other plan benefit modifications are not considered material changes for the purpose of this subsection.
- C. If the commissioner takes no action within sixty (60) days after submission of a material change to a contract by a health carrier, the change is deemed approved.
- D. The health carrier shall maintain provider and intermediary contracts at its principal place of business in the state, or the health carrier shall have access to all contracts

and provide copies to facilitate regulatory review upon twenty (20) days prior written notice from the commissioner.

Source: Miss. Code Ann. § 83-41-405; § 83-41-413 (Rev. 2011)

**Section 16.09. Contracting**

- A. The execution of a contract by a health carrier shall not relieve the health carrier of its liability to any person with whom it has contracted for the provision of services, nor of its responsibility for compliance with the law or applicable regulations.
- B. All contracts shall be in writing and subject to review.
- C. All contracts shall comply with applicable requirements of the law and applicable regulations.

Source: Miss. Code Ann. § 83-41-405; § 83-41-413 (Rev. 2011)

**Section 16.10. Enforcement**

- A. If the commissioner determines that a health carrier has not contracted with enough participating providers to assure that covered persons have accessible health care services in a geographic area, or that a health carrier's access plan does not assure reasonable access to covered benefits, or that a health carrier has entered into a contract that does not comply with this Regulation, or that a health carrier has not complied with a provision of this Regulation, the commissioner may institute a corrective action that shall be followed by the health carrier, or may use any of the commissioner's other enforcement powers to obtain the health carrier's compliance with this Regulation.
- B. The commissioner will not act to arbitrate, mediate or settle disputes regarding a decision not to include a provider in a managed care plan or in a provider network or regarding any other dispute between a health carrier, its intermediaries or a provider network arising under or by reason of a provider contract or its termination.

Source: Miss. Code Ann. § 83-41-405; § 83-41-413 (Rev. 2011)

**Section 16.11. Penalties**

A violation of this Regulation shall be subject to the penalty provisions set forth in Miss. Code Ann. § 83-5-17, as well as other penalty provisions under applicable law.

Source: Miss. Code Ann. § 83-5-17; § 83-41-405; § 83-41-413 (Rev. 2011)

**Section 16.12. Severability**

If any provision of this Regulation, or the application of the provision to any person or circumstance shall be held invalid, the remainder of the Regulation, and the application of the provision to persons or circumstances other than those to which it is held invalid, shall not be affected.

Source: Miss. Code Ann. § 83-5-1; § 83-41-413 (Rev. 2011)

**Section 13. Effective Date**

This Regulation shall be effective thirty (30) days after final adoption with the Office of the Secretary of State.

- A. All provider and intermediary contracts in effect on the effective date of this Regulation shall comply with this Regulation no later than eighteen (18) months after the effective date of this Regulation. The commissioner may extend the eighteen (18) months for an additional period not to exceed six (6) months if the health carrier demonstrates good cause for an extension.
- B. A new provider or intermediary contract that is issued or put in force on or after August 1, 2014, shall comply with this Regulation.
- C. A provider contract or intermediary contract not described in Subsection A or Subsection B shall comply with this Regulation no later than eighteen (18) months after the effective date of this Regulation.

Source: Miss. Code Ann. § 25-43-3.112 (Rev. 2011)