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 submit an alternate access delivery request in accordance with WAC 284-43-220(3)(d):

(a) A reduction, by termination or otherwise, of ten percent or more in the number of specialty providers or mental health 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;

Comment [DOH1]: Should there be requirements around notifying consumer of network change?

Comment [DOH2]: Mental health providers and specialty providers should be in two separate subsections to govern reductions in access. Having them together with an "or" could allow an issuer to reduce only mental health providers because they are too costly. This does not fit with the Affordable Care Act's (ACA) or the state's priorities with integrating physical and behavioral healthcare

Comment [DOH3]: Add to end of subsection "in a service area" to be consistent with other reduction language.

(c) An increase or reduction of twenty-five percent or more in the number of enrollees in the service area since the annual approval date;

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

(e) The termination or expiration of a contract with a hospital or any associated hospital-based medical group within a service area; 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.

(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 plan's service areas.

(3) A closed practice may be included in a provider network for purposes of reporting network adequacy, but must not be used to justify network access for anticipated enrollment growth. Closed network status must be shared with current enrollees at time of approval and available to new consumers prior to enrollment.

Comment [DOH4]: Recommend adding an additional subsection regarding reduction in essential community providers in the network since a certain level of these providers are required under ACA.

Comment [DOH5]: How is this defined?

Comment [DOH6]: Can a closed practice be included to determine network access for current enrollees? Or to maintain the current level of enrollees?

Comment [DOH7]: Addition

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(4) An issuer must have and maintain 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) 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. The baseline for such coordination is monitoring as often as is necessary, but not less than once a year:

(a) The systems or processes for integration of health care services by medical and mental health providers;

(b) The exchange of information between primary and specialty providers, including mental and behavioral health providers;

Comment [DOH8]: Addition. Promotes integration of physical and behavioral health care

(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.

(6) This section is effective for all plans, whether new or renewed, with effective dates on or after January 1, 2016.

[]

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.

(a) Records to support proof of good faith contracting efforts must be retained for six years, including contracts offered, rejected, and the reasons for rejection.

(b) 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 all providers that were made, and that were denied, by benefit year, service, service category, and specialty.

Comment [DOH9]: This addition is to provide proof on having achieved network access, especially in rural areas, and why certain providers may not be in their networks.

Comment [DOH10]: Addition. These specifics should facilitate better understanding of the outreach issuers have done to create and maintain their networks.

[]

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.

(b) The issuer must ensure at all times that there are a sufficient number of primary care providers in the service area accepting new patients to accommodate new enrollees if the plan is open to new enrollment, and to ensure that existing enrollees have the ability to change primary care providers.

(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 pediatricians.

Comment [DOH11]: Who defines what a primary care provider is?

Comment [DOH12]: Add a subsection about minors having access to quality health care services from their chosen in network provider in accordance with laws related to minors' rights to health care (RCW 7.70.050(4); RCW 70.24.110; RCW 9.02.100(2); RCW 9.02.100(1); State v. Koome, 84 Wn.2d 901 (1975); RCW 71.34.530; RCW 71.34.500; RCW 70.96A.096, 230.). Pediatricians cannot always offer the quality services that minors have access to without parental consent. See the following matrix for more guidance: https://depts.washington.edu/hcsats/PDF/guidelines/Minors%20Health%20Care%20Rights%20Washington%20State.pdf

(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) Each issuer must ensure at all times that there are a sufficient number of pediatricians in the service area accepting new patients to accommodate new enrollees if the plan is open to new enrollment, and to ensure that existing enrollees under the age of eighteen have the ability to change pediatricians.

((~~(2)~~)) (3) Each ((~~carrier~~)) issuer must have a process whereby ((~~a covered person~~)) an enrollee with a complex or serious medical condition 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.

Comment [DOH13]: How is this defined/determined? Is this at the discretion of the issuer or provider?

((~~(3)~~)) (4) Each ((~~carrier shall~~)) issuer must provide ((~~covered persons~~)) enrollees with direct access to the participating chiroprac-

tor of the ((~~covered person's~~)) enrollee's choice for covered chiropractic health care without the necessity of prior referral. Nothing in this subsection prevents ((~~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)(a) 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: 1) for at least sixty days following notice of termination to the ((~~covered persons~~)) enrollees or, 2) in group coverage arrangements involving periods of open enrollment, only until the end of the next open enrollment period.

(b) Notice to ((~~covered persons shall~~)) enrollees must include information of the ((~~covered person's~~)) enrollee's right of access to the terminating provider for an additional sixty days.

(c) 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 shall~~)) 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 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.]

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~~)) 1) 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.~~))

2) An issuer must ensure that subcontractors of its contracted providers and facilities comply with the requirements of this ~~subchapter~~subsection. Provider networks must include every provider category and type necessary to deliver covered services at all times during the contract period.

Comment [DOH14]: Addition. This addition will hopefully prevent one-time preventive services offerings, such as HIV tests and screenings.

[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, ((~~and facilities shall be developed by the carrier~~)) for primary care providers, and for each health care provider or facility license or professional 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; or

(c) 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.

Comment [DOH15]: In support of this provision.

(2) 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) 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~~)) access standards of this chapter.

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

[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.

(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~~)) will{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~~)) does not prohibit collection of {deductibles, copayments, coinsurance, and/or payment for 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 pay-

ments 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~~)) must inform participating providers and facilities that willfully collecting or attempting to collect an amount from ((~~a covered person~~)) an enrollee knowing that col-

lection 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 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 (9) of this section.

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

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

((~~(5) The following provision is a restatement of a statutory requirement found in RCW 48.43.075 included here for ease of reference:~~))(7) Each participating provider and participating facility contract must contain the following provisions:

(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 construed 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~~))

(8)Subject to applicable state and federal laws related to the confidentiality of medical or health records, ((~~A Health carrier shall~~))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, appeals, ((~~or~~)) complaints, ((~~of covered persons~~)) or review of any 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 fa-

cilities 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~~)) (9) An issuer and participating provider and facility ((~~shall~~)) must provide at least sixty days' written notice to each other before terminating the contract without cause. ((~~The health carrier shall~~))

(10)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 a specialist; or

(b) By ((~~the provider~~)) a provider for whom they have a standing referral, ((~~whose contract is terminating, irrespective of whether the termination was for cause or without cause. Where a contract termination involves~~)); or

(c) 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~~))

(11) An issuer is responsible for ensuring that participating providers and facilities furnish covered services to each((~~covered persons~~)) enrollee 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~~)) (12) 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."~~))

Comment [DOH16]: Why was this subsection struck? What protections will there be for consumers to go out of network if needed?

((~~(11)~~)) (13) 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. 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), § 284-43-320, 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 for prior approval all participating provider agreements and facility agreements prior to use. An issuer must file sample contract forms proposed for use with its participating providers and facilities, and all negotiated provider agreements. The commissioner must receive the filings electronically

Comment [DOH17]: What will be the criteria for approval? What are you want to look at? Levels of providers in the network?

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~~))(a) All changes to a sample contract form to the commissioner thirty calendar days prior to use. ((~~Carriers shall~~)) (i) 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.

(ii) Alternatively, ((~~carriers~~)) 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.

(b) All negotiated contracts must be filed with the commissioner thirty calendar days prior to the execution of the contract and include all contract documents between the parties.

(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~~)), 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 shall~~)) issuer must 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 detailed in WAC 284-43-220(3)(b)to ensure that all provider and facility contracts are current and signed if the provider is listed in the network 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 result in discrimi-

Comment [DOH18]: In support of this added section. Recommend adding language around notification to consumer around different agreements. Perhaps, limit notification to when the plan network reaches a certain level of contracts with performance standards.

nation 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.

[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.]

Received support on rules from the following Department of Health programs:

- Genetics

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