ARKANSAS REGISTER

Transmittal Sheet

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Effective Date _____ Code Number _____

Name of Agency Arkansas Insurance Department

Department Arkansas Department of Commerce

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Statutory Authority for Promulgating Rules Ark. Code Ann. §23-61-108(a)(1) and 23-61-108 (b)(1) and 23-76-108(a)

Rule Title: Final Rule 106: "Network Adequacy Requirements for Health Benefits Plans"

Intended Effective Date (Check One)

- ☐ Emergency (ACA 25-15-204)
- ☐ 10 Days After Filing (ACA 25-15-204)
- ☑ Other 1/1/2022 (Must be more than 10 days after filing date.)

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Electronic Copy of Rule e-mailed from: (Required under ACA 25-15-218)

Clara D. Mezza | clara.mezza@arkansas.gov | 12/2/2021

Contact Person | E-mail Address | Date

CERTIFICATION OF AUTHORIZED OFFICER

I Hereby Certify That The Attached Rules Were Adopted
In Compliance with the Arkansas Administrative Act. (ACA 25-15-201 et. seq.)

Clara D. Mezza

Signature

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Phone Number E-mail Address

Insurance Administrative Coordinator

Title

12/2/2021

Date

Revised 7/2015 to reflect new legislation passed in the 2015 Regular Session (Act 1258). This act changed the effective date from 30 days to 10 days after filing the rule.

RULE 106
NETWORK ADEQUACY REQUIREMENTS FOR HEALTH BENEFIT PLANS

Table of Contents

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 minimum 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. "Dental Benefits" means benefits for dental services embedded in, or offered by a rider attached to, (i) a QHP offered through the ACA approved marketplace or (ii) an ACA compliant non-Grandfathered plan.

F. "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.

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

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

I. "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.

J. "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 applies to Dental Benefits as defined in Section (3)(E) and Vision Benefits as Defined in Section (3)(W), as well as plans offered by Stand-alone Dental Carriers as defined in Section (3)(U) of this rule,

K. "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.

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

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

N. "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 include an entity that provides Dental and/or Vision Benefits as defined in Section (3)(E) and Section (3)(W) of this rule, respectively, or is a Stand-alone Dental Carrier as defined by Section Three (3) (U) of this Rule.

O. "Network" means the collection of all participating providers providing services to a Health Benefit Plan. The network associated with a health benefit plan should be

identifiable using a suitable network ID, and one Health Benefit Plan can have only one such network ID.

P "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.

Q. "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.

R. "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.

S. "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.

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

U. "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.

V. "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.

W. "Service Area" means the collection of counties serviced by a Health Benefit Plan. Counties may be grouped into larger aggregations called Health Rating Areas and a Health Benefit Plan is required to cover at least one Health Rating Area. The aggregation of counties is published in the annual bulletin setting forth requirements for ACA submissions.

X. "Telemedicine" means the use of electronic information and communication technology to deliver healthcare services, including without limitation the assessment, diagnosis, consultation, treatment, education, care management, and self-management of a patient, as well as store-and-forward technology and remote patient monitoring.

Y. "Vision Benefits" means benefits for vision services embedded in, or offered by a rider attached to, a QHP offered through (i) the ACA approved marketplace or (ii) an ACA compliant non-Grandfathered plan.

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 Minimum Standards

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 and approved by the Commissioner, 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 minimum guidelines related to geographic accessibility through geographical access data or other information in a format and with content specified by the Department set forth in Section 5.F. below, for the plan year:

(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, or within thirty (30) minute travel time, whichever is shorter, 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, or within thirty (30) minute travel time, whichever is shorter, 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, or within sixty (60) minute travel time, whichever is shorter, 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, or within thirty (30) minute travel time, whichever is shorter, between the location of the Essential Community Provider and the residence of the Covered Person.

(5) The Health Carrier shall provide accurate provider practice addresses to the Department. Practice locations should be current at the time of data submission to the Department.

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 data must be submitted for each of the categories of care referenced in Section Five (5)(8)(1-4). Data specifications will be published by the Insurance Department and available online as (SERFF) Network Adequacy Data Submission Instructions updated for each plan year as necessary and appropriate. 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) . Provider data 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 seeking certification through the ACA approved Marketplace must provide geographical access data for Essential Community Providers with the providers grouped as set forth in the ACA and pursuant to CMS guidelines.

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 must attest to not currently having enrollees in Arkansas and provide geographical access data calculated using suitable sampling of US Census data.

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, 2023. 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 data 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.

M. All Time and distance guidelines as set forth in this Rule are minimum standards only. The Commissioner, pursuant to his or her discretion, may publish more detailed and specific network adequacy time/distance standards, as well as guidelines regarding the use of telemedicine to meet network adequacy standards, via SERFF Network Adequacy Data Submission Instructions, and/or annual bulletin for setting forth certification requirements for ACA submissions. Such new standards will become effective for review on January 1, of the following year.

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 data or other information in a format and with content specified by the Department, set forth in Section 5.F. above, for the plan year:

(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, or within thirty (30) minute travel time, whichever is shorter, 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, or within sixty (60) minute travel time, whichever is shorter, 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, or within thirty (30) minute travel time, whichever is shorter, 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.

(4) The Health carrier shall provide accurate and up to date provider practicing addresses to the Department at the time of data submission. 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.

(5) Health carriers shall verify practice addresses at least once every ninety (90) days in accordance to requirements of federal law, and the practice addresses reported to the Department for plan review should reflect the latest round of such verification.

(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 must attest to not currently having enrollees in Arkansas and provide geographical access data calculated suitable sampling of US Census data.

(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. Provider Type NPI Pool Data Maintenance

(A) A list of provider types developed by the Department and the Arkansas Department of Health will be monitored for network adequacy. The provider-types

are defined in terms of National Uniform Claim Committee (NUCC) taxonomy codes. The provider-type list will be reviewed annually for:

a. Sufficiency. This could be to add provider-types deemed necessary for coverage of health care services most appropriate for Arkansans or to remove provider-types that are no longer appropriate.
b. Definitions. This is to ensure that the taxonomies associated with the provider-type conveys the intended scope of the provider-type.

The taxonomy association with a provider-type definition communicates the actual practice of the provider rather than their academic qualification. For example, a provider qualified as an internal medicine physician cannot be considered a Primary Care Provider if the provider works only in emergency rooms or is only associated with a pain management clinic.

(B) The Department will facilitate a system of on-going industry data maintenance of NPI association(s) with various provider types defined in Section 7.(A). This association will be based on the provider's actual practice. This will be done to facilitate a common and uniform understanding of each provider's provider type(s) classification. This NPI association data with provider-types will be referred as Provider-Type-NPI-Pool (PTNP) data. The process and timelines in the PTNP data maintenance effort will be outlined by the Department on an annual basis through online documentation. The process will involve two stages of data submission by the carriers: First stage will involve suggestions of changes in the PTNP followed by the second stage when the carriers will vote on the suggestions consolidated from the first stage. The Department will facilitate oversight of the process and may classify a NPI lacking unanimous agreement among carriers.

(C) Participation exemptions. A carrier with fewer than five thousand (5,000) covered individuals as of December 31 of the previous calendar year will not be required to participate in the PTNP data maintenance process. For purposes of determining whether a carrier is subject to the participation requirements of PTNP data maintenance the carrier must aggregate the number of covered individuals for all companies at the Group Code level as defined by the National Association of Insurance Commissioners. Carriers that offer medical, dental, and pharmaceutical benefits, or any combination thereof, under separate or combined plans will count all covered individuals, irrespective of the comprehensiveness of the plan, toward the five thousand (5,000) covered individual threshold.

If a carrier does not believe it meets the definition of a submitting entity herein or does not believe it meets the 5,000 covered individuals threshold, that entity may dispute the Commissioner's decision in accordance with the Arkansas Administrative Procedure Act.

Section 8. Submission Timeline for Network Adequacy Review

Health Carriers will submit data for network adequacy review according to the timeline contained in the annual certification requirements bulletin.

Section 9.Enforcement

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

Section 10. Effective Date

The effective date of this Rule is January 1, 2022.

ALAN MCCLAIN
INSURANCE COMMISSIONER

12-2-2021
DATE