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# REGULATORY BULLETIN 2006-07[1]

TO: All Health Care Service Organizations, Hospital, Medical, Dental and Optometric Service Corporations, Health Care Providers, Professional Associations and Interested Parties

FROM: Christina Urias
Director of Insurance

DATE: August 22, 2006

RE: Implementation of HCSO Network Adequacy Rules

## INTRODUCTION

On November 1, 2005, the Governors Regulatory Review Committee ("GRRC") approved revisions to the Arizona Administrative Code ("A.A.C."), Title 20, Chapter 6, Article 19, (A.A.C. R20-6-1901, *et seq*.) regarding the Insurance Department's oversight of health care service organizations (HCSOs). The revisions focused on establishing HCSO requirements to maintain an adequate network as part of an effective health care plan, in accordance with Arizona Revised Statutes ("A.R.S.") § 20-1054(A)(2) and A.A.C. R20-6-1904. The revised Rules (the "Rules") took effect December 30, 2005 and are available on the Arizona Secretary of State website at http://azsos.gov/public_services/Title_20/20-06.htm.

This Regulatory Bulletin covers the following aspects of the Department's implementation of the Rules.

1. Application of the Rules. A.A.C. R20-6-1901(A)(D)&(E).
2. HCSO obligation to provide updated information. A.A.C. R20-6-1901(C).
3. Director's designation of a population data gathering service. A.A.C. R20-6-1902.
4. Network exceptions costs. A.A.C. R20-6-1910(E).
5. Demographic information reports. A.A.C. R20-6-1913.

[1] This Substantive Policy Statement is advisory only. A Substantive Policy Statement does not include internal procedural documents that only affect the internal procedures of the Agency, and does not impose additional requirements or penalties on regulated parties or include confidential information. If you believe that this Substantive Policy Statement does impose additional requirements or penalties on regulated parties, you may petition the agency under A.R.S. § 41-1033 for a review of the Statement.

**APPLICABILITY: A.A.C. R20-6-1901(A)(D)&(E)**

The Rules apply to: (1) each health care plan or product that an HCSO provides under its HCSO Certificate of Authority, including any in-network portion of a Point of Service product that an HCSO offers; and, (2) any services that an HCSO covers, including, but not limited to, mental health services and pharmacy benefits, *except* emergency services that an enrollee receives in a licensed hospital emergency facility. While an HCSO must cover the cost of such services, it is not subject to any enforcement action under the Rules if the licensed hospital emergency facility is not in its network; however, the Rules apply to emergency services that an enrollee receives elsewhere, such as in a hospital after admission as an inpatient.

**FILING UPDATED INFORMATION: A.A.C. R20-6-1901(C)**

In conjunction with Rules compliance, each HCSO will also need to update and supplement information previously provided to the Department under A.R.S. § 20-1053(A)(5) and A.A.C. R20-6-1901(C). Among other things, each HCSO must provide the Department with a copy of each "effective process" it maintains under the Rules. See A.A.C. R20-6-1904(B)(2)&(3), R20-6-1-1908(A)&(C), R20-6-1-1909, R20-6-1-1910(A)(B)(C)(D)&(E), and R20-6-1-1911. See Attachment A hereto for a complete list of required HCSO documentation.

The Department will contact each HCSO in writing to request documents that are not on file, or are not up-to-date, and will establish a reasonable timeline for submission. No HCSO should submit documentation before receiving the Department's written request.

**DESIGNATION OF A POPULATION DATA GATHERING SERVICE: A.A.C. R20-6-1902**

GeoAccess is the designated population data gathering service referenced in the A.A.C. R20-6-1902 definitions for "a population data gathering service designated by the director" for "rural," "suburban" and "urban."

**NETWORK EXCEPTIONS: A.A.C. R20-6-1910(E)**

A.A.C. R20-6-19O2 explicitly acknowledges "network exceptions" in which an HCSO enrollee may sometimes receive covered services outside the HCSO network; typically, "network exceptions" involve emergency care, urgent care, or prior authorized services. When out-of-network providers refuse to accept a reduction of their billed charges for covered services (such as a reduction to the usual and customary rate), the result may exceed the in-network costs for similar services. Nonetheless, the HCSO is entirely responsible for any such costs differences and may not charge the enrollee receiving such services for those differences. See A.R.S. § 20-1051(5); A.A.C. R20-6-1904(D).

A.A.C. R20-6-1910(E) provides that "(a)n HCSO shall have an effective process for handling network exceptions that ensures the HCSO reimburses an enrollee for any cost the enrollee incurs that the enrollee would not have incurred if the enrollee had received the services in-network." This subsection contemplates, and the Department expects, that under an HCSO's effective process for handling network exceptions, the HCSO will usually pay out-of-network providers directly, however, circumstances may arise where an enrollee pays an out-of-network provider directly (for example, a provider may aggressively bill an enrollee while waiting for the HCSO to pay, or a provider may refuse to provide urgently needed services without payment in advance) and, in that event, an HCSO's effective process for handling network exceptions must include a mechanism for timely and accurately reimbursing the enrollee in such circumstances.

**DEMOGRAPHIC INFORMATION REPORTS: A.A.C. R20-6-1913**

The Rules require HCSOs to report certain enrollee demographic data to the Department annually, on February 15th of each year. See A.A.C. R20-6-1913(A)(1)&(B)(1). Each HCSO should submit its first enrollee-demographics report for calendar year 2006 on or before February 15, 2007.

The Rules require HCSOs to report certain contract provider demographic data to the Department semi-annually, on February 15 and August 15 of each year. See A.A.C. R20-6-1913(A)(2)&(3) and A.A.C. R20-6-1913(B)(2)&(3). Each HCSO should submit its first provider-demographics reports covering the reporting period from July 1 to December 31, 2006, on or before February 15, 2007.

See Attachment B hereto for specifications for the demographic information reports.

Any HCSO that needs extra time to submit its first enrollee demographic report or first provider demographic report may contact Laura Weng, Managed Care Program Manager, at 602-364-2394 or lweng@id.state.az.us no later January 15, 2007 to request an extension. Any interested party may contact Ms. Weng with questions about this Regulatory Bulletin.

**ATTACHMENT A**
**UPDATING DOCUMENTATION UNDER A.R.S. § 20-1053(A)(5) AND A.A.C. R20-6-1901(C)**

## INFORMATION AND INSTRUCTIONS

1. As defined in A.A.C. R20-6-1902, an "effective process" means written policies and procedures that:
    a. Outline the steps that the HCSO implements and consistently follows internally;
    b. the HCSO subjects to internal quality improvement; and,
    c. the HCSO communicates to providers when established or changed.

2. The following Rules require an HCSO to have an effective process:
    a. A.A.C. R20-6-1904(B)(2)&(3).
    b. A.A.C. R20-6-1908(A)&(C).
    c. A.A.C. R20-6-1909.
    d. A.A.C. R20-6-1910(A)–(E).
    e. A.A.C. R20-6-1911.

3. An HCSO need not have a written policy and procedure dedicated to each effective process, but may submit an organized, indexed combination of written policies and procedures that constitute one or more of its effective processes.

4. In addition to policies and procedures that constitute an effective process, the Department expects each HSCO to have in effect any other written policies, procedures and documents necessary to achieve compliance with the Rules. An HCSO need not have policies, procedures and documents dedicated to each Rule, but may submit an organized, indexed combination of policies, procedures and documents applicable to one or more of the Rules.

5. Each policy, procedure or document that an HCSO submits to the Department in connection with the Rules must:
    a. Adequately cover applicable Rule requirements; and,
    b. be effective on the date of submission.

## REQUIRED DOCUMENTS

**A.A.C. R20-6-1904 Health Care Plan**
- An effective process for promoting a continuing relationship between an enrollee and the same primary care provider. A.A.C. R20-6-1904(B)(2).
- A policy and procedure for providing emergency care and inpatient emergency care.
- A policy and procedure for providing appropriate coverage for out-of-area emergency care to an enrollee traveling outside the company's service area. A.A.C. R20-6-1904(E).

**A.A.C. R20-6-1905 Geographic Area**
- A description of the geographic area served, with a map. A.A.C. R20-6-1905(A)&(B).

**A.A.C. R20-6-1906 Chief Executive Officer**
- A job description for the CEO, defining his/her authority and duties, including (at least) the specified duties and responsibilities. A.A.C. R20-6-1906(A)(B)(1)(B)(2)&(B)(3).
- A plan of authority in the CEO's absence. A.A.C. R20-6-1906 (B)(4).
- A policy and procedure for ensuring that employees and contractors are qualified and knowledgeable about their jobs. A.A.C. R20-6-1906(D).

**A.A.C. R20-6-1907 Medical Director**

- A job description for the Medical Director including at least the specified responsibilities. A.A.C. R20-6-1907(B)&(C).
- A policy and procedure for credentialing, re-credentialing and peer review. A.A.C. R20-6-1907(C)(2) & R20-6-1908.

**A.A.C. R20-6-1908 Quality Assurance**

- Quality Improvement (QI)/Quality Assurance (QA) plan. A.A.C. R20-6-1908(C).
- QI/QA work plan. A.A.C. R20-6-1908(A).
- QI/QA committee membership. A.A.C. R20-6-1908(B).

**A.A.C. R20-6-1909 Evaluation of Network**

An effective process to evaluate network adequacy in urban, suburban and rural areas.

**A.A.C. R20-6-1910 Referrals, Prior Authorizations, Pre-Certs and Network Exceptions**

- An effective process to assist in obtaining timely covered services when the enrollee or enrollee's referring provider cannot find a contracted provider who is timely accessible or available. A.A.C. R20-6-1910(A).
- An effective process to handle referrals, prior authorizations, pre-certifications and network exceptions for timely routine care. A.A.C. R20-6-1910(B). For network exceptions, the process must identify the criteria utilized to determine the propriety of a network exception.
- An effective process for handling referrals or network exceptions for urgent care and, if applicable, for prior authorizing or pre-certification of urgent care. A.A.C. R20-6-1910(C)&(D).
- An effective process to confirm that an enrollee who receives covered services out-of-network does not incur any cost the enrollee would not have incurred in-network. A.A.C. R20-6-1910(E).

**A.A.C. R20-6-1911 Communication with Providers**

An effective process to communicate with contracted providers about:

- Network providers. A.A.C. R20-6-1911(1).
- Contractual or administrative changes related to an access or availability. A.A.C. R20-6-1911(2).
- Procedures for handling provider claims and grievances. A.A.C. R20-6-1911(3).

**A.A.C. R 20-6-1912 Network Directories**

- A hard-copy/paper provider directory. A.A.C. R20-6-1912(A).
- A policy and procedure for entering, updating, and verifying directory data. A.A.C. R20-6-1912(D)&(E).

**A.A.C. R 20-6-1914 Access**

A policy and procedure for ensuring enrollee access to:

- Preventive care services, routine care services and specialty care services within the required timeframes. A.A.C. R20-6-1914(1)(2)&(3).
- Timely in-area urgent care services from a contracted provider. A.A.C. R20-6-1914(4).
- Timely non-emergency inpatient care services from a contracted provider. A.A.C. R20-6-1914(5).
- Timely services from a contracted provider in a contracted facility, including inpatient emergency care. A.A.C. R20-6-1914(6).

**A.A.C. R20-6-1915 Alternative Access**

- Written notice to the Department whether an HCSO provides alternative access to enrollees as described in A.A.C. R20-6-1915(A)(B)&(C).
- In the event an HCSO assigns enrollees to a panel of PCPs. A.A.C. R20-6-1915(D).

**A.A.C. R20-6-1916 Availability Ratios**

A policy and procedure for establishing the required ratios for:

- Adult PCPs to adult enrollees. A.A.C. R20-6-1916(A).
- Pediatric PCPs to pediatric enrollees. A.A.C. R20-6-1916(B).
- High profile specialty care providers to all enrollees. A.A.C. R20-6-1916(C).

**A.A.C. R20-6-1917 Geographic Availability in Urban Areas**

A policy and procedure for ensuring the required availability of contracted providers in urban areas.

**A.A.C. R20-6-1918 Geographic Availability in Suburban Areas**

A policy and procedure for ensuring the required availability of contracted providers in suburban areas.

**A.A.C. R20-6-1919 Geographic Availability in Rural Areas**

A policy and procedure for ensuring the required availability of contracted providers in rural areas.

**A.A.C. R20-6-1920 Travel Requirements**

- A policy and procedure for providing covered services outside the service area when those services are not available in area. A.A.C. R20-6-1920(B).
- Written definition of “travel expenses”. A.A.C. R20-6-1920(B).

**ATTACHMENT B**
**SPECIFICATIONS FOR DEMOGRAPHIC INFORMATION**

Provide demographic information CDs in ASCII text files in comma delimited format (AKA Comma Separated Values "CSV"). Provide a separate CD for the: 1) Enrollee File, 2) Contracted Ancillary or Facility Provider File; and, 3) Contracted Physician or Practitioner File.

**Enrollee File:** (First CD)

Label the enrollee file as follows:

E#####-MMYY.CSV

E = designation for enrollee file
##### = insurer NAIC number
Insert Hyphen to separate the NAIC number and the Month
MMYY= two digit month and two digit year.
.CSV=ASCII Test File (Comma Separated Values)

For example, the file for an insurer with NAIC number of 12345 reporting in January of 2007 would be E12345-0107.CSV.

Submit each enrollee's information on a separate line. Set each column up with the headers listed below:

a. Address 1 (street name and number).
b. Address 2 (apartment number, unit number, box number, etc.).
c. ZIP code (XXXXX-XXXX).
d. Gender (M or F).
e. Year of birth (YYYY).

**Contracted Ancillary or Facility Provider File:** (Second CD)

Label the Contracted Ancillary or Facility Provider file as follows:

AF#####-MMYY.CSV

AF = Ancillary/Facility
##### = insurer NAIC number
Insert Hyphen to separate the NAIC number and Month.
MMYY= two digit month and two digit year.
.CSV=ASCII Test File (Comma Separated Values)

For example, the file for an insurer with NAIC number of 12345 reporting in January of 2007 would be AF12345-0107.CVS. The file for an insurer with NAIC number of 12345 reporting in July of 2007 would be AF12345-0707.CVS.

This file should include structures such as hospitals, skilled nursing facilities, laboratory facilities, radiology facilities, pharmacies, and rehabilitative services facilities. Do not include physicians or practitioners who work in these structures (e.g. radiologists or physical therapists). Report physicians or practitioners in the "Contracted Physician and Practitioner" file (Third CD).

Submit each Ancillary/Facility provider on a separate line. Set each column up with the headers listed below:

a. Provider name.
b. Provider type (for available types, see AAC R20-6-1902 under “ancillary” and “facility”).
c. Address 1 where services are provided (street name and number).
d. Address 2 (suite number, unit number, box number, etc.).
e. ZIP code (XXXXX-XXXX).
f. Arizona license number.

If an Ancillary/Facility provider has multiple service sites, show each service site as a separate record. Please repeat the data above (a-f) for each separate service site.

**Contracted Physician or Practitioner File:** (Third CD)

Label the Contracted Physicians or Practitioners file as follows:

P#####-MMYY.CSV

P = Provider/Practitioner
##### = insurer NAIC number
Insert Hyphen to separate the NAIC number and Month
MMYY = two digit month and two digit year
.CSV=ASCII Test File (Comma Separated Values)

For example, the file for an insurer with NAIC number of 12345 reporting in January of 2007 would be P12345-0107.CVS. The file for an insurer with NAIC number of 12345 reporting in July of 2007 would be P12345-0707.CVS.

Submit each Physician/Practitioner on a separate line. Set each column up with the headers listed below:

a. Provider name.
b. Medical or other applicable degree (For example: MD, DO, PA, DC).
c. Specialty (For example: OB-GYN, Neurosurgeon, Pediatrics).
d. Address 1 where services are provided (street name and number).
e. Address 2 (suite number, unit number, box number, etc.).
f. ZIP code (XXXXX-XXXX).
g. Arizona license number.

If a Physician or Practitioner has multiple service sites, show each service site as a separate record. Please repeat the data above (a-f) for each separate service site.