Title 19, Part 3, Chapter 18: Managed Care Plan Certification Regulation

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Rule 18.01. Title

This Regulation shall be known and may be cited as the Managed Care Plan Certification 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 *Miss. Code Ann*. §§ 25-43-1.101, et seq., the Mississippi Administrative Procedures Law; and the requirements of *Miss. Code Ann*. §§ 83-41-401, et seq., the Mississippi Patient Protection Act of 1995.

Source: *Miss. Code Ann*. §§ 25-43-1.101, et seq.; § 83-5-1; §§ 83-41-401, et seq. (Rev. 2022)

Rule 18.02. Purpose

The purpose of this Regulation is to establish a process for certifying managed care plans pursuant to the provisions of *Miss. Code Ann*. §§ 83-41-401 et seq., also known as the Mississippi Patient Protection Act of 1995. Additionally, it furthers the goals of the Managed Care Plan Network Adequacy Regulation, Title 19, Part 3, Chapter 14, by requiring that managed care plans have adequate networks in order to be certified by the Mississippi Insurance Department.

Source: *Miss. Code Ann.* § 83-41-405; § 83-41-413 (Rev. 2022)

Rule 18.03. Definitions

For purposes of this Regulation, the term "managed care entities" as used herein, shall include a "health carrier" as that term is defined in Rule 14.03 of Title 19, Part 3, Chapter 14. Any term defined in Rule 14.03 of Title 19, Part 3, Chapter 14 will have the same meaning in this Chapter 18. Further, any terms defined in *Miss. Code Ann*. § 83-41-403 (Rev. 2022) shall have the same meaning in this Chapter 18.

Source: *Miss. Code Ann*. § 83-41-403; § 83-41-405; § 83-41-413 (Rev. 2022)

Rule 18.04. Applicability and Scope

This Regulation shall apply to all managed care plans, managed care entities and managed care contractors; provided, however, the Regulation shall not apply to the Mississippi State Employee Health Plan or to any managed care plan regulated by the Mississippi Division of Medicaid.

Source: *Miss. Code Ann*. § 83-41-405; § 83-41-413 (Rev. 2022)

Rule 18.05. Filing Requirements and State Administration

A. Beginning June 1, 2024, managed care entities shall file with the Commissioner sample contract forms proposed for use with its participating providers and intermediaries.

B. By June 1 of each calendar year, managed care entities shall submit to the Commissioner, in an electronic format (such as Excel) that is readily useable by the Department, a complete list, effective January 1 of that calendar year, of: (1) the names of its Participating Providers; (2) each Participating Provider's most closely-affiliated type as provided for in Table 1, Rule 14.05; (3) the complete practice location address for each Participating Provider; and (4) contact information for each Participating Provider.

C. By June 1 of each calendar year, managed care entities shall submit to the Commissioner, in electronic format (such as Excel) that is readily useable by the Department, a complete list, effective January 1 of that calendar year, of: (1) the names of its covered persons; and (2) the complete residential addresses of each covered person.

D. By June 1 of each calendar year, managed care entities shall submit to the Commissioner a certification attestation in the following format: "I attest that [managed care entity] has complied with the Managed Care Plan Network Adequacy Regulation and the Managed Care Plan Certification Regulation promulgated by the Mississippi Department of Insurance." If a managed care entity is unable to meet compliance with any rules in those Regulations, including, but not limited to, Rule 14.05(B) and Rule 14.05(D), such attestation shall include reasons why the carrier contends it was unable to meet such standards and why the Commissioner should give special consideration to the reasons asserted for lack of compliance.

E. By June 1 of each calendar year, managed care entities shall submit to the Commissioner a complete, detailed description of their measures to provide covered persons, in easily understandable language, written information on the terms and conditions of coverage, including:

(1) coverage provisions;

(2) benefits;

(3) limitations;

(4) exclusions and restrictions on the use of any providers of care;

(5) a summary of utilization review and quality assurance policies;

(6) enrollee financial responsibility for copayments, deductions, and payment for out-of-plan services and supplies;

(7) the managed care entity's policies, in circumstances where the managed care entity has an insufficient number or type of participating providers/facilities to provide a covered benefit consistent with the geographic access standards set forth in the Managed Care Network Adequacy Regulation, Section 14.05(B), Table 1, or fails to provide a covered benefit consistent with the geographic access standards set forth in Section 14.05(B), Table 1, to ensure covered persons obtain the covered benefit at no greater cost to the covered person than if the benefit were obtained from participating providers, and to ensure in such situations, the provision of covered persons with reasonable reimbursement for the covered persons travel, lodging, and incidental expenses;

(8) a summary of the managed care entity's credentialing criteria and process and policies relating to the credentialing criteria;

(9) the managed care entity's procedures for ensuring a provider may request a copy of the provider's individual profile if economic or practice profiles, or both, are used in the credentialing process;

(10) the managed care entity's procedures for ensuring a provider is aware that the provider may request to review the reasons for denial or termination with regard to a provider's application that has been denied or where the provider's contract is terminated;

(11) the managed care entity's procedure/policy to ensure adherence with all applicable state and federal laws designed to protect the confidentiality of medical records; and

(12) the managed care entity's procedures to ensure interested healthcare providers within the geographic area of the managed care entity's network are given an opportunity to apply for participation.

Source: *Miss. Code Ann.* § 83-41-405; § 83-41-413 (Rev. 2022)

Rule 18.06. Certification and Enforcement

A. Based on the information managed care entities must submit pursuant to this Regulation and the Managed Care Network Adequacy Regulation, the Commissioner shall review such information and if found sufficient, the Commissioner shall issue an annual certification of each managed care plan. Such certification shall allow the managed care entity's continued operation of the managed care plan except that such certification shall always be subject to reconsideration should the Commissioner determine, in his or her sole discretion, that the managed care entity has not in fact complied with the requirements of this Regulation.

B. If the Commissioner determines that a managed care entity has not sufficiently complied with any provision of the Managed Care Network Adequacy Regulation or this Regulation, the Commissioner may institute a corrective action that shall be followed by the managed care entity, may deny certification of the managed care entity's plan, or may use any of the Commissioner's other enforcement powers to obtain the managed care entity's compliance.

C. If the Commissioner determines that a managed care entity's network does not sufficiently comply with the Managed Care Network Adequacy Regulation or this Regulation, the Commissioner shall afford a managed care entity a hearing, consistent with Mississippi Department of Insurance regulations, upon a managed care entity's request made within twenty (20) days of notification of the Commissioner's determination, before such determination becomes final.

Source: *Miss. Code Ann*. § 83-41-405; § 83-41-413 (Rev. 2022)

Rule 18.07. Ongoing Compliance

The Commissioner, at any time, may review a managed care entity's compliance with this Regulation or the Managed Care Plan Network Adequacy Regulation, request information from the managed care entity necessary to investigate the managed care entity's compliance, and order the corrective measures the Commissioner, in his or her sole discretion, deems necessary. The Commissioner may retain outside consultants to assist in such review if the Commissioner determines such is appropriate, and the fees and costs of such consultants' services shall be paid by the managed care entity to the consultants pursuant to *Miss. Code Ann*. § 83-41-407.

Source: *Miss. Code Ann*. § 83-41-405; § 83-41-407; § 83-41-411, and § 83-41-413 (Rev. 2022)

Rule 18.08. Confidentiality

A managed care entity or managed care contractor may designate material submitted to the Commissioner pursuant to this regulation as confidential and exempt from disclosure to the public under the Mississippi Public Records Act if the health carrier deems the material to meet the criteria set forth in *Miss. Code Ann*. § 25-61-9(1).

Source: *Miss. Code Ann*. § 25-61-9; § 83-41-43 (Rev. 2022)

Rule 18.09. 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. 2022)

Rule 18.10. 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. 2022)

Rule 18.11. Effective Date

This Regulation shall be effective thirty (30) days after final adoption with the Office of the Secretary of State. All provider and intermediary contracts in effect on the effective date of this Regulation, or which are issued or put inforce on or after the effective date of this Regulation, shall comply with this Regulation no later than June 1, 2024. The Commissioner may extend this deadline for an additional period not to exceed six (6) months if the managed care entity demonstrates good cause for an extension.

Source: *Miss. Code Ann*. § 25-43-3.112 (Rev. 2022)