Title 19, Part 3, Chapter 14: Managed Care Plan Network Adequacy

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Rule 14.01. Title

This Regulation shall be known and may be cited as the Managed Care Plan Network Adequacy Regulation and is promulgated by the Commissioner of Insurance pursuant to the authority granted to him by Title 83, the Mississippi Insurance Code; the requirements of *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 14.02. Purpose

The purpose of this Regulation is to establish standards for the creation and maintenance of networks by health carriers and to ensure adequate access to covered persons in a managed care plan. This Regulation enhances the adequacy, accessibility, and quality of health care services offered under a managed care plan. This Regulation also establishes requirements for written agreements between health carriers offering managed care plans and participating providers regarding the standards, terms, and provisions under which the participating provider will provide services to covered persons.

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

Rule 14.03. Definitions

For purposes of this Regulation:

A. “Commissioner” means the Commissioner of Insurance.

B. “Covered benefits” or “benefits” means those health care services to which a covered person is entitled under the terms of a health benefit plan.

C. “Covered person” means a policyholder, subscriber, enrollee, or other individual participating in a health benefit plan.

D. “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.

E. “Emergency services” means health care items and services furnished or required to evaluate and treat an emergency medical condition.

F. “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.

G. “Health benefit plan” means a policy, contract, certificate or agreement entered into, offered or issued by a health carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services.

H. “Health care professional” means a physician or other health care practitioner licensed, accredited, or certified to perform specified health services consistent with state law.

I. “Health care provider” or “provider” means a health care professional or a facility.

J. “Health care services” means services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease.

K. “Health carrier” means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the Commissioner, that contracts or offers to contract, or enters into an agreement to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including a sickness and accident insurance company, a third party administrator, a health maintenance organization, a nonprofit hospital, health service corporation, or any other entity providing a plan of health insurance, health benefits, or health services.

L. “Intermediary” means a person authorized to negotiate and execute provider contracts with health carriers on behalf of health care providers or on behalf of a network.

M. “Managed care plan” means a plan as defined by *Miss. Code Ann*. § 83-41-403(b).

N. “Network” means the group of participating providers providing services to a managed care plan and who have entered into a contract of reimbursement for benefits with a health carrier.

O. “Participating provider” means a provider as defined by *Miss. Code Ann*. § 83-41-403(e).

P. “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.

Q. “Primary care professional” means a participating health care professional designated by the health carrier to supervise, coordinate, or provide initial care or continuing care to a covered person, and who may be required by the health carrier to initiate a referral for specialty care and maintain supervision of health care services rendered to the covered person.

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

Rule 14.04. Applicability and Scope

This Regulation shall apply to all health carriers that offer managed care plans; 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, or to any self-insured health plan.

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

Rule 14.05. Network Adequacy

A. A health carrier providing a managed care plan shall maintain a network that is sufficient in numbers and types of participating providers to ensure that all covered services to covered persons will be accessible without unreasonable delay. In the case of emergency facility services, covered persons shall have access twenty-four (24) hours per day, seven (7) days per week.

B. The sufficiency of health carriers’ networks shall be measured by the network adequacy standards outlined in 45 C.F.R. § 156.230((a)(2)(i) and associated guidance published by the Centers for Medicare and Medicaid Services.

C. In any case where the health carrier has an insufficient number or type of participating providers/facilities to provide a covered benefit to a covered person consistent with the geographic access standards set forth in Rule 14.05(B), the health carrier shall ensure that the covered person obtains the covered benefit at no greater cost to the covered

person than if the benefit were obtained from participating providers/facilities, and additionally, if the covered persons must travel more than one hundred (100) miles one way or more than the distance standard prescribed by this regulation, whichever is greater, to obtain the aforementioned covered benefit, the health carrier shall provide such persons reasonable round trip reimbursement for their food, lodging and travel. Reimbursement for food and lodging shall be at the prevailing federal per diem rates, then in effect, as set by the U.S. General Services Administration. Reimbursement for travel by vehicle shall be reimbursed at the current Internal Revenue Service mileage standard for miles driven for transportation or travel expenses. The health carrier's regulatory obligation in this Subsection C to provide such reimbursement shall not exceed $10,000.00 per covered person in any applicable policy year.

D. The health carrier shall establish and maintain adequate arrangements to ensure reasonable proximity of participating providers/facilities to the locations of covered persons. A health carrier may be deemed to be out of compliance with the geographic access standards in Rule 14.05(B) in the event that the health carrier is not able to meet the applicable time or distance minimum with respect to covered persons' locations. In determining whether a health carrier has complied with the geographic access standards in Rule 14.05(B), the Commissioner shall give due consideration to the relative availability of health care providers in the geographic area under consideration. The fact that no provider specialist, adult or pediatric, provides a covered service within the minimum geographic access standards shall be taken into consideration when determining whether a health carrier has complied with the geographic access standards in Rule 14.05(B), and the Commissioner may accept the attestation of a health carrier as sufficient even if the health carrier does not comply with Rule 14.05(B) and Rule 14.05(D) if the Commissioner determines the health carrier has made reasonable efforts to secure health care providers in the geographic area at issue, but such providers were not available. The Commissioner's assessment of the health carrier's efforts will be performed consistent with the Managed Care Plan Certification Regulation, Title 19, Part 3, Chapter 18.

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

2. If a health carrier does not meet network adequacy standards in a particular geographic area, the Commissioner shall have authority to request and obtain from the health carrier data or information pertaining to the health carrier's efforts to comply with this section and to obtain contracts with providers/facilities and use this information in his determination under this provision. This authority shall extend to contracts offered to but declined by providers/facilities, and to provider applications that were denied by the health carrier. A health carrier shall maintain records as to all providers/facilities who apply to be a participating provider but

were denied such status, along with an explanation of why such status was denied by the health carrier.

E. Beginning June 1, 2025, a health carrier shall file with the Commissioner, in addition to the information required to be submitted in this Regulation and the Managed Care Plan Certification Regulation, an access plan meeting the requirements of Rule 14.05 for each of the managed care plans that the carrier offers in this state. The health carrier shall make the access plans, absent proprietary or confidential commercial or financial information, available on its business premises and shall provide them to any interested party upon request. The health carrier shall prepare an access plan before offering a new managed care plan and shall update an existing access plan whenever it makes any material change to an existing managed care plan. The access plan shall describe or contain at least the following:

1. The health carrier's network;

2. The health carrier's procedures for making referrals within and outside its network;

3. The health carrier's process for monitoring and assuring on an ongoing basis the sufficiency of the network to meet the health care needs of populations that enroll in managed care plans;

4. The health carrier's efforts to address the needs of covered persons with limited English proficiency and illiteracy, with diverse cultural and ethnic backgrounds, and with physical and mental disabilities;

5. The health carrier's methods for assessing the health care needs of covered persons and their satisfaction with services;

6. The health carrier's method of informing covered persons of the plan's services and features, including, but not limited to, the plan's grievance procedures, its process for choosing and changing providers, and its procedures for providing and approving emergency and specialty care;

7. The health carrier's system for ensuring the coordination and continuity of care for covered persons referred to specialty physicians, for covered persons using ancillary services, including social services and other community resources, and for ensuring appropriate discharge planning;

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

9. The health carrier's proposed plan for providing continuity of care in the event of contract termination between the health carrier and any of its participating

providers, or in the event of the health carrier's insolvency or other inability to continue operations. The description shall explain how covered persons will be notified of the contract termination, or the health carrier's insolvency or other cessation of operations, and transferred to other providers in a timely manner; and

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

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

Rule 14.06. Requirements for Health Carriers and Participating Providers

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

A. A health carrier shall establish a mechanism by which the participating provider will be notified on an ongoing basis of the specific covered or non-covered health services for which the provider will be responsible, including any limitations or conditions on services.

B. Every contract between a health carrier and a participating provider shall set forth a hold harmless provision specifying protection for covered persons. This requirement shall be met by including a provision substantially similar to the following:

"Provider agrees that in no event, including but not limited to nonpayment by the health carrier or intermediary, insolvency of the health carrier or intermediary, or breach of this agreement, shall the provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a covered person or a person (other than the health carrier or intermediary) acting on behalf of the covered person for services provided pursuant to this agreement. This agreement does not prohibit the provider from collecting coinsurance, deductibles or copayments, as specifically provided in the evidence of coverage, or fees for uncovered services delivered on a fee-for-service basis to covered persons. Nor does this agreement prohibit a provider (except for a health care professional who is employed full-time on the staff of a health carrier and has agreed to provide services exclusively to that health carrier's covered persons and no others) and a covered person from agreeing to continue services solely at the expense of the covered person, as long as the provider has clearly informed the covered person that the health carrier may not cover or continue to cover a specific service or services. Except as provided herein, this agreement does not prohibit the provider from pursuing any available legal remedy."

C. Every contract between a health carrier and a participating provider shall set forth that in the event of a health carrier or intermediary insolvency or other cessation of

operations, covered services to covered persons will continue through the period for which a premium has been paid to the health carrier on behalf of the covered person or until the covered person's discharge from an inpatient facility, whichever time is greater. Covered benefits to covered persons confined in an inpatient facility on the date of insolvency or other cessation of operations will continue until their continued confinement in an inpatient facility is no longer medically necessary.

D. The contract provisions that satisfy the requirements of Subsections B and C shall be construed in favor of the covered person, shall survive the termination of the contract regardless of the reason for termination, including the insolvency of the health carrier, and shall supersede any oral or written contrary agreement between a participating provider and a covered person or the representative of a covered person if the contrary agreement is inconsistent with the hold harmless and continuation of covered services provisions required by Subsections B and C of this section.

E. In no event shall a participating provider collect or attempt to collect from a covered person any money owed to the provider by the health carrier.

F. 1. Health carrier selection standards for participating providers shall be developed for primary care professionals and each health care professional specialty. The standards shall be used in determining the selection of health care professionals by the health carrier, its intermediaries and any provider networks with which it contracts. As to physicians, the standards shall meet the requirements of 19 Miss. Admin. Code, Part 3, Rule 11, "Health Care Professional Credentialing Verification." Selection criteria shall not be established in a manner:

a. That would allow a health carrier to avoid high-risk populations by excluding providers because they are located in geographic areas that contain populations or providers presenting a risk of higher-than-average claims, losses or health services utilization; or

b. That would exclude providers because they treat or specialize in treating populations presenting a risk of higher-than-average claims, losses, or health services utilization.

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

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

G. A health carrier shall make its selection standards for participating providers available for review by the Commissioner.

H. A health carrier shall notify participating providers of the providers' responsibilities with respect to the health carrier's applicable administrative policies and programs, including, but not limited to, terms of payment, utilization review, quality assessment and improvement programs, credentialing, grievance procedures, data reporting requirements, confidentiality requirements and any applicable federal or state programs.

I. A health carrier shall not offer an inducement under the managed care plan to a provider to provide less than medically necessary services to a covered person.

J. A health carrier shall not prohibit a participating provider from discussing treatment options with covered persons irrespective of the health carrier's position on the treatment options, or from advocating on behalf of covered persons within the utilization review or grievance processes established by the health carrier or a person contracting with the health carrier.

K. A health carrier shall require a participating provider to make health records available to appropriate state and federal authorities involved in assessing the quality of care or investigating the grievances or complaints of covered persons, and to comply with the applicable state and federal laws related to the confidentiality of medical or health records.

L. A health carrier and participating provider shall provide at least sixty (60) days written notice to each other before terminating the contract without cause. The health carrier shall make a good-faith effort to provide written notice of a termination within thirty (30) days of receipt or issuance of a notice of termination to all covered persons who are patients seen on a regular basis by the provider whose contract is terminating, irrespective of whether the termination was for cause or without cause. Where a contract termination involves a primary care professional, all covered persons who are patients of that primary care professional shall also be notified. Within five (5) working days of the date that the provider either gives or receives notice of termination, the provider shall supply the health carrier with a list of those patients of the provider that are covered by a plan of the health carrier.

M. The rights and responsibilities under a contract between a health carrier and a participating provider shall not be assigned or delegated by the participating provider without the prior written consent of the health carrier.

N. A health carrier is responsible for ensuring that a participating provider furnishes covered benefits to all covered persons without regard to the covered person's

enrollment in the plan as a private purchaser of the plan or as a participant in publicly financed programs of health care services. This requirement does not apply to circumstances when the participating provider should not render services due to limitations arising from lack of training, experience, skill or licensing restrictions.

O. A health carrier shall notify the participating providers of their obligations, if any, to collect applicable coinsurance, copayments, or deductibles from covered persons pursuant to the evidence of coverage, or of the providers' obligations, if any, to notify covered persons of their personal financial obligations for non-covered services.

P. A health carrier shall not penalize a provider because the provider, in good faith, reports to state or federal authorities any act or practice by the health carrier that jeopardizes patient health or welfare.

Q. A health carrier shall establish mechanism(s) by which the participating providers may determine in a timely manner whether or not a person is covered by the health carrier, whether a particular service is covered, and whether a particular service requires pre-certification.

R. A health carrier shall establish procedures for the resolution of administrative, payment or other disputes between providers and the health carrier.

S. A contract between a health carrier and a participating provider shall include payment and reimbursement methodologies that are clearly described.

T. A contract between a health carrier and a participating provider shall not contain definitions or other provisions that conflict with the definitions or provisions contained in the managed care plan or this Regulation.

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

Rule 14.07. Intermediaries

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

A. Intermediaries and participating providers with whom they contract shall comply with all the applicable requirements of Rule 14.06.

B. A health carrier's statutory responsibility to monitor the offering of covered benefits to covered persons shall not be delegated or assigned to the intermediary.

C. A health carrier shall have the right to approve or disapprove participation status of a subcontracted provider in its own or a contracted network for the purpose of delivering covered benefits to the carrier's covered persons.

D. A health carrier shall maintain copies of all intermediary health care subcontracts at its principal place of business in the state or ensure that it has access to all intermediary subcontracts. A health carrier shall make copies of intermediary contracts available to the Commissioner upon demand.

E. If applicable, an intermediary shall transmit utilization documentation and claims paid documentation to the health carrier. The carrier shall monitor the timeliness and appropriateness of payments made to providers and health care services received by covered persons.

F. If applicable, an intermediary shall maintain the books, records, financial information and documentation of services provided to covered persons at its principal place of business in the state and preserve them in a manner that facilitates regulatory review by the Commissioner.

G. An intermediary shall allow the Commissioner access to the intermediary's books, records, financial information, and any documentation of services provided to covered persons, as necessary to determine compliance with this Regulation.

H. A health carrier shall have the right, in the event of the intermediary's insolvency, to require the assignment to the health carrier of the provisions of a provider's contract addressing the provider's obligation to furnish covered services.

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

Rule 14.08. Confidentiality

A health carrier 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; § 83-41-413 (Rev. 2022)

Rule 14.09. Contracting

A. The execution of a contract by a health carrier shall not relieve the health carrier of its liability to any person with whom it has contracted for the provision of services, nor of its responsibility for compliance with the law or applicable regulations.

B. All contracts shall be in writing and subject to review.

C. All contracts shall comply with applicable requirements of the law and applicable regulations.

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

Rule 14.10. Compliance and Penalties

The Commissioner may retain outside consultants to assist the Commissioner for determining compliance with this regulation, and the fees and costs of such consultants paid by the health carrier to the consultants pursuant to *Miss. Code Ann.* § 83-41-407. 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 14.11. 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 14.12. 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 in force on or after the effective date of this Regulation, shall comply with this Regulation no later than June 1, 2025. The Commissioner may extend this deadline for an additional period not to exceed six (6) months if the health carrier demonstrates good cause for an extension.

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