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.

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 assure that all 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. Sufficiency shall be determined by the following Table 1 of geographic access standards, along with consideration of the health plan’s provider-covered person ratios by specialty; 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. Delivery of services by telemedicine or other alternative means may be considered, in the discretion of the Commissioner, in evaluating compliance with Table 1.

TABLE 1

Provider/Facility Specialty Type	Large Metro		Metro		Micro		Rural		CEAC	
	Max Time	Max Distance	Max Time	Max Distance	Max Time	Max Distance	Max Time	Max Distance	Max Time	Max Distance
Allergy and Immunology	30	15	45	30	80	60	90	75	125	110
Cardiology	20	10	30	20	50	35	75	60	95	85
Cardiothoracic Surgery	30	15	60	40	100	75	110	90	145	130
Chiropractor	30	15	45	30	80	60	90	75	125	110
Dental	30	15	45	30	80	60	90	75	125	110
Dermatology	20	10	45	30	60	45	75	60	110	100
Emergency Medicine	20	10	45	30	80	60	75	60	110	100
Endincronology	30	15	60	40	100	75	110	90	145	130
ENT/Otolaryngolgy	30	15	45	30	80	60	90	75	125	110
Gastroenterology	20	10	45	30	60	45	75	60	110	100
General Surgery	20	10	30	20	50	35	75	60	95	85
Gynocology, OB/GYN	10	5	15	10	30	20	40	30	70	60
Infectious Diseases	30	15	60	40	100	75	110	90	145	130
Nephrology	30	15	45	30	80	60	90	75	125	110
Neurology	20	10	45	30	60	45	75	60	110	100
Neurosurgery	30	15	60	40	100	75	110	90	145	130
Occupational Therapy	20	10	45	30	80	60	75	60	110	100
Oncology – Medical, Surgical	20	10	45	30	60	45	75	60	110	100
Oncology – Radiation	30	15	60	40	100	75	110	90	145	130
Opthamology	20	10	30	20	50	35	75	60	95	85
Orthopedic Surgery	20	10	30	20	50	35	75	60	95	85
Outpatient Clinical Behavioral Health (Licensed, accredited, or certified professionals)	10	5	15	10	30	20	40	30	70	60
Phyiscal Medicine and Rehabilitation	30	15	45	30	80	60	90	75	125	110
Physical Therapy	20	10	45	30	80	60	75	60	110	100
Plastic Surgery	30	15	60	40	100	75	110	90	145	130
Podiatry	20	10	45	30	60	45	75	60	110	100
Primary Care – Adult	10	5	15	10	30	20	40	30	70	60
Primary Care – Pediatric	10	5	15	10	30	20	40	30	70	60
Psychiatry	20	10	45	30	60	45	75	60	110	100
Pulmonology	20	10	45	30	60	45	75	60	110	100

Rheumatology	30	15	60	40	100	75	110	90	145	130
Speech Therapy	20	10	45	30	80	60	75	60	110	100
Urology	20	10	45	30	80	60	75	60	110	100
Vascular Surgery	30	15	60	40	100	75	110	90	145	130
Acute Inpatient Hospitals	20	10	45	30	80	60	75	60	110	100
Cardiac Surgery Program	30	15	60	40	160	120	145	120	155	140
Cardiac Catheterization Services	30	15	60	40	160	120	145	120	155	140
Critical Care Services—Intensive Care Units (ICU)	20	10	45	30	160	120	145	120	155	140
Surgical Services (Outpatient or ASC)	20	10	45	30	80	60	75	60	110	100
Skilled Nursing Facilities	20	10	45	30	80	60	75	60	95	85
Diagnostic Radiology	20	10	45	30	80	60	75	60	110	100
Mammography	20	10	45	30	80	60	75	60	110	100
Inpatient Psychiatric Facility Services	30	15	70	45	100	75	90	75	155	140
Outpatient Infusion/Chemotherapy	20	10	45	30	80	60	75	60	110	100

C. County Type Designations: Counties are designated as a specific type in Table 1 using the following population size and density parameters:

(1) Large Metro: A large metro designation is assigned to any of the following combinations of population sizes and density parameters:

i A population size greater than or equal to 1,000,000 persons with a population density greater than or equal to 1,000 persons per square mile.

ii A population size greater than or equal to 500,000 and less than or equal to 999,999 persons with a population density greater than or equal to 1,500 persons per square mile.

iii Any population size with a population density of greater than or equal to 5,000 persons per square mile.

(2) Metro: A metro designation is assigned to any of the following combinations of population sizes and density parameters:

i A population size greater than or equal to 1,000,000 persons with a population density greater than or equal to 10 persons per square mile and less than or equal to 999.9 persons per square mile.
ii A population size greater than or equal to 500,000 persons and less than or equal to 999,999 persons with a population density greater than or equal to 10 persons per square mile and less than or equal to 1,499.9 persons per square mile.
iii A population size greater than or equal to 200,000 persons and less than or equal to 499,999 persons with a population density greater than or equal to 10 persons per square mile and less than or equal to 4,999.9 persons per square mile.
iv A population size greater than or equal to 50,000 persons and less than or equal to 199,999 persons with a population density greater than or equal to 100 persons per square mile and less than or equal to 4999.9 persons per square mile.
v A population size greater than or equal to 10,000 persons and less than or equal to 49,999 persons with a population density greater than or equal to 1,000 persons per square mile and less than or equal to 4999.9 persons per square mile.

(3) Micro: A micro designation is assigned to any of the following combinations of population sizes and density parameters:

i A population size greater than or equal to 50,000 persons and less than or equal to 199,999 persons with a population density greater than or equal to 10 persons per square mile and less than or equal to 99.9 persons per square mile.
ii A population size greater than or equal to 10,000 persons and less than or equal to 49,999 persons with a population density greater than or equal to 50 persons per square mile and less than 999.9 persons per square mile.

(4) Rural: A rural designation is assigned to any of the following combinations of population sizes and density parameters:

i A population size greater than or equal to 10,000 persons and less than or equal to 49,999 persons with a population density of greater than or equal to 10 persons per square mile and less than or equal to 49.9 persons per square mile.
ii A population size less than 10,000 persons with a population density greater than or equal 50 persons per square mile and less than or equal to 999.9 persons per square mile.

(5) Counties with extreme access considerations (CEAC): For any population size with a population density of less than 10 persons per square mile.

(6) A list of counties in the State with the appropriate county type designation as maintained by the Centers for Medicare and Medicaid services will be published by the Mississippi Department of Insurance on its publicly available website.

D. Subject to Section 14.05(F), a health carrier must meet the following criteria to be deemed in compliance with this Section 14.05: At least 85 percent of the beneficiaries residing in micro, rural, or CEAC counties must have access to at least one provider of each specialty type within the published time and distance standards measured from the beneficiaries' personal residence, and at least 90 percent of the beneficiaries residing in large metro and metro counties must have access to at least one provider of each specialty type within the published time and distance standards measured from the beneficiaries' personal residence.

E. In any case where the health carrier has an insufficient number or type of participating providers/facilities to provide a covered benefit consistent with the geographic access standards set forth in Table 1, Section 14.05(B), or fails to provide a covered benefit consistent with the geographic access standards set forth in Table 1, Section 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 shall provide covered persons reasonable reimbursement for the covered persons' travel, lodging, food, and incidental expenses, or shall make other arrangements acceptable to the Commissioner.

F. The health carrier shall establish and maintain adequate arrangements to ensure reasonable proximity of participating providers/facilities to the personal residence of covered persons. In the Commissioner's sole discretion, a health carrier may be deemed to be out of compliance with the geographic access standards in Table 1, 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 a covered person's personal residence. In determining whether a health carrier has complied with the geographic access standards in Table 1, 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 health care services 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 Table 1, 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) 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.

G. Beginning June 1, 2024, 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, 2024. 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)

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Rule 14.01. Title

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Source: *Miss. Code Ann.* §§ 25-43-1.101, et seq.; § 83-5-1; §§ 83-41-~~1~~401, et seq. (Rev. 2022~~11~~)

Rule 14.02. Purpose

The purpose ~~and intent~~ of this Regulation is~~are~~ 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 ~~and to assure the~~ adequacy, accessibility, and quality of health care services offered under a managed care plan. This Regulation also establishes ~~by establishing~~ 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. ~~2011~~2022)

Rule 14.03. Definitions

For purposes of this Regulation:

~~A. "Closed plan" means a managed care plan that requires covered persons to use participating providers under the terms of the managed care plan in order to obtain covered benefits.~~

~~B.~~A. "Commissioner" means the Commissioner of Insurance.

~~C.~~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.

~~D.~~C. "Covered person" means a policyholder, subscriber, enrollee, or other individual participating in a health benefit plan.

~~E.~~"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.

D.

~~F.~~E. "Emergency services" means health care items and services furnished or required to evaluate and treat an emergency medical condition.

~~G.~~F. "Facility" means an institution providing health care services or a health care setting, including, but not limited to, hospitals ~~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.

~~H.~~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.

~~I.~~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.

~~J.~~I. "Health care provider" or "provider" means a health care professional or a facility.

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

~~L.~~"Health carrier" means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the C~~c~~ommissioner, 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, ~~and~~ health service corporation, or any other entity providing a plan of health insurance, health benefits, or health services.

~~M.~~M.

~~N.~~K. ~~"Health indemnity plan" means a health benefit plan that is not a managed care plan.~~

~~O.~~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.

~~P.~~M. "Managed care plan" means a plan as defined by Miss. Code Ann. § 83-41-403(b).

~~Q.~~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.

R. ~~"Open plan" means a managed care plan other than a closed plan that provides incentives, including financial incentives (i.e. higher benefits, lower cost sharing) for covered persons to use participating providers under the terms of the managed care plan.~~

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

~~T.~~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.

~~U.~~U.

Source: *Miss. Code Ann*. § 83-41-403; § 83-41-405; § 83-41-413 (Rev. ~~2011~~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.

Source: *Miss. Code Ann*. § 83-41-405; § 83-41-413 (Rev. ~~2011~~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 assure that all 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.

~~A.~~B. Sufficiency shall be determined by the following Table 1 of geographic access standards, ~~in accordance with the requirements of this section, and may be established by~~along with consideration of the health plan's ~~reference to any reasonable criteria used by the health carrier, including but not limited to:~~ provider-covered person ratios by specialty; ~~primary care provider-covered person ratios;~~ 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.~~T 1~~ Delivery ~~by~~ of services by telemedicine or other alternative means may be considered, in the discretion of the Commissioner, in evaluating compliance with Table 1.

TABLE 1

Individual	~~Large Metro~~		~~Metro~~		~~Micro~~		~~Rural~~		~~CEAC~~	
Provider/Facility Specialty Types	Max Time	Max Distance	Max Time	Max Distance	Max Time	Max Distance	Max Time	Max Distance	Max Time	Max Distance
Allergy and Immunology	30	15	45	30	80	60	90	75	125	110
Cardiology	20	10	30	20	50	35	75	60	95	85
Cardiothoracic Surgery	30	15	60	40	100	75	110	90	145	130
Chiropractor	30	15	45	30	80	60	90	75	125	110
Dental	30	15	45	30	80	60	90	75	125	110
Dermatology	20	10	45	30	60	45	75	60	110	100
Emergency Medicine	20	10	45	30	80	60	75	60	110	100
Endincronology	30	15	60	40	100	75	110	90	145	130

ENT/Otolaryngolgy	30	15	45	30	80	60	90	75	125	110
Gastroenterology	20	10	45	30	60	45	75	60	110	100
General Surgery	20	10	30	20	50	35	75	60	95	85
Gynocology, OB/GYN	10	5	15	10	30	20	40	30	70	60
Infectious Diseases	30	15	60	40	100	75	110	90	145	130
Nephrology	30	15	45	30	80	60	90	75	125	110
Neurology	20	10	45	30	60	45	75	60	110	100
Neurosurgery	30	15	60	40	100	75	110	90	145	130
Occupational Therapy	20	10	45	30	80	60	75	60	110	100
Oncology – Medical, Surgical	20	10	45	30	60	45	75	60	110	100
Oncology – Radiation	30	15	60	40	100	75	110	90	145	130
Opthamology	20	10	30	20	50	35	75	60	95	85
Orthopedic Surgery	20	10	30	20	50	35	75	60	95	85
Outpatient Clinical Behavioral Health (Licensed, accredited, or certified professionals)	10	5	15	10	30	20	40	30	70	60
Phyiscal Medicine and Rehabilitation	30	15	45	30	80	60	90	75	125	110
Physical Therapy	20	10	45	30	80	60	75	60	110	100
Plastic Surgery	30	15	60	40	100	75	110	90	145	130
Podiatry	20	10	45	30	60	45	75	60	110	100
Primary Care – Adult	10	5	15	10	30	20	40	30	70	60
Primary Care – Pediatric	10	5	15	10	30	20	40	30	70	60
Psychiatry	20	10	45	30	60	45	75	60	110	100
Pulmonology	20	10	45	30	60	45	75	60	110	100
Rheumatology	30	15	60	40	100	75	110	90	145	130
Speech Therapy	20	10	45	30	80	60	75	60	110	100
Urology	20	10	45	30	80	60	75	60	110	100
Vascular Surgery	30	15	60	40	100	75	110	90	145	130
Acute Inpatient Hospitals	20	10	45	30	80	60	75	60	110	100
Cardiac Surgery Program	30	15	60	40	160	120	145	120	155	140
Cardiac Catheterization Services	30	15	60	40	160	120	145	120	155	140

Critical Care Services—Intensive Care Units (ICU)	20	10	45	30	160	120	145	120	155	140
Surgical Services (Outpatient or ASC)	20	10	45	30	80	60	75	60	110	100
Skilled Nursing Facilities	20	10	45	30	80	60	75	60	95	85
Diagnostic Radiology	20	10	45	30	80	60	75	60	110	100
Mammography	20	10	45	30	80	60	75	60	110	100
Inpatient Psychiatric Facility Services	30	15	70	45	100	75	90	75	155	140
Outpatient Infusion/Chemotherapy	20	10	45	30	80	60	75	60	110	100

C. County Type Designations: Counties are designated as a specific type in Table 1 using the following population size and density parameters:

(1) Large Metro: A large metro designation is assigned to any of the following combinations of population sizes and density parameters:

i. A population size greater than or equal to 1,000,000 persons with a population density greater than or equal to 1,000 persons per square mile.

ii. A population size greater than or equal to 500,000 and less than or equal to 999,999 persons with a population density greater than or equal to 1,500 persons per square mile.

iii. Any population size with a population density of greater than or equal to 5,000 persons per square mile.

(2) Metro: A metro designation is assigned to any of the following combinations of population sizes and density parameters:

i. A population size greater than or equal to 1,000,000 persons with a population density greater than or equal to 10 persons per square mile and less than or equal to 999.9 persons per square mile.

ii. A population size greater than or equal to 500,000 persons and less than or equal to 999,999 persons with a population density greater than or equal to 10 persons per square mile and less than or equal to 1,499.9 persons per square mile.

iii. A population size greater than or equal to 200,000 persons and less than or equal to 499,999 persons with a population density greater than or equal to 10 persons per square mile and less than or equal to 4,999.9 persons per square mile.

iv. A population size greater than or equal to 50,000 persons and less than or equal to 199,999 persons with a population density greater than or

equal to 100 persons per square mile and less than or equal to 4999.9 persons per square mile.

v A population size greater than or equal to 10,000 persons and less than or equal to 49,999 persons with a population density greater than or equal to 1,000 persons per square mile and less than or equal to 4999.9 persons per square mile.

(3)Micro: A micro designation is assigned to any of the following combinations of population sizes and density parameters:

iA population size greater than or equal to 50,000 persons and less than or equal to 199,999 persons with a population density greater than or equal to 10 persons per square mile and less than or equal to 99.9 persons per square mile.

iiA population size greater than or equal to 10,000 persons and less than or equal to 49,999 persons with a population density greater than or equal to 50 persons per square mile and less than 999.9 persons per square mile.

(4)Rural: A rural designation is assigned to any of the following combinations of population sizes and density parameters:

iA population size greater than or equal to 10,000 persons and less than or equal to 49,999 persons with a population density of greater than or equal to 10 persons per square mile and less than or equal to 49.9 persons per square mile.

iiA population size less than 10,000 persons with a population density greater than or equal 50 persons per square mile and less than or equal to 999.9 persons per square mile.

(5)Counties with extreme access considerations (CEAC): For any population size with a population density of less than 10 persons per square mile.

(6)A list of counties in the State with the appropriate county type designation as maintained by the Centers for Medicare and Medicaid services will be published by the Mississippi Department of Insurance on its publicly available website.

D.Subject to Section 14.05(F), a health carrier must meet the following criteria to be deemed in compliance with this Section 14.05: A ~~a~~At least 85 percent of the beneficiaries residing in micro, rural, or CEAC counties must have access to at least one provider of each specialty type within the published time and distance standards measured from the beneficiaries' personal residence, and~~.~~ a~~A~~t least 90 percent of the beneficiaries residing in large metro and metro counties must have access to at least one provider of each specialty type within the published time and distance standards measured from the beneficiaries' personal residence.

~~B.~~ In any case where the health carrier has an insufficient number or type of participating providers/facilities to provide a covered benefit consistent with these geographic access standards set forth in Table 1, Section 14.05(B), or fails to provide a covered benefit consistent with the geographic access standards set forth in Table 1, Section 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, ~~or shall make other arrangements acceptable to the Ccommissioner and~~ and additionally shall provide covered persons reasonable reimbursement for the covered persons' travel, lodging, food, and incidental expenses, ~~,~~ or shall make other arrangements acceptable to the Commissioner.

E.E.

~~C.C.~~

~~D.~~ The health carrier shall establish and maintain adequate arrangements to ensure reasonable proximity of participating providers/facilities to the ~~business or~~ personal residence of covered persons. In the Commissioner's sole discretion, a health carrier may be deemed to be out of compliance with the geographic access standards in Table 1, 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 a covered person's personal residence. ~~-~~In determining whether a health carrier has complied with ~~this provision~~ the geographic access standards in Table 1, Rule 14.05(B), the ~~commissioner~~ Commissioner ~~may~~ shall ~~-~~give due consideration to the relative availability of health care providers in the ~~service~~ geographic area under consideration. The fact that no provider specialist, adult or pediatric, provides health care services 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 Table 1, Rule 14.05(B) and Rule 14.05(D) if the Commissioner determines the health carrier has made reasonable efforts to secure health care provi~~fi~~ders 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 15. ~~. The Commissioner shall have the authority to request and obtain from the health carrier data pertaining to the health carrier's efforts to comply with this~~ section. /facilities/facilities

F.F.

(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) 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.

~~The Commissioner shall have authority to request and obtain from the health carrier data 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~~

~~, along with~~

~~(1) The Commissioner shall afford a health carrier a hearing before making a final determination that a health carrier's network does not meet sufficiency requirements.~~

~~E.~~C.~~.~~Beginning ~~August 1, 2014~~June 1, 2024, a health carrier shall file with the ~~commissioner~~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 ~~this Regulation~~Rule 14.05 for each of the managed care plans that the carrier offers in this state. ~~The health carrier may request the commissioner~~Commissioner consider sections to deem sections of the access plan as ~~proprietary or competitive information that shall not be made public. Under this~~For the ~~purposes of this section, information is proprietary or competitive if revealing the information would cause the health carrier's competitors to obtain valuable business information.~~ 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~~plan prior to offering~~ a new managed care ~~plan, and~~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,~~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~~Commissioner to determine compliance with the provisions of this Regulation.

Source: *Miss. Code Ann*. § 83-41-405; § 83-41-413 (Rev. ~~2011~~2022)

Rule 14.06. Requirements for Health Carriers and Participating Providers

A health carrier offering a managed care plan shall ~~include~~ 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 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 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 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 including but not limited to term ofs, including 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 with~~ without~~for~~ cause. ~~provider~~ The health carrier shall make a good-faith effort~~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~~ 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 ~~a~~ mechanism(s) by which the participating providers may determine in a timely manner whether or not a person is covered by the health carrier,~~and~~ whether a particular service is covered, and whether a particular service requires pre-certification.~~.~~ ~~A health carrier shall submit such mechanism)s) to the Commissioner for approval by the Commissioner.~~

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

R.R.

S.~~S.~~

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

T.~~T.~~

~~U.~~S.

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.

~~V. The Commissioner may retain an outside consultant to assist in such review if the Commission determines such is appropriate, and the cost of such consultant shall be assessed to the health carrier as a fee pursuant to Miss. Code Ann. § 83-41-407.~~

Source: *Miss. Code Ann*. § 83-41-405; §83-41-411; and § 83-41-413 (Rev. 2011)

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~~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. ~~including the right to make copies to facilitate regulatory review, upon twenty (20) days prior written notice from the health carrier.~~

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~~ Commissioner access to the intermediary's books, records, financial ~~information~~ 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. ~~2011~~2022)

Rule 14.08. ~~**Filing Requirements and State Administration**~~ **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).

~~A.Beginning August 1, 2014, a health carrier shall file with the commissioner sample contract forms proposed for use with its participating providers and intermediaries.~~

~~B.A health carrier shall submit material changes to a contract that would affect a provision required by this regulation to the commissioner for approval prior to use. Changes in provider payment rates, coinsurance, copayments or deductibles, or other plan benefit modifications are not considered material changes for the purpose of this subsection.~~

~~C.If the commissioner takes no action within sixty (60) days after submission of a material change to a contract by a health carrier, the change is deemed approved.~~ Table 1.

~~D.~~D.

~~E.The health carrier shall maintain provider and intermediary contracts at its principal place of business in the state, or the health carrier shall have access to all contracts and provide copies to facilitate regulatory review upon twenty (20) days prior written notice from the commissioner.~~ Table 1, and Rule 14.05(D)Table 1,

Source: *Miss. Code Ann.* §§ 25-61-9; ~~83-41-405;~~ § 83-41-413 (Rev. 20~~11~~ 22)

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. ~~2011~~2022)

~~Rule 14.10. Enforcement~~

~~B.If the commissioner determines that a health carrier has not contracted with enough participating providers to assure that covered persons have accessible health care services in a geographic area, or that a health carrier's access plan does not assure reasonable access to covered benefits, or that a health carrier has entered into a contract that does not comply with this Regulation, or that a health carrier has not not complied with a provision of this Regulation, the commissioner may institute a corrective action that shall be followed by the health carrier, or may use any of the commissioner's other enforcement powers to obtain the health carrier's compliance with this Regulation.~~

~~A.A.~~

~~B. The commissioner will not act to arbitrate, mediate or settle disputes regarding a decision not to include a provider in a managed care plan or in a provider network or regarding any other dispute between a health carrier, its intermediaries or a provider network arising under or by reason of a provider contract or its termination.~~

~~Source: *Miss. Code Ann.* § 83-41-405; § 83-41-413 (Rev. 2011)~~

Rule 14.~~11~~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. ~~2011~~2022)

Rule 14.~~12~~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. ~~2011~~2022)

Rule 1~~4.133~~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, 2024. 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.

~~A.All provider and intermediary contracts in effect on the effective date of this Regulation shall comply with this Regulation no later than June 1, 2024eighteen (18) months after the effective date of this Regulation. The commissionerCommissioner may extend the eighteen (18) monthsthis deadline for an additional period not to exceed six (6) months if the health carrier demonstrates good cause for an extension.~~

~~B.B.~~

~~Any new health carrier issuing a provider or intermediary contract that is issued or put in force on or after June 1, 2024, shall comply with this Regulation within six months of the issuance of any provider or intermediary contract.~~

~~C.A new provider or intermediary contract that is issued or put in force on or after August 1, 2014, shall comply with this Regulation.~~

~~D.A provider contract or intermediary contract not described in Subsection A or Subsection B shall comply with this Regulation no later than eighteen (18) months after the effective date of this Regulation.~~

Source: *Miss. Code Ann.* § 25-43-3.112 (Rev. ~~2011~~2022)