Title 23. Public Utilities and Regulated Industries
Chapter I. State Insurance Department, Department of Commerce
Subchapter B. Life, Health, and Accident
Part 137. Network Adequacy Requirements for Health Benefit Plans

Codification Notes. This part as promulgated prior to codification into the Code of Arkansas Rules provided as follows:

"Section 1. Authority
This Rule is issued pursuant to the authority granted the Arkansas Insurance Commissioner ("Commissioner") under Ark. Code Ann.§ 23-61-108(a)(1) and by Ark. Code Ann. § 23-61-108(b)(1) to promulgate rules necessary for the effective regulation of the business of insurance and as required for this State to be in compliance with federal laws, namely Section 2702(c) of the Public Health Service Act and 45 CFR § 156.230 which require that Qualified Health Plans provide sufficiently accessible medical providers. In addition, this Rule is issued pursuant to the authority granted the Commissioner to issue regulations related to the provision of adequate health care services by health maintenance organizations under Ark. Code Ann. § 23-76-108(a)."

"Section 10. Effective Date
The effective date of this Rule is January 1, 2022."

Subpart 1. Generally

23 CAR § 137-101. Purpose.

The purpose of this part is to:

(1) Establish minimum standards for the creation and maintenance of networks by health carriers; and

(2) Ensure the adequacy, accessibility, and quality of healthcare services offered under health benefit plans.

Authority. Arkansas Code §§ 23-61-108, 23-76-108, 23-76-125.

23 CAR § 137-102. Applicability and scope.

This part applies to all health carriers that offer health benefit plans in this state that are issued or renewed on or after January 1, 2015.

Authority. Arkansas Code §§ 23-61-108, 23-76-108, 23-76-125.

23 CAR § 137-103. Definitions.

For purposes of this part:

(1) "Accredited health carrier" means a health carrier that has an adequate network as certified by an approved accrediting organization under the provisions of 23 CAR § 137-104(k);

(2) "Commissioner" means the Insurance Commissioner;

(3) "Covered benefits" or "benefits" means those healthcare services to which a covered person is entitled under the terms of a health benefit plan;

(4) "Covered person" means a policyholder, subscriber, enrollee, or other individual participating in a health benefit plan;

(5) "Dental benefits" means benefits for dental services embedded in, or offered by, a rider attached to:

(A) A QHP offered through the Affordable Care Act-approved marketplace; or

(B) An Affordable Care Act-compliant nongrandfathered plan;

(6) "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:

(A) Result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part; or

(B) Place the person's health in serious jeopardy;

(7) "Emergency services" means healthcare items and services furnished or required to evaluate and treat an emergency medical condition;

(8) "Essential community provider" means a provider that serves predominantly low-income, medically underserved individuals as defined in 45 C.F.R. § 156.235;

(9) "Facility" means an institution providing healthcare services or a healthcare setting, including, but not limited to:

(A) Hospitals and other licensed inpatient centers;

(B) Ambulatory surgical or treatment centers;

(C) Skilled nursing centers;

(D) Residential treatment centers;

(E) Diagnostic, laboratory, and imaging centers; and

(F) Rehabilitations and other therapeutic health settings;

(10)(A) "Health benefit plan" means any individual, blanket, or group plan, policy, or contract for healthcare services issued or renewed by a health carrier on or after January 1, 2015, that requires a covered person to use healthcare providers managed, owned, under contract with, or employed by the health carrier.

(B) "Health benefit plan" does not include a plan providing healthcare services pursuant to the Arkansas Constitution, Article 5, § 32, the Workers' Compensation Law, Arkansas Code § 11-9-101 et seq., and the Public Employee Workers' Compensation Act, Arkansas Code § 21-5-601 et seq., nor include an accident-only, specified disease, hospital indemnity, long-term care, disability income, or limited-benefit health insurance policy.

(C) The provisions of this part also do not apply to Medicare Supplement or Medicare Advantage policies.

(D) This part applies to dental benefits as defined in subdivision (5) of this section and vision benefits as defined in subdivision (25) of this section, as well as plans offered by standalone dental carriers as defined in subdivision (23) of this section;

(11)(A) "Health carrier" means an entity subject to the insurance laws and rules of this state, or subject to the jurisdiction of the Insurance 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 healthcare services, including:

(i) A health insurer;

(ii) A health maintenance organization;

(iii) A hospital and medical service corporation; or

(iv) Any other entity providing health benefit plans.

(B) A "health carrier" does not include an automobile insurer paying medical or hospital benefits under Arkansas Code § 23-89-202(1) nor shall it include a self-insured employer health benefits plan.

(C) A "health carrier" does not include any person, company, or organization, licensed or registered to issue or who issues any insurance policy or insurance contract in this state providing medical or hospital benefits for accidental injury or accidental disability.

(D) A "health carrier" shall include an entity that provides dental and/or vision benefits as defined in subdivision (5) of this section and subdivision (25) of this section, respectively, or is a standalone dental carrier as defined by subdivision (23) of this section;

(12) "Healthcare professional" means a physician or other healthcare practitioner licensed, accredited, or certified to perform physical, behavioral, mental health, or substance use disorder and health services consistent with state law;

(13) "Healthcare provider" or "provider" means a participating healthcare or dental professional or a facility;

(14) "Healthcare services" means services for the diagnosis, prevention, treatment, cure, or relief of:

(A) A health condition;

(B) An illness;

(C) An injury; or

(D) A disease;

(15)(A) "Network" means the collection of all participating providers providing services to a health benefit plan.

(B) The network associated with a health benefit plan should be identifiable using a suitable network ID, and one (1) health benefit plan can have only one (1) such network ID;

(16)(A) “Patient-centered medical home (PCMH)” means a local point of access to care that proactively looks after patients' health on a twenty-four-hours-per-day, seven-days-per-week basis.

(B) A PCMH supports patients to connect with other providers to form a health services team, customized for their patients' care needs with a focus on prevention and management of chronic disease through monitoring patient progress and coordination of care;

(17) "Person" means:

(A) An individual;

(B) A corporation;

(C) A partnership;

(D) An association;

(E) A joint venture;

(F) A joint stock company;

(G) A trust;

(H) An unincorporated organization;

(I) Any similar entity; or

(J) Any combination of the foregoing;

(18) "Primary care professional" means a participating healthcare professional practicing within their licensed scope of practice and designated by the health carrier to supervise, coordinate, or provide initial care or continuing care to a covered person, and who may be required by the health carrier to initiate a referral for specialty care and maintain supervision of healthcare services rendered to the covered person;

(19) "Provider" means a provider who, under a contract with a health carrier or with its contractor or subcontractor, has agreed to provide healthcare services to covered persons with an expectation of receiving payment, other than coinsurance, copayments, or deductibles, directly or indirectly from the health carrier;

(20) "Qualified health plan" means an insurance policy that meets the requirements of 42 U.S.C. § 18021(a)(1);

(21)(A) "Service area" means the collection of counties serviced by a health benefit plan.

(B) Counties may be grouped into larger aggregations called health rating areas, and a health benefit plan is required to cover at least one (1) health rating area.

(C) The aggregation of counties is published in the annual bulletin setting forth requirements for Affordable Care Act submissions;

(22) "Specialty care professional" means a participating healthcare professional that is specially qualified to practice by having:

(A) Attended an advanced program of study;

(B) Passed an examination given by an organization of the members of the specialty; or

(C) Gained experience through extensive practice in the specialty;

(23) "Standalone dental carrier" means an entity subject to the insurance laws and rules of this state, or subject to the jurisdiction of the Insurance Commissioner, that offers plans through the Affordable Care Act-approved marketplace and/or offers plans outside the Affordable Care Act-approved marketplace for the purpose of providing the essential health benefits category of pediatric-level oral benefits;

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

(25) "Vision benefits" means benefits for vision services embedded in, or offered by a rider attached to, a QHP offered through:

(A) The Affordable Care Act-approved marketplace; or

(B) An Affordable Care Act-compliant nongrandfathered plan.

Authority. Arkansas Code §§ 23-61-108, 23-76-108, 23-76-125.

Codification Notes. "QHP" means qualified health plan.

23 CAR § 137-104. Network adequacy minimum standards.

(a)(1) A health carrier providing a health benefit plan shall maintain a network that is sufficient in numbers and types of providers to ensure that all healthcare services to covered persons will be accessible without unreasonable delay.

(2) Sufficiency may be established by reference to any reasonable criteria used by the health carrier and approved by the Insurance Commissioner, including, but not limited to:

(A) Provider-to-covered person ratios by specialty;

(B) Primary care professional-to-covered person ratios;

(C) Typical referral patterns;

(D) Provider's hospital admitting privileges;

(E) Geographic accessibility;

(F) Waiting times for appointments with participating providers;

(G) Hours of operation; and

(H) The volume of technological and specialty services available to serve the needs of covered persons requiring technologically advanced or specialty care.

(b) Every health carrier shall strive to meet the following minimum guidelines related to geographic accessibility through geographical access data or other information in a format and with content specified by the State Insurance Department set forth in subsection (f) of this section, for the plan year:

(1) In the case of emergency services, a covered person will have access to emergency services twenty-four-hours-per-day, seven-days-per-week within a thirty-mile radius, or within thirty-minute travel time, whichever is shorter, between the location of the emergency services and the residence of the covered person;

(2) In the case of a primary care professional, a covered person will have access to at least one (1) primary care professional within a thirty-mile radius, or within

thirty-minute travel time, whichever is shorter, between the location of the primary care professional and the residence of the covered person;

(3) In the case of a specialty care professional, a covered person will have access to covered specialty care services within a sixty-mile radius, or within sixty-minute travel time, whichever is shorter, between the location of the specialty care professional and the residence of the covered person;

(4) For qualified health plans participating in the Affordable Care Act-approved marketplace, in the case of essential community providers, a covered person will have access to at least one (1) essential community provider within a thirty-mile radius, or within thirty-minute travel time, whichever is shorter, between the location of the essential community provider and the residence of the covered person; and

(5)(A) The health carrier shall provide accurate provider practice addresses to the department.

(B) Practice locations should be current at the time of data submission to the department.

(c) In the event that a health carrier has an insufficient number or type of participating providers to provide a covered benefit, the health carrier shall ensure that the covered person obtains the covered benefit at no greater cost to the covered person than if the benefit were obtained from a participating provider.

(d) In determining whether a health carrier has complied with the requirements in this section, the commissioner shall give due consideration to the relative availability of healthcare providers in the service area under consideration.

(e)(1) A health carrier shall monitor, on an ongoing basis, the ability of its participating providers to furnish all contracted benefits to covered persons.

(2) A health carrier shall reasonably monitor:

(A) Provider-to-covered person ratios by specialty;

(B) Primary care professional-to-covered person ratios;

(C) Typical referral patterns;

(D) Provider's hospital admitting privileges;

(E) Geographic accessibility;

(F) Waiting times for appointments with participating providers;

(G) General hours of operation, including part-time or full-time status and weekend and after-hours availability; and

(H) The volume of technological and specialty services available to serve the needs of covered persons requiring technologically advanced or specialty care.

(f)(1) Geographical access data must be submitted for each of the categories of care referenced in subdivisions (b)(1) – (4) of this section.

(2) Data specifications will be published by the department and available online as SERFF Network Adequacy Data Submission Instructions updated for each plan year as necessary and appropriate.

(3) A health carrier shall strive to meet a compliance percentage of eighty percent (80%) for each of the categories of care referenced in subdivisions (b)(1) – (4) of this section.

(4) Provider data must indicate which providers are accepting new patients.

(5) The following are special requirements for each category of care:

(A) Health carriers must provide geographical access maps for primary care professionals that include each:

(i) General/family practitioner;

(ii) Internal medicine provider; and

(iii) Family practitioner/pediatrician;

(B) Health carriers must provide geographical access maps for hospitals and specialty care professionals according to the following categories:

(i) Hospitals by Arkansas hospital licensure type;

(ii) Home health agencies;

(iii) Skilled nursing facilities; and

(iv) All specialty care categories and sub-specialty categories covered under the health benefit plan;

(C) Health carriers must provide geographical access maps for mental health, behavioral health, and substance use disorder providers categorized between:

(i) Psychiatric and state-licensed clinical psychologists;

(ii) Substance use disorder providers; and

(iii) Other mental health, behavioral health, and substance use disorder providers with additional documentation describing the provider and facility types included within the other category; and

(D) Health carriers seeking certification through the Affordable Care Act-approved marketplace must provide geographical access data for essential community providers with the providers grouped as set forth in the Affordable Care Act and pursuant to Centers for Medicare & Medicaid Services guidelines.

(g) **Performance metrics.**

(1) Nonaccredited health carriers will be required to submit metrics demonstrating performance for each of the above standards for each county in the service area and overall service area.

(2)(A) Accredited health carriers will be required to submit the following metrics for reporting purposes.

(B) These include:

(i) The number of members and percentage of total members meeting the geographical requirements under subsection (b) of this section; and

(ii) The average distance to first, second, and third closest provider for each provider type.

(C)(i) These figures should be provided overall (entire state) for each category as well as stratified by county for each category.

(ii) For example, the percent of enrolled members that are within thirty (30) minutes or thirty (30) miles of a general/family practitioner will be submitted with percentages overall and for each county.

(iii) The average distance to the first, second, and third closest provider will be submitted overall and for each county.

(D) Health carriers who do not yet have enrollees in the State of Arkansas must attest to not currently having enrollees in Arkansas and provide geographical access data calculated using suitable sampling of United States Census data.

(h) **Essential community providers.**

(1) Health carriers issuing qualified health plans are required to meet all federal requirements for inclusion of essential community providers in the plan network.

(2) Qualifying essential community providers include providers described in Section 340B of the Public Health Service Act and Section 1927(c)(1)(D)(i)(IV) of the Social Security Act.

(3) In addition, the following state guidelines must be met regarding essential community providers:

(A) Each health carrier issuing qualified health plans will be required to meet conditions of the Heath Care Independence Program 1115 Waiver and offer at least one (1) qualified health plan that has at least one (1) federally qualified health center or rural health center in each service area of the plan network;

(B) Each health carrier issuing qualified health plans must submit a list of school-based providers included in the plan network; and

(C) Each health carrier issuing qualified health plans must offer a contract to at least one (1) school-based provider in each county in the service area, where a school-based provider is identifiable and available and meets issuer certification and credentialing standards.

(i) **Access plans.**

(1) A health carrier shall file with the commissioner an access plan meeting the requirements of subdivisions (i)(4)(A) – (L) of this section for health benefit plans issued or renewed in this state on or after January 1, 2023.

(2) The health carrier shall make the access plans, absent proprietary information, available to its insureds.

(3) The health carrier shall prepare an access plan prior to offering a new health benefit plan, and shall update an existing access plan whenever it makes any material change to an existing health benefit plan such as the loss of a material provider such as a hospital or multi-specialty clinic.

(4) The access plan shall describe or contain at least the following:

(A) The health carrier's network;

(B) The health carrier’s procedures for making referrals within and outside its network and for notifying enrollees and potential enrollees regarding availability of network and out-of-network providers;

(C) The health carrier’s process for monitoring and assuring on an ongoing basis the sufficiency of the network to meet the healthcare needs of populations that enroll in its health benefit plans;

(D) The health carrier’s efforts to address the needs of covered persons with:

(i) Limited English proficiency and illiteracy;

(ii) Diverse cultural and ethnic backgrounds; and

(iii) Physical and mental disabilities;

(E) The health carrier’s methods for assessing the healthcare needs of covered persons;

(F) The health carrier’s method of informing covered persons of the plan's services and features, including:

(i) Cost sharing;

(ii) The plan's grievance procedures;

(iii) Its process for choosing and changing providers; and

(iv) Its procedures for providing and approving emergency and specialty care;

(G) The health carrier’s method for assessing consumer satisfaction;

(H) The health carrier’s method for using assessments of enrollee complaints and satisfaction to improve carrier performance;

(I) The health carrier’s system for ensuring the coordination and continuity of care for covered persons referred to specialty providers, for covered persons using ancillary services, including social services and other community resources, and for ensuring appropriate discharge planning;

(J) The health carrier’s process for enabling covered persons to change primary care professionals;

(K)(i) 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.

(ii) 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

(L) Any other information required by the commissioner to determine compliance with the provisions of this part.

(j) **Provider directories.**

(1) A health carrier shall make a provider directory available for online publication by the commissioner and shall also make its provider directory accessible:

(A) By a link to the health carrier's website; and

(B) To potential enrollees in hardcopy upon request.

(2) The provider directory shall identify providers who are currently accepting new patients.

(3) Health carriers shall update any changes to the provider directory within fourteen (14) days of that change becoming effective.

(4)(A) If the provider directory must be taken offline for any reason for a period to exceed forty-eight (48) hours, that carrier shall notify the department at least two (2) weeks in advance of the provider directory going offline, or as soon as practically known.

(B) In the department notification, health carriers shall state:

(i) The reason for online unavailability;

(ii) What steps are being taken to get the information back online; and

(iii) The expected online relaunch date.

(5) Online provider directories must be available in Spanish.

(6) The directory search must include the ability to filter by each category of ECP.

(7) The directory search must include an indication of hours of operation, including part-time or full-time as well as after-hours availability as reported by providers.

(8) Providers who participate in the patient-centered medical home program must be indicated in the provider directory.

(k) If a health carrier has accreditation that includes an audit of the health carrier's network adequacy, the commissioner will accept that accreditation in lieu of the health carrier demonstrating it has complied with the requirements under subsections (a) – (h) of this section, if the following conditions are met:

(1) A certificate of accreditation must be submitted by the certified accrediting entity that is recognized pursuant to 45 C.F.R. § 156.275, or any other certified entity as recognized by the department;

(2) The certified accrediting entity has submitted information showing that its audit includes a review of all reasonable and/or necessary requirements of state and federal law;

(3) The health carrier agrees to provide to the department any and all material and information submitted to the certified accrediting entity upon the commissioner’s request;

(4) The accredited health carrier has submitted annual geographical access data and performance metrics as required in this section for reporting purposes only;

(5) Nothing in the above conditions shall supersede the federal accreditation requirements of qualified health plans as described in 45 C.F.R. § 156.275; and

(6) The commissioner reserves the right to reverify compliance of network adequacy as a part of any quarterly audit or request for certification of a qualified health plan.

(l) The commissioner will also accept an accreditation of a health carrier’s access plan by a certified accrediting entity that a health carrier has an access plan meeting the requirements of subdivisions (i)(4)(A) – (L) of this section, although such plan must be filed with the commissioner.

(m)(1) All time and distance guidelines as set forth in this part are minimum standards only.

(2) The commissioner, pursuant to his or her discretion, may publish more detailed and specific network adequacy time/distance standards, as well as guidelines regarding the use of telemedicine to meet network adequacy standards, via SERFF Network Adequacy Data Submission Instructions, and/or annual bulletin for setting forth certification requirements for Affordable Care Act submissions.

(3) Such new standards will become effective for review on January 1 of the following year.

Authority. Arkansas Code §§ 23-61-108, 23-76-108, 23-76-125.

Codification Notes. Section 340B of the Public Health Service Act is codified at 42 U.S.C. § 256b.

Section 1927(c)(1)(D)(i)(IV) of the Social Security Act is codified at 42 U.S.C. § 1396r-8(c)(1)(D)(i)(IV).

"SERFF" means System for Electronic Rates & Forms Filing.

"ECP" means essential community provider.

23 CAR § 137-105. Standalone dental plans.

(a)(1) For standalone dental plans offered through the Affordable Care Act-approved marketplace or where a standalone dental plan is offered outside of the Affordable Care Act-approved marketplace for the purpose of providing the essential health benefit category of pediatric oral benefits, all such standalone dental plans must ensure that all covered services to enrollees will be accessible in a timely manner appropriate for the enrollee's conditions.

(2) Dental networks for oral services must be sufficient for the enrollee population in the service area based on potential utilization.

(3) Determination of whether a standalone dental carrier's network is sufficient will be based on reasonable criteria used by the standalone dental carrier, including, but not limited to:

(A) Provider-to-covered ratios by general dentist;

(B) Typical referral patterns;

(C) Geographic accessibility;

(D) Waiting times for appointments with participating providers;

(E) Hours of operation; and

(F) The volume of technologically advanced or specialty care.

(4) Standalone dental carriers shall strive to meet the following guidelines through geographical access data or other information in a format and with content specified by the State Insurance Department, set forth in 23 CAR § 137-104(f), for the plan year:

(A) In the case of a nonspecialist oral care provider, a covered person will have access to at least one (1) dentist within a thirty-mile radius, or within thirty-minute travel time, whichever is shorter, between the location of the dentist and the residence of the covered person;

(B) In the case of a specialist oral care provider, a covered person will have access to at least one (1) specialist dentist within a sixty-mile radius, or within sixty-minute travel time, whichever is shorter, between the location of the specialty care professional and the residence of the covered person;

(C) If an essential community provider that provides oral health services is located within a thirty-mile radius, or within thirty-minute travel time, whichever is shorter, between the location of the essential community provider and the residence of a covered person, a standalone dental carrier must make reasonably best efforts to provide the covered person access to that essential community provider;

(D)(i) The health carrier shall provide accurate and up-to-date provider practicing addresses to the department at the time of data submission.

(ii) For purposes of satisfying the requirements of subdivisions (a)(4)(A) – (C) of this section, a standalone dental carrier may submit an accreditation that such requirements are met by a certified accredited entity abiding by the same conditions as described in 23 CAR § 137-104(k); and

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

(b)(1) Standalone dental carriers applying to the Insurance Commissioner to participate in the Affordable Care Act-approved marketplace or offer a standalone dental plan outside of the Affordable Care Act-approved marketplace for the purpose of providing the essential health benefit category of pediatric oral benefits are required to submit metrics demonstrating performance for each of the standards above for each county in the service area and overall service area.

(2) These figures should be provided overall (entire state) for each category as well as stratified by county for each category.

(3) For example, the percent of enrolled members that are within thirty (30) minutes or thirty (30) miles of a general dentist will be submitted with percentages overall and for each county.

(4) The average distance to the first, second, and third closest provider will be submitted overall and for each county.

(5) These include:

(A) The number of members and percentage of total members meeting the geographical requirements under subsection (a) of this section;

(B) The average distance to first, second, and third closest provider for each provider type; and

(C) Standalone dental carriers who do not yet have enrollees in the State of Arkansas must attest to not currently having enrollees in Arkansas and provide geographical access data calculated suitable sampling of United States Census data.

(c) In the event that a standalone dental carrier has an insufficient number or type of participating providers to provide a covered benefit, the health carrier shall ensure that the covered person obtains the covered benefit at no greater cost to the covered person than if the benefit were obtained from a participating provider, or shall make other arrangements acceptable to the commissioner that shall include reasonable criteria utilized by the carrier, including, but not limited to:

(1) Provider-to-covered person ratios by dental specialty;

(2) General dentist-to-covered person ratios;

(3) Typical referral patterns;

(4) Geographic accessibility;

(5) Waiting times for appointments with participating providers; and

(6) General hours of operation, including part-time or full-time status and weekend and after-hours availability.

(d) In determining whether a health carrier has complied with the requirements in this section, the commissioner shall give due consideration to the relative availability of dental providers in the service area under consideration.

(e) A standalone dental carrier shall monitor, on an ongoing basis, the ability of its participating providers to furnish all contracted benefits to covered persons.

(f) **Access plans.**

(1) A standalone dental carrier shall file with the commissioner an access plan meeting the requirements of subdivisions (f)(4)(A) – (L) of this section for standalone dental plans issued or renewed in this state on or after January 1, 2015.

(2) The standalone dental carrier shall make the access plans, absent proprietary information, available to its insureds.

(3) The standalone dental carrier shall:

(A) Prepare an access plan prior to offering a new standalone dental plan; and

(B) Update an existing access plan whenever it makes any material change to an existing standalone dental plan, such as the loss of a material provider.

(4) The access plan shall describe or contain at least the following:

(A) The standalone dental carrier's network;

(B) The standalone dental carrier's procedures for making referrals to the extent applicable within and outside its network and for notifying enrollees and potential enrollees regarding availability of network and out-of-network providers;

(C) The standalone dental carrier's process for monitoring and assuring on an ongoing basis the sufficiency of the network to meet the health care needs of populations that enroll in its health benefit plans;

(D) The standalone dental carrier's efforts to address the needs of covered persons with:

(i) Limited English proficiency and illiteracy;

(ii) Diverse cultural and ethnic backgrounds; and

(iii) Physical and mental disabilities;

(E) The standalone dental carrier's methods for assessing the healthcare needs of covered persons;

(F) The standalone dental carrier's method of informing covered persons of the plan's services and features, including cost sharing, the plan's grievance procedures, its process for choosing and changing providers, and its procedures for providing and approving emergency and specialty care;

(G) The standalone dental carrier's method for assessing consumer satisfaction;

(H) The standalone dental carrier's method for using assessments of enrollee complaints and satisfaction to improve carrier performance;

(I) The standalone dental carrier's system for ensuring the coordination and continuity of care for covered persons referred to specialty providers, for covered persons using ancillary services, including social services and other community resources, and for ensuring appropriate discharge planning;

(J) The standalone dental carrier's process for enabling covered persons to change non-specialist dental providers;

(K)(i) The standalone dental carrier’s proposed plan for providing continuity of care in the event of:

(a) Contract termination between the health carrier and any of its participating providers; or

(b) The health carrier's insolvency or other inability to continue operations.

(ii) 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

(L) Any other information required by the commissioner to determine compliance with the provisions of this part.

(g) **Provider directories.**

(1) A standalone dental carrier shall make a provider directory available for online publication by the commissioner and shall also make its provider directory accessible:

(A) By a link to the standalone dental carrier's website; and

(B) To potential enrollees in hardcopy upon request.

(2) The provider directory shall identify providers who are currently accepting new patients.

(3) Standalone dental carriers shall update any changes to the provider directory within fourteen (14) days of that change becoming effective.

(4)(A) If the provider directory must be taken offline for any reason for a period to exceed forty-eight (48) hours, that carrier shall notify the department at least two (2) weeks in advance of the provider directory going offline, or as soon as practically known.

(B) In the department notification, standalone dental carriers shall state:

(i) The reason for online unavailability;

(ii) What steps are being taken to get the information back online; and

(iii) The expected online relaunch date.

(5) Online provider directories must be available in Spanish.

(6) The directory search must include the ability to filter by ECP.

(7) The directory search must include an indication of hours of operation including part-time or full-time as well as after-hours availability as reported by providers.

Authority. Arkansas Code §§ 23-61-108, 23-76-108, 23-76-125.

Codification Notes. "ECP" means essential community provider.

23 CAR § 137-106. Provider Type NPI Pool data maintenance.

(a)(1) A list of provider types developed by the State Insurance Department and the Department of Health will be monitored for network adequacy.

(2) The provider types are defined in terms of National Uniform Claim Committee taxonomy codes.

(3) The provider type list will be reviewed annually for:

(A)(i) Sufficiency.

(ii) This could be to add provider types deemed necessary for coverage of healthcare services most appropriate for Arkansans or to remove provider types that are no longer appropriate; and

(B)(i) Definitions.

(ii) This is to ensure that the taxonomies associated with the provider type conveys the intended scope of the provider type.

(iii)*(a)* The taxonomy association with a provider type definition communicates the actual practice of the provider rather than their academic qualification.

(b) For example, a provider qualified as an internal medicine physician cannot be considered a primary care provider if the provider works only in emergency rooms or is only associated with a pain management clinic.

(b)(1) The State Insurance Department will facilitate a system of ongoing industry data maintenance of NPI associations with various provider types defined in subsection (a) of this section.

(2) This association will be based on the provider's actual practice.

(3) This will be done to facilitate a common and uniform understanding of each provider's provider type or types classification.

(3) This NPI association data with provider types will be referred to as Provider Type NPI Pool (PTNP) data.

(4) The process and timelines in the PTNP data maintenance effort will be outlined by the State Insurance Department on an annual basis through online documentation.

(5)(A) The process will involve two (2) stages of data submission by the carriers.

(B) The first stage will involve suggestions of changes in the PTNP followed by the second stage when the carriers will vote on the suggestions consolidated from the first stage.

(6) The State Insurance Department will facilitate oversight of the process and may classify an NPI lacking unanimous agreement among carriers.

(c) **Participation exemptions.**

(1) A carrier with fewer than five thousand (5,000) covered individuals as of December 31 of the previous calendar year will not be required to participate in the PTNP data maintenance process.

(2) For purposes of determining whether a carrier is subject to the participation requirements of PTNP data maintenance the carrier must aggregate the number of covered individuals for all companies at the Group Code level as defined by the National Association of Insurance Commissioners.

(3) Carriers that offer medical, dental, and pharmaceutical benefits, or any combination thereof, under separate or combined plans will count all covered individuals, irrespective of the comprehensiveness of the plan, toward the five thousand (5,000) covered individuals threshold.

(4) If a carrier does not believe it meets the definition of a submitting entity herein or does not believe it meets the five thousand (5,000) covered individuals

threshold, that entity may dispute the Insurance Commissioner's decision in accordance with the Arkansas Administrative Procedure Act, Arkansas Code § 25-15-201 et seq.

Authority. Arkansas Code §§ 23-61-108, 23-76-108, 23-76-125.

Codification Notes. "NPI" means National Provider Identifier.

23 CAR § 137-107. Submission timeline for network adequacy review.

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

Authority. Arkansas Code §§ 23-61-108, 23-76-108, 23-76-125.

23 CAR § 137-108. Enforcement.

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

Authority. Arkansas Code §§ 23-61-108, 23-76-108, 23-76-125.