

**WAC 284-170-330 Tiered provider networks.** (1) "Tiered provider network" means a network that identifies and groups providers and facilities into specific groups to which different provider reimbursement, enrollee cost-sharing, or provider access requirements, or any combination thereof, apply as a means to manage cost, utilization, quality, or to otherwise incentivize enrollee or provider behavior.

(a) An issuer may use a term other than tiered network as long as the term is not misleading or susceptible to confusion with a specific licensee designation, such as accountable care organization.

(b) An issuer must not use tiered networks to limit access to certain categories of providers or facilities.

(2) When an issuer's contracts include the placement of providers or facilities in tiers, and the network design results in cost differentials for enrollees, the issuer must disclose to enrollees at the time of enrollment the cost difference and the basis for the issuer's placement of providers or facilities in one tier or another.

(3) The lowest cost-sharing tier of a tiered network must provide enrollees with adequate access and choice among health care providers and facilities for essential health benefits as set forth in WAC 284-43-5640 and 284-43-5642, 284-43-5700 and 284-43-5702, and 284-43-5780 and 284-43-5782.

(4) Cost-sharing differentials between tiers must not be imposed on an enrollee if the sole provider or facility type or category required to deliver a covered service is not available to the enrollee in the lowest cost-sharing tier of the network.

(a) All enrollees must have reasonable access to providers and facilities at the lowest cost tier of cost-sharing.

(b) Variations in cost-sharing between tiers must be reasonable in relation to the premium rate charged.

(5) An issuer must include with the Provider Compensation Agreement the metrics and methodology used to assign participating providers and facilities to tiers. An issuer must be able to demonstrate to the commissioner's satisfaction that its assignment of providers and facilities to tiers, when based on a rating system, is consistent with the issuer's placement methodology.

(a) When an issuer revises or amends a quality, cost-efficiency or tiering program related to its provider network, it must provide notice to affected providers and facilities of the proposed change sixty days before notifying the public of the program. The notice must explain the methodology and data, if any, used for particular providers and facilities and include information on provider appeal rights as stated in the provider agreement.

(b) An issuer must make its physician cost profile available to providers and facilities under a tiered network, including the written criteria by which the provider's performance is measured.

(6) An issuer's provider and facility ranking program, and the criteria used to assign providers and facilities to different tiers, must not be described in advertising or plan documents so as to deceive consumers as to issuer rating practices and their affect on available benefits. When a tiered network is used, an issuer must provide detailed information on its website and if requested, make available in paper form information about the tiered network including, but not limited to:

(a) The providers and facilities participating in the tiered network;

(b) The selection criteria, if any, used to place the providers and facilities, but not including the results of applying those selection criteria to a particular provider or facility;

(c) The potential for providers and facilities to move from one tier to another at any time; and

(d) The tier in which each participating provider or facility is assigned.

(7) For any health plan in effect on a tiered network's reassignment date, an issuer must make a good faith effort to provide information to affected enrollees at least sixty days before the reassignment takes effect. This information includes, but is not limited to, the procedure the enrollee must follow to choose an alternate provider or facility to obtain treatment at the same cost-sharing level. The specific classes of enrollees to whom notice must be sent are:

(a) Patients of a reassigned primary care provider if their primary care provider is reassigned to a higher cost-sharing level;

(b) A patient in the second or third trimester of pregnancy if a care provider or facility in connection with her pregnancy is reassigned to a higher cost-sharing level;

(c) A terminally ill patient if a provider or facility in connection with the illness is reassigned to a higher cost-sharing level; and

(d) Patients under active treatment for cancer or hematologic disorders, if the provider or facility that is delivering the care is reassigned to a higher cost-sharing level.

[Statutory Authority: RCW 48.02.060. WSR 16-14-106 (Matter No. R 2016-11), § 284-170-330, filed 7/6/16, effective 8/6/16; WSR 16-07-144 (Matter No. R 2016-01), recodified as § 284-170-330, filed 3/23/16, effective 4/23/16. WSR 16-01-081, recodified as § 284-43-9980, filed 12/14/15, effective 12/14/15. Statutory Authority: RCW 48.02.060, 48.18.120, 48.20.460, 48.43.505, 48.43.510, 48.43.515, 48.43.530, 48.43.535, 48.44.050, 48.46.200, 48.20.450, 48.44.020, 48.44.080, 48.46.030, 45 C.F.R. §§ 156.230, 156.235, and 156.245. WSR 14-10-017 (Matter No. R 2013-22), § 284-43-229, filed 4/25/14, effective 5/26/14.]