

31A-22-617.1 Objective criteria for adding or terminating participating providers -- Termination of contracts -- Review process.

- (1)
 - (a) Every insurer, including a health maintenance organization governed by Chapter 8, Health Maintenance Organizations and Limited Health Plans, shall establish criteria for adding health care providers to a new or existing provider panel.
 - (b) Criteria under Subsection (1)(a) may include, but are not limited to:
 - (i) training, certification, and hospital privileges;
 - (ii) number of physicians needed to adequately serve the insurer's population; and
 - (iii) any other factor that is reasonably related to promote or protect good patient care, address costs, take into account on-call and cross-coverage relationships between providers, or serve the lawful interests of the insurer.
 - (c) An insurer shall make such criteria available to any provider upon request and shall file the same with the department.
 - (d) Upon receipt of a provider application and upon receiving all necessary information, an insurer shall make a decision on a provider's application for participation within 120 days.
 - (e) If the provider applicant is rejected, the insurer shall inform the provider of the reason for the rejection relative to the criteria established in accordance with Subsection (1)(b).
 - (f) An insurer may not reject a provider applicant based solely on:
 - (i) the provider's staff privileges at a general acute care hospital not under contract with the insurer; or
 - (ii) the provider's referral patterns for patients who are not covered by the insurer.
 - (g) Criteria set out in Subsection (1)(b) may be modified or changed from time to time to meet the business needs of the market in which the insurer operates and, if modified, will be filed with the department as provided in Subsection (1)(c).
 - (h) With the exception of Subsection (1)(f), this section does not create any new or additional private right of action for redress.
- (2)
 - (a) For the first two years, an insurer may terminate its contract with a provider with or without cause upon giving the requisite amount of notice provided in the agreement, but in no case shall it be less than 60 days.
 - (b) An agreement may be terminated for cause as provided in the contract established between the insurer and the provider. Such contract shall contain sufficiently certain criteria so that the provider can be reasonably informed of the grounds for termination for cause.
 - (c) Prior to termination for cause, the insurer shall:
 - (i) inform the provider of the intent to terminate and the grounds for doing so;
 - (ii) at the request of the provider, meet with the provider to discuss the reasons for termination;
 - (iii) if the insurer has a reasonable basis to believe that the provider may correct the conduct giving rise to the notice of termination, the insurer may, at its discretion, place the provider on probation with corrective action requirements, restrictions, or both, as necessary to protect patient care; and
 - (iv) if the insurer has a reasonable basis to believe that the provider has engaged in fraudulent conduct or poses a significant risk to patient care or safety, the insurer may immediately suspend the provider from further performance under the contract, provided that the remaining provisions of this Subsection (2) are followed in a timely manner before termination may become final.

- (d) Each insurer shall establish an internal appeal process for actions that may result in terminated participation with cause and make known to the provider the procedure for appealing such termination.
 - (i) Providers dissatisfied with the results of the appeal process may, if both parties agree, submit the matters in dispute to mediation.
 - (ii) If the matters in dispute are not mediated, or should mediation be unsuccessful, the dispute shall be subject to binding arbitration by an arbitrator jointly selected by the parties, the cost of which shall be jointly shared. Each party shall bear its own additional expenses.
- (e) A termination under Subsection (2)(a) or (b) may not be based on:
 - (i) the provider's staff privileges at a general acute care hospital not under contract with the insurer; or
 - (ii) the provider's referral patterns for patients who are not covered by the insurer.
- (3) Notwithstanding any other section of this title, an insurer may not take adverse action against or reduce reimbursement to a contracted provider who is not under a capitated reimbursement arrangement because of the decision of an insured to access health care services from a noncontracted provider in a manner permitted by the insured's health insurance plan, regardless of how the plan is designated.

Enacted by Chapter 3, 2005 Special Session 1

Enacted by Chapter 3, 2005 Special Session 1