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211 CMR 52.00: MANAGED CARE CONSUMER PROTECTIONS AND ACCREDITATION OF CARRIERS

Section

52.01: Authority

211 CMR 52.00 is promulgated in accordance with authority granted to the Commissioner of Insurance by M.G.L. c. 175, § 24B, M.G.L. c. 176J, § 32A11, M.G.L. c. 176O, §§ 2 and 17, and M.G.L. c. 176R, § 6.

52.02: Applicability

211 CMR 52.00 applies to any carrier that offers for sale, provides or arranges for the provision of a defined set of hHealth cCare sServices to insureds through affiliated and contracting pProviders or employs uUtilization rReview in making decisions about whether services are cCovered bBenefits under a hHealth bBenefit Pplan. A cCarrier that provides coverage for LLimited hHealth care sServices only, that provides specified services through a workers' compensation preferred provider arrangement, or that does not provide services through a nNetwork or through pParticipating pProviders shall be subject to those requirements of 211 CMR 52.00 as deemed appropriate by the Commissioner in a manner consistent with a duly filed application for aAccreditation as outlined in 211 CMR 52.06(2).

Certain requirements of 211 CMR 52.00 *et seq*., as specified, shall also apply to dDental and vVision cCarriers. Such provisions are: 211 CMR 52.12(1) through (4); 211 CMR 52.12(11); 211 CMR 52.12(13); 211 CMR 52.143(2), 211 CMR 52.143(3)(a), (c) through (e), (g) through (i), (m) through (p); 211 CMR 52.143(4) through (10); 211 CMR 52.154(1)(c) and (d); 211 CMR 52.154(2), (3) and (7); and 211 CMR 52.198.

52.03: Definitions

As used in 211 CMR 52.00, the following words mean:

Accreditation, a written determination by the Bureau of Managed Care of compliance with M.G.L. c. 176O, 211 CMR 52.00 and 105 958 CMR 1283.000.

Actively PracticingPractices, means that a health care professional regularly treats patients in a clinical setting.

Administrative Disenrollment, a change in the status of an iInsured whereby the iInsured remains with the same cCarrier but his or her membership may appear under a different

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identification number. Examples of an ~~a~~Administrative ~~d~~Disenrollment are a change in employers, a move from an individual plan to a spouse's plan, or any similar change that may be recorded by the ~~c~~Carrier as both a disenrollment and an enrollment.

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Adverse Determination, a determination, based upon a review of information provided, by a ~~c~~Carrier or its designated ~~u~~Utilization ~~r~~Review ~~o~~Organization, to deny, reduce, modify, or terminate an admission, continued inpatient stay, or the availability of any other ~~h~~Health ~~c~~Care ~~s~~Services, for failure to meet the requirements for coverage based on ~~m~~Medical ~~n~~Necessity, appropriateness of health care setting and level of care, or effectiveness.

Ambulatory Review, ~~u~~Utilization ~~r~~Review of ~~h~~Health ~~c~~Care ~~s~~Services performed or provided in an outpatient setting, including, but not limited to, outpatient or ambulatory surgical, diagnostic and therapeutic services provided at any medical, surgical, obstetrical, psychiatric and chemical dependency ~~f~~Facility, as well as other locations such as laboratories, radiology facilities, ~~p~~Provider offices and patient homes.

Authorized Representative, an ~~i~~Insured's guardian, conservator, holder of a power of attorney, health care agent designated pursuant to M.G.L. c. 210, family member, or other person authorized by the ~~i~~Insured in writing or by law with respect to a specific ~~g~~Grievance or external review, provided, that if the ~~i~~Insured is unable to designate a representative, where such designation would otherwise be required, a ~~-~~conservator, holder of a power of attorney, or family member, in that order of priority, may be the ~~i~~Insured's representative or appoint another responsible party to serve as the ~~i~~Insured's ~~a~~Authorized ~~r~~Representative.

Behavioral Health Manager, a company, organized under the laws of the Commonwealth of Massachusetts or organized under the laws of another state and qualified to do business in the Commonwealth, that has entered into a contractual arrangement with a ~~c~~Carrier to provide or arrange for the provision of behavioral ~~h~~Health ~~s~~Services to voluntarily enrolled members of the ~~c~~Carrier.

Bureau of Managed Care or Bureau, the bureau in the Division of Insurance established by M.G.L. c. 176O, § 2.

Capitation, a set payment per patient per unit of time made by a ~~c~~Carrier to a licensed ~~h~~Health ~~c~~Care ~~p~~Professional, ~~h~~Health ~~c~~Care ~~p~~Provider group or organization that employs or utilizes services of ~~h~~Health ~~c~~Care ~~p~~Professionals to cover a specified set of services and administrative costs without regard to the actual number of services provided.

Carrier, an insurer licensed or otherwise authorized to transact accident or health insurance under M.G.L. c. 175; a nonprofit hospital service corporation organized under M.G.L. c. 176A; a nonprofit medical service corporation organized under M.G.L. c. 176B; a health maintenance organization organized under M.G.L. c. 176G; and an organization entering into a preferred provider arrangement under M.G.L. c. 176I, but not including an employer purchasing coverage or acting on behalf of its employees or the employees of one or more subsidiaries or affiliated corporations of the employer. Unless otherwise noted, the term "~~c~~Carrier" shall not include any entity to the extent it offers a policy, certificate, or contract that provides coverage solely for ~~d~~Dental ~~c~~Care ~~s~~Services or ~~v~~Vision ~~c~~Care ~~s~~Services.

Case Management, a coordinated set of activities conducted for individual patient management of serious, complicated, protracted or other health conditions.

Clean and Complete Credentialing Application, a credentialing application which is appropriately signed and dated by the Provider, and which includes all of the applicable information requested from the Provider by the Carrier.

Clinical Peer Reviewer, a physician or other ~~h~~Health ~~c~~Care ~~p~~Professional, other than the physician or other ~~h~~Health ~~c~~Care ~~p~~Professional who made the initial decision, who holds a nonrestricted license from the appropriate professional licensing board in Massachusetts, current board certification from a specialty board approved by the American Board of Medical Specialties or of the Advisory Board of Osteopathic Specialists from the major areas of clinical services or, for non-physician ~~h~~Health ~~c~~Care ~~p~~Professionals, the recognized professional board for their specialty, who ~~actively~~ Actively ~~practices~~ Practices in the ~~s~~Same

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or ~~s~~Similar ~~s~~Specialty as typically manages the medical condition, procedure or treatment under review, and whose compensation does not directly or indirectly depend upon the quantity, type or cost of the services that such person approves or denies.

Clinical Review Criteria, the written screening procedures, decisions, abstracts, clinical protocols and practice guidelines used by a ~~c~~Carrier to determine the ~~m~~Medical ~~n~~Necessity and appropriateness of ~~h~~Health ~~c~~Care ~~s~~Services.

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Commissioner, the Commissioner of Insurance, appointed pursuant to M.G.L. c. 26, § 6, or his or her designee.

Complaint,

(a) any inquiry made by or on behalf of an iInsured to a cCarrier or uUtilization rReview oOrganization that is not explained or resolved to the iInsured's satisfaction within three business dDays of the iInquiry; or

(b) any matter concerning an aAdverse dDetermination. In the case of a cCarrier or uUtilization rReview oOrganization that does not have an internal iInquiry process, a cComplaint means any iInquiry.

Concurrent Review, uUtilization rReview conducted during an iInsured's inpatient hospital stay or course of treatment.

Covered Benefits or Benefits, hHealth cCare sServices to which an iInsured is entitled under the terms of the hHealth bBenefit pPlan.

Days, calendar dDays unless otherwise specified in 211 CMR 52.00; provided, that computation of dDays specified in 211 CMR 52.00 begins with the first day following the referenced action, and provided further that if the final day of a period specified in 211 CMR 52.00 falls on a Saturday, Sunday or state holiday, the final day of the period will be deemed to occur on the next working day.

Dental Carrier, an insurer licensed or otherwise authorized to transact accident or health insurance under M.G.L. c. 175; a nonprofit hospital service corporation organized under M.G.L. c. 176A; a nonprofit medical service corporation organized under M.G.L. c. 176B; a dental service corporation organized under M.G.L. c. 176E, or an organization entering into a preferred provider arrangement under M.G.L. c. 176I, but not including an employer purchasing coverage or acting on behalf of its employees or the employees or one or more subsidiaries or affiliated corporations of the employer, that offers a policy, certificate or contract that provides coverage solely for dDental cCare sServices.

Dental Benefit Plan, a policy, contract, certificate or agreement of insurance entered into, offered or issued by a dDental cCarrier to provide, deliver, arrange for, pay for, or reimburse any of the costs solely for dDental cCare sServices.

Dental Care Professional, a dentist or other dental care practitioner licensed, accredited or certified to perform specified dDental sServices consistent with the law.

Dental Care Provider, a dDental cCare pProfessional or fFacility.

Dental Care Services, or dDental sServices, services for the diagnosis, prevention, treatment, cure or relief of a dental condition, illness, injury or disease.

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Discharge Planning, the formal process for determining, prior to discharge from a fFacility, the coordination and management of the care that an iInsured receives following discharge from a fFacility.

Division, the Division of Insurance.

Emergency Medical Condition, a medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine, to result in placing the health of an Iinsured or another person in serious jeopardy, serious impairment to body function, or serious dysfunction of any body organ or part, or, with respect to a pregnant woman, as further defined in § 1867(e)(l)(B) of the Social Security Act, 42 U.S.C. § 1395dd(e)(1)(B).

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Evidence of Coverage, any certificate, contract or agreement of health insurance including riders, amendments, endorsements and any other supplementary inserts or a summary plan description pursuant to § ~~–~~104(b)(1) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1024(b), issued to an ~~i~~Insured specifying the ~~b~~Benefits to which the I~~i~~nsured is entitled. For workers' compensation preferred provider arrangements, the ~~e~~Evidence of ~~c~~Coverage will be considered to be the information annually distributed pursuant to 211 CMR 51.04(3)(i)1. through 3.

Facility, a licensed institution providing ~~h~~Health ~~c~~Care ~~s~~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.

Finding of Neglect, a written determination by the Commissioner that a ~~c~~Carrier has failed to make and file the materials required by M.G.L. c. 176O or 211 CMR 52.00 in the form and within the time required.

Grievance, any oral or written ~~c~~Complaint submitted to the ~~c~~Carrier that has been initiated by an ~~i~~Insured, or the ~~i~~Insured's ~~a~~Authorized ~~r~~Representative, concerning any aspect or action of the carrier relative to the ~~i~~Insured, including, but not limited to, review of ~~a~~Adverse ~~d~~Determinations regarding scope of coverage, denial of services, quality of care and administrative operations, in accordance with the requirements of M.G.L. c. 176O and ~~105~~ 958 CMR ~~128~~3.000.

HMO, a health maintenance organization licensed pursuant to M.G.L. c. 176G.

Health Benefit Plan, a policy, contract, certificate or agreement of insurance entered into, offered or issued by a ~~c~~Carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of ~~h~~Health ~~c~~Care ~~s~~Services. Unless otherwise noted, "~~h~~Health ~~b~~Benefit ~~p~~Plan" shall not include a ~~d~~Dental ~~b~~Benefit ~~p~~Plan or a ~~v~~Vision ~~b~~Benefit ~~p~~Plan.

Health Care Professional, a physician or other health care practitioner licensed, accredited or certified to perform specified ~~h~~Health ~~s~~Services consistent with the law.

Health Care Provider or Provider, a ~~h~~Health ~~c~~Care ~~p~~Professional or ~~f~~Facility.

Health Care Services or Health Services, services for the diagnosis, prevention, treatment, cure or relief of a health ~~-~~condition, illness, injury or disease.

Incentive Plan, any compensation arrangement between a ~~c~~Carrier and ~~h~~Health ~~c~~Care ~~p~~Professional or ~~l~~Licensed ~~h~~Health ~~c~~Care ~~p~~Provider ~~g~~Group or organization that employs or utilizes services of one or more licensed ~~h~~Health ~~c~~Care ~~p~~Professionals that may directly or indirectly have the effect of reducing or limiting specific services furnished to insureds of the organization. "Incentive ~~p~~Plan" shall not mean contracts that involve general payments such as ~~c~~Capitation payments or shared risk agreements that are made with respect to physicians, ~~n~~Nurse ~~p~~Practitioners, or physician and/or ~~n~~Nurse ~~p~~Practitioner groups or which are made with respect to groups of ~~i~~Insureds if such contracts, which impose risk on such physicians, ~~n~~Nurse ~~p~~Practitioners, or physician and/or ~~n~~Nurse ~~p~~Practitioner groups for the cost of medical care, services and equipment provided or authorized by another physician, ~~n~~Nurse ~~p~~Practitioner, or ~~h~~Health ~~c~~Care ~~p~~Provider, comply with 211 CMR 52.00.

Inquiry, any communication by or on behalf of an ~~i~~Insured to the ~~c~~Carrier or ~~u~~Utilization ~~r~~Review ~~o~~Organization that has not been the subject of an ~~a~~Adverse ~~d~~Determination and that requests redress of an action, omission or policy of the ~~c~~Carrier.

Insured, an enrollee, covered person, insured, member, policy holder or subscriber of a ~~c~~Carrier, including a ~~d~~Dental or ~~v~~Vision ~~c~~Carrier, including an individual whose eligibility as an ~~i~~Insured of a ~~c~~Carrier is in dispute or under review, or any other individual whose care may be subject to review by a ~~u~~Utilization ~~r~~Review program or entity as described under the

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provisions of M.G.L. c. 176O, 211 CMR 52.00 and ~~105~~ 958 CMR ~~128~~3.000.

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JCAHO, the Joint Commission on Accreditation of Healthcare Organizations.

Licensed Health Care Provider Group, a partnership, association, corporation, individual practice association, or other group that distributes income from the practice among members. An individual practice association is a ~~l~~Licensed ~~h~~Health ~~c~~Care ~~p~~Provider ~~g~~Group only if it is composed of individual ~~h~~Health ~~c~~Care ~~p~~Professionals and has no subcontracts with ~~l~~Licensed ~~h~~Health ~~c~~Care ~~p~~Provider ~~g~~Groups.

Limited Health Service, pharmaceutical services, and such other services as may be determined by the Commissioner to be ~~l~~Limited ~~h~~Health ~~s~~Services. Limited ~~h~~Health ~~s~~Service shall not include hospital, medical, surgical or emergency services except as such services are provided in conjunction with the ~~l~~Limited ~~h~~Health ~~s~~Services set forth in the preceding sentence.

Managed Care Organization or MCO, a ~~c~~Carrier subject to M.G.L. c. 176O.

Material Change, a modification to any of a ~~c~~Carrier's, including a ~~d~~Dental or ~~v~~Vision ~~c~~Carrier's procedures or documents required by 211 CMR 52.00 that substantially affects the rights or responsibilities of an insured ~~c~~Carrier, including a ~~d~~Dental or ~~v~~Vision ~~c~~Carrier, or health, ~~d~~Dental or ~~v~~Vision ~~c~~Care ~~p~~Provider.

Medical Necessity or Medically Necessary, ~~h~~Health ~~c~~Care ~~s~~Services that are consistent with generally accepted principles of professional medical practice as determined by whether:

(a) the service is the most appropriate available supply or level of service for the ~~i~~Insured in question considering potential benefits and harms to the individual;

(b) is known to be effective, based on scientific evidence, professional standards and expert opinion, in improving health outcomes; or

(c) for services and interventions not in widespread use, is based on scientific evidence.

National Accreditation Organization, JCAHO, NCQA, URAC or any other national accreditation entity approved by the Division that accredits C~~c~~arriers that are subject to the provisions of M.G.L. c. 176O and 211 CMR 52.00.

NCQA, the National Committee for Quality Assurance.

NCQA Standards, the Standards and Guidelines for the Accreditation of Health Plans published annually by the NCQA.

Network, a group of health, ~~d~~Dental or ~~v~~Vision ~~c~~Care ~~p~~Providers who contract with a ~~c~~Carrier, including a ~~d~~Dental or ~~v~~Vision ~~c~~Carrier, or affiliate to provide health, ~~d~~Dental or ~~v~~Vision ~~c~~Care ~~s~~Services to insureds covered by any or all of the ~~c~~Carrier's, including a ~~d~~Dental or ~~v~~Vision ~~c~~Carrier's or affiliate's plans, policies, contracts or other arrangements. Network shall not mean those ~~p~~Participating ~~p~~Providers who provide services to subscribers of a nonprofit hospital service corporation organized under M.G.L. c. 176A, or a nonprofit medical service corporation organized under M.G.L. c. 176B.

Nongatekeeper Preferred Provider Plan, an insured preferred provider plan approved for offer under M.G.L. c. 176I which offers preferred ~~b~~Benefits when a covered person receives care from preferred ~~n~~Network ~~p~~Providers but does not require the ~~i~~Insured to designate a ~~p~~Primary ~~c~~Care ~~p~~Provider to coordinate the delivery of care or receive referrals from the ~~c~~Carrier or any ~~n~~Network ~~p~~Provider as a condition of receiving ~~b~~Benefits at the preferred benefit level.

Nurse Practitioner, a registered nurse who holds authorization in advanced nursing practice as a nurse practitioner under M.G.L. c. 112, § 80B.

Office of Patient Protection, the office within the Health Policy Commission ~~in the Department of Public Health~~ established by M.G.L. c. ~~111~~6D, § ~~21~~7~~(a)~~16.

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Participating Provider, a pProvider who, under a contract with the cCarrier, including a dDental or vVision cCarrier, or with its contractor or subcontractor, has agreed to provide health, dDental or vVision cCare sServices to iInsureds with an expectation of receiving payment, other than coinsurance, copayments or deductibles, directly or indirectly from the cCarrier, including a dDental or vVision cCarrier.

Preventive Health Services, any periodic, routine, screening or other services designed for the prevention and early detection of illness that a carrier is required to provide pursuant to Massachusetts or federal law.

Primary Care Provider, a hHealth cCare pProfessional qualified to provide general medical care for common health care problems, who supervises, coordinates, prescribes, or otherwise provides or proposes hHealth cCare sServices, initiates referrals for specialist care, and maintains continuity of care within the scope of his or her practice.

Prospective Review, uUtilization rReview conducted prior to an admission or a course of treatment. The term "Ppprospective rReview" shall include any pre-authorization and pre-certification requirements of a cCarrier or uUtilization rReview oOrganization.

Religious Non-medical Provider, a pProvider who provides no medical care but who provides only religious non-medical treatment or religious non-medical nursing care.

Retrospective Review, uUtilization rReview of mMedical nNecessity that is conducted after services have been provided to a patient. The term "rRetrospective rReview" shall not include the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication for payment.

Same or Similar Specialty, the hHealth cCare pProfessional has similar credentials and licensure as those who typically provide the treatment in question and has experience treating the same condition that is the subject of the gGrievance. Such experience shall extend to the treatment of children in a gGrievance involving a child where the age of the patient is relevant to the determination of whether a requested service or supply is mMedically nNecessary.

Second Opinion, an opportunity or requirement to obtain a clinical evaluation by a hHealth cCare pProfessional other than the hHealth cCare pProfessional who made the original recommendation for a proposed hHealth sService, to assess the clinical necessity and appropriateness of the initial proposed hHealth sService.

Service Area, the geographical area as approved by the Commissioner within which the cCarrier, including a dDental or vVision cCarrier, has developed a nNetwork of pProviders to afford adequate access to members for covered hHealth, dDental or vVision sServices.

Terminally Ill or Terminal Illness, an illness that is likely, within a reasonable degree of medical certainty, to cause one's death within six months, or as otherwise defined in section 1861(dd)(3)(A) of the Social Security Act, 42 U.S.C. section 1395x(dd)(3)(A).

URAC, the American Accreditation HealthCare Commission/URAC, formerly known as the Utilization Review Accreditation Commission.

Utilization Review, a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, hHealth cCare sServices, procedures or settings. Such techniques may include, but are not limited to, aAmbulatory rReview, pProspective rReview, sSecond oOpinion, certification, cConcurrent rReview, cCase mManagement, dDischarge pPlanning or rRetrospective rReview.

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Utilization Review Organization, an entity that conducts uUtilization rReview under contract with or on behalf of a cCarrier, but does not include a cCarrier performing uUtilization rReview for its own hHealth bBenefit Pplans. A bBehavioral hHealth Mmanager is considered a uUtilization rReview oOrganization.

Vision Benefit Plan, a policy, contract, certificate or agreement of insurance entered into, offered or issued by a cCarrier to provide, deliver, arrange for, pay for, or reimburse any of the costs solely for vVision cCare sServices.

Vision Care Professional, an ophthalmologist, optometrist or other vision care practitioner licensed, accredited or certified to perform specified vVision sServices consistent with the law.

Vision Care Provider, a vVision cCare pProfessional or fFacility.

Vision Care Services, or vVision sServices, services for the diagnosis, prevention, treatment, cure or relief of a vision condition, illness, injury or disease.

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Vision Carrier, an insurer licensed or otherwise authorized to transact accident or health insurance under M.G.L. c. 175; an optometric service corporation organized under M.G.L. c. 176F, or an organization entering into a preferred provider arrangement under M.G.L. c. 176I, but not including an employer purchasing coverage or acting on behalf of its employees or the employees of one or more subsidiaries or affiliated corporations of the employer, that offers a policy, certificate or contract that provides coverage solely for vVision cCare sServices.

52.04: Accreditation of Carriers

(1) A cCarrier must be accredited according to the requirements set forth in 211 CMR 52.00 in order to offer for sale, provide, or arrange for the provision of a defined set of hHealth cCare sServices to iInsureds through affiliated and contracting pProviders or employ uUtilization rReview in making decisions about whether services are cCovered bBenefits under a hHealth bBenefit pPlan.

(2) Accreditation granted to cCarriers pursuant to 211 CMR 52.00 shall remain in effect for 24 months unless revoked or suspended by the Commissioner.

(3) A cCarrier shall be exempt from 211 CMR 52.00 if in the written opinion of the Attorney General, the Commissioner of Insurance and the Commissioner of Public Health, the health and safety of health care consumers would be materially jeopardized by requiring aAccreditation of the cCarrier.

(a) Before publishing a written exemption pursuant to 211 CMR 52.04(3), the Attorney General, the Commissioner of Insurance and the Commissioner of Public Health shall jointly hold at least one public hearing at which testimony from interested parties on the subject of the exemption shall be solicited.

(b) A cCarrier granted an exemption pursuant to 211 CMR 52.04(3) shall be provisionally accredited and, during such provisional aAccreditation, shall be subject to review not less than every four months and shall be subject to those requirements of M.G.L. c. 176O and 211 CMR 52.00 as deemed appropriate by the Commissioner.

(c) Before the end of each four-month period specified in 211 CMR 52.04(3)(b) the Commissioner shall review the cCarrier's exemption.

1. If the Bureau determines that the Ccarrier has met the requirements of 211 CMR 52.00, then the cCarrier shall be accredited and the exemption shall expire upon aAccreditation.

2. If the Commissioner determines that the cCarrier's exemption should be continued, the Commissioner shall communicate that determination in writing to the Attorney General and the Commissioner of Public Health. Continuation of the exemption shall be granted only upon a written decision by the Commissioner, the Attorney General and the Commissioner of Public Health.

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52.05: Deemed Accreditation

(1) A ~~c~~Carrier may apply for deemed ~~a~~Accreditation. A carrier that applies for deemed ~~a~~Accreditation may be deemed to be in compliance with the standards set forth in 211 CMR 52.00 and may be so accredited by the Bureau if it meets the following requirements:

(a) It must be accredited by JCAHO, NCQA or URAC;

(b) It must meet all the requirements set forth in M.G.L. c. 176O, 211 CMR 52.00 and ~~105~~ 958 CMR ~~128~~3.000; and

(c) It must have received the ratings specified in 211 CMR 52.06(5)(c) and (d).

(2) For a carrier that applies for deemed ~~a~~Accreditation:

(a) If the ~~c~~Carrier meets or exceeds the ratings identified in 211 CMR 52.06(5)(c), the ~~c~~Carrier shall not be further reviewed by the Bureau for compliance with the standards set forth in 211 CMR 52.08 and 211 CMR 52.09 for that applicable period.

(b) If the ~~c~~Carrier meets or exceeds the ratings identified in 211 CMR 52.06(5)(d), the ~~c~~Carrier shall not be further reviewed by the Bureau for compliance with the standards set forth in 211 CMR 52.10 for that applicable period.

(3) A ~~c~~Carrier shall not be eligible for deemed ~~a~~Accreditation status if the ~~n~~National ~~a~~Accreditation ~~o~~Organization has revoked the ~~c~~Carrier's ~~a~~Accreditation status in the past 24 months or the ~~a~~Accreditation status of an entity that currently contracts with the ~~c~~Carrier to provide services regulated by M.G.L. c. 176O.

(4) A carrier that has applied for deemed ~~a~~Accreditation and been denied, shall be considered an applicant for ~~a~~Accreditation under 211 CMR 52.06(3) or 211 CMR 52.06(4). Denial of a request for deemed ~~a~~Accreditation shall not be eligible for reconsideration under 211 CMR 52.07(5).

(5) If a ~~c~~Carrier has received ~~a~~Accreditation from a ~~n~~National ~~a~~Accreditation ~~o~~Organization, or a subcontracting organization, with whom the ~~c~~Carrier has a written agreement delegating certain services, or has received ~~a~~Accreditation or certification from a ~~n~~National ~~a~~Accreditation ~~o~~Organization, but under standards other than those identified in 211 CMR 52.06(5), the ~~c~~Carrier may submit the documents indicating such ~~a~~Accreditation or certification so that the Division may consider this in developing the scores described in 211 CMR 52.07(1).

52.06: Application for Accreditation

(1) Timing of Application.

(a) Carriers must submit renewal applications by July 1st for renewals to be effective on November 1st.

(b) A ~~c~~Carrier seeking initial ~~a~~Accreditation must submit an application at least 90 days prior to the date on which it intends to offer ~~h~~Health ~~b~~Benefit ~~p~~Plans.

(2) Inapplicability of Accreditation Requirements.

(a) A ~~c~~Carrier that provides coverage for ~~l~~Limited ~~h~~Health ~~s~~Services only, that does not provide services through a ~~n~~Network or through ~~p~~Participating ~~p~~Providers or for which other requirements set forth in 211 CMR~~-~~ 52.06 are otherwise inapplicable may indicate within its application which of those items are inapplicable to its ~~h~~Health ~~b~~Benefit ~~p~~Plan and provide an explanation of why the ~~c~~Carrier is exempt from each particular requirement.

(b) A carrier that provides coverage for specified services through a workers' compensation preferred provider arrangement may provide evidence of compliance with 211 CMR 51.00 and 452 CMR 6.00 to satisfy the materials required by 211 CMR 52.06(3)(b), (e), (g), (h), (i), (j), (l), and (n). A carrier that provides coverage for specified services through a workers' compensation preferred provider arrangement may provide evidence of compliance with 211 CMR 51.00 and 452 CMR 6.00 to satisfy the materials required by 211 CMR 52.06(4)(d) and (g).

(3) Initial Application. Any carrier seeking initial ~~a~~Accreditation under M.G.L. c. 176O must submit an application that contains at least the materials applicable for Massachusetts

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described in 211 CMR 52.06(3)(a) through (p) and 211 CMR 52.13(2) in a format specified by the Commissioner. Any ~~e~~Carrier that contracts with another organization to perform any of the functions specified in 211 CMR 52.00 is responsible for collecting and submitting all of such materials from the contracting organization.

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(a) A filing fee of $1,000 made payable to the Commonwealth of Massachusetts:
(b) A complete description of the cCarrier's uUtilization rReview policies and procedures;
(c) A written attestation to the Commissioner that the uUtilization rReview program of the cCarrier or its designee complies with all applicable state and federal laws concerning confidentiality and reporting requirements;
(d) A copy of the most recent existing survey described in 211 CMR 52.08(10);
(e) A complete description of the cCarrier's internal gGrievance procedures consistent with 105 958 CMR 3128.200 through 128.313 .000and a complete description of the external review process consistent with 105 958 CMR 1283.400 through 128.401000;
(f) A complete description of the cCarrier's process to establish guidelines for mMedical nNecessity consistent with 105 958 CMR 1283.101000;
(g) A complete description of the cCarrier's quality management and improvement policies and procedures, including the Carrier's Network adequacy standards;
(h) A complete description of the Ccarrier's credentialing policies and procedures for all pParticipating pProviders;
(i) A complete description of the cCarrier's policies and procedures for providing or arranging for the provision of pPreventive hHealth sServices;
(j) A sample of every pProvider contract used by the cCarrier or the organization with which the cCarrier contracts;
(k) A statement that advises the Bureau whether the cCarrier has issued new contracts, revised existing contracts, made revisions to fee schedules in any existing contract with a physician, nNurse pPractitioner, or physician and/or nNurse pPractitioner group that imposes financial risk on such physician, nNurse pPractitioner, or physician and/or nNurse pPractitioner group for the costs of medical care, services or equipment provided or authorized by another physician, nNurse pPractitioner, or hHealth cCare pProvider. If the cCarrier has issued or revised any such contracts or revised any fee schedules or made any of the specified changes, the cCarrier shall identify the contracts in which such changes were made and identify the sections of the contracts that comply with 211 CMR 52.12(4) and, if applicable, 211 CMR 152.05;
(l) A copy of every pProvider directory used by the cCarrier;
(m) The eEvidence of cCoverage for every product offered by the cCarrier;
(n) A copy of each disclosure described in 211 CMR 52.154, if applicable;
(o) A written attestation that the cCarrier has complied with 211 CMR 52.176; and
(p) Any additional information as deemed necessary by the Commissioner.

(4) Renewal Application. Any cCarrier seeking renewal of aAccreditation under M.G.L. c. 176O must submit an application that contains at least the materials for Massachusetts described in 211 CMR 52.06(4)(a) through (j) 211 CMR 52.13(2) in a format specified by the Commissioner. Any Ccarrier that contracts with another organization to perform any of the functions specified in 211 CMR 52.00 is responsible for collecting and submitting all of such materials from the contracting organization.
(a) A filing fee of $1,000 made payable to the Commonwealth of Massachusetts;
(b) A written attestation to the Commissioner that the uUtilization rReview pProgram of the cCarrier or its designee complies with all applicable state and federal laws concerning confidentiality and reporting requirements;
(c) A copy of the most recent survey described in 211 CMR 52.08(10);
(d) A sample of every pProvider contract used by the cCarrier or the organization with which the cCarrier contracts since the cCarrier's most recent aAccreditation;
(e) A statement that advises the Bureau whether the cCarrier has issued new contracts, revised existing contracts, made revisions to fee schedules in any existing contract with a physician, nNurse pPractitioner, or physician and/or nNurse pPractitioner group that impose financial risk on such physician, nNurse pPractitioner, or physician and/or nNurse pPractitioner group for the costs of medical care, services or equipment provided or authorized by another physician, nNurse pPractitioner, or HhHealth cCare pProvider. If the cCarrier has issued or revised any such contracts or revised any fee schedules has made any of the specified changes, the cCarrier shall identify the contracts in which such changes were made and identify the sections of the contracts that comply with 211 CMR 52.12(4), and, if applicable, 211 CMR 152.05;

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(f) The ~~e~~Evidence of ~~c~~Coverage for every product offered by the ~~c~~Carrier that was revised since the ~~c~~Carrier's most recent ~~a~~Accreditation;
(g) A copy of the most recently revised ~~p~~Provider directory used by the ~~c~~Carrier;
(h) Material ~~c~~Changes to any of the information contained in 211 CMR 52.06(3)(b), (e), (f), (g), (h), (i), and (n);

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52.06: continued

(i) Evidence satisfactory to the Commissioner that the ~~c~~Carrier has complied with 211 CMR 52.17~~6~~; and

(j) Any additional information as deemed necessary by the Commissioner.

(5) Application for Deemed Accreditation. A ~~c~~Carrier seeking deemed ~~a~~Accreditation pursuant to 211 CMR 52.05 shall submit an application that contains the materials described in 211 CMR 52.06(5)(a) through (d).

(a) For initial applicants, the information required by 211 CMR 52.06(3).

(b) For renewal applicants, the information required by 211 CMR 52.06(4).

(c) Proof in a form satisfactory to the Commissioner that the ~~c~~Carrier has attained:

1. a score equal to or above 80% of the standard in effect at the time of the most recent review by NCQA for the ~~a~~Accreditation of ~~m~~Managed ~~c~~Care ~~o~~Organizations, in the categories of utilization management, quality management and improvement, and members' rights and responsibilities;

2. a score equal to or above the rating of "accredited" in the categories of utilization management, ~~n~~Network management, quality management and member protections for the most recent review of health plan standards by URAC; or

3. for ~~n~~Nongatekeeper ~~p~~Preferred ~~p~~Provider ~~p~~Plans, a score equal to or above 80% of the standard in effect at the time of the most recent review by NCQA for the ~~a~~Accreditation of preferred provider organizations, in the categories of utilization management, quality management and improvement, and enrollees' rights and responsibilities.

4. for ~~n~~Nongatekeeper ~~p~~Preferred ~~p~~Provider ~~p~~Plans, a score equal to or above the rating of "accredited" in the most recent review of health utilization management standards by URAC and a score equal or above the rating of "accredited" in the categories of ~~n~~Network management, quality management and member protections for the most recent review of health ~~n~~Network standards by URAC.

(d) Proof in a form satisfactory to the Commissioner that the ~~c~~Carrier has attained:

1. a score equal to or above 80% of the standard in effect at the time of the most recent review by NCQA for the ~~a~~Accreditation of ~~m~~Managed ~~c~~Care ~~o~~Organizations, in the category of credentialing and recredentialing;

2. a score equal to or above the rating of "accredited" in the category of ~~p~~Provider credentialing for the most recent review of health plan standards by URAC; or

3. for ~~n~~Nongatekeeper ~~p~~Preferred ~~p~~Provider plans, a score equal to or above 80% of the standard in effect at the time of the most recent review by NCQA for the ~~a~~Accreditation of preferred provider organizations in the category of credentialing and recredentialing.

4. for ~~n~~Nongatekeeper ~~p~~Preferred ~~p~~Provider ~~p~~Plans, a score equal to or above the rating of "accredited" in the category of ~~p~~Provider credentialing for the most recent review of health ~~n~~Network standards by URAC.

(6) Application to be Reviewed as a Nongatekeeper Preferred Provider Plan. A ~~c~~Carrier shall ~~-~~submit a statement signed by a corporate officer certifying that none of the ~~c~~Carrier's insured plans require the ~~i~~Insured to designate a ~~p~~Primary ~~c~~Care ~~p~~Provider to coordinate the delivery of care or receive referrals from the ~~c~~Carrier or any ~~n~~Network ~~p~~Provider as a condition of receiving ~~b~~Benefits at the preferred benefit level.

(7) Material Changes. Carriers shall submit to the Bureau any ~~m~~Material ~~c~~Changes to any of the items required by 211 CMR 52.06(3) and 211 CMR 52.06(4) at least 30 D~~d~~ays before the effective date of the changes.

52.07: Review of Application for Accreditation

(1) The Bureau shall review all applications for ~~a~~Accreditation according to the standards set forth in M.G.L. c. 176O, 211 CMR 52.00 and ~~105 CMR~~ 958 CMR ~~128~~3.000~~.~~; 211 CMR 152.00, if applicable~~.~~; and other applicable law.

(a) For all products, a ~~c~~Carrier shall not be accredited unless the ~~c~~Carrier scores 65% or higher of an aggregate of the applicable elements in the NCQA Standards, effective July 1, 2011~~08~~ for reviews performed through June 30, 2011~~09~~, and standards effective July 1,

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20~~09~~12 thereafter~~,~~ for the ~~a~~Accreditation of ~~h~~Health ~~b~~Benefit ~~p~~Plans, including health maintenance organizations, gatekeeper preferred provider plans, and ~~n~~Nongatekeeper ~~p~~Preferred ~~p~~Provider ~~p~~Plans, in the categories of utilization management, quality management and improvement, and credentialing and recredentialing.

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52.07: continued

(b) The NCQA Standards, effective July 1, 201108 and beginning on July 1, 201209, effective July 1, 201209, are incorporated by reference into 211 CMR 52.00 to the extent that the NCQA Standards do not conflict with other laws of this Commonwealth. The NCQA Standards can be obtained from the NCQA.

(c) In reviewing the cCarrier's application for aAccreditation under 211 CMR 52.07, the cCarrier may be given credit toward the relevant score for any aAccreditation that it received separately or a subcontracting organization, with which whom the cCarrier has a written agreement delegating certain services, has received aAccreditation or certification from a nNational aAccreditation oOrganization for the standards described in 211 CMR 52.08, 211 CMR 52.09 or 211 CMR 52.10.

(2) A cCarrier's application will not be considered to be complete until all materials required by M.G.L. c. 176O and 211 CMR 52.00 have been received by the Bureau. A cCarrier shall respond to any request for additional information by the Bureau within 15 dDays of the date of the Bureau's request. A cCarrier that fails to respond in writing to requests within the 15 dDays shall be subject to the penalties described in 211 CMR 52.198.

(3) The Bureau may schedule, at the cCarrier's expense, on-site surveys of the cCarrier's uUtilization rReview, quality management and improvement, credentialing and pPreventive hHealth sServices activities in order to examine records. Any on-site visit shall be scheduled within 15 dDays of receipt of a cCarrier's complete application.

(4) The Bureau shall notify a cCarrier in writing that it is accredited or that its application for aAccreditation has been denied. If an aAccreditation is denied, the Bureau shall identify those items that require improvement in order to comply with aAccreditation standards.

(5) A cCarrier may seek reconsideration of a denial of its application for aAccreditation.

(a) A cCarrier whose application for aAccreditation has been denied may make a written request to the Bureau for reconsideration within ten dDays of receipt of the Bureau's notice.

(b) The Bureau shall schedule a meeting with the cCarrier within ten dDays of the receipt of the request for reconsideration to review any additional materials presented by the cCarrier.

(c) Following the meeting pursuant to 211 CMR 52.07(5)(b) the Bureau may conduct a second on-site survey at the expense of the cCarrier.

(d) The Bureau shall notify a cCarrier in writing of the final disposition of its reconsideration.

52.08: Standards for Utilization Review

(1) Standards. A cCarrier's application will be reviewed for compliance with the applicable NCQA Standards for utilization management. In addition, cCarriers shall meet the requirements identified in 211 CMR 52.08(2) through (10). In cases where the standards in 211 CMR 52.08(2) through (10) differ from those in the NCQA Standards, the standards in 211 CMR 52.08(2) through (10) shall apply.

(2) Written Plan. Utilization rReview conducted by a cCarrier or a uUtilization rReview oOrganization shall be conducted pursuant to a written plan, under the supervision of a physician and staffed by appropriately trained and qualified personnel, and shall include a documented process to:

(a) review and evaluate its effectiveness;

(b) ensure the consistent application of uUtilization rReview criteria; and

(c) ensure the timeliness of uUtilization rReview determinations.

(3) Criteria. A cCarrier or uUtilization rReview oOrganization shall adopt uUtilization rReview criteria and conduct all uUtilization rReview activities pursuant to said criteria.

(a) The criteria shall be, to the maximum extent feasible, scientifically derived and evidence-based, and developed with the input of pParticipating pProviders, consistent with the development of mMedical nNecessity criteria consistent with 105 958 CMR

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(b) Utilization ~~r~~Review criteria shall be applied consistently by a ~~c~~Carrier or the ~~u~~Utilization ~~r~~Review ~~o~~Organization.

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52.08: continued

(c) Adverse dDeterminations rendered by a program of uUtilization rReview, or other denials of requests for hHealth sServices, shall be made by a person licensed in the appropriate specialty related to such health service and, where applicable, by a pProvider in the same licensure category as the ordering pProvider, and shall explain the reason for any denial, including the specific uUtilization rReview criteria or bBenefits provisions used in the determination, and all appeal rights applicable to the denial.

(4) Initial Determination Regarding a Proposed Admission, Procedure or Service. In addition to any other requirements under applicable law, Aa cCarrier or uUtilization rReview oOrganization shall make an initial determination regarding a proposed admission, procedure or service that requires such a determination within two working dDays of obtaining all necessary information.

(a) For purposes of 211 CMR 52.08(4), "necessary information" shall include the results of any face-to-face clinical evaluation or sSecond oOpinion that may be required.

(b) In the case of a determination to approve an admission, procedure or service, the cCarrier or uUtilization rReview oOrganization shall notify the pProvider rendering the service by telephone within 24 hours, and shall send written or electronic confirmation of the telephone notification to the insured and the pProvider within two working dDays thereafter.

(c) In the case of an aAdverse dDetermination, the cCarrier or the uUtilization rReview oOrganization shall notify the pProvider rendering the service by telephone within 24 hours, and shall send written or electronic confirmation of the telephone notification to the insured and the pProvider within one working day thereafter.

(5) Concurrent Review. A cCarrier or the uUtilization rReview oOrganization shall make a cConcurrent rReview determination within one working day of obtaining all necessary information.

(a) In the case of a determination to approve an extended stay or additional services, the cCarrier or uUtilization rReview oOrganization shall notify the pProvider rendering the service by telephone within one working day, and shall send written or electronic confirmation to the iInsured and the pProvider within one working day thereafter. A written or electronic notification shall include the number of extended Ddays or the next review date, the new total number of Ddays or services approved, and the date of admission or initiation of services.

(b) In the case of an aAdverse dDetermination, the cCarrier or uUtilization rReview oOrganization shall notify the pProvider rendering the service by telephone within 24 hours, and shall send written or electronic notification to the iInsured and the pProvider within one working dDay thereafter.

(c) The service shall be continued without liability to the iInsured until the iInsured has been notified of the determination.

(6) Written Notice. The written notification of an aAdverse dDetermination shall include a substantive clinical justification that is consistent with generally accepted principles of professional medical practice, and shall, at a minimum:

(a) identify the specific information upon which the aAdverse dDetermination was based;

(b) discuss the iInsured's presenting symptoms or condition, diagnosis and treatment interventions and the specific reasons such medical evidence fails to meet the relevant medical review criteria;

(c) specify any alternative treatment option offered by the cCarrier, if any;

(d) reference and include applicable clinical practice guidelines and review criteria; and

(e) include a clear, concise and complete description of the cCarrier's formal internal gGrievance process and the procedures for obtaining external review pursuant toconsistent with the requirements of 105 958 CMR 1283.400000.

(7) Reconsideration of an Adverse Determination. A cCarrier or uUtilization rReview oOrganization shall give a pProvider treating an iInsured an opportunity to seek reconsideration of an aAdverse dDetermination from a cClinical pPeer rReviewer in any case involving an initial determination or a cConcurrent rReview determination.

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(a) The reconsideration process shall occur within one working day of the receipt of the request and shall be conducted between the ~~p~~Provider rendering the service and the ~~c~~Clinical ~~p~~Peer ~~r~~Reviewer or a clinical peer designated by the ~~c~~Clinical ~~p~~Peer ~~r~~Reviewer if the reviewer cannot be available within one working day.

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(b) If the aAdverse dDetermination is not reversed by the reconsideration process, the iInsured, or the pProvider on behalf of the iInsured, may pursue the gGrievance process established pursuant to 105 958 CMR 1283.000.

(c) The reconsideration process allowed pursuant to 211 CMR 52.08(6) shall not be a prerequisite to the internal gGrievance process or an expedited appeal required by 105 958 CMR 1283.000.

(8) Continuity of Care. A eCarrier must provide evidence that its policies regarding continuity of care comply with all provisions requirements of 105 958 CMR 1283.500 000through 128.503.

(9) Workers' Compensation Preferred Provider Arrangement. A eCarrier that provides specified services through a workers' compensation preferred provider arrangement shall be deemed to have met the requirements of 211 CMR 52.08, except 211 CMR 52.08(9), if it has met the requirements of 452 CMR 6.00.

(10) Annual Survey. A eCarrier or uUtilization rReview oOrganization shall conduct an annual survey of iInsureds to assess satisfaction with access to primary care services, specialist services, ancillary services, hospitalization services, durable medical equipment and other covered services.

(a) The survey shall compare the actual satisfaction of insureds with projected measures of their satisfaction.

(b) Carriers that utilize iIncentive pPlans shall establish mechanisms for monitoring the satisfaction, quality of care and actual utilization compared with projected utilization of hHealth eCare sServices of iInsureds.

(11) Religious Non-medical Treatment and Providers. Nothing in 211 CMR 52.08 shall be construed to require hHealth bBenefit pPlans to use medical professionals or criteria to decide insured access to rReligious nNon-mMedical pProviders, utilize medical professionals or criteria in making decisions in internal appeals from decisions denying or limiting coverage or care by rReligious nNon-mMedical pProviders, compel an iInsured to undergo a medical examination or test as a condition of receiving coverage for treatment by a rReligious nNon-mMedical pProvider, or require hHealth bBenefit pPlans to exclude rReligious nNon-mMedical pProviders because they do not provide medical or other data otherwise required, if such data is inconsistent with the religious non-medical treatment or nursing care provided by the pProvider.

52.09: Standards for Quality Management and Improvement

(1) Standards. A eCarrier's application will be reviewed for compliance with the applicable NCQA Standards for quality management and improvement.

(2) Workers' Compensation Preferred Provider Arrangements. A eCarrier that provides specified services through a workers' compensation preferred provider arrangement shall be deemed to have met the requirements of 211 CMR 52.09 if it has met the requirements of 452 CMR 6.00.

52.10: Standards for Credentialing

(1) The A eCarrier's credentialing and recredentialing processes set forth in the Carrier's application for Accreditation will be reviewed for compliance with the applicable NCQA Standards for credentialing and recredentialing.

(2) A Carrier shall accept, in both electronic and paper form, a Provider credentialing application that is submitted in an application format specified by the Commissioner. For purposes of this subsection, acceptance in electronic form shall mean that a Carrier, at minimum, shall accept a Provider credentialing application by means of facsimile and electronic mail.

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(3) Nothing in this section shall be construed to prevent a Carrier from utilizing additional credentialing information in selecting the Providers with which it contracts.

(4) Nothing in this section shall be construed to require a Carrier to select a Provider as a Participating Provider, even if the Provider meets the Carrier's credentialing criteria.

(5) A Carrier shall notify a Provider that a submitted credentialing application is incomplete not later than 15 business Days after the Carrier receives the credentialing application.

(6) All Carriers shall complete credentialing within a reasonable time frame, and shall inform the Provider within 60 Days of receipt of a Clean and Complete Credentialing Application of the status of the application, including the reason for delay, if any, and a timeline of the expected resolution of the application.

(7) Carriers shall maintain documentation regarding all submissions.

(8~~2~~) A ~~c~~Carrier shall not be required to meet the requirements of 211 CMR 52.10 if the ~~c~~Carrier does not provide ~~b~~Benefits through a ~~n~~Network or does not have contracts with ~~p~~Participating ~~p~~Providers.

(9~~3~~) A ~~c~~Carrier that provides specified services through a workers' compensation preferred provider arrangement shall be deemed to have met the requirements of 211 CMR 52.10 if it has met the requirements of 211 CMR 51.00 and 452 CMR 6.00.

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52.11: ~~Standards for~~ Preventive Health Services

(1) A ~~c~~Carrier's application will be reviewed for compliance with preventive services mandated by applicable law. A ~~c~~Carrier that is not an HMO shall be required to comply with 211 CMR 52.11 only to the extent of those ~~p~~Preventive ~~h~~Health ~~s~~Services mandated by its licensing or enabling statute.

(2) A ~~c~~Carrier that provides specified services through a workers' compensation preferred provider arrangement shall not be required to meet the requirements of 211 CMR 52.11.

52.12: ~~Standards for~~ Provider Contracts

(1) Contracts between C~~c~~arriers and P~~p~~roviders shall state that a ~~c~~Carrier shall not refuse to contract with or compensate for covered services an otherwise eligible ~~h~~Health ~~c~~Care ~~p~~Provider solely because such ~~p~~Provider has in good faith:

(a) communicated with or advocated on behalf of one or more of his or her prospective, current or former patients regarding the provisions, terms or requirements of the ~~c~~Carrier's ~~h~~Health ~~b~~Benefit ~~p~~Plans as they relate to the needs of such ~~p~~Provider's patients; or

(b) communicated with one or more of his or her prospective, current or former patients with respect to the method by which such provider is compensated by the C~~c~~arrier for services provided to the patient.

(2) Contracts between ~~c~~Carriers and ~~p~~Providers shall state that the ~~p~~Provider is not required to indemnify the ~~c~~Carrier for any expenses and liabilities, including, without limitation, judgments, settlements, attorneys' fees, court costs and any associated charges, incurred in connection with any claim or action brought against the ~~c~~Carrier based on the ~~c~~Carrier's management decisions, ~~u~~Utilization ~~r~~Review provisions or other policies, guidelines or actions.

(3) No contract between a ~~c~~Carrier and a ~~l~~Licensed ~~h~~Health ~~c~~Care ~~p~~Provider ~~g~~Group may contain any ~~i~~Incentive ~~p~~Plan that includes a specific payment made to a ~~h~~Health ~~c~~Care ~~p~~Professional as an inducement to reduce, delay or limit specific, ~~m~~Medically ~~n~~Necessary services covered by the health care contract.

(a) Health ~~c~~Care ~~p~~Professionals shall not profit from provision of covered services that are not ~~m~~Medically ~~n~~Necessary or medically appropriate.

(b) Carriers shall not profit from denial or withholding of covered services that are ~~m~~Medically ~~n~~Necessary or medically appropriate.

(c) Nothing in 211 CMR 52.12(3) shall be construed to prohibit contracts that contain ~~i~~Incentive ~~p~~Plans that involve general payments such as ~~c~~Capitation payments or shared risk agreements that are made with respect to ~~p~~Providers or which are made with respect to groups of insureds if such contracts, which impose risk on such ~~p~~Providers for the costs of care, services and equipment provided or authorized by another ~~h~~Health ~~c~~Care ~~p~~Provider, comply with 211 CMR 52.12(4).

(4) No ~~c~~Carrier may enter into a new contract, revise the risk arrangements in an existing contract, or revise the fee schedule in an existing contract with a ~~h~~Health ~~c~~Care ~~p~~Provider which imposes financial risk on such ~~p~~Provider for the costs of care, services or equipment provided or authorized by another ~~p~~Provider unless such contract includes specific provisions with respect to the following:

(a) stop loss protection;

(b) minimum patient population size for the ~~p~~Provider group; and

(c) identification of the ~~h~~Health ~~c~~Care ~~s~~Services for which the ~~p~~Provider is at risk.

(5) No Carrier shall enter into an agreement or contract with a Health Care Provider if the agreement or contract contains a provision that:

(a) (i) limits the ability of the Carrier to introduce or modify a limited Network plan or tiered Network plan by granting the Health Care Provider a guaranteed right of participation; (ii) requires the Carrier to place all members of a Provider group, whether local practice groups or facilities, in the same tier of a tiered Network plan; (iii) requires the Carrier to include all members of a Provider group, whether local practice groups or

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facilities, in a limited Network plan on an all-or-nothing basis; or (iv) requires a Provider to participate in a new plan subject to 211 CMR 152.00 that the Carrier introduces without granting the Provider the right to opt-out of the new plan at least 60 Days before the new plan is submitted to the Commissioner for approval; or

(b) requires or permits the Carrier or the Health Care Provider to alter or terminate a contract or agreement, in whole or in part, to affect parity with an agreement or contract with other Carriers or Health Care Providers or based on a decision to introduce or modify a select Network plan or tiered Network plan; or

(c) requires or permits the Carrier to make any form of supplemental payment unless each supplemental payment is publicly disclosed to the Commissioner as a condition of Accreditation, including the amount and purpose of each payment and whether or not each payment is included within the Provider's reported relative prices and health status adjusted total medical expenses under section 610 of chapter 118G2C.

(65) Contracts between cCarriers and hHealth cCare pProviders shall state that neither the cCarrier nor the pProvider has the right to terminate the contract without cause.

(76) Contracts between cCarriers and hHealth cCare pProviders shall state that a cCarrier shall provide a written statement to a pProvider of the reason or reasons for such pProvider's involuntary disenrollment.

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(~~8~~7) Contracts between ~~c~~Carriers and ~~h~~Health ~~c~~Care ~~p~~Providers shall state that the ~~c~~Carrier shall notify ~~p~~Providers in writing of modifications in payments, modifications in covered services or modifications in a ~~c~~Carrier's procedures, documents or requirements, including those associated with ~~u~~Utilization ~~r~~Review, quality management and improvement, credentialing and ~~p~~Preventive ~~h~~Health ~~s~~Services, that have a substantial impact on the rights or responsibilities of the ~~p~~Providers, and the effective date of the modifications. The notice shall be provided 60 ~~d~~Days before the effective date of such modification unless such other date for notice is mutually agreed upon between the ~~c~~Carrier and the ~~p~~Provider.

(~~9~~8) Contracts between ~~c~~Carriers and ~~h~~Health ~~c~~Care ~~p~~Providers shall state that ~~p~~Providers shall not bill patients for charges for covered services other than for deductibles, copayments, or coinsurance.

(10~~9~~) Contracts between ~~c~~Carriers and ~~h~~Health ~~c~~Care ~~p~~Providers shall prohibit ~~h~~Health ~~c~~Care ~~p~~Providers from billing patients for nonpayment by the ~~c~~Carrier of amounts owed under the contract due to the insolvency of the ~~c~~Carrier. Contracts shall further state that this requirement shall survive the termination of the contract for services rendered prior to the termination of the contract, regardless of the cause of the termination.

(11~~0~~) Contracts between ~~c~~Carriers and ~~h~~Health ~~c~~Care ~~p~~Providers shall require ~~p~~Providers to comply with the ~~c~~Carrier's requirements for ~~u~~Utilization ~~r~~Review, quality management and improvement, credentialing and the delivery of ~~p~~Preventive ~~h~~Health ~~s~~Services.

(12~~1~~) Nothing in 211 CMR 52.12 shall be construed to preclude a ~~c~~Carrier from requiring a ~~h~~Health ~~c~~Care ~~p~~Provider to hold confidential specific compensation terms.

(13~~2~~) Nothing in 211 CMR 52.12 shall be construed to restrict or limit the rights of ~~h~~Health ~~b~~Benefit ~~p~~Plans to include as ~~p~~Providers ~~r~~Religious ~~n~~Non-~~m~~Medical ~~p~~Providers or to utilize medically based eligibility standards or criteria in deciding ~~p~~Provider status for ~~r~~Religious ~~n~~Non-~~m~~Medical ~~p~~Providers.

(14~~3~~) For ~~d~~Dental and ~~v~~Vision ~~b~~Benefit ~~p~~Plans: The following provisions regarding the standards for ~~p~~Provider contracts found at 211 CMR 51.12, shall apply for ~~d~~Dental and ~~v~~Vision ~~b~~Benefits: 211 CMR 52.12(1) through (4) and 211 CMR 52.12(11).

(15~~4~~) A ~~p~~Participating ~~p~~Provider ~~n~~Nurse ~~p~~Practitioner practicing within the scope of his or her license, including all regulations requiring collaboration with a physician under M.G.L. c. 112, § 80B, shall be considered qualified within the ~~c~~Carrier's definition of ~~p~~Primary ~~c~~Care ~~p~~Provider to an ~~i~~Insured.

(16~~5~~) Contracts between ~~c~~Carriers and ~~h~~Health ~~c~~Care ~~p~~Providers shall recognize ~~n~~Nurse ~~p~~Practitioners as ~~p~~Participating ~~p~~Providers and shall treat services provided by ~~p~~Participating ~~p~~Provider ~~n~~Nurse ~~p~~Practitioners to their ~~i~~Insureds in a nondiscriminatory manner for care provided for the purposes of health maintenance, diagnosis and treatment. Such nondiscriminatory treatment shall include, but not be limited to, coverage of ~~b~~Benefits for primary care, intermediate care and inpatient care, including care provided in a hospital, clinic, professional office, home care setting, long-term care setting, mental health or substance abuse program, or any other setting when rendered by a ~~n~~Nurse ~~p~~Practitioner who is a ~~p~~Participating ~~p~~Provider and is practicing within the scope of his or her professional license to the extent that such policy or contract currently provides ~~b~~Benefits for identical services rendered by a ~~p~~Provider of healthcare licensed by the Commonwealth.

52.13: Network Adequacy

(1) A Carrier offering a plan(s) that includes a Network(s) shall maintain such Network(s) such that it is adequate in numbers and types of Providers to assure that all services will be accessible to Insureds without unreasonable delay. Adequacy shall be determined in accordance with the requirements of this section, and shall be established by reference to reasonable criteria used by the Carrier, which shall include but not be limited to the

reasonableness of cost-sharing in relation to the Benefits provided. In any case where the Carrier has an inadequate number or type of Participating Provider(s) to provide services for a covered benefit, the Carrier shall ensure that the Insured receives the covered benefit at the same benefit level ~~than~~as if the benefit was obtained from a Participating Provider, or shall make other arrangements acceptable to the Commissioner.

(2) In accordance with 211 CMR 52.06(3) and (4), a Carrier shall file with the Commissioner an access analysis that meet~~ings~~s the requirements of this section for each plan that includes a Network that the Carrier offers in the Commonwealth. The Carrier shall also prepare an access analysis prior to offering a plan that includes a Provider Network, and shall update an existing access analysis whenever ~~it~~the Carrier makes any Material Change to such an existing plan. The access plan shall describe or contain at least the following:

(a) The Carrier's Network(s);

(b) A summary of the Carrier's Network adequacy standards;

(c) The Carrier's process for monitoring and assuring on an ongoing basis the sufficiency of the Network(s) to meet the health care needs of populations that enroll in plans with Provider Networks;

(d) The Carrier's efforts to address the ability of the Network(s) to meet the needs of Insureds with limited English proficiency and illiteracy, with diverse cultural and ethnic backgrounds, or with disabilities;

(e) The Carrier's methods for assessing the health care needs of Insureds and the Insureds' satisfaction with services in relation to the development of the Network(s);

(f) A report developed using a Network accessibility analysis system such as GeoNetworks, which shall include the following:

1. maps showing the residential location of Insureds in Massachusetts, Primary Care Providers for both adults and children, specialty care practitioners, and institutional Providers;
2. the Carrier's Network adequacy standards;
3. geographic access tables illustrating the geographic relationship between Providers and Insureds, or for proposed plans or Service Areas, the population according to the Carrier's standards for every city and town, including at a minimum:

a. The total number of ~~i~~Insureds, if applicable;

b. The total number of Primary Care Providers accepting new patients;

c. The total number of Primary Care Providers not accepting new patients;

d. The total number of practitioners for each of the top five specialty care Provider types.

d. The total number of acute inpatient hospitals and tertiary hospitals ("hospital");

e. The percentage of the number of Insureds or population, as applicable, meeting the Primary Care Provider access standard;

f. The percentage of the Insureds, or population meeting the specialty care practitioner access standard(s);

g. The percentage of the population meeting the hospital access standard.

(g) In instances where the Commissioner finds that cost-sharing levels could cause inadequate access to Provider types, Carriers shall provide at the Commissioner's request a cost-sharing access analysis, illustrating the relationship between Providers at various cost-sharing levels and insureds, or for proposed plans or Service Areas, the population, according to the Carrier's standard, by for every city and town. For tiered Networks, the analysis shall indicate the relationship between Providers at each tier and associated cost-sharing level and Insureds or, for proposed plans or Service Areas, the population, according to the Carrier's standard for every city and town.

(h) Any other information required by the Commissioner to determine compliance with the provisions of 211 CMR 52.13.

(3) A Carrier shall make its selection standards for Participating Providers available for review by the Commissioner.

52.1~~3~~4: Evidences of Coverage

(1) Evidences of Coverage as to a Carrier. A ~~c~~Carrier shall issue and deliver to at least one

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adult ~~i~~Insured in each household residing in Massachusetts, upon enrollment:

(a) an ~~e~~Evidence of ~~e~~Coverage; or

(b) refer the ~~i~~Insured to resources where the information described in such ~~e~~Evidence of ~~e~~Coverage can be accessed, including, but not limited to, an internet website. References to the terms, "internet website" shall include "intranet website" and "electronic mail" or "e-mail." An ~~e~~Evidence of ~~e~~Coverage in paper format shall always be delivered to the group representative in the case of a group policy.

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(2) Evidences of Coverage as to Dental and Vision Carriers. Dental and ~~v~~Vision ~~c~~Carriers shall issue and deliver to at least one adult insured in each household residing in Massachusetts, upon enrollment:

(a) an ~~e~~Evidence of ~~c~~Coverage;

(b) a summary of the information contained in the ~~e~~Evidence of ~~c~~Coverage; or

(c) refer the ~~i~~Insured to resources where the information described in such ~~e~~Evidence of ~~c~~Coverage can be accessed, including, but not limited to, an internet website.

Dental and ~~v~~Vision carriers shall be exempt from the provisions of 211 CMR 52.1~~4~~3(3)(b), 211 CMR 52.1~~3~~4(3)(f), 211 CMR 52.1~~3~~4(3)(j) through (l) and 211 CMR 52.1~~3~~4(3)(q) through (aa).

(3) Evidence of Coverage Requirements. An ~~e~~Evidence of ~~c~~Coverage shall contain a clear, concise and complete statement of all of the information described at 211 CMR 52.1~~3~~4(3)(a) through (aa). In addition, for limited, regional and tiered plans, an Evidence of Coverage shall also contain any information as required by 211 CMR 152.00.

(a) The health, ~~d~~Dental or ~~v~~Vision ~~c~~Care ~~s~~Services and any other ~~b~~Benefits to which the ~~i~~Insured is entitled on a nondiscriminatory basis, including ~~b~~Benefits mandated by state or federal law;

(b) The prepaid fee which must be paid by or on behalf of the ~~i~~Insured and an explanation of any grace period for the payment of any ~~h~~Health ~~b~~Benefit ~~p~~Plan ~~p~~Premium;

(c) The limitations on the scope of health, ~~d~~Dental or ~~v~~Vision ~~c~~Care ~~s~~Services and any other ~~b~~Benefits to be provided, including an explanation of any deductible or copayment feature;

(d) All restrictions relating to preexisting condition limitations or exclusions, or a statement that there are no preexisting condition limitations or exclusions if there are none under the health, ~~d~~Dental or ~~v~~Vision ~~b~~Benefit ~~p~~Plan;

(e) The locations where, and the manner in which, health, ~~d~~Dental or ~~v~~Vision ~~c~~Care ~~s~~Services and other ~~b~~Benefits may be obtained;

(f) A description of eligibility of coverage for dependents, including a summary description of the procedure by which dependents may be added to the plan;

(g) The criteria by which an insured may be disenrolled or denied enrollment. 211 CMR 52.13(3)(g) shall apply to ~~c~~Carriers, including ~~d~~Dental and ~~v~~Vision ~~c~~Carriers.

(h) The involuntary disenrollment rate among insureds of the ~~c~~Carrier. 211 CMR 52.1~~4~~3(3)(h) shall apply to ~~c~~Carriers, including ~~d~~Dental and ~~v~~Vision ~~c~~Carriers.

1. For the purposes of 211 CMR 52.1~~3~~4(3)(h), ~~c~~Carriers shall exclude all ~~a~~Administrative ~~d~~Disenrollments, ~~i~~Insureds who are disenrolled because they have moved out of a health plan's ~~s~~Service ~~a~~Area, ~~i~~Insureds whose continuation of coverage periods have expired, former dependents who no longer qualify as dependents, or ~~i~~Insureds who lose coverage under an employer-sponsored plan because they have ceased employment or because their employer group has cancelled coverage under the plan, reduced the numbers of hours worked, become disabled, retired or died.

2. For the purposes of 211 CMR 52.1~~4~~3(3)(h), the term "involuntary disenrollment" means that a ~~c~~Carrier has terminated the coverage of the ~~i~~Insured due to any of the reasons contained in 211 CMR 52.1~~4~~3(3)(i)2. and 3.

(i) The requirement that an ~~i~~Insured's coverage may be canceled, or its renewal refused may arise only in the circumstances listed in 211 CMR 52.1~~3~~4(3)(i)1. through 5. 211 CMR 52.1~~4~~3(3)(i) shall apply to ~~c~~Carriers, including ~~d~~Dental and ~~v~~Vision ~~c~~Carriers.

1. failure by the insured or other responsible party to make payments required under the contract;

2. misrepresentation or fraud on the part of the ~~i~~Insured;

3. commission of acts of physical or verbal abuse by the ~~i~~Insured which pose a threat to ~~p~~Providers or other ~~i~~Insureds of the ~~c~~Carrier and which are unrelated to the physical or mental condition of the ~~i~~Insured; provided, that the ~~c~~Commissioner prescribes or approves the procedures for the implementation of the provisions of 211 CMR 52.1~~4~~3(3)(i)3.;

4. failure to comply in a material way with the provisions of the Health Benefit Plan, the member contract or the subscriber agreement, including but not limited to

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relocation of the insured outside the ~~s~~Service ~~a~~Area of the ~~c~~Carrier; or

5. non-renewal or cancellation of the group contract through which the ~~i~~Cnsured receives coverage;

(j) A description of the ~~c~~Carrier's method for resolving ~~i~~Insured inquiries and ~~c~~Complaints, including a description of the internal G~~g~~rievance process consistent with ~~105 CMR 128.300 through 128.313~~958 CMR 1283.300 through 128.313000, and the external review process consistent with ~~105 CMR 128.400 through 128.416~~958 CMR 1283.400 000through 128.416;

(k) A statement telling ~~i~~Insureds how to obtain the report regarding ~~g~~Grievances pursuant to ~~105 CMR 128.600(A)(4)~~958 CMR 1283.600(A1)(4d) from the Office of Patient Protection;

(l) A description of the Office of Patient Protection, including its toll-free telephone number, facsimile number, and internet site;

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(m) A description of the cCarrier's, including a dDental or vVision cCarrier's, method for resolving iInsured inquiries and cComplaints;

(n) A summary description of the procedure, if any, for out-of-nNetwork referrals and any additional charge for utilizing out-of-network pProviders. 211 CMR 52.143(3)(n) shall apply to cCarriers, including dDental and vVision cCarriers;

(o) A summary description of the uUtilization rReview procedures and quality assurance programs used by the cCarrier, including a dDental or vVision cCarrier, including the toll-free telephone number to be established by the cCarrier that enables consumers to determine the status or outcome of uUtilization rReview decisions;

(p) A statement detailing what translator and interpretation services are available to assist insureds, including that the cCarrier will provide, upon request, interpreter and translation services related to administrative procedures. The statement must appear in at least Arabic, Cambodian, Chinese, English, French, Greek, Haitian-Creole, Italian, Lao, Portuguese, Russian and Spanish. 211 CMR 52.143(3)(p) shall apply to cCarriers, including dDental and vVision cCarriers.

(q) A list of prescription drugs excluded from any closed or restricted formulary available to iInsureds under the hHealth bBenefit pPlan; provided, that the cCarrier shall annually disclose any changes in such a formulary, and shall provide a toll-free telephone number to enable consumers to determine whether a particular drug is included in the closed or restricted formulary.

1. A cCarrier will be deemed to have met the requirements of 211 CMR 52.143(3)(q) if the cCarrier does all of the following:
   a. provides a complete list of prescription drugs that are included in any closed or restricted formulary;
   b. clearly states that all other prescription drugs are excluded;
   c. provides a toll-free number that is updated within 48 hours of any change in the closed or restricted formulary to enable iInsureds to determine whether a particular drug is included in or excluded from the closed or restricted formulary; and
   d. provides an internet site that is updated as soon as practicable relative to any change in the closed or restricted formulary to enable iInsureds to determine whether a particular drug is included in or excluded from the closed or restricted formulary;

(r) A summary description of the procedures followed by the cCarrier in making decisions about the experimental or investigational nature of individual drugs, medical devices or treatments in clinical trials;

(s) Requirements for continuation of coverage mandated by state and federal law;

(t) A description of coordination of bBenefits consistent with 211 CMR 38.00;

(u) A description of coverage for emergency care and a statement that iInsureds have the opportunity to obtain hHealth cCare sServices for an eEmergency mMedical cCondition, including the option of calling the local pre-hospital emergency medical service system, whenever the iInsured is confronted with an eEmergency mMedical cCondition which in the judgment of a prudent layperson would require pre-hospital emergency services;

(v) If the cCarrier offers services through a nNetwork or through pParticipating pProviders, the following statements regarding continued treatment:

1. If the cCarrier allows or requires the designation of a pPrimary cCare pProvider, a statement that the cCarrier will notify an iInsured at least 30 dDays before the disenrollment of such iInsured's pPrimary cCare pProvider and shall permit such iInsured to continue to be covered for hHealth sServices, consistent with the terms of the eEvidence of cCoverage, by such pPrimary cCare pProvider for at least 30 dDays after said pProvider is disenrolled, other than disenrollment for quality related reasons or for fraud. The statement shall also include a description of the procedure for choosing an alternative pPrimary cCare pProvider.
2. A statement that the cCarrier will allow any female iInsured who is in her second or third trimester of pregnancy and whose pProvider in connection with her pregnancy is involuntarily disenrolled, other than disenrollment for quality-related reasons or for fraud, to continue treatment with said pProvider, consistent with the terms of the eEvidence of cCoverage, for the period up to and including the iInsured's first postpartum visit.

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3. A statement that the ~~c~~Carrier will allow any ~~i~~Insured who is ~~t~~Terminally ~~i~~Ill and whose ~~p~~Provider in connection with said illness is involuntarily disenrolled, other than disenrollment for quality related reasons or for fraud, to continue treatment with said ~~p~~Provider, consistent with the terms of the ~~e~~Evidence of ~~c~~Coverage, until the ~~i~~Insured's death.

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4. A statement that the cCarrier will provide coverage for hHealth sServices for up to 30 dDays from the effective date of coverage to a new iInsured by a physician who is not a pParticipating pProvider in the cCarrier's nNetwork if:
   a. the insured's employer only offers the iInsured a choice of cCarriers in which said physician is not a pParticipating pProvider; and
   b. said physician is providing the iInsured with an ongoing course of treatment or is the insured's pPrimary cCare pProvider; and
   c. With respect to an iInsured in her second or third trimester of pregnancy, 211 CMR 52.143(3)(v)4. shall apply to services rendered through the first postpartum visit. With respect to an insured with a tTerminal iIllness, 211 CMR 52.143(3)(v)4. shall apply to services rendered until death;
   d. For the purposes of 211 CMR 52.143(3)(v)4.a. and b., the term "physician" shall include nNurse pPractitioners.
5. A cCarrier may condition coverage of continued treatment by a pProvider under 211 CMR 52.143(3)(v)1. through 52.143(3)(v)4. upon the pProvider's agreeing as follows:
   a. to accept reimbursement from the cCarrier at the rates applicable prior to notice of disenrollment as payment in full and not to impose cost--sharing with respect to the iInsured in an amount that would exceed the cost--sharing that could have been imposed if the pProvider had not been disenrolled;
   b. to adhere to the quality assurance standards of the cCarrier and to provide the cCarrier with necessary medical information related to the care provided; and
   c. to adhere to the cCarrier's policies and procedures, including procedures regarding referrals, obtaining prior authorization and providing services pursuant to a treatment plan, if any, approved by the cCarrier;
6. Nothing in 211 CMR 52.143(3)(v) shall be construed to require the coverage of bBenefits that would not have been covered if the pProvider involved remained a pParticipating pProvider;

(w) If a cCarrier requires an iInsured to designate a pPrimary cCare pProvider, a statement that the cCarrier will allow the pPrimary cCare pProvider to authorize a standing referral for specialty health care provided by a hHealth cCare pProvider participating in the cCarrier's nNetwork when:

1. the pPrimary cCare pProvider determines that such referrals are appropriate;
2. the pProvider of specialty health care agrees to a treatment plan for the iInsured and provides the pPrimary cCare pProvider with all necessary clinical and administrative information on a regular basis;
3. the hHealth cCare sServices to be provided are consistent with the terms of the eEvidence of cCoverage; and
4. Nothing in 211 CMR 52.143(3)(w) shall be construed to permit a pProvider of specialty health care who is the subject of a referral to authorize any further referral of an iInsured to any other pProvider without the approval of the iInsured's cCarrier;

(x) If a cCarrier requires an iInsured to obtain referrals or prior authorization from a pPrimary cCare pProvider for specialty care, a statement that the cCarrier will not require an iInsured to obtain a referral or prior authorization from a pPrimary cCare pProvider for the following specialty care provided by an obstetrician, gynecologist, certified nurse midwife or family practitioner participating in such cCarrier's hHealth cCare pProvider nNetwork and that the cCarrier will not require higher copayments, coinsurance, deductibles or additional cost sharing arrangements for such services provided to such iInsureds in the absence of a referral from a pPrimary cCare pProvider:

1. annual preventive gynecologic health examinations, including any subsequent obstetric or gynecological services determined by such obstetrician, gynecologist, certified nurse midwife or family practitioner to be mMedically nNecessary as a result of such examination;
2. maternity care;
3. mMedically nNecessary evaluations and resultant hHealth cCare sServices for acute or emergency gynecological conditions;
4. Carriers may establish reasonable requirements for participating obstetricians, gynecologists, certified nurse midwives or family practitioners to communicate with an iInsured's pPrimary cCare pProvider regarding the iInsured's condition, treatment,

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and need for follow-up care; and

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5. Nothing in 211 CMR 52.1~~4~~3(3)(x) shall be construed to permit an obstetrician, gynecologist, certified nurse midwife or family practitioner to authorize any further referral of an ~~i~~Insured to any other ~~p~~Provider without the approval of the ~~i~~Insured's ~~c~~Carrier; and

(y) A statement that the ~~c~~Carrier will provide coverage of pediatric specialty care, including, for the purposes of 211 CMR 52.1~~4~~3(3)(y), mental health care, by persons with recognized expertise in specialty pediatrics to insureds requiring such services.

(z) If a ~~c~~Carrier allows or requires an ~~i~~Insured to designate a ~~p~~Primary ~~c~~Care ~~p~~Provider, a statement that the ~~c~~Carrier shall provide the ~~i~~Insured with an opportunity to select a ~~p~~Participating ~~p~~Provider ~~n~~Nurse ~~p~~Practitioner as a ~~p~~Primary ~~c~~Care ~~p~~Provider or to change his or her ~~p~~Primary ~~c~~Care ~~p~~Provider to a ~~p~~Participating ~~p~~Provider ~~n~~Nurse ~~p~~Practitioner at any time during the ~~i~~Insured's coverage period, if a ~~n~~Nurse ~~p~~Practitioner is a ~~p~~Participating ~~p~~Provider in the ~~n~~Network.

(aa) Evidence that the ~~c~~Carrier will provide coverage on a nondiscriminatory basis for covered services when delivered or arranged for by a ~~p~~Participating ~~p~~Provider ~~n~~Nurse ~~p~~Practitioner. For the purposes of 211 CMR 52.1~~4~~3(3)(aa), nondiscriminatory basis shall mean that a ~~c~~Carrier's plan does not contain any annual or lifetime dollar or unit of service limitation imposed on coverage for the care provided by a ~~n~~Nurse ~~p~~Practitioner which is less than any annual or lifetime dollar or unit of service limitation imposed on coverage for the same services by other ~~p~~Participating ~~p~~Providers, in accordance with M.G.L. c. 176R, § 16(1).

(4) Internet Websites. If the ~~c~~Carrier, including any ~~d~~Dental or ~~v~~Vision ~~c~~Carrier, refers the ~~i~~Insured to resources where the information described in the ~~e~~Evidence of ~~c~~Coverage can be accessed, including, but not limited to, an internet website, such ~~c~~Carrier must be able to demonstrate compliance with applicable law, and with the following with respect to the internet website, where the term "internet website" shall include "intranet website," "electronic mail," or "e-mail":

(a) The ~~c~~Carrier has issued and delivered written notice to the ~~i~~Insured that includes:

1. All necessary information and a clear explanation of the manner by which ~~i~~Insureds can access their specific ~~e~~Evidences of ~~c~~Coverage and any amendments thereto through such internet website;
2. A list of the specific information to be furnished by the ~~c~~Carrier through an internet website;
3. The significance of such information to the ~~i~~Insured;
4. The ~~i~~Insured's right to receive, free of charge, a paper copy of evidences of coverage and any amendments thereto at any time;
5. The manner by which the insured can exercise the right to receive a paper copy at no cost to the insured; and
6. A toll-free number for the ~~i~~Insured to call with any questions or requests.

(b) The ~~c~~Carrier has taken reasonable measures to ensure that the information and documents furnished in an internet website is substantially the same as that contained in its paper documents. All notice and time requirements applicable to ~~e~~Evidences of ~~c~~Coverage shall apply to information and documents furnished by an internet website.

(c) The ~~c~~Carrier has taken reasonable measures to ensure that it furnishes, upon request of the ~~i~~Insured, a paper copy of ~~e~~Evidences of ~~c~~Coverage and any amendments thereto.

(5) Group Plans. A ~~c~~Carrier, including a ~~d~~Dental and ~~v~~Vision ~~c~~Carrier, shall always deliver at least one ~~e~~Evidence of ~~c~~Coverage to the group representative of a group plan, notwithstanding the provisions of 211 CMR 52.1~~4~~3, 211 CMR 52.1~~5~~4 or 211 CMR 52.1~~6~~5.

(6) General Notice of Material Changes. A ~~c~~Carrier, including a ~~d~~Dental and ~~v~~Vision ~~c~~Carrier, shall provide to at least one adult ~~i~~Insured in each household residing in Massachusetts, or in the case of a group policy, to the group representative, notice of all ~~m~~Material ~~c~~Changes to the ~~e~~Evidence of ~~c~~Coverage.

(7) Advance Notice of Material Modifications. A ~~c~~Carrier, including a ~~d~~Dental or ~~v~~Vision ~~c~~Carrier, shall issue and deliver to at least one adult ~~i~~Insured in each household residing in Massachusetts, or in the case of a group policy, to the group representative, prior notice of

material modifications in covered services under the health, ~~d~~Dental or ~~v~~Vision ~~p~~Plan, at least 60 ~~d~~Days before the effective date of the modifications. Such notices shall include the following:

(a) any changes in ~~c~~Clinical ~~r~~Review ~~c~~Criteria; and

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(b) a statement of the effect of such changes on the personal liability of the ~~i~~Insured for the cost of any such changes.

(8) Advance Filing of Evidence of Coverage. A ~~c~~Carrier, including a ~~d~~Dental or ~~v~~Vision ~~c~~Carrier, shall submit all ~~e~~Evidences of ~~c~~Coverage to the Bureau at least 30 ~~d~~Days prior to their effective dates.

~~(9) Evidences of Coverage Used Prior to July 1, 2006. Carriers, including dental or vision carriers, may use evidences of coverage issued prior to 90 days after November 3, 2006 as if in compliance with 211 CMR 52.13. Evidences of coverage issued or renewed on or after 90 days after November 3, 2006 must comply with all of the requirements of 211 CMR 52.13. Carriers may provide notice of material changes by issuing riders, amendments or endorsements to insureds who have received evidences of coverage in compliance with 211 CMR 52.13.~~

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(9~~10~~) Dates Required. Every ~~e~~Evidence of ~~c~~Coverage described in 211 CMR 52.1~~4~~3 must contain the effective date, date of issue and, if applicable, expiration date.

(10~~1~~) Workers' Compensation. A ~~c~~Carrier that provides specified services through a workers' compensation preferred provider arrangement shall be deemed to have met the requirements of 211 CMR 52.1~~4~~3 if it has met the requirements of 211 CMR 51.00 and 452 CMR 6.00.

(12) Certain Requirements also Applicable to Evidences of Coverage for Dental and Vision Carriers. The following provisions of 211 CMR 52.1~~4~~3 shall also apply to ~~e~~Evidences of ~~c~~Coverage issued by ~~d~~Dental and ~~v~~Vision ~~c~~Carriers: 211 CMR 52.1~~4~~3(4) through (10).

52.1~~5~~4: Required Disclosures for Carriers and Behavioral Health Managers

(1) A ~~c~~Carrier shall provide to at least one adult ~~i~~Insured in each household upon enrollment, and to a prospective ~~i~~Insured upon request, the following information:

(a) a statement that physician profiling information, so-called, may be available from the Board of Registration in Medicine for physicians licensed to practice in Massachusetts;

(b) a summary description of the process by which clinical guidelines and ~~u~~Utilization ~~r~~Review criteria are developed;

(c) the voluntary and involuntary disenrollment rate among insureds of the ~~c~~Carrier;

1. For the purposes of 211 CMR 52.1~~5~~4(1)(c), ~~c~~Carriers shall exclude all ~~a~~Administrative ~~d~~Disenrollments, insureds who are disenrolled because they have moved out of a health plan's ~~s~~Service ~~a~~Area, insureds whose continuation of coverage periods have expired, former dependents who no longer qualify as dependents, or insureds who lose coverage under an employer-sponsored plan because they have ceased employment or because their employer group has cancelled coverage under the plan, reduced the numbers of hours worked, retired or died.

2. For the purposes of 211 CMR 52.1~~5~~4(1)(c), the term "voluntary disenrollment" means that an ~~i~~Insured has terminated coverage with the ~~c~~Carrier for nonpayment of premium.

3. For the purposes of 211 CMR 52.1~~5~~4(1)(c), the term "involuntary disenrollment" means that a ~~c~~Carrier has terminated the coverage of the insured due to any of the reasons contained in 211 CMR 52.1~~4~~3(3)(i)2. and 3.

(d) a notice to ~~i~~Insureds regarding ~~e~~Emergency ~~m~~Medical ~~c~~Conditions that states all of the following:

1. that ~~i~~Insureds have the opportunity to obtain ~~h~~Health ~~c~~Care ~~s~~Services for an ~~e~~Emergency M~~m~~edical ~~c~~Condition, including the option of calling the local pre-hospital emergency medical service system by dialing the emergency telephone access number 911, or its local equivalent, whenever the ~~i~~Insured is confronted with an ~~e~~Emergency ~~m~~Medical ~~c~~Condition which in the judgment of a prudent layperson would require pre-hospital emergency services;

2. that no ~~i~~Insured shall in any way be discouraged from using the local pre-hospital emergency medical service system, the 911 telephone number, or the local equivalent;

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3. that no ~~i~~Insured will be denied coverage for medical and transportation expenses incurred as a result of such ~~e~~Emergency ~~m~~Medical ~~c~~Condition; and

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4. if the cCarrier requires an iInsured to contact either the cCarrier or its designee or the pPrimary cCare pProvider of the insured within 48 hours of receiving emergency services, that notification already given to the cCarrier, designee or pPrimary cCare pProvider by the attending emergency pProvider shall satisfy that requirement.

(e) a description of the Office of Patient Protection and a statement that the information specified in 211 CMR 52.176 is available to the iInsured or prospective iInsured from the Office of Patient Protection.

(f) a statement:

1. that an iInsured has the right to request referral assistance from a cCarrier if the iInsured or the iInsured's pPrimary cCare pProvider has difficulty identifying mMedically nNecessary sServices within the cCarrier's nNetwork;

2. that the cCarrier, upon request by the iInsured, shall identify and confirm the availability of these services directly; and

3. that the cCarrier, if necessary, shall obtain or arrange for out-of-nNetwork services if they are unavailable within the nNetwork.

(2) The information required of cCarriers by 211 CMR 52.154 may be contained in the cEvidence of cCoverage and need not be provided in a separate document.

(3) Every disclosure required of cCarriers and described in 211 CMR 52.154 must contain the effective date, date of issue and, if applicable, expiration date.

(4) Carriers shall submit mMaterial cChanges to the disclosures required by 211 CMR 52.154 to the Bureau at least 30 dDays before their effective dates.

(5) Carriers shall submit mMaterial cChanges to the disclosures required by 211 CMR 52.154 to at least one adult iInsured in every household residing in Massachusetts at least once every two years.

(6) A cCarrier that provides specified services through a workers' compensation preferred provider arrangement shall be deemed to have met the requirements of 211 CMR 52.154 if it has met the requirements of 211 CMR 51.00 and 452 CMR 6.00.

(7) A cCarrier, including a dDental or vVision cCarrier, shall provide to a health, dDental or vVision cCare pProvider, a written reason or reasons for denying the application of any health, dDental, or vVision cCare pProvider who has applied to be a pParticipating pProvider.

(8) A cCarrier for whom a bBehavioral hHealth mManager is administering behavioral health sServices shall state on its new enrollment cards issued in the normal course of business, within one year, the name and telephone number of the bBehavioral hHealth mManager.

(9) A bBehavioral hHealth mManager shall provide the following information to at least one adult iInsured in each household covered by their services:

(a) a notice to the iInsured regarding emergency mental hHealth sServices that states:

1. that the iInsured may obtain emergency mental hHealth sServices, including the option of calling the local pre-hospital emergency medical service system by dialing the 911 emergency telephone number or its local equivalent, if the insured has an emergency mental health condition that would be judged by a prudent layperson to require pre-hospital emergency services;

2. that no iInsured shall be discouraged from using the local pre-hospital emergency medical service system, the 911 emergency telephone number or its local equivalent;

3. that no iInsured shall be denied coverage for medical and transportation expenses incurred as a result of such emergency mental health condition; and

4. if the bBehavioral hHealth mManager requires an iInsured to contact either the bBehavioral hHealth mManager, cCarrier or pPrimary cCare pProvider of the iInsured within 48 hours of receiving emergency services, notification already given to the bBehavioral hHealth mManager, cCarrier or pPrimary cCare pProvider by the

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attending emergency ~~p~~Provider shall satisfy that requirement;

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(b) a summary of the process by which clinical guidelines and ~~u~~Utilization ~~r~~Review ~~c~~Criteria are developed for behavioral ~~h~~Health ~~s~~Services; and

(c) a statement that the Office of Patient Protection~~,~~ is available to assist consumers, a description of the ~~g~~Grievance and review processes available to consumers, and relevant contact information to access the office and these processes.

(10) The information required of ~~b~~Behavioral ~~h~~Health ~~m~~Managers by 211 CMR 52.1~~5~~4(9) may be contained in the ~~c~~Carrier's ~~e~~Evidence of ~~c~~Coverage and need not be provided in a separate document. Every disclosure described in 211 CMR 52.1~~5~~4(9) shall contain the effective date, date of issue and, if applicable, expiration date.

(11) A ~~b~~Behavioral ~~h~~Health ~~m~~Manager shall submit a ~~m~~Material ~~c~~Change to the information required by 211 CMR 52.1~~5~~4(9) to the Bureau at least 30 ~~d~~Days before its effective date and to at least one adult ~~i~~Insured in every household residing in the Commonwealth at least biennially.

(12) A ~~b~~Behavioral ~~h~~Health ~~m~~Manager that provides specified services through a workers' compensation preferred provider arrangement that meets the requirements of 211 CMR 112.00 and 452 CMR 6.00 shall be considered to comply with 211 CMR 52.1~~5~~4.

(13) A carrier for whom a ~~b~~Behavioral ~~h~~Health ~~m~~Manager is administering behavioral ~~h~~Health ~~s~~Services shall be responsible for the ~~b~~Behavioral ~~h~~Health ~~m~~Manager's failure to comply with the requirements of 211 CMR 52.00 in the same manner as if the ~~c~~Carrier failed to comply and shall be subject to the provisions of 211 CMR 52.1~~8~~7.

52.1~~6~~5: Provider Directories

In addition to Provider directory requirements under 211 CMR 152.08, if applicable:

(1) A ~~c~~Carrier shall deliver a ~~p~~Provider directory to at least one adult ~~i~~Insured in each household upon enrollment and to a prospective or current ~~i~~Insured upon request. Annually, thereafter, a ~~c~~Carrier shall deliver to at least one adult ~~i~~Insured in each household, or in the case of a group policy, to the group representative, a ~~p~~Provider directory. The ~~c~~Carrier may deliver a ~~p~~Provider directory through an internet website. References to the term "internet website" shall include "intranet websites" and "electronic mail", or "e-mail".

(a) The ~~p~~Provider directory must contain a list of ~~h~~Health ~~c~~Care ~~p~~Providers in the ~~c~~Carrier's ~~n~~Network available to ~~i~~Insureds residing in Massachusetts, organized by specialty and by location and summarizing on its internet website for each such ~~p~~Provider: (i) the method used to compensate or reimburse such ~~p~~Provider, including details of measures and compensation percentages tied to any Incentive Plan or pay for performance provision; (ii) the Provider price relativity, as defined in and reported under section ~~6~~10 of chapter ~~118G~~12C; (iii) the Provider's health status adjusted total medical expenses, as defined in and reported under said section ~~6~~10 of said chapter 1~~18G~~2C; and (iv) current measures of the Provider's quality based on measures from the Standard Quality Measure Set, as defined in the regulations promulgated by the department of public health under section ~~25P~~14 of chapter ~~111~~12C; provided, however, that if any specific Providers or type of Providers requested by an Insured are not available in said Network, or are not a covered benefit, such information shall be provided in an easily obtainable manner, provided further, that the Carrier shall prominently promote Providers based on quality performance as measured by the standard quality measure set and cost performance as measured by health status adjusted total medical expenses and relative prices. ~~.~~

1. Nothing in 211 CMR 52.1~~6~~5(1)(a) shall be construed to require disclosure of the specific details of any financial arrangements between a ~~c~~Carrier and a ~~p~~Provider.

~~2. A carrier will be deemed to be in compliance with 211 CMR 52.15(1)(a) if the method of compensation is identified at least as specifically as "fee for service" or "capitation."~~

~~3~~2. If any specific ~~p~~Providers or type of ~~p~~Providers requested by an ~~i~~Insured are not available in said ~~n~~Network, or are not a covered benefit, such information shall be provided in an easily obtainable manner.

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~~4~~3. Notwithstanding any general or specific law to the contrary, a ~~c~~Carrier shall ensure that all ~~p~~Participating ~~p~~Provider ~~n~~Nurse ~~p~~Practitioners are included and displayed in a nondiscriminatory manner on any publicly accessible list of ~~p~~Participating ~~p~~Providers for the ~~c~~Carrier.

(b) The ~~p~~Provider directory must contain a toll-free number that insureds can call to determine whether a particular ~~h~~Health ~~c~~Care ~~p~~Provider is affiliated with the ~~c~~Carrier.

(c) The ~~p~~Provider directory must contain an internet website address or link that ~~i~~Insureds can visit to determine whether a particular ~~p~~Provider is affiliated with the ~~c~~Carrier.

(d) If the ~~c~~Carrier refers an ~~i~~Insured to access ~~p~~Provider directory information through an internet website, the ~~c~~Carrier must be able to demonstrate compliance with the following:

1. The ~~c~~Carrier has issued and delivered written notice to the ~~i~~Insured that includes:
   a. All necessary information and a clear explanation of the manner by which ~~i~~Insureds can access their specific ~~p~~Provider directory through an internet website;
   b. A list of the specific information to be furnished by the ~~c~~Carrier through an internet website;

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c. The significance of such information to the ~~i~~Insured;
d. The insured's right to receive, free of charge, a paper copy of the ~~p~~Provider directory at any time;
e. The manner by which the ~~i~~Insured can exercise the right to receive a paper copy at no cost to the ~~i~~Insured; and
f. A toll-free number for the ~~i~~Insured to call with any questions or requests.

2. The ~~c~~Carrier has taken reasonable measures to ensure that the information and documents furnished in an internet website is substantially the same as that contained in its paper documents.
3. All notice and time requirements applicable to evidences of coverage shall apply to information and documents made available by internet. Information contained in the documents furnished in an internet website shall include the effective date and the published date of any updates, modifications or ~~m~~Material ~~c~~Changes.
4. The ~~c~~Carrier updates the website as soon as practicable.
5. In the case of a group policy, the ~~c~~Carrier delivers a paper copy of the ~~p~~Provider directory to the group representative.
6. The ~~c~~Carrier has taken reasonable measures to ensure that it furnishes, upon request of the ~~i~~Insured, a paper copy of the ~~p~~Provider directory.

(2) A ~~c~~Carrier shall not be required to deliver a ~~p~~Provider directory upon enrollment if a ~~p~~Provider directory is delivered to the prospective or current insured, or in the case of a group policy, to the group representative, during applicable open enrollment periods.

(3) If delivering a paper copy of the ~~p~~Provider directory, a ~~c~~Carrier shall be deemed to have met the requirements of 211 CMR 52.1~~6~~5~~5~~(1) if the ~~c~~Carrier:
(a) provides to at least one adult insured in each household, or in the case of a group policy, to the group representative, at least once per calendar year an addendum, insert, or other update to the ~~p~~Provider directory originally provided under 211 CMR 52.1~~6~~5~~5~~(1); and
(b) updates its toll-free number within 48 hours and internet website as soon as practicable.

(4) Every ~~p~~Provider directory described in 211 CMR 52.1~~6~~5~~5~~ must contain the effective date, date of issue and expiration date if applicable, and reference to any government-sponsored website(s) providing quality and cost information, as designated by the Commissioner.

(5) A ~~c~~Carrier that provides specified services through a workers' compensation preferred provider arrangement shall be deemed to have met the requirements of 211 CMR 52.1~~6~~5~~5~~ if it has met the requirements of 211 CMR 51.00 and 452 CMR 6.00.

52.1~~6~~7: Material to be Provided to the Office of Patient Protection

(1) A ~~c~~Carrier shall provide the following to the Office of Patient Protection at the same time the ~~c~~Carrier provides such material to the Bureau of Managed Care:
(a) A copy of every ~~e~~Evidence of ~~c~~Coverage and amendments thereto offered by the ~~c~~Carrier.
(b) A copy of the ~~p~~Provider directory described in 211 CMR 52.1~~6~~5~~5~~.
(c) A copy of the materials specified in 211 CMR 52.1~~5~~4.

(2) A ~~c~~Carrier shall provide the following to the Office of Patient Protection by no later than April 1st:
(a) A list of sources of independently published information assessing insured satisfaction and evaluating the quality of ~~h~~Health ~~c~~Care ~~s~~Services offered by the ~~c~~Carrier.
(b) A report of the percentage of physicians and ~~n~~Nurse ~~p~~Practitioners who voluntarily and involuntarily terminated participation contracts with the ~~c~~Carrier during the previous calendar year for which such data has been compiled and the three most common reasons for voluntary and involuntary ~~p~~Provider disenrollment;
1. For the purposes of 211 CMR 52.1~~8~~7(2)(b) ~~c~~Carriers shall exclude physicians and ~~n~~Nurse ~~p~~Practitioners who have moved from one physician and/or ~~n~~Nurse

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~~p~~Practitioner group to another but are still under contract with the ~~c~~Carrier.

2. For the purposes of 211 CMR 52.1~~8~~7(2)(b) "voluntarily terminated" means that the physician or ~~n~~Nurse ~~p~~Practitioner terminated its contract with the ~~c~~Carrier.

3. For the purposes of 211 CMR 52.1~~8~~7(2)(b) "involuntarily terminated" means that the ~~c~~Carrier terminated its contract with the physician or ~~n~~Nurse ~~p~~Practitioner.

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(c) The percentage of premium revenue expended by the cCarrier for hHealth cCare sServices provided to iInsureds for the most recent year for which information is available; and

(d) A report detailing, for the previous calendar year, the total number of

1. filed gGrievances, gGrievances that were approved internally, gGrievances that were denied internally, and gGrievances that were withdrawn before resolution; and
2. external appeals pursued after exhausting the internal gGrievance process and the resolution of all such external appeals. The report shall identify for each such category, to the extent such information is available, the demographics of such iInsureds, which shall include, but need not be limited to, race, gender and age.

(e) A cCarrier that provides specified services through a workers' compensation preferred provider arrangement shall be deemed to have meet the requirements of 211 CMR 52.176(1)(a), (b), and (c) and 211 CMR 52.176(2)(c) and (d).

52.178: Noncompliance with 211 CMR 52.00

(1) Reporting. If the Commissioner issues a fFinding of nNeglect on the part of a cCarrier, the Commissioner shall notify the cCarrier in writing that the cCarrier has failed to make and file the materials required by M.G.L. c. 176O or 211 CMR 52.00 in the form and within the time required. The notice shall identify all deficiencies and the manner in which the neglect must be remedied. Following the written notice, the Commissioner shall fine the cCarrier $5000 for each day during which the neglect continues.

Following notice and hearing, the Commissioner shall suspend the Ccarrier's authority to do new business until all required reports or materials are received in a form satisfactory to the Commissioner and the Commissioner has determined that the fFinding of nNeglect can be removed.

(2) Noncompliance with ~~Accreditation Standards Set Forth in~~ 211 CMR 52.00.

(a) Investigation. The Bureau shall investigate all cComplaints made against a cCarrier or any entity with which it contracts for allegations of noncompliance with the aAccreditation requirements established under 211 CMR 52.00.

(b) Notice. The Bureau shall notify a cCarrier when, in the opinion of the Bureau, cComplaints made against a cCarrier or any entity with which it contracts indicate a pattern of noncompliance with a particular requirement. The notice shall detail the alleged noncompliance and establish a hearing date for the matter.

(c) Hearing Held Pursuant to 211 CMR 52.178(2)(b).

1. The hearing shall be held no later than 21 dDays following the date of the notice specified in 211 CMR 52.187(2)(b).
2. The hearing shall be conducted pursuant to M.G.L. c. 30A.
3. The hearing shall provide the cCarrier with an opportunity to respond to the alleged noncompliance.

(d) Penalties. Following the hearing specified in 211 CMR 52.187(2)(c), the Bureau may issue a finding against the cCarrier, including but not limited to:

1. An order requesting a corrective action plan and timeframe to achieve compliance.
2. A reprimand or censure of the cCarrier.
3. A penalty not to exceed $10,000 for each classification of violation.
4. The suspension or revocation of the cCarrier's aAccreditation.

(3) Action by a National Accreditation Organization. If a nNational aAccreditation oOrganization takes any action to revoke the aAccreditation or otherwise limit or negatively affect the aAccreditation status of a cCarrier, or any entity with which a cCarrier contracts for services subject to M.G.L. c. 176O, the cCarrier must notify the Bureau within two dDays and shall specify the action taken and the reasons given by the nNational aAccreditation oOrganization for such action.

(4) Revocation by a National Accreditation Organization. If the nNational aAccreditation oOrganization revokes aAccreditation, the Bureau shall initiate proceedings pursuant to M.G.L. c. 30A to revoke or suspend the cCarrier's aAccreditation.

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(5) Informal Resolutions. Nothing in 211 CMR 52.18~~7~~ shall be construed to prohibit the Bureau and a ~~c~~Carrier from resolving compliance issues through informal means.

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52.1~~8~~9: Severability

If any provision of 211 CMR 52.00 or the applicability thereof to any person, entity or circumstance is held invalid by a court, the remainder of 211 CMR 52.00 or the applicability of such provision to other persons, entities or circumstances shall not be affected.

REGULATORY AUTHORITY

211 CMR 52.00: M.G.L. c. 175, § 24B and c. 176O, §§ 2 and 17.

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