RESET FORM

MANAGED CARE CHECKLIST:
FILING CONTENT FOR INITAL ACCREDITATION APPLICATIONS

NOTE TO CARRIER COMPLETING THIS CHECKLIST:
Pursuant to Bulletin No. 2001-05 and 2008-19, please include a completed checklist when submitting an accreditation application.

When completing this checklist, please indicate the page number(s) or section(s) of the application where the required information may be found. If a requirement is not applicable, please place "N/A" next to the requirement and explain, either within the checklist or on a separate sheet, the legal basis under which the requirement does not apply to the accreditation application.

Carrier Name & NAIC #: _____

Contact Name & Title: _____

Address: _____

Telephone & Fax: _____

Email Address: _____
Product Name(s) &
Form #(s): _____

_____

_____

_____

Date Submitted: _____

FILINGS THAT DO NOT INCLUDE APPLICABLE COMPLETED CHECKLISTS WILL BE RETURNED. PLEASE REVIEW THE FOLLOWING ADDITIONAL CHECKLISTS TO ASSURE THAT YOUR SUBMISSION IS COMPLETE:

- REVIEW OF HEALTH MAINTENANCE ORGANIZATIONS LICENSED UNDER M.G.L. c. 176G ;
- REVIEW OF INSURANCE CARRIERS LICENSED UNDER M.GL. c. 175, c. 176A, and c. 176B; and
- REQUIREMENTS FOR PROVIDER CONTRACTS

FOR DIVISION OF INSURANCE USE ONLY:

Date Received: _____

Reviewed by: _____

Initial Application

According to 211 CMR 52.06(3), "[a]ny carrier seeking initial accreditation under M.G.L. c. 176O must submit an application that contains at least the materials applicable for Massachusetts described in 211 CMR 52.06(3)(a) through (p) in a format specified by the Commissioner. Any 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 the materials from the contracting organization."

IDENTIFY THE SECTION OF THE SUBMISSION WHERE THE FOLLOWING INFORMATION MAY BE LOCATED

SECTION	DOCUMENTS SUBMITTED
_____	A filing fee of $1,000 made payable to the Commonwealth of Massachusetts: ***[211 CMR 52.06(3)(a)]***
_____	A complete description of the carrier's utilization review policies and procedures; ***[211 CMR 52.06(3)(b)]***
_____	A written attestation to the Commissioner that the utilization review program of the carrier or its designee complies with all applicable state and federal laws concerning confidentiality and reporting requirements; ***[211 CMR 52.06(3)(c)]***
_____	A copy of the most recent existing survey described in 211 CMR 52.08(10); ***[211 CMR 52.06(3)(d)]***
_____	A complete description of the carrier's internal grievance procedures consistent with 105 CMR 128.200 through 128.313 and the external review process consistent with 105 CMR 128.400 through 401; ***[211 CMR 52.06(3)(e)]***
_____	A complete description of the carrier's process to establish guidelines for medical necessity consistent with 105 CMR 128.101; ***[211 CMR 52.06(3)(f)]***
_____	A complete description of the carrier's quality management and improvement policies and procedures; ***[211 CMR 52.06(3)(g)]***
_____	A complete description of the carrier's credentialing policies and procedures. ***[211 CMR 52.06(3)(h)]***
_____	A complete description of the carrier's policies and procedures for providing or arranging for the provision of preventive health services; ***[211 CMR 52.06(3)(i)]***
_____	A sample of every provider contract used by the carrier or the organization with which the carrier contracts; ***[211 CMR 52.06(3)(j)]***
_____	A statement that advises the Bureau whether the carrier has issued new contracts, revised existing contracts, or made revisions to fee schedules in any existing contract with a physician, nurse practitioner, or physician and/or nurse practitioner group that imposes financial risk on such physician, nurse practitioner, or physician and/or nurse practitioner group for the costs of medical care, services or equipment provided or authorized by another physician, nurse practitioner, or health care provider. If the carrier has made any of the specified changes, the carrier 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); ***[211 CMR 52.06(3)(k)]***
_____	A copy of every provider directory used by the carrier; ***[211 CMR 52.06(3)(l)]***
_____	The evidence of coverage for every product offered by the carrier; ***[211 CMR 52.06(3)(m)]***
_____	A copy of each disclosure described in 211 CMR 52.14; ***[211 CMR 52.06(3)(n)]***
_____	A written attestation that the carrier has complied with 211 CMR 52.16; and ***[211 CMR 52.06(3)(o)]***
_____	Any additional information as deemed necessary by the Commissioner. ***[211 CMR 52.06(3)(p)]***

Deemed Accreditation

The carrier is ☐ is not ☐ seeking deemed accreditation.
(Please place a checkmark (√) next to the requirement acknowledging confirmation.)

If the carrier **IS** seeking deemed accreditation, please complete the following:
According to 211 CMR 52.06(5)(a)-(d), "[a] carrier seeking deemed accreditation pursuant to 211 CMR 52.05 shall submit an application that contains the following:

_____ (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 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 accreditation of managed care 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, network management, quality management and member protections for the most recent review of health plan standards by URAC; or
_____ 3. for nongatekeeper preferred 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 accreditation of preferred provider organizations, in the categories of utilization management, quality management and improvement, and enrollees' rights and responsibilities.
_____ 4. for nongatekeeper preferred provider 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 network management, quality management and member protections for the most recent review of health network standards by URAC.

(d) Proof in a form satisfactory to the Commissioner that the 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 accreditation of managed care organizations, in the category of credentialing and recredentialing;
_____ 2. a score equal to or above the rating of "accredited" in the category of provider credentialing for the most recent review of health plan standards by URAC; or
_____ 3. for nongatekeeper preferred 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 accreditation of preferred provider organizations in the category of credentialing and recredentialing.
_____ 4. for nongatekeeper preferred provider plans, a score equal to or above the rating of "accredited" in the category of provider credentialing for the most recent review of health network standards by URAC.

As noted in 211 CMR 52.05(5), if a carrier has received accreditation from a national accreditation organization, or a subcontracting organization with whom the carrier has a written agreement delegating certain services has received accreditation or certification from a national accreditation organization, but under standards other than those identified in 211 CMR 52.06(5), please submit the documents indicating such accreditation or certification so that the Division may consider this in developing the scores described in 211 CMR 52.07(1).

The carrier has ☐ has not ☐ submitted documents for the Division's consideration in developing the scores described in 211 CMR 52.07(1).
(Please place a checkmark (√) next to the requirement acknowledging confirmation.)

Application to be reviewed as a nongatekeeper preferred provider plan

The carrier is [✔] is not [ ] seeking to be reviewed as a nongatekeeper preferred provider plan.
(Please place a checkmark (√) next to the requirement acknowledging confirmation.)

If the carrier is seeking to be reviewed as a nongatekeeper preferred provider plan, please submit a statement signed by a corporate officer certifying that none of the carrier's insured plans require the insured to designate a primary care provider to coordinate the delivery of care or receive referrals from the carrier or any network provider as a condition of receiving benefits at the preferred benefit level pursuant to the requirements of 211 CMR 52.06(6).

Inapplicability of accreditation requirements

(Please place a checkmark (√) next to the appropriate response to the question posed.)

The carrier provides coverage for limited health services only.
[ ] YES or [✔] NO

The carrier provides specified services through a workers' compensations preferred provider arrangement.
[✔] YES or [ ] NO

The carrier does not provide services through a network or through participating providers.
[ ] YES or [ ] NO

If the carrier answered "YES" to any of the above, please respond to the following:

_____ According to 211 CMR 52.06(2)(a), if you are a carrier that provides coverage for limited health services only, that does not provide services through a network or through participating providers, or for which other requirements set forth in 211 CMR 52.06 are otherwise inapplicable please indicate within your application those items that are inapplicable to your health benefit plan and provide the legal basis under which you are exempt from each particular requirement.

_____ According to 211 CMR 52.06(2)(b) if you are a carrier that provides coverage for specified services through a workers' compensation preferred provider arrangement please 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), and 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).

MATERIALS TO BE SUBMITTED TO THE OFFICE OF PATIENT PROTECTION - (211 CMR 52.16)

According to 211 CMR 52.16(1), "[a] carrier shall provide the following to the Office of Patient Protection **at the same time the carrier provides such material to the Bureau of Managed Care**:
(a) A copy of every evidence of coverage and amendments thereto offered by the carrier;
(b) A copy of the provider directory[ies] described in 211 CMR 52.15;
(c) A copy of the materials specified in 211 CMR 52.14.

Please confirm that the filer understands this requirement.

_____

_____

According to 211 CMR 52.16(2) "[a] 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 health care services offered by the carrier.

(b) A report of the percentage of physicians and nurse practitioners who voluntarily and involuntarily terminated participation contracts with the carrier during the previous calendar year for which such data has been compiled and the three most common reasons for voluntary and involuntary provider disenrollment;

1. For the purposes of 211 CMR 52.16(2)(b) carriers shall exclude physicians and nurse practitioners who have moved from one physician and/or nurse practitioner group to another but are still under contract with the carrier.
2. For the purposes of 211 CMR 52.16(2)(b) "voluntarily terminated" means that the physician or nurse practitioner terminated its contract with the carrier.
3. For the purposes of 211 CMR 52.16(2)(b) "involuntarily terminated" means that the carrier terminated its contract with the physician or nurse practitioner.

(c) The percentage of premium revenue expended by the carrier for health care services provided to insureds 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 grievances, grievances that were approved internally, grievances that were denied internally, and grievances that were withdrawn before resolution; and
2. external appeals pursued after exhausting the internal grievance 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 insureds, which shall include, but need not be limited to, race, gender and age.

(e) A carrier that provides specified services through a workers' compensation preferred provider arrangement shall not be required to meet the requirements of 211 CMR 52.16(1)(a), (b), and (c) and 211 CMR 52.16(2)(c) and (d).

Please confirm that the filer understands this requirement.

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