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, § 11, M.G.L. c. 176O, §§ 2 and 17, M.G.L. c. 176R, § 6, and M.G.L. c. ~~176R, §~~ 176S, §6.

52.02: Applicability

211 CMR 52.00 applies to any ~~carrier~~Carrier that offers for sale, provides or arranges for the provision of a defined set of ~~health care services~~Health Care Services to ~~insureds~~Insureds through affiliated and contracting ~~providers~~Providers or employs ~~utilization review~~Utilization Review in making decisions about whether services are ~~covered benefits~~Covered Benefits under a ~~health benefit plan.~~Health Benefit Plan. A ~~carrier~~Carrier that provides coverage for ~~limited health care services~~Limited Health Services only, that provides specified services through a workers' compensation preferred provider arrangement, or that does not provide services through a ~~network~~Network or through ~~participating providers~~Participating Providers 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 ~~accreditation~~Accreditation as outlined in 211 CMR 52.06(2).

Certain requirements of 211 CMR 52.00 *et seq*., as specified, shall also apply to ~~dental~~Dental and ~~vision carriers~~Vision Carriers. Such provisions are: 211 CMR 52.12(1) through (4); 211 CMR 52.12(11); 211 CMR 52.12(13); 211 CMR 52.~~13~~14(2), 211 CMR 52.~~13~~14(3)(a), (c) through (e), (g) through (i), (m) through (p); 211 CMR 52.~~13~~14(4) through (10); 211 CMR 52.~~14~~15(1)(c) and (d); 211 CMR 52.~~14~~15(2), (3) and (7); and 211 CMR 52.18.

A Carrier that ~~designates~~ delegates to or contracts with another entity, including a Utilization Review Organization, for the performance of some or all of the functions governed by M.G.L. c. 176O and/or 211 CMR 52.00 shall be responsible for ensuring compliance by said entity with the provisions of M.G.L. c. 176O and 211 CMR 52.00.

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 ~~128~~3.000.

Actively ~~Practicing~~Practices, means that a ~~health care professional~~Health Care Professional regularly treats patients in a clinical setting.

Administrative Disenrollment, a change in the status of an ~~insured~~Insured whereby the ~~insured~~Insured remains with the same ~~carrier~~Carrier but his or her membership may appear under a different identification number. Examples of an ~~administrative disenrollment~~Administrative 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 ~~carrier~~Carrier as both a disenrollment and an enrollment.

52.03: continued

Adverse Determination, a determination, based upon a review of information provided, by a ~~carrier~~Carrier or its designated ~~utilization review organization~~Utilization Review Organization, to deny, reduce, modify, or terminate an admission, continued inpatient stay, or the availability of any other ~~health care services~~Health Care Services, for failure to meet the requirements for coverage based on ~~medical necessity~~Medical Necessity, appropriateness of health care setting and level of care, or effectiveness, including a determination that a requested or recommended ~~h~~Health ~~c~~Care ~~s~~Service or treatment is experimental or investigational.

Alternative Payment Contract, any contract between a Carrier and a Provider or Provider organization that utilizes alternative payment methodologies, which are methods of payment that are not solely based on fee-for-service reimbursements and that may include, but is not limited to, shared savings arrangements, bundled payments, global payments, and fee-for-service payments that are settled or reconciled with a bundled or global payment.

Ambulatory Review, ~~utilization review~~Utilization Review of ~~health care services~~Health Care 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 ~~facility~~Facility, as well as other locations such as laboratories, radiology facilities, ~~provider~~Provider offices and patient homes.

~~Authorized Representative, an 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 insured in writing or by law with respect to a specific grievance or external review, provided, that if the 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 insured's representative or appoint another responsible party to serve as the insured's authorized 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 ~~carrier~~Carrier to provide or arrange for the provision of behavioral, substance use disorder and mental health services to voluntarily enrolled members of the ~~carrier~~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 ~~carrier~~Carrier to a licensed ~~health care professional, health care provider~~Health Care Professional, Health Care Provider group, or organization that employs or utilizes services of ~~health care professionals~~Health Care 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 "~~carrier~~Carrier" shall not include any entity to the extent it offers a policy, certificate, or contract that is not a health benefit plan as defined in M.G.L. c. 176J, §1.~~provides coverage solely for dental care services or vision care 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 ~~health care professional~~Health Care Professional, other than the physician or other ~~health care professional~~Health Care 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 ~~health care professionals~~Health Care Professionals, the recognized professional board for their specialty, who ~~actively practices~~Actively Practices in the ~~same~~Same or ~~similar specialty~~Similar 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 ~~carrier~~Carrier to determine the ~~medical necessity~~Medical Necessity and appropriateness of ~~health care services~~Health Care Services.

52.03: continued

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

Complaint,

(a) any ~~inquiry~~ Inquiry made by or on behalf of an ~~insured~~Insured to a ~~carrier~~Carrier or ~~utilization review organization~~Utilization Review Organization that is not explained or resolved to the ~~insured's~~Insured's satisfaction within three business ~~days~~Days of the ~~inquiry~~Inquiry; ~~or~~

(b) any matter concerning an ~~adverse determination~~Adverse Determination~~.~~; or

(c) ~~I~~in the case of a ~~carrier~~Carrier or ~~utilization review organization~~Utilization Review Organization that does not have an internal ~~inquiry~~Inquiry process, a ~~complaint~~Complaint means any ~~inquiry~~Inquiry.

Concurrent Review, ~~utilization review~~Utilization Review conducted during an ~~insured's~~Insured's inpatient hospital stay or course of treatment.

Cost Sharing or Cost-Sharing, includes deductibles, coinsurance, copayments, or similar charges required of an Insured, but does not include premiums, balance-billing amounts for out-of-network Providers, or spending for non-covered Benefits.

Covered Benefits or Benefits, ~~health care services~~Health Care Services to which an ~~insured~~Insured is entitled under the terms of the ~~health benefit plan~~Health Benefit Plan.

Days, calendar days unless otherwise specified in 211 CMR 52.00; provided, that computation of days 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 entity that offers a policy, certificate or contract that provides coverage solely for Dental Care Services and is: 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 ~~dental care services.~~Dental Care Services.

Dental Benefit Plan, a policy, contract, certificate or agreement of insurance entered into, offered or issued by a ~~dental carrier~~Dental Carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs solely for ~~dental care services~~Dental Care Services.

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

Dental Care Provider, a ~~dental care professional~~Dental Care Professional or ~~facility~~Facility licensed to provide Dental Care Services.

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

Discharge Planning, the formal process for determining, prior to discharge from a ~~facility~~Facility, the coordination and management of the care that an ~~insured~~Insured receives following discharge from a ~~facility~~Facility.

Division, the Division of Insurance established pursuant to M.G.L. c. 26, § 1.

Emergency Medical Condition, a medical condition, whether physical, behavioral, related to

substance use disorder, 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 ~~insured~~Insured 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).

52.03: continued

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 ~~insured~~Insured specifying the ~~benefits~~Benefits to which the ~~insured~~Insured is entitled. For workers' compensation preferred provider arrangements, the ~~evidence~~Evidence of ~~coverage~~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 ~~health care services~~Health Care 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 ~~carrier~~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 ~~complaint~~Complaint submitted to the ~~carrier~~Carrier that has been initiated by an ~~insured~~Insured, or on behalf of an Insured with the ~~insured's authorized representative~~consent of the Insured, concerning any aspect or action of the ~~carrier~~Carrier relative to the ~~insured~~Insured, including, but not limited to, review of ~~adverse determinations~~Adverse Determinations regarding scope of coverage, denial of services, rescission of coverage, 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 ~~carrier~~Carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of ~~health care services.~~Health Care Services. Unless otherwise noted, "~~health benefit plan~~Health Benefit Plan" shall not include any policy, certificate, or contract that is not a health benefit plan as defined in M.G.L. c. 176J, §1~~a dental benefit plan or a vision benefit plan~~.

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

Health Care Provider or Provider, a ~~health care professional~~Health Care Professional or ~~facility~~Facility.

Health Care Services or Health Services, services for the diagnosis, prevention, treatment, cure or relief of a ~~health~~ physical, behavioral, substance use disorder or mental health condition, illness, injury or disease.

Incentive Plan, any compensation arrangement between a ~~carrier~~Carrier and ~~health care professional~~Health Care Professional or ~~licensed health care provider group or~~ Licensed Health Care Provider Group or organization that employs or utilizes services of one or more licensed ~~health care professionals~~Health Care Professionals that may directly or indirectly have the effect of reducing or limiting specific services furnished to ~~insureds~~Insureds of the organization. "Incentive ~~plan~~Plan" shall not mean contracts that involve general payments such as ~~capitation~~Capitation payments or shared risk agreements that are made with respect to ~~physicians, nurse practitioners,~~Health Care Professionals or ~~physician and~~/Providers, or ~~nurse practitioner~~Health Care Professional groups or Provider groups which are made with respect to groups of ~~insureds~~Insureds if such contracts, which impose risk on such ~~physicians, nurse practitioners,~~ Health Care Professionals or ~~physician and~~/Providers or ~~nurse practitioner~~Health Care Professional groups or Provider groups for the cost of medical care, services and equipment provided or authorized by another ~~physician, nurse practitioner, or health care provider,~~Health Care Professional or Provider or by another Health Care Professional group or Provider group, comply with 211 CMR 52.00.

Inquiry, any communication by or on behalf of an ~~insured~~Insured to the ~~carrier or utilization review organization~~Carrier or Utilization Review Organization that has not been the subject of an ~~adverse determination~~Adverse Determination and that requests redress of an action, omission or policy of the ~~carrier~~Carrier.

Insured, an enrollee, covered person, ~~insured~~Insured, member, policy holder or subscriber of a ~~carrier~~Carrier, including a ~~dental~~Dental or ~~vision carrier~~Vision Carrier, including an individual whose eligibility as an ~~insured~~Insured of a ~~carrier~~Carrier is in dispute or under review, or any other individual whose care may be subject to review by a ~~utilization review~~Utilization Review program or entity as described under the provisions of M.G.L. c. 176O, 211 CMR 52.00 and ~~105~~958 CMR ~~128~~3.000.

52.03: continued

Internet Website, shall include, but not be limited to, an internet website, an intranet website, a web portal, or electronic mail.

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 ~~licensed health care provider group~~Licensed Health Care Provider Group only if it is composed of individual ~~health care professionals~~Health Care Professionals and has no subcontracts with ~~licensed health care provider groups~~Licensed Health Care Provider Groups.

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

Limited Network Plan, a limited network plan as defined in 211 CMR 152.00.

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

Material Change, a modification to any of a ~~carrier's~~Carrier's, including a ~~dental~~Dental or ~~vision carrier's~~Vision Carrier's, procedures or documents required by 211 CMR 52.00 that substantially affects the rights or responsibilities of: (1) an ~~insured carrier~~Insured; (2) a Carrier, including a ~~dental~~Dental or ~~vision carrier~~Vision Carrier~~,~~; and/or (3) a health, ~~dental~~Dental, or ~~vision care provider~~Vision Care Provider.

Medical Necessity or Medically Necessary, ~~health care services~~Health Care 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 ~~insured~~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 ~~carriers~~Carriers 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 or Provider Network, a group of health, ~~dental~~Dental or ~~vision care providers~~Vision Care Providers who contract with a ~~carrier~~Carrier, including a ~~dental~~Dental or ~~vision carrier~~Vision Carrier, or affiliate to provide health, ~~dental~~Dental or ~~vision care services~~Vision Care Services to ~~insureds~~Insureds covered by any or all of the ~~carrier's~~Carrier's, including a ~~dental~~Dental or ~~vision carrier's~~Vision Carrier's or affiliate's, plans, policies, contracts or other arrangements. Network shall not mean those ~~participating providers~~Participating 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 ~~benefits~~Benefits when a covered person receives care from preferred ~~network providers~~Network Providers but does not require the ~~insured~~Insured to designate a ~~primary care provider~~Primary Care Provider to coordinate the

delivery of care or receive referrals from the ~~carrier~~Carrier or any ~~network provider~~Network Provider as a condition of receiving ~~benefits~~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 ~~in~~within the ~~Department of Public~~ Health Policy Commission established by M.G.L. c. ~~111, § 217(a).~~ 6D, § 16, responsible for the administration and enforcement of M.G.L. c. 176O sections 13, 14, 15 and 16.

52.03: continued

Participating Provider, a ~~provider~~Provider who, under a contract with the ~~carrier~~Carrier, including a ~~dental~~Dental or ~~vision carrier~~Vision Carrier, or with its contractor or subcontractor, has agreed to provide health, ~~dental~~Dental or ~~vision care services~~Vision Care Services to ~~insureds~~Insureds with an expectation of receiving payment, other than coinsurance, copayments or deductibles, directly or indirectly from the ~~carrier~~Carrier, including a ~~dental~~Dental or ~~vision carrier~~Vision Carrier.

Physician Assistant, a person who is a graduate of an approved program for the training of physician assistants who is supervised by a registered physician in accordance with sections 9C to 9H, inclusive, of M.G.L. c. 112, and who has passed the Physician Assistant National Certifying Exam or its equivalent.

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

Primary Care Provider, a ~~health care professional~~Health Care Professional qualified to provide general medical care for common health care problems, who supervises, coordinates, prescribes, or otherwise provides or proposes ~~health care services,~~Health Care Services; initiates referrals for specialist care~~,~~; and maintains continuity of care within the scope of his or her practice.

Prospective Review, ~~utilization review~~Utilization Review conducted prior to an admission or a course of treatment. The term "~~prospective review~~Prospective Review" shall include any pre-authorization and pre-certification requirements of a ~~carrier~~Carrier or ~~utilization review organization~~Utilization Review Organization.

Regional Network Plan, a regional network plan as defined in 211 CMR 152.00.

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

Retrospective Review, ~~utilization review~~Utilization Review of ~~medical necessity~~Medical Necessity that is conducted after services have been provided to a patient. The term "~~retrospective review~~Retrospective Review" 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.

~~Alternative~~
Same or Similar Specialty, the ~~health care professional~~Health Care Professional 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 ~~grievance~~Grievance. Such experience shall extend to the treatment of children in a ~~grievance~~Grievance involving a child where the age of the patient is relevant to the determination of whether a requested service or supply is ~~medically necessary~~Medically Necessary.

Second Opinion, an opportunity or requirement to obtain a clinical evaluation by a ~~health care professional~~Health Care Professional other than the ~~health care professional~~Health Care Professional who made the original recommendation for a proposed ~~health service~~Health Service, to assess the clinical necessity and appropriateness of the initial proposed ~~health service~~Health Service.

Service Area, the geographical area as approved by the Commissioner within which the ~~carrier~~Carrier, including a ~~dental~~Dental or ~~vision carrier~~Vision Carrier, has developed a ~~network~~Network of ~~providers~~Providers to afford adequate access to members for covered ~~health, dental~~Health, Dental or ~~vision services~~Vision Services.

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).

Tiered Network Plan, a tiered network plan as defined in 211 CMR 152.00.

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, ~~health care services~~Health Care Services, procedures or settings. Such techniques may include, but are not limited to, ~~ambulatory review, prospective review, second opinion~~Ambulatory Review, Prospective Review, Second Opinion, certification, ~~concurrent review, case management, discharge planning~~Concurrent Review, Case Management, Discharge Planning or ~~retrospective review~~Retrospective Review.

52.03: continued

Utilization Review Organization, an entity that conducts ~~utilization review~~Utilization Review under contract with or on behalf of a ~~carrier~~Carrier, but does not include a ~~carrier~~Carrier performing ~~utilization review~~Utilization Review for its own ~~health benefit plans~~Health Benefit Pplans. A ~~behavioral health manager~~Behavioral Health Manager is considered a ~~utilization review organization~~Utilization Review Organization.

Vision Benefit Plan, a policy, contract, certificate or agreement of insurance entered into, offered or issued by a ~~carrier~~Carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs solely for ~~vision care services~~Vision Care Services.

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

Vision Care Provider, a ~~vision care professional~~Vision Care Professional; or a ~~facility~~Facility licensed to perform and provide Vision Care Services.

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

Vision Carrier, an entity that offers a policy, certificate or contract that provides coverage solely for Vision Care Services and is: 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 ~~vision care services.~~Vision Care Services.

52.04: Accreditation of Carriers

(1) A ~~carrier~~Carrier 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 ~~health care services~~Health Care Services to ~~insureds~~Insureds through affiliated and contracting ~~providers~~Providers or employ ~~utilization review~~Utilization Review in making decisions about whether services are ~~covered benefits~~Covered Benefits under a ~~health benefit plan~~Health Benefit Plan.

(2) Accreditation granted to ~~carriers~~Carriers pursuant to 211 CMR 52.00 shall remain in effect for up to 24 months until the end of the respective biennial Accreditation period, unless revoked or suspended by the Commissioner.

(3) A ~~carrier~~Carrier 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 ~~accreditation~~Accreditation of the ~~carrier~~Carrier.

(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 ~~carrier~~Carrier granted an exemption pursuant to 211 CMR 52.04(3) shall be provisionally accredited and, during such provisional ~~accreditation~~Accreditation, 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 ~~carrier's~~Carrier's exemption.

1. If the Bureau determines that the ~~carrier~~Carrier has met the requirements of 211 CMR 52.00, then the ~~carrier~~Carrier shall be accredited and the exemption shall expire upon ~~accreditation~~Accreditation.

2. If the Commissioner determines that the ~~carrier's~~Carrier'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.

52.05: Deemed Accreditation

(1) A ~~carrier~~Carrier may apply for deemed ~~accreditation.~~Accreditation. A ~~carrier~~Carrier that applies for deemed ~~accreditation~~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 ~~1283~~.000; and

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

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

(a) If the ~~carrier~~Carrier meets or exceeds the ratings identified in 211 CMR 52.06(5)(c), the ~~carrier~~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 ~~carrier~~Carrier meets or exceeds the ratings identified in 211 CMR 52.06(5)(d), the ~~carrier~~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 ~~carrier~~Carrier shall not be eligible for deemed ~~accreditation~~Accreditation status if the ~~national accreditation organization~~National Accreditation Organization has revoked the ~~carrier's accreditation~~Carrier's accreditation status in the past 24 months or the ~~accreditation~~accreditation status of an entity that currently contracts with the ~~carrier~~Carrier to provide services regulated by M.G.L. c. 176O.

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

(5) If a ~~carrier~~Carrier has received accreditation from a ~~national accreditation organization~~National Accreditation Organization, or a subcontracting organization, with whom the ~~carrier~~Carrier has a written agreement delegating certain services, or has received accreditation or certification from a ~~national accreditation organization~~National Accreditation Organization, but under standards other than those identified in 211 CMR 52.06(5), the ~~carrier~~Carrier may 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).

52.06: Application for Accreditation

(1) Timing of Application.

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

(b) A ~~carrier~~Carrier seeking initial ~~accreditation~~Accreditation must submit an application at least 90 ~~days~~Days prior to the date on which it intends to offer ~~health benefit plans~~Health Benefit Plans.

(2) Inapplicability of Accreditation Requirements.

(a) A ~~carrier~~Carrier that provides coverage for ~~limited health services~~Limited Health Services only, that does not provide services through a ~~network~~Network or through ~~participating providers~~Participating 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 ~~health benefit plan~~Health Benefit Plan and provide an explanation of why the ~~carrier~~Carrier is exempt from each particular requirement.

(b) A ~~carrier~~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~~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~~Carrier seeking initial ~~accreditation~~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~~r) in a format specified by the Commissioner. Any ~~carrier~~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.

52.06: continued

(a) A filing fee of $1,000 made payable to the Commonwealth of Massachusetts~~:~~;
(b) A complete description of the ~~carrier's utilization review~~Carrier's Utilization Review policies and procedures;
(c) A written attestation to the Commissioner that the ~~utilization review~~Utilization Review program of the ~~carrier~~Carrier 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 ~~carrier's~~Carrier's internal ~~grievance~~Grievance procedures consistent with ~~105~~958 CMR ~~128.200 through 128.313 and~~3.000 and a complete description of the external review process consistent with ~~105~~958 CMR ~~128.400 through 128.401~~3.000;
(f) A complete description of the ~~carrier's~~Carrier's process to establish guidelines for ~~medical necessity~~Medical Necessity consistent with ~~105~~958 CMR ~~128.101~~3.000;
(g) A complete description of the ~~carrier's~~Carrier's quality management and improvement policies and procedures;
(h) A complete description of the ~~carrier's~~Carrier's credentialing policies and procedures for all ~~participating providers~~Participating Providers;
(i) A complete description of the ~~carrier's~~Carrier's policies and procedures for providing or arranging for the provision of ~~preventive health services~~Preventive Health Services;
(j) A sample of every ~~provider~~Provider contract used by the ~~carrier~~Carrier or the organization with which the ~~carrier~~Carrier contracts;
(k) A statement that advises the Bureau whether the ~~carrier~~Carrier has issued new contracts, revised existing contracts, made revisions to fee schedules in any existing contract with a ~~physician, nurse practitioner,~~Health Care Professional or ~~physician and/~~Provider or ~~nurse practitioner~~Health Care Professional or Provider group that imposes financial risk on such ~~physician, nurse practitioner, or physician and/~~Health Care Professional or ~~nurse practitioner~~Provider or Health Care Professional or Provider group for the costs of medical care, services or equipment provided or authorized by another ~~physician, nurse practitioner, or health care provider.~~Health Care Professional or Health Care Provider. If the ~~carrier~~Carrier has any such contracts or fee schedules~~made any of the specified changes~~, the ~~carrier~~Carrier shall identify the contracts in which such ~~changes were made~~arrangement exist and identify the sections of the contracts that comply with 211 CMR 52.12(4);
(l) A statement that advises the Bureau whether the Carrier has contracts with Providers that places the Provider into a Limited, Regional, or Tiered Network Plan subject to 211 CMR 152.00. If the Carrier has any such contract, the Carrier shall identify the contracts in which such arrangements exist and identify the sections of the contracts that comply with 211 CMR 152.05;
(m) A complete description of the Carrier's network adequacy standards, along with an access analysis meeting the requirements of 211 CMR 52.13(2);
~~–~~(n) A copy of every ~~provider~~Provider directory used by the ~~carrier~~Carrier;
(o~~m~~) The ~~evidence~~Evidence of ~~coverage~~Coverage for every product offered by the ~~carrier~~Carrier;
(p~~n~~) A copy of each disclosure described in 211 CMR 52.~~14~~15, if applicable;
(q~~o~~) A written attestation that the ~~carrier~~Carrier has complied with 211 CMR 52.~~16~~17; and
(r~~p~~) Any additional information as deemed necessary by the Commissioner.

(4) Renewal Application. Any ~~carrier~~Carrier seeking renewal of ~~accreditation~~Accreditation 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~~l) in a format specified by the Commissioner. Any ~~carrier~~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.
(a) A filing fee of $1,000 made payable to the Commonwealth of Massachusetts;
(b) A written attestation to the Commissioner that the ~~utilization review program~~Utilization Review Program of the ~~carrier~~Carrier 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 ~~provider~~Provider contract used by the ~~carrier~~Carrier or the organization with which the ~~carrier~~Carrier contracts since the ~~carrier's~~Carrier's most recent ~~accreditation~~Accreditation;

(e) A statement that advises the Bureau whether the ~~carrier~~Carrier has issued new contracts, revised existing contracts, made revisions to fee schedules in any existing contract with a ~~physician, nurse practitioner,~~Health Care Professional or ~~physician and/~~Provider or ~~nurse practitioner~~Health Care Professional or Provider group that impose financial risk on such ~~physician, nurse practitioner, or physician and/~~Health Care Professional or ~~nurse practitioner~~Provider, or Health Care Professional or Provider group for the costs of medical care, services or equipment provided or authorized by another ~~physician, nurse practitioner, or health care provider.~~Health Care Professional or Health Care Provider. If the ~~carrier~~Carrier has ~~made~~issued or revised any ~~of~~such contracts or revised any fee schedules, the ~~specified changes, the carrier~~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 152.05;

(f) A statement that advises the Bureau whether the Carrier has issued new contracts or revised existing contracts with Providers that places the Provider into a limited, regional, or tiered network subject to 211 CMR 152.00. 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 152.05;

(g) Any Material Change made to the Carrier's network adequacy standards, along with an access analysis meeting the requirements of 211 CMR 52.12(2);

(h) The ~~evidence~~Evidence of ~~coverage~~Coverage for every product offered by the ~~carrier~~Carrier, and for every product that has Insureds but is no longer offered, ~~that~~ which was revised since the ~~carrier's~~Carrier's most recent ~~accreditation~~Accreditation;

(~~g~~i) A copy of ~~the most recently revised~~each ~~provider~~Provider directory used by the ~~carrier~~Carrier;

(~~h~~j) Material ~~changes~~Changes to any of the information contained in 211 CMR 52.06(3)(b), (e), (f), (g), (h), (i), and (~~n~~p);

52.06: continued

(~~i~~k) Evidence satisfactory to the Commissioner that the ~~carrier~~Carrier has complied with 211 CMR 52.~~16~~17; and

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

(5) Application for Deemed Accreditation. A ~~carrier~~Carrier seeking deemed ~~accreditation~~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 ~~carrier~~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~~Aaccreditation 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~~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~~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~~Aaccreditation 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~~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~~Network management, quality management and member protections for the most recent review of health ~~network~~Network standards by URAC.

(d) Proof in a form satisfactory to the Commissioner that the ~~carrier~~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~~Aaccreditation 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~~Provider credentialing for the most recent review of health plan standards by URAC; or

3. for ~~nongatekeeper preferred provider~~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~~Aaccreditation of preferred provider organizations in the category of credentialing and recredentialing.

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

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

(7) Material Changes. Carriers shall submit to the Bureau any ~~material changes~~Material Changes to any of the items ~~required by~~under 211 CMR 52.06(3) and 211 CMR 52.06(4) at least 30 ~~days~~Days before the effective date of the changes.

52.07: Review of Application for Accreditation

(1) ~~The Bureau shall review all applications for~~Carriers shall comply with ~~accreditation~~

~~according to~~ the standards set forth in M.G.L. c. 176O, 211 CMR 52.00; ~~and 105~~958 CMR ~~128~~3.000; 211 CMR 152.00, if applicable; and all other applicable state and federal law.

(a) For all products, a ~~carrier~~Carrier shall not be accredited unless the ~~carrier~~Carrier scores 65% or higher of an aggregate of the applicable elements in the NCQA Standards, effective July 1, 2015, or any subsequent edition of such standards determined by the Commissioner to be functionally equivalent or appropriate, for the ~~2008 for reviews performed through June 30, 2009, and standards effective July 1, 2009 thereafter, for the accreditation~~Accreditation of ~~health benefit plans~~Health Benefit Plans, including health maintenance organizations, gatekeeper preferred provider plans, and ~~nongatekeeper preferred provider plans~~Nongatekeeper Preferred Provider Plans, in the categories of utilization management, quality management and improvement, and credentialing and recredentialing.

52.07: continued

(b) The NCQA Standards, effective July 1, 2015, or any subsequent edition of such standards determined by the Commissioner to be functionally equivalent or appropriate~~2008 and beginning on July 1, 2009, effective July 1, 2009~~, 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 ~~carrier's~~Carrier's application for ~~accreditation~~Accreditation under 211 CMR 52.07, the ~~carrier~~Carrier may be given credit toward the relevant score for any ~~accreditation~~Accreditation that it received~~ separately~~, or which the Carrier's~~a~~ subcontracting organization, with ~~whom~~which the ~~carrier~~Carrier has a written agreement delegating certain services, ~~has~~ received, ~~accreditation or certification~~ from a ~~national accreditation organization~~National Accreditation Organization for the standards described in 211 CMR 52.08, 211 CMR 52.09 or 211 CMR 52.10.

(2) A ~~carrier's~~Carrier'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 ~~carrier~~Carrier shall respond to any request for additional information by the Bureau within 15 ~~days~~Days of the date of the Bureau's request. A ~~carrier~~Carrier that fails to respond in writing to requests within the 15 ~~days~~Days shall be subject to the penalties described in 211 CMR 52.18.

(3) The Bureau may schedule, at the ~~carrier's~~Carrier's expense, on-site surveys of the ~~carrier's utilization review~~Carrier's Utilization Review, quality management and improvement, credentialing and ~~preventive health services~~Preventive Health Services activities in order to examine records. Any on-site visit shall be scheduled within 15 ~~days~~Days of receipt of a ~~carrier's~~Carrier's complete application.

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

(5) A ~~carrier~~Carrier may seek reconsideration of a denial of its application for ~~accreditation~~Accreditation.

(a) A ~~carrier~~Carrier whose application for ~~accreditation~~Accreditation has been denied may make a written request to the Bureau for reconsideration within ten ~~days~~Days of receipt of the Bureau's notice.

(b) The Bureau shall schedule a meeting with the ~~carrier~~Carrier within ten ~~days~~Days of the receipt of the request for reconsideration to review any additional materials presented by the ~~carrier~~Carrier.

(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 ~~carrier~~Carrier.

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

52.08: ~~Standards for~~ Utilization Review

(1) Standards. A ~~carrier's~~Carrier's application will be reviewed for compliance with the applicable NCQA Standards for utilization management. In addition, ~~carriers~~Carriers 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 ~~review~~Review conducted by a ~~carrier~~Carrier or a ~~utilization review organization~~Utilization Review Organization 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 ~~utilization review~~Utilization Review criteria; and

(c) ensure the timeliness of ~~utilization review~~Utilization Review determinations.

(3) Criteria. A ~~carrier~~Carrier or ~~utilization review organization~~Utilization Review Organization shall adopt ~~utilization review~~Utilization Review criteria and conduct all ~~utilization review~~Utilization Review 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 ~~participating providers~~Participating Providers, consistent with the development of ~~medical necessity~~Medical Necessity criteria consistent with ~~105~~958 CMR ~~128~~3.101.

~~(b) Utilization review criteria shall be applied consistently by a carrier or the utilization review organization.~~

(b) Utilization Review criteria shall be up to date and applied consistently by a Carrier or the Utilization Review Organization and made easily accessible to subscribers, Health Care Providers and the general public on a Carrier's website; or, in the alternative, on the Carrier's Utilization Review Organization's website so long as the Carrier provides a link on its website to the Utilization Review Organization's website; provided, however, that a Carrier shall not be required to disclose licensed, proprietary criteria purchased by a Carrier or Utilization Review Organization on its website, but must disclose such criteria to a Provider or subscriber upon request.

(c) Any new or amended preauthorization requirement or restriction shall not be implemented unless the Carrier's and/or Utilization Review Organization's respective website has been updated to clearly reflect the new or amended requirement or restriction.

52.08: continued

(~~c~~d) Adverse ~~determinations~~Determinations rendered by a program of ~~utilization review~~Utilization Review, or other denials of requests for ~~health services~~Health Services, shall be made by a person licensed in the appropriate specialty related to such ~~health~~ Health ~~service~~ Services and, where applicable, by a ~~provider~~Provider in the same licensure category as the ordering ~~provider~~Provider.~~, and shall explain the reason for any denial, including the specific utilization review criteria or benefits provisions used in the determination, and all appeal rights applicable to the denial.~~

(4) Initial Determination Regarding a Proposed Admission, Procedure or Service. ~~A carrier~~

(a) When requiring prior authorization for a Health Care Service or ~~utilization review organization~~Benefit, a Carrier shall use and accept, or a Carrier shall require and ensure that its Utilization Review Organization use and accept, only the prior authorization forms designated by the Commissioner for the specific types of Health Care Services and Benefits identified in the designated forms.

(b)If the Carrier fails to use or accept the designated prior authorization form, or fails to respond within two (2) business days after receiving a completed prior authorization request from a Provider, pursuant to the submission of the prior authorization form under subsection (a), the prior authorization request shall be deemed to have been granted.

(c) In addition to any other requirements under applicable law, a Carrier shall make, or a Carrier shall require and ensure that its Utilization Review Organization makes, an initial determination regarding a proposed admission, procedure or service that requires such a determination within two working days 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 ~~second opinion~~Second Opinion that may be required.

~~(b)~~ (d) In the case of a determination to approve an admission, procedure or service, the ~~carrier~~Carrier or ~~utilization review organization~~Utilization Review Organization shall notify the ~~provider~~Provider rendering the service by telephone within 24 hours, and shall send written or electronic confirmation of the telephone notification to the ~~insured~~Insured and the ~~provider~~Provider within two working days thereafter.

~~(c)~~ (e) In the case of an ~~adverse determination~~Adverse Determination, the ~~carrier~~Carrier or the ~~utilization review organization~~Utilization Review Organization shall notify the ~~provider~~Provider rendering the service by telephone within 24 hours, and shall send written or electronic confirmation of the telephone notification to the ~~insured~~Insured and the ~~provider~~Provider within one working day thereafter.

(f) Any new or amended Prospective Review requirement or restriction shall not be effective unless and until the Carrier's or Utilization Review Organization's website has been updated to reflect the new or amended requirement or restriction.

(g) Nothing in 211 CMR 52.08(4) shall: (i) require a treating Health Care Provider to obtain information regarding whether a proposed admission, procedure or service is Medically Necessary on behalf of an Insured; (ii) restrict the ability of a Carrier or Utilization Review Organization to deny a claim for an admission, procedure or service if the admission, procedure or service was not Medically Necessary, based on information provided at the time of claim; or (iii) shall restrict the ability of a Carrier or Utilization Review Organization to deny a claim for an admission, procedure or service if other terms and conditions of coverage are not met at the time of service or time of claim.

(5) Concurrent Review. A ~~carrier~~Carrier or the ~~utilization review organization~~Utilization Review Organization shall make a ~~concurrent review~~Concurrent Review 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 ~~carrier~~Carrier or ~~utilization review organization~~Utilization Review Organization shall notify the ~~provider~~Provider rendering the service by telephone within one working day, and shall send written or electronic confirmation to the ~~insured~~Insured and the ~~provider~~Provider within one working day thereafter. A written or electronic notification shall include the number of extended ~~days~~Days or the next review date, the new total

number of ~~days~~Days or services approved, and the date of admission or initiation of services.

(b) In the case of an ~~adverse determination~~Adverse Determination, the ~~carrier~~Carrier or ~~utilization review organization~~Utilization Review Organization shall notify the ~~provider~~Provider rendering the service by telephone within 24 hours, and shall send written or electronic notification to the ~~insured~~Insured and the ~~provider~~Provider within one working ~~day~~Day thereafter.

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

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

(a) include information about the claim including, if applicable, the date(s) of service, the ~~h~~Health ~~c~~Care ~~p~~Provider(s), the claim amount, and any diagnosis, treatment, and denial code(s) and their corresponding meaning(s);

(b) identify the specific information upon which the Adverse Determination was based shall explain the reason for any denial, including the specific Utilization Review criteria or Benefits provisions used in the determination, and;

(c) discuss the Insured's presenting symptoms or condition, diagnosis and treatment interventions;

(d) explain in a reasonable level of detail the specific reasons such medical evidence fails to meet the relevant medical review criteria;

(e) reference and include, or provide a website link(s) to the specifically applicable, clinical practice guidelines, medical review criteria, or other clinical basis for the Adverse Determination;

(f) a description of any additional material or information necessary for the Insured to perfect the claim and an explanation of why such material or information is necessary;

(g) if the carrier specifies alternative treatment options which are ~~c~~Covered ~~b~~Benefits, include identification of providers who are currently accepting new patients;

(h) prominently explain all appeal rights applicable to the denial, including a clear, concise and complete description of the Carrier's formal internal Grievance process and the procedures for obtaining external review pursuant to 958 CMR 3.000, and a clear, prominent description of the process for seeking expedited internal review and concurrent expedited internal and external reviews, including applicable timelines, pursuant to 958 CMR 3.000; and a clear and prominent notice of a patient's right to file a grievance with the with the Office of Patient Protection; and information on how to file a grievance with the Office of Patient Protection.

(i) prominently notify the Insured of the availability of, and contact information for, the consumer assistance toll-free number maintained by the Office of Patient Protection, and if applicable, the Massachusetts consumer assistance program; and

(j) include a statement, prominently displayed in English, Arabic, Khmer (Cambodian), Chinese, French, Greek, Haitian-Creole, Italian, Lao, Portuguese, Russian, Spanish, and any non-English language in which 10% or more of the population residing in any Massachusetts county served by the Carrier is only literate in the same non-English language as specified by the Office of Patient Protection, that clearly indicates how the Insured can request oral interpretation and written translation services from the Carrier consistent with 958 CMR 3.000.

~~(a) identify the specific information upon which the adverse determination was based;~~

~~(b) discuss the insured'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 carrier, if any;~~

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

~~(e) include a clear, concise and complete description of the carrier's formal internal grievance process and the procedures for obtaining external review pursuant to 105 CMR 128.400.~~

(7) Reconsideration of an Adverse Determination. A ~~carrier~~Carrier or ~~utilization review organization~~Utilization Review Organization shall give a ~~provider~~Provider treating an ~~insured~~Insured an opportunity to seek reconsideration of an ~~adverse determination~~Adverse Determination from a ~~clinical peer reviewer~~Clinical Peer Reviewer in any case involving an

initial determination or a ~~concurrent review~~Concurrent Review determination.

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

52.08: continued

(b) If the ~~adverse determination~~Adverse Determination is not reversed by the reconsideration process, the ~~insured~~Insured, or the ~~provider~~Provider on behalf of the ~~insured~~Insured, may pursue the ~~grievance~~Grievance process established pursuant to ~~105~~958 CMR ~~128~~3.000.

(c) The reconsideration process allowed pursuant to 211 CMR 52.08(~~7~~6) shall not be a prerequisite to the internal ~~grievance~~Grievance process or an expedited appeal required by ~~105~~ 958 CMR ~~128~~3.000.

(8) Continuity of Care. A ~~carrier~~Carrier must provide evidence that its policies regarding continuity of care comply with all provisions of ~~105~~958 CMR ~~128.500 through 128.503~~3.000.

(9) Workers' Compensation Preferred Provider Arrangement. A ~~carrier~~Carrier 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~~10), if it has met the requirements of 452 CMR 6.00.

(10) Annual Survey. A ~~carrier~~Carrier or ~~utilization review organization~~Utilization Review Organization shall conduct an annual survey of ~~insureds~~Insureds 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~~Insureds with projected measures of their satisfaction.

(b) Carriers that utilize ~~incentive plans~~Incentive Plans shall establish mechanisms for monitoring the satisfaction, quality of care and actual utilization compared with projected utilization of ~~health care services~~Health Care Services of ~~insureds~~Insureds.

(11) Religious Non-medical Treatment and Providers. Nothing in 211 CMR 52.08 shall be construed to require ~~health benefit plans~~Health Benefit Plans to use medical professionals or criteria to decide insured access to ~~religious non-medical providers~~Religious Non-medical Providers, utilize medical professionals or criteria in making decisions in internal appeals from decisions denying or limiting coverage or care by ~~religious non-medical providers~~Religious Non-medical Providers, compel an ~~insured~~Insured to undergo a medical examination or test as a condition of receiving coverage for treatment by a ~~religious non-medical provider~~Religious Non-medical Provider, or require ~~health benefit plans~~Health Benefit Plans to exclude ~~religious non-medical providers~~Religious Non-medical Providers 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 ~~provider~~Provider.

52.09: ~~Standards for~~ Quality Management and Improvement

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

(2) Workers' Compensation Preferred Provider Arrangements. A ~~carrier~~Carrier 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) A carrier's application~~(1) A Carrier will credential all Health Care Providers according to the NCQA standards for credentialing and recredentialing, and the Bureau of Managed Care will review a Carrier's credentialing and recredentialing processes that are set forth in the Carrier's application for Accreditation ~~will be reviewed~~ for compliance with the applicable NCQA Standards for credentialing and recredentialing if the Carrier does not have Deemed Accreditation with respect to credentialing and recredentialing.

(2) Credentialing of Health Care Professionals

(a) A ~~carrier~~Carrier shall accept, in both electronic and paper form, a Health Care Professional 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 Health Care Professional credentialing application by means of facsimile and electronic mail and may implement an online process for the purpose of processing credentialing applications. For purposes of this subsection, Carriers may charge Health Care Professionals a reasonable administrative charge associated with the costs of processing submissions in electronic or paper form that differs from the form used by the majority of Health Care Professionals

(b) Unless there are otherwise binding arrangements between a Carrier and specific Providers holding Carriers to a shorter time standard, a Carrier shall notify a Health Care Professional that a submitted credentialing application is incomplete no later than 20 business days after the Carrier receives the credentialing application.

(c) All Carriers shall complete credentialing of 95 percent of Health Care Professionals' initial Clean and Complete Credentialing Applications within 60 Days of receipt of the Health Care Professional's Clean and Complete Credentialing Application, and all Carriers shall complete credentialing of 95 percent of Health Care Professionals' Clean and Complete re-Credentialing Applications within 120 ~~d~~Days of receipt of the Health Care Professional's Clean and Complete re-Credentialing Application, and Carriers shall inform a Health Care Professional within 75 Days of receipt of an initial Clean and Complete Credentialing Application of the status of the application, including, if applicable, the reasons for any delay in the completion of credentialing and a timeline of the expected resolution of the application and, if a Health Care Professional is not credentialed, the reasons that the Health Care Professional is not credentialed..

(3) Nothing in this ~~section~~ 211 CMR 52.10 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~~ 211 CMR 52.10 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) Carriers shall maintain documentation regarding all submissions.

(6) A Carrier shall not be required to meet the requirements of 211 CMR 52.10 if the ~~carrier~~Carrier does not provide ~~benefits~~Benefits through a ~~network~~Network or does not have contracts with ~~participating providers~~Participating Providers.

(~~3~~7) A ~~carrier~~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.

(8) Nothing in this ~~section~~ 211 CMR 52.10 shall be construed to prevent a Carrier from implementing timelines that are more stringent than otherwise provided in 211 CMR 52.10.

52.11: ~~Standards for~~ Preventive Health Services

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

(2) A ~~carrier~~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 ~~carriers~~Carriers and ~~providers~~Providers shall state that a ~~carrier~~Carrier shall not refuse to contract with or compensate for covered services an otherwise eligible ~~health care provider~~Health Care Provider solely because such ~~provider~~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 ~~carrier's health benefit plans~~Carrier's Health Benefit Plans as they relate to the needs of such ~~provider's~~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~~Provider is compensated by the ~~carrier~~Carrier for services provided to the patient.

(2) Contracts between ~~carriers~~Carriers and ~~providers~~Providers shall state that the ~~provider~~Provider is not required to indemnify the ~~carrier~~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 ~~carrier~~Carrier based on the ~~carrier's~~Carrier's management decisions, ~~utilization review~~Utilization Review provisions or other policies, guidelines or actions.

(3) No contract between a ~~carrier~~Carrier and a ~~licensed health care provider group~~Licensed Health Care Provider Group may contain any ~~incentive plan~~Incentive Plan that includes a specific payment made to a ~~health care professional~~Health Care Professional as an inducement to reduce, delay or limit specific, ~~medically necessary~~Medically Necessary services covered by the health care contract.

(a) Health ~~care professionals~~Care Professionals shall not profit from provision of covered services that are not ~~medically necessary~~Medically Necessary or medically appropriate.

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

(c) Nothing in 211 CMR 52.12(3) shall be construed to prohibit contracts that contain ~~incentive plans~~Incentive Plans that involve general payments such as ~~capitation~~Capitation payments or shared risk agreements ~~that are made with respect to providers or which are made with respect to groups of insureds if~~between Carriers and Providers, so long as such contracts, which impose risk on such ~~providers~~Providers for the costs of care, services and equipment provided or authorized by another ~~health care provider~~Health Care Provider, comply with 211 CMR 52.12(4~~).~~), 211 CMR 155.00, and any other applicable law.

(d) In the event that a Provider with which a Carrier has a contract makes any decisions about coverage of requested care, then the Carrier remains responsible to ensure compliance with all applicable utilization review processes, including but not limited to adverse determination notices that describe rights to appeal medical necessity denials.

(4) No ~~carrier~~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 ~~health care provider~~Health Care Provider which imposes financial risk on such ~~provider~~Provider for the costs of care, services or equipment provided or authorized by another ~~provider~~Provider unless such contract includes specific provisions with respect to the following:

(a) stop loss protection;

(b) minimum patient population size for the ~~provider~~Provider group; and
(c) identification of the ~~health care services~~ Health Care Services for which the ~~provider~~Provider is at risk.

(5) ~~Contracts between carriers~~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, Regional 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 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;

(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 ~~health care providers~~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 10 of chapter 12C;

(d) limits the ability of either the Carrier or the Health Care Provider to disclose the allowed amount and fees of services to an Insured's treating Health Care Provider; or

(e) limits the ability of either the Carrier or the Health Care Provider to disclose out-of-pocket costs to an Insured.

(6) Contracts between Carriers and Health Care Providers shall state that neither the ~~carrier~~Carrier nor the ~~provider~~Provider has the right to terminate the contract without cause.

(~~6~~7) Contracts between ~~carriers~~Carriers and ~~health care providers~~Health Care Providers shall state that a ~~carrier~~Carrier shall provide a written statement to a ~~provider~~Provider of the reason or reasons for such ~~provider's~~Provider's involuntary disenrollment.

52.12: continued

(~~7~~8) Contracts between ~~carriers~~Carriers and ~~health care providers~~Health Care Providers shall state that the ~~carrier~~Carrier shall notify ~~providers~~Providers, ~~either in writing~~by mail or electronically, of modifications in payments, modifications in covered services or modifications in a ~~carrier's~~Carrier's procedures, documents or requirements, including those associated with ~~utilization review~~Utilization Review, quality management and improvement, credentialing and ~~preventive health services~~Preventive Health Services, that have a substantial impact on the rights or responsibilities of the ~~providers~~Providers, and the effective date of the modifications. The notice shall be provided 60 ~~days~~Days before the effective date of such modification unless such other date for notice is mutually agreed upon between the ~~carrier~~Carrier and the ~~provider~~Provider.

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

(~~9~~10) Contracts between ~~carriers~~Carriers and ~~health care providers~~Health Care Providers shall prohibit ~~health care providers~~Health Care Providers from billing patients for nonpayment by the ~~carrier~~Carrier of amounts owed under the contract due to the insolvency of the ~~carrier~~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.

(~~10~~11) Contracts between ~~carriers~~Carriers and ~~health care providers~~Health Care Providers shall require ~~providers~~Providers to comply with the ~~carrier's~~Carrier's requirements for ~~utilization review~~Utilization Review, quality management and improvement, credentialing and the delivery of ~~preventive health services~~Preventive Health Services.

(~~11~~12) Nothing in 211 CMR 52.12 shall be construed to preclude a ~~carrier~~Carrier from requiring a ~~health care provider~~Health Care Provider to hold confidential specific compensation terms.

(~~12~~13) Nothing in 211 CMR 52.12 shall be construed to restrict or limit the rights of ~~health benefit plans~~Health Benefit Plans to include as ~~providers religious non-medical providers~~Providers Religious Non-medical Providers or to utilize medically based eligibility standards or criteria in deciding ~~provider~~Provider status for ~~religious non-medical providers~~Religious Non-medical Providers.

(~~13~~14) For ~~dental~~Dental and ~~vision benefit plans~~Vision Benefit Plans~~:~~, ~~T~~the following provisions regarding the standards for ~~provider~~Provider contracts found at 211 CMR 51.12, shall apply for ~~dental~~Dental and ~~vision benefits~~Vision Benefits: 211 CMR 52.12(1) through (4) and 211 CMR 52.12(11).

~~(14) A participating provider nurse 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 carrier's definition of primary care provider to an insured.~~

(15) Contracts between ~~carriers~~Carriers and ~~health care providers~~Health Care Providers shall recognize ~~nurse practitioners~~Nurse Practitioners and Physician Assistants as ~~participating providers~~Participating Providers and shall treat services provided by ~~participating provider nurse practitioners~~Participating Provider Nurse Practitioners and Physician Assistants to their ~~insureds~~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 ~~benefits~~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 ~~nurse practitioner~~Nurse Practitioner or Physician Assistant who is a ~~participating provider~~Participating Provider and is practicing within the scope of his or her professional license to the extent that such policy or contract currently provides ~~benefits~~Benefits for identical services rendered by a

~~provider~~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 covered services will be accessible to Insureds without unreasonable delay. Adequacy shall be determined in accordance with the requirements of this ~~section~~211 CMR 52.13, 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 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 meets 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 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, including but not limited to the Insureds' needs set forth in 211 CMR 52.13(2)(d), and the Insureds' satisfaction with services in relation to the development of the Network(s);

(f) The Carrier's methods for monitoring the ability of Insureds to access services out-of-Network;

(g) A report developed using a Network accessibility analysis system such as GeoNetworks, which shall include the following, or, for Carriers in a new geographic area(s) or an area(s) that does not currently have Insureds, estimates for the following, as applicable;

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 Insureds, if applicable;
   b. The total number of Network Primary Care Providers who are accepting new patients;
   c. The total number of Network Primary Care Providers who are not accepting new patients;
   d. The total number of Network Health Care Professionals who specialize in the treatment of behavioral health and substance ~~abuse~~use disorders ~~that~~who are accepting new patients;
   e. The total number of Network Health Care Professionals who specialize in the treatment of behavioral health and substance ~~abuse~~use disorders ~~that~~but are not accepting new patients;
   f. The total number of Network Health Care Professionals who specialize in the top five types of specialty care by volume of utilization who ~~that~~ are accepting new patients;
   g. The total number of Network Health Care Professionals who specialize in the top five types of specialty care by volume of utilization who ~~that~~ are not accepting new patients;

a.h. The total number of Network inpatient hospitals that provide treatment for acute and tertiary care.;

i. The total number of Network inpatient hospitals that provide treatment for behavioral health and substance use disorders;

j. The percentage of Insureds meeting the Carrier's standard(s) for access through its Network to Primary Care Providers;

k. The percentage of Insureds meeting the Carrier's standard(s) for access through its Network to behavioral health and substance use disorder Health Care Professionalsractitioners:

l. The percentage of Insureds, meeting the Carrier's standard(s) for access through its Network to specialty care Health Care Professionals;

m. The percentage of Insureds meeting the Carrier's standard(s) for access through its Network to inpatient behavioral health and substance use disorder treatment;

n. The percentage of the number of Insureds meeting the Carrier's standard(s) for access through its Network to inpatient acute tertiary care.

(h) If, at any time, the Carrier becomes aware of changes to the numbers of Health Care Professionals or Providers within its Network that would cause the Carrier to not meet any of its standard(s) for access, then within 30 Days of becoming aware the Carrier will submit a corrective action plan for the Commissioner's review and approval that will identify the steps that the Carrier will take to address the geographic areas where it is not meeting its standard(s) and how the Carrier plans to address access to care in those areas until Network changes are made so that the Carrier can once again satisfy its standard(s) for access to care.

(i) In tiered nNetworks and/or other 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 relationship between Providers and the population, according to the Carrier's standard, 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 relationship between Providers and the population, according to the Carrier's standard, for every city and town.

i) 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.

52.14: Evidences of Coverage

(1) Evidences of Coverage as to a Carrier. A It shall constitute delivery of an Evidence of Coverage if a carrier chooses to, shall upon or after enrollment, require the Insured to designate whether the Insured wants to receiveissue an Evidence of Coverage electronically or in writing. If no option is designated, the Evidence of Coverage shall be provided electronically. If the insured designates written notice, a carrier shall issue and deliver to at least one adult Insured in the household an Evidence of Coverage. If the Insured designates electronic notice, a carrier shall upon enrollment issue and deliver to at least one adult insured in each household residing in Massachusetts, upon enrollment: The Carrier may provide the Insured the option of:

(a) receiving a paper copy of the an evidence of coverage; or

(b) being referred the insured to a resources where the information described in such Eevidence of Cceoverage can be accessed, including, but not limited to, an Iinternet Wwebsite. References to the terms, "internet website" shall include "intranet website" and "electronic mail" or "e-mail." In such instance, the Evidence of Coverage must meet the requirements of 211 CMR 52.14 (4), below.

In the event that the Insured does not designate an option as described above, the Carrier may issue the Evidence of Coverage via an Internet website, as referenced in 211 CMR 52.14 (1)(b), above.

An electronic copy of the evidenceEvidence of coverageCoverage in paper format shall

always be delivered to the group representative in the case of a group policy.

52.~~13~~14: continued

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

(a) an ~~evidence~~Evidence of ~~coverage~~Coverage;

(b) a summary of the information contained in the ~~evidence~~Evidence of ~~coverage~~Coverage; or

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

Dental and ~~vision carriers~~Vision Carriers shall be exempt from the provisions of 211 CMR 52.~~13~~14(3)(b), 211 CMR 52.~~13~~14(3)(f), 211 CMR 52.~~13~~14(3)(j) through (l) and 211 CMR 52.~~13~~14(3)(q) through (aa).

(3) Evidence of Coverage Requirements. An ~~evidence~~Evidence of ~~coverage~~Coverage shall contain a clear, concise and complete statement of all of the information described at 211 CMR 52.~~13(3)(a) through (aa).~~14(3)(a) through (aa). In addition, for ~~l~~Limited, ~~r~~Regional and ~~t~~Tiered Network ~~p~~Plans, an Evidence of Coverage shall also contain any information as required by 211 CMR 152.00.

(a) The health, ~~dental~~Dental or ~~vision care services~~Vision Care Services and any other ~~benefits~~Benefits to which the ~~insured~~Insured is entitled on a nondiscriminatory basis, including ~~benefits~~Benefits mandated by state or federal law;

(b) The prepaid fee which must be paid by or on behalf of the ~~insured~~Insured and an explanation of any grace period for the payment of any ~~health benefit plan premium~~Health Benefit Plan ~~P~~premium;

(c) The toll-free telephone number and website established by the Carrier to present Provider cost information and an explanation of the information that a Insured may obtain through such toll-free number and website.

(d) The limitations on the scope of ~~health, dental or vision care services~~:

1. Health Care Services and any other ~~benefits~~Benefits to be provided, including:

a. an explanation of any ~~f~~Facility fee, allowed amount, coinsurance, copayment, deductible or other amount that the Insured may be responsible to pay to obtain Covered Benefits from Network or out-of-~~n~~Network Providers; and

b. an explanation of the information that an Insured may obtain through the toll-free number and website established by the Carrier under 211 CMR 52.15(4).

2. Dental or Vision Care Services and any other Benefits to be provided, including an explanation of any deductible or copayment feature~~;~~.

(~~e~~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~~Health, ~~dental~~Dental or ~~vision benefit plan~~Vision Benefit Plan;

(~~e~~f) ~~The~~ A description of the locations where, and the manner in which, ~~health, dental~~Health, Dental or ~~vision care services~~ Vision Care Services and other ~~benefits~~Benefits may be obtained~~;~~, and, additionally, for Health Care Services:

1. the method to locate ~~p~~Provider directory information on a Carrier's website and the method to obtain a paper ~~p~~Provider directory;
2. an explanation that whenever a proposed admission, procedure or covered service that is Medically Necessary is not available to an Insured within the Carrier's Network, the Carrier will cover the out-of-~~n~~Network admission, procedure or service, and the Insured will not be responsible for paying more than the amount which would be required for a similar admission, procedure or service offered within the Carrier's Network; and
3. an explanation that whenever a location where Health Care Services are provided is part of a Carrier's Network, the Carrier will cover Medically Necessary covered Benefits delivered at that location, and an explanation that the Insured will not be responsible for paying more than the amount required for Network services delivered at that location even if part of the Medically Necessary Covered Benefits are performed by out-of-~~n~~Network Provider(s), unless the Insured has a reasonable opportunity to choose to have the service performed by a Network Provider.

(~~f~~g) 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~~h) The criteria by which an ~~insured~~Insured may be disenrolled or denied enrollment. 211 CMR 52.~~13~~14(3)(~~g~~h) shall apply to ~~carriers~~Carriers, including ~~dental~~Dental and ~~vision carriers~~Vision Carriers.

(~~h~~i) The involuntary disenrollment rate among ~~insureds~~Insureds of the ~~carrier~~Carrier. 211 CMR 52.~~13~~14(3)(~~h~~i) shall apply to ~~carriers~~Carriers, including ~~dental~~Dental and ~~vision carriers~~Vision Carriers.

1. For the purposes of 211 CMR 52.~~13~~14(3)(~~h~~i), ~~carriers~~Carriers shall exclude all ~~administrative disenrollments, insureds~~Administrative Disenrollments, Insureds who are disenrolled because they have moved out of a health plan's ~~service area, insureds~~Service Area, Insureds whose continuation of coverage periods have expired, former dependents who no longer qualify as dependents, or ~~insureds~~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.~~13~~14(3)(~~h~~i), the term "involuntary disenrollment" means that a ~~carrier~~Carrier has terminated the coverage of the ~~insured~~Insured due to any of the reasons contained in 211 CMR 52.~~13~~14(3)(~~i~~j)2. and 3.

(~~i~~j) The requirement that an ~~insured's~~Insured's coverage may be canceled, or its renewal refused may arise only in the circumstances listed in 211 CMR 52.~~13~~14(3)(~~i~~j)1. through 5. 211 CMR 52.~~13~~14(3)(~~i~~j) shall apply to ~~carriers~~Carriers, including ~~dental~~Dental and ~~vision carriers~~Vision 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 ~~insured~~Insured;

3. commission of acts of physical or verbal abuse by the ~~insured~~Insured which pose a threat to ~~providers~~Providers~~, the Carrier~~ or other ~~insureds~~Insureds of the ~~carrier~~Carrier and which are unrelated to the physical or mental condition of the ~~insured~~Insured; provided, that the ~~commissioner~~Commissioner prescribes or approves the procedures for the implementation of the provisions of 211 CMR 52.~~13(3)(i)3.;~~14(3)(i)3;

4. relocation of the ~~i~~Insured outside the service area of the carrier; or

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

(~~j~~k) A description of the Carrier's, including a Dental or Vision Carrier's, method for resolving Insured Inquiries and Complaints. For a Health Benefit Plan, this description shall include a description of the internal Grievance process and the external review process consistent with 958 CMR 3.000, including a description of the process for seeking expedited internal review and concurrent expedited internal and external reviews pursuant to 958 CMR 3.000~~A description of the carrier's method for resolving insured inquiries and complaints, including a description of the internal grievance process consistent with 105 CMR 128.300 through 128.313, and the external review process consistent with 105 CMR 128.400 through 128.416~~;

(~~k~~l) A statement telling ~~insureds~~Insureds how to obtain the report regarding ~~grievances~~Grievances pursuant to ~~105~~958 CMR ~~128~~3.600(~~A~~)(~~4~~1)(d) from the Office of Patient Protection;

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

52.~~13~~14: continued

~~(m) A description of the carrier's, including a dental or vision carrier's, method for resolving insured inquiries and complaints;~~

(n) A summary description of the procedure, if any, for out-of-~~network~~Network referrals and any additional charge for utilizing out-of-network ~~providers~~Providers. 211 CMR 52.~~13~~14(3)(n) shall apply to ~~carriers~~Carriers, including ~~dental~~Dental and ~~vision carriers~~Vision Carriers;

(o) A summary description of the ~~utilization review~~Utilization Review procedures and quality assurance programs used by the ~~carrier~~Carrier, including a ~~dental~~Dental or ~~vision carrier~~Vision Carrier, including the toll-free telephone number to be established by the ~~carrier~~Carrier that enables consumers to determine the status or outcome of ~~utilization review~~Utilization Review decisions;

(p) A statement detailing what translator and interpretation services are available to assist ~~insureds~~Insureds, including that the ~~carrier~~Carrier 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.~~13~~14(3)(p) shall apply to ~~carriers~~Carriers, including ~~dental~~Dental and ~~vision carriers~~Vision Carriers.

(q) A list of prescription drugs excluded from any closed or restricted formulary available to ~~insureds~~Insureds under the ~~health benefit plan~~Health Benefit Plan; provided, that the ~~carrier~~Carrier 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 ~~carrier~~Carrier will be deemed to have met the requirements of 211 CMR 52.~~13~~14(3)(q) if the ~~carrier~~Carrier does all of the following:

~~a~~1. provides a complete list of prescription drugs that are included in any closed or restricted formulary;

~~b~~2. clearly states that all other prescription drugs are excluded;

~~c~~3. provides a toll-free number that is updated within 48 hours of any change in the closed or restricted formulary to enable ~~insureds~~Insureds to determine whether a particular drug is included in or excluded from the closed or restricted formulary; ~~and~~

~~d~~4. provides an ~~internet~~ Internet Website that is updated as soon as practicable relative to any change in the closed or restricted formulary to enable ~~insureds~~Insureds to determine whether a particular drug is included in or excluded from the closed or restricted formulary; and

5. clearly states that there shall be no financial penalty for a patient's choice to receive a lesser quantity of any opioid contained in schedule II or III of section 3 of chapter 94C of the General Laws, and lists each of such schedule II or III drugs.

(r) A summary description of the procedures followed by the ~~carrier~~Carrier 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 ~~benefits~~Benefits consistent with 211 CMR 38.00;

(u) A description of coverage for emergency care and a statement that ~~insureds~~Insureds have the opportunity to obtain ~~health care services~~Health Care Services for an ~~emergency medical condition~~Emergency Medical Condition, including the option of calling the local pre-hospital emergency medical service system, whenever the ~~insured~~Insured is confronted with an ~~emergency medical condition~~Emergency Medical Condition which in the judgment of a prudent layperson would require pre-hospital emergency services;

(v) If the ~~carrier~~Carrier offers services through a ~~network~~Network or through ~~participating providers~~Participating Providers, the following statements regarding continued treatment:

1. If the ~~carrier~~Carrier allows or requires the designation of a ~~primary care provider~~Primary Care Provider, a statement that the ~~carrier~~Carrier will notify an ~~insured~~Insured at least 30 ~~days~~Days before the disenrollment of such ~~insured's primary care provider~~Insured's Primary Care Provider and shall permit such ~~insured~~Insured to continue to be covered for ~~health services~~Health Services, consistent with the terms of the ~~evidence~~Evidence of ~~coverage~~Coverage, by such ~~primary care provider~~Primary Care Provider for at least 30 ~~days~~Days after said ~~provider~~Provider 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 ~~primary care provider~~Primary Care Provider.

2. A statement that the ~~carrier~~Carrier will allow any female ~~insured~~Insured who is in her second or third trimester of pregnancy and whose ~~provider~~Provider in connection with her pregnancy is involuntarily disenrolled, other than disenrollment for quality-related reasons or for fraud, to continue treatment with said ~~provider~~Provider, consistent with the terms of the ~~evidence~~Evidence of ~~coverage~~Coverage, for the period up to and including the ~~insured's~~Insured's first postpartum visit.

3. A statement that the ~~carrier~~Carrier will allow any ~~insured~~Insured who is ~~terminally ill~~Terminally Ill and whose ~~provider~~Provider in connection with said illness is involuntarily disenrolled, other than disenrollment for quality related reasons or for fraud, to continue treatment with said ~~provider~~Provider, consistent with the terms of the ~~evidence~~Evidence of ~~coverage~~Coverage, until the ~~insured's~~Insured's death.

52.~~13~~14: continued

4. A statement that the ~~carrier~~Carrier will provide coverage for ~~health services~~Health Services for up to 30 ~~days~~Days from the effective date of coverage to a new ~~insured~~Insured by a ~~physician~~ Provider who is not a ~~participating provider~~Participating Provider in the ~~carrier's network~~Carrier's Network if:

a. the ~~insured's~~Insured's employer only offers the ~~insured~~Insured a choice of ~~carriers~~Carriers in which said ~~physician~~ Provider is not a ~~participating provider~~Participating Provider; and

b. said ~~physician~~Provider is providing the ~~insured~~Insured with an ongoing course of treatment or is the ~~insured's primary care provider~~Insured's Primary Care Provider; and

c. With respect to an ~~insured~~Insured in her second or third trimester of pregnancy, 211 CMR 52.~~13~~14(3)(v)4. shall apply to services rendered through the first postpartum visit. With respect to an ~~insured~~Insured with a ~~terminal illness~~Terminal Illness, 211 CMR 52.~~13~~14(3)(v)4. shall apply to services rendered until death;

~~d. For the purposes of 211 CMR 52.13(3)(v)4.a. and b., the term "physician" shall include nurse practitioners.~~

5. A ~~carrier~~Carrier may condition coverage of continued treatment by a ~~provider~~Provider under 211 CMR 52.~~13~~14(3)(v)1. through 52.~~13~~14(3)(v)4. upon the ~~provider's~~Provider's agreeing as follows:

a. to accept reimbursement from the ~~carrier~~Carrier at the rates applicable prior to notice of disenrollment as payment in full and not to impose ~~cost sharing~~Cost Sharing with respect to the ~~insured~~Insured in an amount that would exceed the ~~cost sharing~~Cost Sharing that could have been imposed if the ~~provider~~Provider had not been disenrolled;

b. to adhere to the quality assurance standards of the ~~carrier~~Carrier and to provide the ~~carrier~~Carrier with necessary medical information related to the care provided; and

c. to adhere to the ~~carrier's~~Carrier's policies and procedures, including procedures regarding referrals, obtaining prior authorization and providing services pursuant to a treatment plan, if any, approved by the ~~carrier~~Carrier;

6. Nothing in 211 CMR 52.~~13~~14(3)(v) shall be construed to require the coverage of ~~benefits~~Benefits that would not have been covered if the ~~provider~~Provider involved remained a ~~participating provider~~Participating Provider;

(w) If a ~~carrier~~Carrier requires an ~~insured~~Insured to designate a ~~primary care provider~~Primary Care Provider, a statement that the ~~carrier~~Carrier will allow the ~~primary care provider~~Primary Care Provider to authorize a standing referral for specialty health care provided by a ~~health care provider~~Health Care Provider participating in the ~~carrier's network~~Carrier's Network when:

1. the ~~primary care provider~~Primary Care Provider determines that such referrals are appropriate;

2. the ~~provider~~Provider of specialty health care agrees to a treatment plan for the ~~insured~~Insured and provides the ~~primary care provider~~Primary Care Provider with all necessary clinical and administrative information on a regular basis; and

3. the ~~health care services~~Health Care Services to be provided are consistent with the terms of the ~~evidence~~Evidence of ~~coverage~~Coverage; ~~. and~~

~~4.~~ Nothing in 211 CMR 52.~~13~~14(3)(w) shall be construed to permit a ~~provider~~Provider of specialty health care who is the subject of a referral to authorize any further referral of an ~~insured~~Insured to any other ~~provider~~Provider without the approval of the ~~insured's carrier~~Insured's Carrier;

(x) If a ~~carrier~~Carrier requires an ~~insured~~Insured to obtain referrals or prior authorization from a ~~primary care provider~~Primary Care Provider for specialty care, a statement that the ~~carrier~~Carrier will not require an ~~insured~~Insured to obtain a referral or prior authorization from a ~~primary care provider~~Primary Care Provider for the following specialty care provided by an obstetrician, gynecologist, certified nurse midwife or family practitioner participating in such ~~carrier's health care provider network~~Carrier's Health Care Provider Network and that the ~~carrier~~Carrier will not require higher copayments, coinsurance, deductibles or additional Cost-Sharing features ~~cost sharing arrangements~~ for such services provided to such ~~insureds~~Insureds in the absence of a referral from a ~~primary care provider~~Primary Care Provider:

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 ~~medically necessary~~Medically Necessary as a result of such examination;

2. maternity care; and

3. ~~medically necessary~~Medically Necessary evaluations and resultant ~~health care services~~Health Care Services 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 ~~insured's primary care provider~~Insured's Primary Care Provider regarding the ~~insured's~~Insured's condition, treatment, and need for follow-up care; and

52.13: continued

5. nNothing in 211 CMR 52.1314(3)(x) shall be construed to permit an obstetrician, gynecologist, certified nurse midwife or family practitioner to authorize any further referral of an insuredInsured to any other providerProvider without the approval of the insured's carrierInsured's Carrier; and

(y) A statement that the carrierCarrier will provide coverage of pediatric specialty care, including, for the purposes of 211 CMR 52.1314(3)(y), mental health care, by persons with recognized expertise in specialty pediatrics to insuredsInsureds requiring such services.

(z) If a carrierCarrier allows or requires an insuredInsured to designate a primary care providerPrimary Care Provider, a statement that the carrierCarrier shall provide the insuredInsured with an opportunity to select a participating provider nurse practitionerParticipating Provider Nurse Practitioner or a Participating Provider Physician Assistant as a primary care providerPrimary Care Provider or to change his or her primary care providerPrimary Care Provider to a participating provider nurse practitionerParticipating Provider Nurse Practitioner or a Participating Provider Physician Assistant at any time during the insured'sInsured's coverage period, if a nurse practitioner is a participating provider in the network.

(aa) Evidence that the carrierCarrier will provide coverage on a nondiscriminatory basis for covered services when delivered or arranged for by a participating provider nurse practitioner.Participating Provider Nurse Practitioner or a Participating Provider Physician Assistant. For the purposes of 211 CMR 52.1314(3)(aa), nondiscriminatory basis shall mean that a carrier'sCarrier's plan does not contain any annual or lifetime dollar or unit of service limitation imposed on coverage for the care provided by a Participating Provider nurse practitionerNurse Practitioner or Participating Provider Physician Assistant which is less than any annual or lifetime dollar or unit of service limitation imposed on coverage for the same services by other participating providersParticipating Providers, in accordance with M.G.L. c. 176R, § 16(1) and M.G.L. c. 176S, § 1;

(bb) A statement that the Carrier shall be required to pay for Health Care Services ordered by a treating physician or a Primary Care Provider if the Health Services are a Covered Benefit under the Insured's Health Benefit Plan and the Health Services are Medically Necessary.

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(4) Internet Websites. If the carrierCarrier, including any dentalDental or vision carrierVision Carrier, refers the insuredInsured to resources where the information described in the evidenceEvidence of coverageCoverage can be accessed, including, but not limited to, an internet Internet websiteWebsite, such carrierCarrier must be able to demonstrate compliance with applicable law, and with the following with respect to the internet Internet websiteWebsite, where the term "internet website" shall include "intranet website," "electronic mail," or "e-mail":

(a) The carrierCarrier has issued and delivered written notice to the insuredInsured that includes:

1. All necessary information and a clear explanation of the manner by which insuredsInsureds can access their specific evidencesEvidence of coverageCoverage and any amendments thereto through such internet Internet websiteWebsite;

2. A list of the specific information to be furnished by the carrierCarrier through an internet Internet websiteWebsite;

3. The significance of such information to the insuredInsured;

4. The insured'sInsured'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 insuredInsured can exercise the right to receive a paper copy at no cost to the insuredInsured; and

6. A toll-free number for the insuredInsured to call with any questions or requests.

(b) The carrierCarrier has taken reasonable measures to ensure that the information and documents furnished in an Internet Website internet website is substantially the same as that contained in its paper documents. All notice and time requirements applicable to evidencesEvidences of coverageCoverage shall apply to information and documents furnished by an Internet Websiteinternet website.

(c) The carrierCarrier has taken reasonable measures to ensure that it furnishes, upon

request of the ~~insured~~Insured, a paper copy of the ~~evidences~~Evidence of ~~coverage~~Coverage and any amendments thereto.

(5) Group Plans. A ~~carrier~~Carrier, including a ~~dental~~Dental and ~~vision carrier~~Vision Carrier, shall always deliver at least one ~~evidence~~Evidence of ~~coverage~~Coverage to the group representative of a group plan, notwithstanding the provisions of 211 CMR 52.~~13~~14, 211 CMR 52.~~14~~15 or 211 CMR 52.~~15~~16.

(6) General Notice of Material Changes. A ~~carrier~~Carrier, including a ~~dental~~Dental and ~~vision carrier~~Vision Carrier, shall provide to at least one adult ~~insured~~Insured in each household residing in Massachusetts, or in the case of a group policy, to the group representative, notice of all ~~material changes~~Material Changes to the ~~evidence~~Evidence of ~~coverage~~Coverage.

(7) Advance Notice of Material Modifications. A ~~carrier~~Carrier, including a ~~dental~~Dental or ~~vision carrier~~Vision Carrier, shall issue and deliver to at least one adult ~~insured~~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, ~~dental~~Dental or ~~vision plan~~Vision Plan, at least 60 ~~days~~Days before the effective date of the modifications. Such notices shall include the following:

(a) any changes in ~~clinical review criteria~~Clinical Review Criteria; and

52.~~13~~14: continued

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

(8) Advance Filing of Evidence of Coverage. A ~~carrier~~Carrier, including a ~~dental~~Dental or ~~vision carrier~~Vision Carrier, shall submit all ~~evidences~~Evidences of ~~coverage~~Coverage to the Bureau at least 30 ~~days~~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.~~

~~(10)~~ Dates Required. Every ~~evidence~~Evidence of ~~coverage~~Coverage described in 211 CMR 52.~~13~~14 must contain the effective date, date of issue and, if applicable, expiration date.

(~~11) Workers~~10) Workers' Compensation. A ~~carrier~~Carrier that provides specified services through a workers' compensation preferred provider arrangement shall be deemed to have met the requirements of 211 CMR 52.~~13~~14 if it has met the requirements of 211 CMR 51.00 and 452 CMR 6.00.

(~~12~~11) Certain Requirements also Applicable to Evidences of Coverage for Dental and Vision Carriers. The following provisions of 211 CMR 52.~~13~~14 shall also apply to ~~evidences~~Evidences of ~~coverage~~Coverage issued by ~~dental~~Dental and ~~vision carriers~~Vision Carriers: 211 CMR 52.~~13~~14(4) through (10).

52.~~14~~15: Required Disclosures for Carriers and Behavioral Health Managers

(1) A ~~carrier~~Carrier shall provide to at least one adult ~~insured~~Insured in each household upon enrollment, and to a prospective ~~insured~~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 ~~utilization review~~Utilization Review criteria are developed;

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

1. For the purposes of 211 CMR 52.~~14~~15(1)(c), ~~carriers~~Carriers shall exclude all ~~administrative disenrollments, insureds~~Administrative Disenrollments, Insureds who are disenrolled because they have moved out of a health plan's ~~service area, insureds~~Service Area, Insureds whose continuation of coverage periods have expired, former dependents who no longer qualify as dependents, or ~~insureds~~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.~~14~~15(1)(c), the term "voluntary disenrollment" means that an ~~insured~~Insured has terminated coverage with the ~~carrier~~Carrier ~~for~~ by nonpayment of premium.

3. For the purposes of 211 CMR 52.~~14~~15(1)(c), the term "involuntary disenrollment" means that a ~~carrier~~Carrier has terminated the coverage of the ~~insured~~Insured due to any of the reasons contained in 211 CMR 52.~~13~~14(3)(~~i~~j)2. and 3.

(d) a notice to ~~insureds~~Insureds regarding ~~emergency medical conditions~~Emergency Medical Conditions that states all of the following:

1. that ~~insureds~~Insureds have the opportunity to obtain ~~health care services~~Health Care Services for an ~~emergency medical condition~~Emergency Medical 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 ~~insured~~Insured is confronted with an ~~emergency medical condition~~Emergency Medical Condition which in the judgment of a prudent layperson would require pre-hospital emergency services;

2. that no ~~insured~~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;

3. that no ~~insured~~Insured will be denied coverage for medical and transportation expenses incurred as a result of such ~~emergency medical condition~~Emergency Medical Condition; and

52.~~14~~15: continued

4. if the ~~carrier~~Carrier requires an ~~insured~~Insured to contact either the ~~carrier~~Carrier or its designee or the ~~primary care provider~~Primary Care Provider of the ~~insured~~Insured within 48 hours of receiving emergency services, that notification already given to the ~~carrier~~Carrier, designee or ~~primary care provider~~Primary Care Provider by the attending emergency ~~provider~~Provider shall satisfy that requirement.

(e) a description of the Office of Patient Protection and a statement that the information specified in 211 CMR 52.~~16~~17 is available to the ~~insured~~Insured or prospective ~~insured~~Insured from the Office of Patient Protection.~~;~~ and

(f) a statement:

1. that an ~~insured~~Insured has the right to request referral assistance from a ~~carrier~~Carrier if the ~~insured~~Insured or the ~~insured's primary care provider~~ Insured's Primary Care Provider has difficulty identifying ~~medically necessary services~~Medically Necessary services within the ~~carrier's network~~Carrier's Network;

2. that the ~~carrier~~Carrier, upon request by the ~~insured~~Insured, shall identify and confirm the availability of these services directly; and

3. that the ~~carrier~~Carrier, if necessary, shall obtain or arrange for out-of-~~network~~Network services if they are unavailable within the ~~network~~Network.

(2) The information required of ~~carriers~~Carriers by 211 CMR 52.~~14~~15(1) (a-f) may be contained in the ~~evidence~~Evidence of ~~coverage~~Coverage and need not be provided in a separate document.

(3) Every disclosure required of ~~carriers~~Carriers and described in 211 CMR 52.~~14~~15(1) (a-f) must contain the effective date, date of issue and, if applicable, expiration date.

(4) A Carrier must maintain a toll-free telephone number and website available to Insureds to present Provider cost information to Insureds that meets the following requirements:

(a) the Insured may request and obtain the following, in real time:

i. the estimated or maximum allowed amount or charge for a proposed admission, procedure or service and

ii. the estimated amount the Insured will be responsible to pay for a proposed admission, procedure or service that is a Medically Necessary Covered Benefit, based on the information available to the Carrier at the time the request is made, including any facility fee, copayment, deductible, coinsurance or other Cost-Sharing requirements for any Covered Benefits;

(b) notwithstanding anything to the contrary in 211 CMR 52.15(4)(a),the Insured shall not be required to pay more than the disclosed amounts for the Covered Benefits that were actually provided;

(c) nothing in 211 CMR 52.15(4) shall prevent a Carrier from imposing Cost-Sharing requirements disclosed in the Insured's Evidence of Coverage for unforeseen services that arise out of the proposed admission, procedure or service;

(d) the Carrier must alert the Insured that these are estimated costs, and that the actual amount the Insured will be responsible to pay may vary due to unforeseen services that arise out of the proposed admission, procedure or service.

(5) To provide information to Insureds about the disposition of ~~p~~Provider claims submitted to the Carrier, the Carrier shall issue to Insureds the summary of payments form, as authorized by the Commissioner, and the form shall be issued to the individual Insured rather than to the subscriber, and the form may be issued in paper or through an Internet Website, provided that a Carrier will issue the form by paper upon request by the Insured.

(6) Carriers shall submit ~~material changes~~Material Changes to the disclosures required by 211 CMR 52.~~14~~ 15 to the Bureau at least 30 ~~d~~Days before their effective dates.

(~~5~~7) Carriers shall submit ~~material changes~~Material Changes to the disclosures required by 211 CMR 52.~~14~~15(1) (a-f) to at least one adult ~~insured~~Insured in every household residing in Massachusetts at least once every two years.

(~~6~~8) A ~~carrier~~Carrier that provides specified services through a workers' compensation preferred provider arrangement shall be deemed to have met the requirements of 211 CMR

52.~~14~~15 if it has met the requirements of 211 CMR 51.00 and 452 CMR 6.00.

(~~7~~9) A ~~carrier~~Carrier, including a ~~dental~~Dental or ~~vision carrier~~Vision Carrier, shall provide to a health, ~~dental~~Dental or ~~vision care provider~~Vision Care Provider, a written reason or reasons for denying the application of any health, ~~dental~~Dental, or ~~vision care provider~~Vision Care Provider who has applied to be a ~~participating provider~~Participating Provider.

(~~8~~10) A ~~carrier~~Carrier for whom a ~~behavioral health manager~~Behavioral Health Manager is administering behavioral ~~health~~ Health ~~services~~Services shall state on its new enrollment cards issued in the normal course of business, within one year, the name and telephone number of the ~~behavioral health manager~~Behavioral Health Manager.

(~~9~~11) A ~~behavioral health manager~~Behavioral Health Manager shall provide the following information to at least one adult ~~insured~~Insured in each household covered by their services:

(a) a notice to the ~~insured~~Insured regarding emergency mental ~~health services~~Health Services that states:

1. that the ~~insured~~Insured may obtain emergency mental ~~health services~~Health Services, 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~~Insured has an emergency mental health condition that would be judged by a prudent layperson to require pre-hospital emergency services;

2. that no ~~insured~~Insured 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 ~~insured~~Insured shall be denied coverage for medical and transportation expenses incurred as a result of such emergency mental health condition; and

4. if the ~~behavioral health manager~~Behavioral Health Manager requires an ~~insured~~Insured to contact either the ~~behavioral health manager, carrier~~Behavioral Health Manager, Carrier or ~~primary care provider~~Primary Care Provider of the ~~insured~~Insured within 48 hours of receiving emergency services, notification already given to the ~~behavioral health manager, carrier~~Behavioral Health Manager, Carrier or ~~primary care provider~~Primary Care Provider by the attending emergency ~~provider~~Provider shall satisfy that requirement;

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(b) a summary of the process by which clinical guidelines and ~~utilization review criteria~~Utilization Review ~~C~~criteria are developed for behavioral ~~health services~~Health Services; and

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

(~~10~~12) The information required of ~~behavioral health managers~~Behavioral Health Managers by 211 CMR 52.~~14~~15(~~9~~11) may be contained in the ~~carrier's evidence~~Carrier's Evidence of ~~coverage~~Coverage and need not be provided in a separate document. Every disclosure described in 211 CMR 52.~~14~~15(~~9~~11) shall contain the effective date, date of issue and, if applicable, expiration date.

(~~11~~13) A ~~behavioral health manager~~Behavioral Health Manager shall submit a ~~material change~~Material Change to the information required by 211 CMR 52.~~14~~15(~~9~~11) to the Bureau at least 30 ~~days~~Days before its effective date and to at least one adult ~~insured~~Insured in every household residing in the Commonwealth at least biennially.

(~~12~~14) A ~~behavioral health manager~~Behavioral Health Manager that provides specified services through a workers' compensation preferred provider arrangement that meets the requirements of 211 CMR ~~112~~51.00 and 452 CMR 6.00 shall be considered to comply with 211 CMR 52.~~14~~15.

(~~13~~15) A ~~carrier~~Carrier for whom a ~~behavioral health manager~~Behavioral Health Manager is administering behavioral ~~health services~~Health Services shall be responsible for the ~~behavioral health manager's~~Behavioral Health Manager's failure to comply with the requirements of 211 CMR 52.00 in the same manner as if the ~~carrier~~Carrier failed to comply and shall be subject to the provisions of 211 CMR 52.~~17~~18.

52.~~15~~16: Provider Directories

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

(1) A ~~carrier~~Carrier shall deliver a ~~provider~~Provider directory to at least one adult ~~insured~~Insured in each household upon enrollment and to a prospective or current ~~insured~~Insured upon request. Annually, thereafter, a ~~carrier~~Carrier shall deliver to at least one adult ~~insured~~Insured in each household, or in the case of a group policy, to the group representative, a ~~provider~~Provider directory. The ~~carrier~~Carrier may deliver a ~~provider~~Provider directory through an ~~i~~Internet ~~w~~Website, provided that any Provider ~~D~~directory available through an ~~i~~Internet ~~w~~Website be updated at least on a monthly basis. ~~References to the term "internet website" shall include "intranet websites" and "electronic mail", or "e-mail".~~

. (a) The ~~provider~~Provider directory must contain a list of ~~health care providers~~Health Care Providers in the ~~carrier's network~~Carrier's Network available to ~~insureds~~Insureds residing in Massachusetts, organized by specialty and by location and summarizing on its ~~i~~Internet ~~w~~Website for each such ~~provider~~Provider: (i) the method used to compensate or reimburse such ~~provider.~~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 10 of chapter 12C; (iii) the Provider's health status adjusted total medical expenses, as defined in and reported under said section 10 of said chapter 12C; 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 Center for Health Information and Analysis established by M.G.L. c. 12C, § 2; provided, 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.~~15~~16(1)(a) shall be construed to require disclosure of the specific details of any financial arrangements between a ~~carrier~~Carrier and a ~~provider~~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.~~ If any specific ~~providers~~Providers or type of ~~providers~~Providers requested by an ~~insured~~Insured are not available in said ~~network~~Network, or are not a covered benefit, or if any Primary Care Provider or behavioral health or substance use disorder Health Care Professional is not accepting new patients, such information shall be provided in an easily obtainable manner, including in the Provider directory.

~~4~~3. Notwithstanding any general or specific law to the contrary, a ~~carrier~~Carrier shall ensure that all ~~participating provider nurse practitioners~~Participating Provider Nurse Practitioners and Participating Provider Physician Assistants are included and displayed in a nondiscriminatory manner on any publicly accessible list of ~~participating providers~~Participating Providers for the ~~carrier~~Carrier.

(b) The ~~provider~~Provider directory must contain a toll-free number that ~~insureds~~Insureds can call to determine whether a particular ~~health care provider~~Health Care Provider is affiliated with the ~~carrier~~Carrier.

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

(d) ~~If the carrier~~Carrier ~~refers an insured~~Insured ~~to access provider~~Provider ~~directory information through an Internet Website internet website,~~ T~~t~~he ~~carrier~~Carrier must be able to demonstrate compliance with the following:

1. The ~~carrier~~Carrier has issued and delivered written notice to the ~~insured~~Insured that includes:

   a. All necessary information and a clear explanation of the manner by which ~~insureds~~Insureds can access their specific ~~provider~~Provider directory through an Internet Website~~internet website~~;

   b. A list of the specific information to be furnished by the ~~carrier~~Carrier through an Internet Website~~internet website~~;

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c. The significance of such information to the ~~insured~~Insured;

d. The ~~insured's~~Insured's right to receive, free of charge, a paper copy of the ~~provider~~Provider directory at any time;

e. The manner by which the ~~insured~~Insured can exercise the right to receive a paper copy at no cost to the ~~insured~~Insured; and

f. A toll-free number for the ~~insured~~Insured to call with any questions or requests.

2. The ~~carrier~~Carrier has taken reasonable measures to ensure that the information and documents furnished in an Internet Website ~~internet website~~ is substantially the same as that contained in its paper documents.

3. All notice and time requirements applicable to ~~e~~Evidences of ~~c~~Coverage shall apply to information and documents made available by internet. Information contained in the documents furnished in an Internet Website ~~internet website~~ shall include the effective date and the published date of any updates, modifications or ~~material changes~~Material Changes.

4. The ~~carrier~~Carrier updates the Internet Website~~website~~ as soon as practicable, and at least monthly.

5. In the case of a group policy, the ~~carrier~~Carrier delivers a paper copy of the ~~provider~~Provider directory to the group representative.

6. The ~~carrier~~Carrier has taken reasonable measures to ensure that it furnishes, upon request of the ~~insured~~Insured, a paper copy of the ~~provider~~Provider directory.

(2) A ~~carrier~~Carrier shall not be required to deliver a ~~provider~~Provider directory upon enrollment if a ~~provider~~Provider directory is delivered to the prospective or current ~~insured~~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 ~~provider~~Provider directory, a ~~carrier~~Carrier shall be deemed to have met the requirements of 211 CMR 52.~~15~~16(1) if the ~~carrier~~Carrier:

(a) provides to at least one adult ~~insured~~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 ~~provider~~Provider directory originally provided under 211 CMR 52.~~15~~16(1); and

(b) updates its toll-free number within 48 hours and ~~i~~Internet ~~w~~Website as soon as practicable.

(4) Every ~~provider~~Provider directory described in 211 CMR 52.~~15~~16 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 may be designated by the Commissioner.

(5) A ~~carrier~~Carrier that provides specified services through a workers' compensation preferred provider arrangement shall be deemed to have met the requirements of 211 CMR 52.~~15~~16 if it has met the requirements of 211 CMR 51.00 and 452 CMR 6.00.

52.~~16~~17: Material to be Provided to the Office of Patient Protection

(1) A ~~carrier~~Carrier shall provide the following to the Office of Patient Protection at the same time the ~~carrier~~Carrier provides such material to the Bureau of Managed Care:

(a) A copy of every ~~evidence~~Evidence of ~~coverage~~Coverage and amendments thereto offered by the ~~carrier~~Carrier.

(b) A copy of the ~~provider~~Provider directory described in 211 CMR 52.~~15~~16.

(c) A copy of the materials specified in 211 CMR 52.~~14~~15.

(2) A ~~carrier~~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~~Insured satisfaction and evaluating the quality of ~~health care services~~Health Care Services offered by the ~~carrier~~Carrier.

(b) A report of the percentage of physicians and ~~nurse practitioners~~Nurse

Practitioners and Physician Assistants who voluntarily and involuntarily terminated participation contracts with the ~~carrier~~Carrier during the previous calendar year for which such data has been compiled and the three most common reasons for voluntary and involuntary ~~provider~~Provider disenrollment;

1. For the purposes of 211 CMR 52.17(2)(b), ~~carriers~~Carriers shall exclude physicians, ~~and nurse practitioners~~Nurse Practitioners, and Physician Assistants who have moved from one physician and/or ~~nurse practitioner~~Nurse Practitioner or Physician Assistant group to another but are still under contract with the ~~carrier~~Carrier.
2. For the purposes of 211 CMR 52.17(2)(b) "voluntarily terminated" means that the physician, ~~or nurse practitioner~~Nurse Practitioner, or Physician Assistant terminated ~~its~~ the contract with the ~~carrier~~Carrier.
3. For the purposes of 211 CMR 52.17(2)(b) "involuntarily terminated" means that the ~~carrier~~Carrier terminated its contract with the physician, ~~or nurse practitioner~~Nurse Practitioner, or Physician Assistant~~.~~;

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(c) The percentage of premium revenue expended by the ~~carrier~~Carrier for ~~health care services~~Health Care Services provided to ~~insureds~~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~~Grievances, Grievances that were approved internally, ~~grievances~~Grievances that were denied internally, and ~~grievances~~Grievances that were withdrawn before resolution; and

2. external appeals pursued after exhausting the internal ~~grievance~~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~~Insureds, which shall include, but need not be limited to, race, gender and age; and~~.~~

(e) A report detailing for the previous calendar year the total number of:

(1) medical or surgical claims submitted to the carrier;

(2) medical or surgical claims denied by the carrier;

(3) mental health or substance use disorder claims submitted to the carrier;

(4) mental health or substance use disorder claims denied by the carrier; and

(5) medical or surgical claims and mental health or substance use disorder claims denied by the carrier because:

(i) the insured failed to obtain pre-treatment authorization or referral for services;

(ii) the service was not medically necessary;

(iii) the service was experimental or investigational;

(iv) the insured was not covered or eligible for benefits at the time services occurred;

(v) the carrier does not cover the service or the provider under the insured's plan;

(vi) duplicate claims had been submitted;

(vii) incomplete claims had been submitted;

(viii) coding errors had occurred; or

(ix) of any other specified reason.

(~~e~~f) A ~~carrier~~Carrier that provides specified services through a workers' compensation preferred provider arrangement shall be deemed to have meet the requirements of 211 CMR 52.~~16~~17(1)(a), (b), and (c) and 211 CMR 52.~~16~~17(2)(c)~~, and~~ (d), and (e).

52.~~17~~18: Noncompliance with 211 CMR 52.00

(1) Reporting. If the Commissioner issues a ~~finding~~Finding of ~~neglect~~Neglect on the part of a ~~carrier~~Carrier, the Commissioner shall notify the ~~carrier~~Carrier in writing that the ~~carrier~~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. 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 ~~carrier~~Carrier $5000 for each ~~day~~ Day during which the neglect continues.

Following notice and hearing, the Commissioner shall suspend the ~~carrier's~~Carrier'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 ~~finding~~Finding of ~~neglect~~Neglect can be removed.

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

(a) Investigation. The Bureau shall investigate all ~~complaints~~Complaints made against a ~~carrier~~Carrier or any entity with which it contracts for allegations of noncompliance with the ~~accreditation~~ Accreditation requirements established under 211 CMR 52.00.

(b) Notice. The Bureau shall notify a ~~carrier~~Carrier when, in the opinion of the Bureau, ~~complaints~~Complaints made against a ~~carrier~~Carrier 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.~~17~~18(2)(b).

1. The hearing shall be held no later than 21 ~~days~~Days following the date of the notice specified in 211 CMR 52.~~17~~18(2)(b).

2. The hearing shall be conducted pursuant to M.G.L. c. 30A.
3. The hearing shall provide the ~~carrier~~Carrier with an opportunity to respond to the alleged noncompliance.

(d) Penalties. Following the hearing specified in 211 CMR 52.~~17~~18(2)(c), the Bureau may issue a finding against the ~~carrier~~Carrier, 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 ~~carrier~~Carrier.
3. A penalty not to exceed $10,000 for each classification of violation.
4. The suspension or revocation of the ~~carrier's accreditation~~Carrier's Accreditation.

(3) Action by a National Accreditation Organization. If a ~~national accreditation organization~~National Accreditation Organization takes any action to revoke the accreditation or otherwise limit or negatively affect the accreditation status of a ~~carrier~~Carrier, or any entity with which a ~~carrier~~Carrier contracts for services subject to M.G.L. c. 176O, the ~~carrier~~Carrier must notify the Bureau within two ~~days~~Days and shall specify the action taken and the reasons given by the ~~national accreditation organization~~National Accreditation Organization for such action.

(4) Revocation by a National Accreditation Organization. If the ~~national accreditation organization~~National Accreditation Organization revokes accreditation, the Bureau shall initiate proceedings pursuant to M.G.L. c. 30A to revoke or suspend the ~~carrier's accreditation~~Carrier's Accreditation.

(5) Informal Resolutions. Nothing in 211 CMR 52.~~17~~18 shall be construed to prohibit the Bureau and a ~~carrier~~Carrier from resolving compliance issues through informal means.

52.~~18~~19: 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; M.G.L. c. 176J, § 11; ~~and~~ M.G.L.c. 176O, §§ 2 and 17; M.G.L. c. 176R, § 6; and M.G.L. c. 176S, §6.

(PAGES 302.~~19~~32 THROUGH 302.52 ARE RESERVED FOR FUTURE USE.)