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

Section

52.01: Applicability

211 CMR 52.00 applies to any Carrier that offers for sale, provides or arranges for the provision of a defined set of Health Care Services to Insureds through affiliated and contracting Providers or employs Utilization Review in making decisions about whether services are Covered Benefits under a Health Benefit Plan. A Carrier that provides coverage for Limited Health Services only, that provides specified services through a workers' compensation preferred Provider arrangement, or that does not provide services through a Network or through 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 as outlined in 211 CMR 52.05(2).

Certain requirements of 211 CMR 52.00, as specified, shall also apply to Dental and Vision Carriers. Such provisions are: 211 CMR 52.11(1) through (4); (11); (13); 52.13(2), (3)(a), (c) through (e), (g), (h), (l) through (o); (4) through (10); 52.14(1)(c) and (d); (2), (3) and (7); and 211 CMR 52.17.

A Carrier that 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.

52.02: 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 958 CMR 3.000: *Health Insurance Consumer Protection*.

Actively Practices. A Health Care Professional who regularly treats or manages patients in a clinical setting.

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

52.02: continued

Adverse Determination. A determination, based upon a review of information provided, by a Carrier or its designated Utilization Review Organization, to deny, reduce, modify, or terminate an admission, continued inpatient stay, or the availability of any other Health Care Services, for failure to meet the requirements for coverage based on Medical Necessity, appropriateness of health care setting and level of care, or effectiveness, including a determination that a requested or recommended Health Care Service or treatment is experimental or investigational. An Adverse Determination includes any denial of access to an out-of-Network Provider at an in-Network benefit level where there is an oral or written assertion by an Insured or treating Provider that a Carrier's preferred Provider Network does not have Providers who are able and available to treat the patient's specific condition and the preferred Provider Network is therefore not adequate to deliver the needed benefits at the preferred Provider level.

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 of 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, as well as other locations such as laboratories, radiology facilities, Provider offices and patient homes.

Application Programming Interface. An electronic interface that enables software applications used by Carriers, Utilization Review Organizations and Providers to communicate with each other to exchange data.

Asynchronous or Asynchronous Telehealth. An exchange of information regarding a patient that does not occur in real time, including but not limited to the secure collection and transmission of a patient's medical information, clinical data clinical images, laboratory results, or a self-reported medical history.

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 to provide or arrange for the provision of behavioral, substance use disorder and mental Health Services to voluntarily enrolled members of the Carrier.

Behavioral Health Services. Care and services for the evaluation, diagnosis, treatment, consultation, prescribing, monitoring or management of mental health, developmental, or substance use disorders. Such care and services may be provided by any Health Care Professional for whom such services are within the scope of licensure for such Health Care Professional. Behavioral Health Services shall also include but not be limited to Partial Hospital Programs- and Intensive Outpatient Programs.

Behavioral Health Specialty Care. Behavioral Health Services dedicated to treating particular behavioral health conditions. A behavioral health Provider should be listed as providing specific Behavioral Health Specialty Care when they regularly provide the care.

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 to a licensed Health Care Professional, Health Care Provider group, or organization that employs or utilizes services of 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

52.02: continued

corporations of the employer. Unless otherwise noted, the term "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.

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

Chronic Disease Management. Care and services for the management of chronic conditions, including

(a) conditions, defined by the federal Centers for Medicare and Medicaid Services that include, but are not limited to, diabetes, chronic obstructive pulmonary disease, asthma, congestive heart failure, hypertension, history of stroke, cancer, and coronary artery disease;
(b) congenital anomalies and hereditary conditions; and
(c) other chronic conditions that last one year or more and require ongoing medical attention or limit activities of daily living or both.

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, other than the physician or other 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, the recognized professional board for their Specialty, who Actively Practices in the Same or 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 to determine the Medical Necessity and appropriateness of Health Care Services.

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

Complaint.

(a) any Inquiry made by or on behalf of an Insured to a Carrier or Utilization Review Organization that is not explained or resolved to the Insured's satisfaction within three business Days of the Inquiry;
(b) any matter concerning an Adverse Determination; or
(c) in the case of a Carrier or Utilization Review Organization that does not have an internal Inquiry process, a Complaint means any Inquiry.

Concurrent Review. Utilization Review conducted during an 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 to which an Insured is entitled under the terms of the 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.

52.02: continued

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

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

Dental Care Provider. A Dental Care Professional or Facility licensed to provide Dental Care Services.

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

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.

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

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 specifying the Benefits to which the Insured is entitled. For workers' compensation preferred Provider arrangements, the Evidence of 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 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 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 submitted to the Carrier that has been initiated by an Insured, or on behalf of an Insured with the consent of the Insured, concerning any aspect or action of the Carrier relative to the Insured including, but not limited to, review of 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 958 CMR 3.000: *Health Insurance Consumer Protection*.

52.02: continued

Health Benefit Plan. A policy, contract, certificate or agreement of insurance entered into, offered or issued by a Carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of Health Care Services. Unless otherwise noted, 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.

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

Health Care Provider or Provider. A Health Care Professional or Facility.

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

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

Incentive Plan. Any compensation arrangement between a Carrier and Health Care Professional or Licensed Health Care Provider Group or organization that employs or utilizes services of one or more licensed Health Care Professionals that may directly or indirectly have the effect of reducing or limiting specific services furnished to Insureds of the organization. Incentive Plan shall not mean contracts that involve general payments such as Capitation payments or shared risk agreements that are made with respect to Health Care Professionals or Providers, or Health Care Professional groups or Provider groups which are made with respect to groups of Insureds if such contracts, which impose risk on such Health Care Professionals or Providers or Health Care Professional groups or Provider groups for the cost of medical care, services and equipment provided or authorized by another 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 to the Carrier or Utilization Review Organization that has not been the subject of an Adverse Determination and that requests redress of an action, omission or policy of the Carrier.

Insured. An enrollee, covered person, Insured, member, policy holder or subscriber of a Carrier, including a Dental or Vision Carrier, including an individual whose eligibility as an Insured of a Carrier is in dispute or under review, or any other individual whose care may be subject to review by a Utilization Review program or entity as described under the provisions of M.G.L. c. 176O, 211 CMR 52.00 and 958 CMR 3.000: *Health Insurance Consumer Protection*.

Internet Website. Includes, but shall 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 only if it is composed of individual Health Care Professionals and has no subcontracts with 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 Services shall not include hospital, medical, surgical or emergency services, except as such services are provided in conjunction with the Limited Health Services set forth in the preceding sentence.

Limited Network Plan. A Limited Network plan as defined in 211 CMR 152.00: *Health Benefit Plans Using Limited, Regional or Tiered Provider Networks*.

Managed Care Organization or MCO. A Carrier subject to M.G.L. c. 176O.

52.02: continued

Material Change. A modification to any of a Carrier's, including a Dental or Vision Carrier's, procedures or documents required by 211 CMR 52.00 that substantially affects the rights or responsibilities of:

(a) an Insured;
(b) a Carrier, including a Dental or Vision Carrier; and/or
(c) a Health, Dental, or Vision Care Provider.

Medical Necessity or Medically Necessary. 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 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 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 or Vision Care Providers who contract with a Carrier, including a Dental or Vision Carrier, or affiliate to provide health, Dental or Vision Care Services to Insureds covered by any or all of the Carrier's, including a Dental or Vision Carrier's or affiliate's, plans, policies, contracts or other arrangements. Network shall not mean those 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 when a covered person receives care from preferred Network Providers but does not require the Insured to designate a Primary Care Provider to coordinate the delivery of care or receive referrals from the Carrier or any Network Provider as a condition of receiving Benefits at the preferred benefit level.

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

Office of Patient Protection. The office within the Health Policy Commission established by M.G.L. c. 6D, § 16, responsible for the administration and enforcement of M.G.L. c. 176O, §§ 13, 14, 15 and 16.

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

Pharmacy Benefit Manager. A person, business or other entity, however organized, that directly or through a subsidiary provides Pharmacy Benefit Management Services for prescription drugs and devices on behalf of a Health Benefit Plan sponsor, including but not limited to, a self-insurance plan, labor union or other third-party payer. Beginning January 1, 2026, a Carrier may contract for Pharmacy Benefit Management Services in Massachusetts only with a Pharmacy Benefit Manager licensed by the Division.

Pharmacy Benefit Management Services. Services performed by a Pharmacy Benefit Manager, including: (i) negotiating the price of prescription drugs, including negotiating and contracting for direct or indirect rebates, discounts or other price concessions; (ii) managing any aspects of a

prescription drug benefit, including, but not limited to, formulary administration, mail-order pharmacy and specialty drug pharmacy services, clinical, safety and adherence programs for pharmacy service, the processing and payment of claims for prescription drugs, arranging alternative access to or funding for prescription drugs, the performance of drug Utilization Review, the processing of drug Prospective Review requests, the adjudication of appeals or grievances related to the prescription drug benefit, contracting with network pharmacies, controlling the cost of covered prescription drugs and managing or providing data relating to the prescription drug benefit or the provision of services related thereto; (iii) performance of any administrative, managerial, clinical, pricing, financial, reimbursement, data administration or reporting or billing service related to a Health Benefit Plan's prescription drug benefit; and (iv) such other services as defined by the Division.

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 M.G.L. c. 112, § 9C through 9H 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 is required to provide pursuant to Massachusetts or federal law.

52.02: continued

Primary Care Provider. A 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; initiates referrals for Specialty Care; and maintains continuity of care within the scope of his or her practice. A Primary Care Provider may include but not be limited to medical doctors and Nurse Practitioners and Physician Assistants who concentrate in primary care, pediatric primary care, and/or gynecological and reproductive health.

Primary Care Services. Services delivered by a Primary Care Provider.

Prospective Review. Utilization Review conducted prior to an admission or a course of treatment. Prospective Review shall include any pre-authorization and pre-certification requirements of a Carrier or Utilization Review Organization.

Regional Network Plan. A Regional Network Plan as defined in 211 CMR 152.00: *Health Benefit Plans Using Limited, Regional or Tiered Provider Networks.*

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

Retrospective Review. Utilization Review of Medical Necessity that is conducted after services have been provided to a patient. 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.

Same or Similar Specialty. The 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. Such experience shall extend to the treatment of children in a 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.

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

Service Area. The geographical area as approved by the Commissioner within which the Carrier, including a Dental or Vision Carrier, has developed a Network of Providers to afford adequate access to members for covered Health, Dental or Vision Services.

Site of Service Plan. An insured Health Benefit Plan where access to certain specified Network Providers or access to care in certain specified settings may only be available when the Carrier determines that it is medically necessary to receive covered care from these certain Providers or the certain settings. The Utilization Review processes and Medical Necessity criteria used are required to meet the relevant requirements of 211 CMR 52.00 and any requirements as determined by the Commissioner. Whenever a request for services provided by certain specified Network Providers for care at certain specified locations is denied, Carriers with Site of Service Plans are to follow all required protocols for Adverse Determination notices and appeals as required under 211 CMR 52.00.

Specialty or Specialty Care. Healthcare services dedicated to a specific branch of medicine or all healthcare services not considered primary care. Patients can be referred to a specialist by a Primary Care Provider for disease-specific care that requires expert support.

Telehealth. The use of synchronous or asynchronous audio, video, electronic media or other telecommunications technology including, but not limited to:

(i) interactive audio-video technology;
(ii) remote patient monitoring devices;
(iii) audio-only telephone; and
(iv) online adaptive interviews, for the purpose of evaluating, diagnosing, consulting, prescribing, treating, managing, or monitoring of a patient's physical health, oral health, mental health or substance use disorder condition.

52.02: continued

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. § 1395x(dd)(3)(A).

Tiered Network Plan. A Tiered Network Plan as described in 211 CMR 152.00: *Health Benefit Plans Using Limited, Regional or Tiered Provider Networks*.

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

Utilization Review. Set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, Health Care Services, procedures or settings. Such techniques may include, but are not limited to, Ambulatory Review, Prospective Review, Second Opinion, certification, Concurrent Review, Case Management, Discharge Planning or Retrospective Review.

Utilization Review Organization. An entity that conducts Utilization Review under contract with or on behalf of a Carrier, but does not include a Carrier performing Utilization Review for its own Health Benefit Plans. A Behavioral Health Manager is considered a Utilization Review Organization. A Pharmacy Benefit Manager may be considered a Utilization Review Organization if it conducts Utilization Review.

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

Vision Care Professional. An ophthalmologist, optometrist or other practitioner licensed, accredited or certified to perform specified Vision Services consistent with the law.

Vision Care Provider. A Vision Care Professional; or a Facility licensed to perform and provide Vision Care Services.

Vision Care Services or 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.

Visit. A scheduled, urgent, or emergency encounter between a covered patient and a Health Care Professional, whether conducted within the Health Care Professional's office, another physical location or conducted via synchronous or Asynchronous Telehealth, to evaluate, diagnose, consult, treat, conduct clinical trials, prescribe, manage or monitor a covered medical, oral health or behavioral health condition. Within a Visit, the Health Care Professional will review patient history, examine the patient's condition, and exercise medical judgment in treating a patient. In the case of Telehealth Visits, a Health Care Professional must receive consent from a patient that the encounter will constitute a Visit and may be subject to Health Benefit Plan Cost-sharing if the Health Care Professional ever seeks reimbursement for the Telehealth encounter from either the patient or the patient's Carrier.

52.03: Accreditation of Carriers

(1) A 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 to Insureds through affiliated and contracting Providers or employ Utilization Review in making decisions about whether services are Covered Benefits under a Health Benefit Plan.

52.03: continued

(2) Accreditation granted to 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 shall be exempt from 211 CMR 52.00 if in the written opinion of the Attorney General, the Commissioner, and the Commissioner of Public Health, the health and safety of health care consumers would be materially jeopardized by requiring Accreditation of the Carrier.

(a) Before publishing a written exemption pursuant to 211 CMR 52.03(3), the Attorney General, the Commissioner, 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 granted an exemption pursuant to 211 CMR 52.03(3) shall be provisionally accredited and, during such provisional 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 52.03(3)(b) the Commissioner shall review the Carrier's exemption.

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

2. If the Commissioner determines that the 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.

52.04: Deemed Accreditation

(1) A Carrier may apply for deemed Accreditation. A Carrier that applies for deemed 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 958 CMR 3.000: *Health Insurance Consumer Protection*; and

(c) It must have received the ratings specified in 211 CMR 52.05(5)(c) and (d).

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

(a) If the Carrier meets or exceeds the ratings identified in 211 CMR 52.05(5)(c), the Carrier shall not be further reviewed by the Bureau for compliance with the standards set forth in 211 CMR 52.07 and 52.08 for that applicable period.

(b) If the Carrier meets or exceeds the ratings identified in 211 CMR 52.05(5)(d), the Carrier shall not be further reviewed by the Bureau for compliance with the standards set forth in 211 CMR 52.09 for that applicable period.

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

(4) A Carrier that has applied for deemed Accreditation and been denied, shall be considered an applicant for Accreditation under 211 CMR 52.05(3) or (4). Denial of a request for deemed Accreditation shall not be eligible for reconsideration under 211 CMR 52.06(5).

(5) If a Carrier has received Accreditation from a National Accreditation Organization, or a subcontracting organization, with whom the Carrier has a written agreement delegating certain services, or has received Accreditation or certification from a National Accreditation Organization, but under standards other than those identified in 211 CMR 52.05(5), the 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 52.06(1).

52.05: 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 seeking initial Accreditation must submit an application at least 90 Days prior to the date on which it intends to offer Health Benefit Plans.

(2) Inapplicability of Accreditation Requirements.

(a) A Carrier that provides coverage for Limited Health Services only, that does not provide services through a Network or through Participating Providers or for which other requirements set forth in 211 CMR 52.05 are otherwise inapplicable may indicate within its application which of those items are inapplicable to its Health Benefit Plan and provide an explanation of why the Carrier is exempt from each particular requirement.

(b) A Carrier that provides coverage for specified services through a workers' compensation preferred Provider arrangement may provide evidence of compliance with 211 CMR 51.00: *Preferred Provider Health Plans and Workers' Compensation Preferred Provider Arrangements* and 452 CMR 6.00: *Utilization Review and Quality Assessment* to satisfy the materials required by 211 CMR 52.05(3)(b), (e), (g), (h), (i), (j), (l), and (n). A Carrier that provides coverage for specified services through a workers' compensation preferred Provider arrangement may provide evidence of compliance with 211 CMR 51.00 and 452 CMR 6.00 to satisfy the materials required by 211 CMR 52.05(4)(d) and (g).

(3) Initial Application. Any Carrier seeking initial Accreditation under M.G.L. c. 176O must submit an application that contains at least the materials applicable for Massachusetts described in 211 CMR 52.05(3)(a) through (s) in a format specified by the Commissioner. Any Carrier that contracts with another organization to perform any of the functions specified in 211 CMR 52.00 is responsible for collecting and submitting all of such materials from the contracting organization.

(a) A filing fee of $1,000 made payable to the Commonwealth of Massachusetts;

(b) A complete description of the Carrier's Utilization Review policies and procedures;

(c) A written attestation by a company officer to the Commissioner that the Utilization Review program of the Carrier or its designee complies with all applicable state and federal laws concerning confidentiality and reporting requirements;

(d) A copy of the most recent existing survey described in 211 CMR 52.07(13)~~0~~;

(e) A complete description of the Carrier's internal Grievance procedures consistent with 958 CMR 3.000: *Health Insurance Consumer Protection* and a complete description of the external review process consistent with 958 CMR 3.000: *Health Insurance Consumer Protection*;

(f) A complete description of the Carrier's process to establish guidelines for Medical Necessity consistent with 958 CMR 3.000: *Health Insurance Consumer Protection*;

(g) A complete description of the Carrier's quality management and improvement policies and procedures;

(h) A complete description of the Carrier's credentialing policies and procedures for all Participating Providers;

(i) A complete description of the Carrier's policies and procedures for providing or arranging for the provision of Preventive Health Services;

(j) A sample of every Provider contract used by the Carrier or the organization with which the Carrier contracts, unless the Commissioner has requested the Provider contract under 52.05(3)(k);

(k) All contracts the Carrier has with a subcontracting organization and/or delegated vendor that performs Utilization Review, member services, or pharmacy benefit management on behalf of the Carrier, as well as any Provider contracts requested by the Commissioner;

(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: *Health Benefit Plans Using Limited, Regional or Tiered Provider Networks*. 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: *Provider Contracts in Limited, Regional and Tiered Provider Network Plans*;~~ A statement that advises the Bureau whether the Carrier has issued new contracts, revised existing contracts, made revisions to fee schedules in any existing contract with a Health Care Professional or Provider or Health Care Professional or Provider group that imposes financial risk on such Health Care Professional or Provider or Health Care Professional or Provider group for the costs of medical care, services or equipment provided or authorized by another Health Care Professional or Health Care Provider. If the Carrier has any such contracts or fee schedules, the Carrier shall identify the contracts in which such arrangement

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exists and identify the sections of the contracts that comply with 211 CMR 52.11(4);

(m) 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: *Health Benefit Plans Using Limited, Regional or Tiered Provider Networks*. 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: *Provider Contracts in Limited, Regional and Tiered Provider Network Plans*;

(n) A complete description of the Carrier's Network adequacy standards, along with an access analysis meeting the requirements of 211 CMR 52.12(2);

(o) A copy of every Provider directory used by the Carrier, including a summary description of the insured's Telehealth coverage and access to Telehealth services including, but not limited to, Behavioral Health Services, Chronic Disease Management, and Primary Care Services *via* Telehealth, as well as the telecommunications technology platforms that are available for insureds to use to access Telehealth services;

(p) Evidence satisfactory to the Commissioner that the Carrier is providing adequate access within its Network to pain management services, including non-opioid and non-pharmaceutical service options;

(q) Evidence satisfactory to the Commissioner that the Carrier is providing adequate access within its Network to Behavioral Health Services, Chronic Disease Management, and Primary Care Services via Telehealth, including the following:

1. Communications for use with Providers that specify the Providers' service and documentation standards necessary in order for Telehealth services to be covered by the Carrier;
2. A statement that restricts covered Telehealth visits to those that are compatible with state/federal privacy standards;
3. A list of the services that will not be covered when provided to a covered person *via* Telehealth, and an explanation for why these services are not covered;
4. An explanation of how and when cost-sharing (copayments, coinsurance, and deductibles) will apply for Telehealth services, and if cost-sharing is waived, a description of the exact circumstances under which the cost-sharing will be waived with a company officer stating how the Carrier intends to reimburse Providers for Telehealth services, including an identification of the billing codes, location codes or other codes that the Carrier intends to use to reimburse Providers for Telehealth services, and the following information for Telehealth services.
5. A statement of how the Carrier intends to reimburse Providers for the following Telehealth services:
   a. Behavioral Health Services;
   b. Primary Care Services;
   c. Chronic Disease Management Services;
   d. Physical exams, including those that have both Telehealth and in-person components; and
6. When Telehealth may be used for follow-up care, including but not limited to follow-up care provided by Asynchronous Telehealth that may be considered less than a Visit, a description of how the Carrier intends to reimburse Providers for these follow-up Telehealth services;

(r) The Evidence of Coverage for every product offered by the Carrier;

(s) A copy of each disclosure described in 211 CMR 52.14, if applicable;

(t) A written attestation by a company officer that the Carrier has complied with 211 CMR 52.16;

(u) An explanation of how the Carrier, directly or through any entity that manages or administers mental health or substance use disorder benefits for the Carrier, utilizes a base fee schedule for evaluation and management services for Behavioral Health Providers that is not less than the base fee schedule used for evaluation and management services for Primary Care Providers of the same or similar licensure type and in the same geographic region, and an explanation how the Carrier has established such a base fee schedule for Behavioral Health Providers while not lowering its base fee schedule for Primary Care Providers; and

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

(4) Renewal Application. Any Carrier seeking renewal of Accreditation under M.G.L. c. 176O must submit an application that contains at least the materials for Massachusetts described in 211 CMR 52.05(4)(a) through (m) in a format specified by the Commissioner. Any Carrier that contracts with another organization to perform any of the functions specified in 211 CMR 52.00 is responsible for collecting and submitting all of such materials from the contracting organization.

(a) A filing fee of $1,000 made payable to the Commonwealth of Massachusetts;

(b) A written attestation by a company officer to the Commissioner that the Utilization Review Program of the Carrier or its designee complies with all applicable state and federal laws concerning confidentiality and reporting requirements;
(c) A copy of the most recent survey described in 211 CMR 52.07(130);
(d) A copy of the Prospective Review requirements, criteria and data reports described in 211 CMR 52.07(12);
(ce) A sample of every Provider contract used by the Carrier or the organization with which the Carrier contracts since the Carrier's most recent Accreditation, unless the Commissioner has requested the Provider contract under 52.05(4)(e);
(fe) All contracts the Carrier has with a subcontracting organization or delegated vendor that performs Utilization Review, medical management, member services, or pharmacy benefits management on behalf of the Carrier, as well as any Provider contracts requested by the Commissioner;
(gf) ~~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: *Health Benefit Plans Using Limited, Regional or Tiered Provider Networks*. 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: *Provider Contracts in Limited, Regional and Tiered Provider Network Plans*;~~ A statement that advises the Bureau whether the Carrier has issued new contracts, revised existing contracts, made revisions to fee schedules in any existing contract with a Health Care Professional or Provider or Health Care Professional or Provider group that impose financial risk on such Health Care Professional or Provider, or Health Care Professional or Provider group for the costs of medical care, services or equipment provided or authorized by another Health Care Professional or Health Care Provider. If the Carrier has issued or revised any such contracts or revised any fee schedules, the Carrier shall identify the contracts in which such changes were made and identify the sections of the contracts that comply with 211 CMR 52.11(4) and 152.05: *Provider Contracts in Limited, Regional and Tiered Provider Network Plans*;
(hg) 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: *Health Benefit Plans Using Limited, Regional or Tiered Provider Networks*. 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: *Provider Contracts in Limited, Regional and Tiered Provider Network Plans*;
(ih) Any Material Change made to the Carrier's Network adequacy standards, along with an access analysis meeting the requirements of 211 CMR 52.11(2);
(ji) The Evidence of Coverage for every product offered by the Carrier, and for every product that has Insureds but is no longer offered, which was revised since the Carrier's most recent Accreditation;
(kj) A copy of each Provider directory used by the Carrier, including a summary description of the insured's Telehealth coverage and access to Telehealth services including, but not limited to, Behavioral Health Services, Chronic Disease Management, and Primary Care Services via Telehealth, as well as the telecommunications technology platforms that are available for insureds to use to access Telehealth services;
(lk) Material Changes to any of the information contained in 211 CMR 52.05(3)(b), (e), (f), (g), (h), (i), and (s);
(ml) Evidence satisfactory to the Commissioner that the Carrier is providing adequate access within its Network to pain management services, including non-opioid and non-pharmaceutical service options;
(nm) Evidence satisfactory to the Commissioner that the Carrier is providing adequate access within its Network to Behavioral Health Services, Chronic Disease Management, and Primary Care Services via Telehealth, including the following;

1. The communications for use with Providers that specify the Providers' service and documentation standards necessary in order for Telehealth services to be covered by the Carrier;
2. A statement that restricts covered Telehealth visits to those that are compatible with state/federal privacy standards;
3. A list of the services that will not be covered when provided to a covered person via Telehealth, and an explanation for why these services are not covered;
4. An explanation of how and when cost-sharing (copayments, coinsurance, and deductibles) will apply for Telehealth services, and if cost-sharing is waived, a description of the exact circumstances under which the cost-sharing will be waived, with

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a company officer stating how the Carrier intends to reimburse Providers for Telehealth services, including an identification of the billing codes, location codes or other codes that the Carrier intends to use to reimburse Providers for Telehealth services;

5. A statement of how the Carrier intends to reimburse Providers for the following Telehealth services:

(a) Behavioral Health Services;
(b) Primary Care Services;
(c) Chronic Disease Management Services; and

(n) Evidence that the Carrier, directly or through any entity that manages or administers mental health or substance use disorder benefits for the Carrier, utilizes a base fee schedule for evaluation and management services for Behavioral Health Providers that is not less than the base fee schedule used for evaluation and management services for Primary Care Providers of the same or similar licensure type and in the same geographic region, and an explanation how the Carrier has established such a base fee schedule for Behavioral Health Providers while not lowering its base fee schedule for Primary Care Providers;
(o) A written attestation by a company officer that the Carrier has complied with 211 CMR 52.16; and
(p) Any additional information as deemed necessary by the Commissioner.

(5) Application for Deemed Accreditation. A Carrier seeking deemed Accreditation pursuant to 211 CMR 52.04 shall submit an application that contains the materials described in 211 CMR 52.05(5)(a) through (d).
(a) For initial applicants, the information required by 211 CMR 52.05(3).
(b) For renewal applicants, the information required by 211 CMR 52.05(4).
(c) Proof in a form satisfactory to the Commissioner that the Carrier has attained:
1. a score equal to or above 80% of the standard in effect at the time of the most recent review by NCQA for the Accreditation of Managed Care Organizations, in the categories of utilization management, quality management and improvement, and members' rights and responsibilities;
2. a score equal to or above the rating of "accredited" in the categories of utilization management, Network management, quality management and member protections for the most recent review of health plan standards by URAC; or
3. for Non-gatekeeper Preferred Provider Plans, a score equal to or above 80% of the standard in effect at the time of the most recent review by NCQA for the Accreditation of preferred Provider organizations, in the categories of utilization management, quality management and improvement, and enrollees' rights and responsibilities.
4. for Non-gatekeeper Preferred Provider Plans, a score equal to or above the rating of "accredited" in the most recent review of health utilization management standards by URAC and a score equal or above the rating of "accredited" in the categories of Network management, quality management and member protections for the most recent review of health Network standards by URAC.
(d) Proof in a form satisfactory to the Commissioner that the Carrier has attained:
1. a score equal to or above 80% of the standard in effect at the time of the most recent review by NCQA for the Accreditation of Managed Care Organizations, in the category of credentialing and recredentialing;
2. a score equal to or above the rating of "accredited" in the category of Provider credentialing for the most recent review of health plan standards by URAC; or
3. for Non-gatekeeper Preferred Provider plans, a score equal to or above 80% of the standard in effect at the time of the most recent review by NCQA for the Accreditation of preferred Provider organizations in the category of credentialing and recredentialing.
4. for Non-gatekeeper Preferred Provider Plans, a score equal to or above the rating of "accredited" in the category of Provider credentialing for the most recent review of health Network standards by URAC.

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

(7) Material Changes. Carriers shall submit to the Bureau any Material Changes to any of the items under 211 CMR 52.05(3) and (4) at least 30 Days before the effective date of the changes.

52.06: Review of Application for Accreditation

(1) Carriers shall comply with the standards set forth in M.G.L. c. 176O, 211 CMR 52.00; 958 CMR 3.000: *Health Insurance Consumer Protection*; 211 CMR 152.00: *Health Benefit Plans Using Limited, Regional or Tiered Provider Networks*, if applicable; and all other applicable state and federal law.

52.06: continued

(a) For all products, a Carrier shall not be accredited unless the Carrier scores 65% or higher of an aggregate of the applicable elements in the NCQA Standards, effective July 1, 2017, or any edition of such standards determined by the Commissioner to be functionally equivalent or appropriate, for the Accreditation of Health Benefit Plans, including health maintenance organizations, gatekeeper preferred Provider plans, and Nongatekeeper Preferred Provider Plans, in the categories of utilization management, quality management and improvement, and credentialing and recredentialing.

(b) The NCQA Standards, effective July 1, 2017, or any edition of such standards determined by the Commissioner to be functionally equivalent or appropriate, 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 application for Accreditation under 211 CMR 52.06, the Carrier may be given credit toward the relevant score for any Accreditation that it received, or which the Carrier's subcontracting organization, with which the Carrier has a written agreement delegating certain services, received, from a National Accreditation Organization for the standards described in 211 CMR 52.07, 52.08 or 52.09.

(2) A 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 shall respond to any request for additional information by the Bureau within 15 Days of the date of the Bureau's request. A Carrier that fails to respond in writing to requests within the 15 Days shall be subject to the penalties described in 211 CMR 52.17.

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

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

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

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

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

(c) Following the meeting pursuant to 211 CMR 52.06(5)(b) the Bureau may conduct a second on-site survey at the expense of the Carrier.

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

52.07: Utilization Review

(1) Standards. A Carrier's application will be reviewed for compliance with the applicable NCQA Standards for utilization management. In addition, Carriers shall meet the requirements identified in 211 CMR 52.07(2) through (1~~0~~1). In cases where the standards in 211 CMR 52.07(2) through (1~~0~~1) differ from those in the NCQA Standards, the standards in 211 CMR 52.07(2) through (1~~0~~1) shall apply.

(2) Written Plan. Utilization Review conducted by a Carrier or a 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 criteria; and

(c) ensure the timeliness of Utilization Review determinations.

(3) Criteria. A Carrier or Utilization Review Organization shall adopt Utilization Review criteria and conduct all 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, consistent with the development of Medical Necessity criteria consistent with 958 CMR 3.101: *Carrier's Medical Necessity Guidelines*.

(b) Utilization Review criteria, including a list of Health Services, supplies and/or pharmaceuticals requiring preauthorization or Prospective Review, shall be up to date and applied consistently by a Carrier or the Utilization Review Organization and made readily accessible- in a searchable electronic format 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 or Prospective Review requirement or restriction shall not be implemented unless the Carrier's publicly accessible website has been updated to clearly reflect the new or amended requirement or restriction and the Carrier has notified providers at least 60 days prior to the effective date of the new or amended requirement or restriction.

(d) Adverse Determinations rendered by a program of Utilization Review, or other denials of requests for Health Services, shall be made by a person licensed in the appropriate Specialty related to such Health Services and, where applicable, by a Provider in the same licensure category as the ordering Provider.

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

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

(b) If the Carrier fails to use or accept the designated ~~prior authorization~~Prospective Review form, or fails to respond within ~~two business days~~time limitations established under 211 CMR 52.07(4)(c) after receiving ~~a completed prior authorization request from a Provider~~all necessary information~~,~~ pursuant to the submission of the designated ~~prior authorization~~ form under 211 CMR 52.07(4)(a), the ~~prior authorization~~Prospective Review request shall be deemed to have been granted. For purposes of 211 CMR 52.07, "necessary information" includes the results of any clinical evaluation that may be required.

(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; provided that if additional delay would result in serious jeopardy to the Insured's health or well-being, and the Provider presents documentation to the Carrier or Utilization Review Organization of the potential serious jeopardy to the Insured's health or well-being, a Carrier or its Utilization Review Organization shall make and communicate to the requesting Provider an initial determination not more than 24 hours following the receipt of all necessary information by the Carrier or Utilization Review Organization as applicable.~~. For purposes of 211 CMR 52.07, "necessary information" means shall include the results of any face to face clinical evaluation or Second Opinion that may be required.~~

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

(e) A Prospective Review authorization for a prescribed Health Service, supply and/or pharmaceutical shall be valid for at least 90 days or until the end of the benefit year, whichever is earlier.

(f) When an Insured moves to a new Health Benefit Plan, a Prospective Review authorization from the previous Health Benefit Plan will be honored by the new Carrier or Health Benefit Plan for at least 90 days after enrollment; provided that the original requesting Provider is in Network under the new Health Benefit Plan and it is a covered benefit under the new Health Benefit Plan.

(g) For an Insured who is stable on a prescribed Health Service, supply and/or pharmaceutical as determined by a Provider and approved for coverage by the Carrier or its Utilization Review Organization, and where the Health Service, supply and/or pharmaceutical is then removed from a Health Benefit Plan's formulary or is subject to new coverage restrictions after the Insured's enrollment period has ended, a Carrier shall cover the approved Health Service, supply and/or pharmaceutical for the rest of the benefit year or at least 90 days, whichever is shorter.

(~~e~~h) In the case of an Adverse Determination, the Carrier or the Utilization Review Organization shall notify the Provider rendering the service by telephone within 24 hours, and shall send written or electronic confirmation of the telephone notification to the Insured and the 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~~i) Subject to 211 CMR 52.07(4)(a) through (~~f~~h), nothing in 211 CMR 52.07(4) shall:

1. 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;
2. 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
3. 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) Prospective Review for Certain Health Services, Supplies and Pharmaceuticals.

(a) A Carrier or its Utilization Review Organization shall not require Prospective Review for:

1. emergency services provided to an Insured for emergency medical conditions, whether provided in or out of Network;
2. inpatient acute care services that are provided to the Insured in Network;
3. post-acute care services that are provided on weekends or holidays to the Insured in Network;
4. urgent care services that are provided to the Insured in Network;
5. Primary Care Services that are provided to the Insured in Network;
6. Chronic Disease Management services, devices and prescription drugs, pursuant to requirements established under Chapter 342 of the Acts of 2024, that are provided to the Insured in Network;
7. Preventive Health Services that are provided to the Insured in Network;
8. vaccinations that are provided to the Insured in Network;
9. abortion and abortion-related care that is provided to the Insured in Network;

10. maternity services that are provided to the Insured in Network;
11. physical therapy, occupational therapy, and speech therapy that are provided to the Insured in Network; and
12. outpatient substance use disorder services that are provided to the Insured in Network.

(b) Notwithstanding the foregoing, with regard to services within the categories of physical therapy, occupational therapy, speech therapy, and chronic conditions, if a Carrier experiences and can demonstrate to the Division's satisfaction that there has been a significant increase in the risk-adjusted utilization of a specific Health Services, supplies and/or pharmaceuticals for two consecutive quarters, the Carrier may submit an application with corresponding supportive data to the Division for consideration of a limited use of Prospective Review requirements for a designated, time-limited period. The notice and website provisions set forth in this regulation shall otherwise apply to the introduction of the new limited period Prospective Review requirements so approved by the Division.

(c) The Division shall examine and report at least every 3 years on the financial, administrative and clinical impacts of maintaining or eliminating Prospective Review for other specific Health Services, supplies, and/or pharmaceuticals, including the impacts on appropriate or inappropriate use, the extent to which alternative services or benefits that are more expensive or less expensive may exist, the effects on the overall cost, quality of patient care and health equity in the Commonwealth; and the results of any professionally accepted research pertaining thereto. The Division may request public comment, and may contract with an actuary, economist or other technical experts as necessary for this examination and report.

(~~5~~6) Concurrent Review. A Carrier or the Utilization Review Organization shall make a 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 or Utilization Review Organization shall notify the Provider rendering the service by telephone within one working day, and shall send written or electronic confirmation to the Insured and the Provider within one working day thereafter. A written or electronic notification shall include the number of extended Days or the next review date, the new total number of Days or services approved, and the date of admission or initiation of services.
(b) In the case of an Adverse Determination, the Carrier or Utilization Review Organization shall notify the Provider rendering the service by telephone within 24 hours, and shall send written or electronic notification to the Insured and the Provider within one working Day thereafter.
(c) The service shall be continued without liability to the Insured until the Insured has been notified of the determination.

(7~~6~~) Written Notice. The written notification of an 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 Health Care 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 Covered 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: *Health Insurance Consumer Protection*, 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 on all product/plan materials in at least the languages identified by the Centers for Medicare & Medicaid Services as the top non-English languages in Massachusetts, that clearly indicates how the Insured can request oral interpretation and written translation services from the Carrier consistent with 958 CMR 3.000: *Health Insurance Consumer Protection*.

(7~~8~~) Reconsideration of an Adverse Determination. A Carrier or Utilization Review Organization shall give a Provider treating an Insured an opportunity to seek reconsideration of an Adverse Determination from a Clinical Peer Reviewer in any case involving an initial determination or a 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 rendering the service and the Clinical Peer Reviewer or a clinical peer designated by the Clinical Peer Reviewer if the reviewer cannot be available within one working day.
(b) If the Adverse Determination is not reversed by the reconsideration process, the Insured, or the Provider on behalf of the Insured, may pursue the Grievance process established pursuant to 958 CMR 3.000: *Health Insurance Consumer Protection*.

(c) The reconsideration process allowed pursuant to 211 CMR 52.07(7) shall not be a prerequisite to the internal Grievance process or an expedited appeal required by 958 CMR 3.000: *Health Insurance Consumer Protection*.

(~~9~~8) Continuity of Care. A Carrier must provide evidence that its policies regarding continuity of care comply with all provisions of 958 CMR 3.000: *Health Insurance Consumer Protection*.

(~~10~~9) Step Therapy. A Carrier must provide evidence that its protocols regarding step therapy comply with all provisions of section 12A of chapter 176O.

(~~10~~11) Workers' Compensation Preferred Provider Arrangement. A Carrier that provides specified services through a workers' compensation preferred Provider arrangement shall be deemed to have met the requirements of 211 CMR 52.07, except 211 CMR 52.07(10), if it has met the requirements of 452 CMR 6.00: *Utilization Review and Quality Assessment*.

(12) Prospective Review Submissions.

(a) A Carrier shall submit a report as part of its biennial managed care accreditation submission under 211 CMR 52.05, signed by the Carrier's medical officer, that presents detailed information about the manner and timing of how the Carrier has reviewed Health Services, supplies and pharmaceuticals, including specific service codes, subject to Prospective Review. The report shall specifically include:

1. a list of the Health Services, supplies and pharmaceuticals, including specific service codes, subject to Prospective Review as of January 1 of the following year where the carrier has approved over 98% of all requests, including approvals following an appeal of a denial, for that specific service, supply or drug in the prior calendar year and the reasons supporting the continued use of Prospective Review;
2. a list of the Health Services, supplies and pharmaceuticals, including service codes, for which Prospective Review requests will no longer be required by the Carrier as of January 1 of the following year and the reasons supporting their discontinued use; and
3. a list of the Health Services, supplies and pharmaceuticals, including service codes, subject to Prospective Review for the prior calendar year, the number of requests reviewed per item, the number of requests approved, modified, and denied, as well as information about denied requests that were appealed and the results of those appeals for the prior calendar year

(~~11~~13) Annual Survey. A Carrier ~~or its Utilization Review Organization~~ shall conduct an annual survey of Insureds to assess satisfaction with access to Primary Care Services, Specialty Care services, ancillary services, hospitalization services, durable medical equipment and other covered Health Services, supplies and/or pharmaceuticals, including ~~services. The survey shall also assess Insureds'~~ satisfaction with Utilization Review processes used by a Carrier or its Utilization Review Organization.

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

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

(c) Carriers shall submit the results of these annual surveys to the Division as part of their biennial managed care accreditation filings under 211 CMR 52.05.

(~~12~~14) Religious Nonmedical Treatment and Providers. Nothing in 211 CMR 52.07 shall be construed to require Health Benefit Plans to use medical professionals or criteria to decide insured access to Religious Nonmedical Providers, utilize medical professionals or criteria in making decisions in internal appeals from decisions denying or limiting coverage or care by Religious Nonmedical Providers, compel an Insured to undergo a medical examination or test as a condition of receiving coverage for treatment by a Religious Nonmedical Provider, or require Health Benefit Plans to exclude Religious Nonmedical Providers because they do not provide medical or other data otherwise required, if such data is inconsistent with the religious nonmedical treatment or nursing care provided by the Provider.

(15) Application Programming Interface. A Carrier or its Utilization Review Organization may implement and maintain an Application Programming Interface for the automated processing of Prospective Review requests to enable a Provider to: determine whether

Prospective Review is required for a Health Service, supply and/or pharmaceutical; identify Prospective Review information and documentation requirements, including any standardized forms; and facilitate the exchange through secure electronic submission of Prospective Review requests and determinations from the Provider's electronic health records or practice management systems.

(a) Beginning January 1, 2027, if a Carrier or its Utilization Review Organization implements an Application Programming Interface it shall conform with the most appropriate standards, including specifications adopted by the Secretary of the United States Department of Health and Human Services as specified in federal regulations and utilize the appropriate standard in accordance with the federal regulations and the most recent standards and guidance adopted by the United States Department of Health and Human Services to implement said regulations; provided, however, that the Application Programming Interface shall:

1. support a Health Insurance Portability and Accountability Act-compliant Prospective Review requests and responses, as described in related federal regulations and
2. communicate the following information about Prospective Review requests:
   (i) whether the Carrier or its Utilization Review Organization:
      (A) approves the Prospective Review request and the date or circumstance under which the authorization ends;
      (B) denies the Prospective Review request; or
      (C) requests more information; and
   (ii) if the Carrier or its Utilization Review Organization denies the Prospective Review request, the Carrier or Utilization Review Organization shall include a specific reason for the denial.

(b) Beginning January 1, 20287, unless otherwise determined by the Commissioner, if a Carrier or its Utilization Review Organization implements and maintains a Prospective Review Application Programming Interface it shall comply with the most recent version of the National Council for Prescription Drug Programs SCRIPT standard or its successor standard, and relevant federal regulations.

(c) A Carrier or its Utilization Review Organization may use financial incentives in order to require a Provider to participate in the implementation of an Application Programming Interface for the automated processing of Prospective Review.

52.08: Quality Management and Improvement

(1) Standards. A 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 that provides specified services through a workers' compensation preferred Provider arrangement shall be deemed to have met the requirements of 211 CMR 52.08 if it has met the requirements of 452 CMR 6.00: *Utilization Review and Quality Assessment*.

52.09: Credentialing

(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 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 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 211 CMR 52.09(2), 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 211 CMR 52.09(2), 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% 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% of Health Care Professionals' Clean and Complete re-Credentialing Applications within 120 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 211 CMR 52.09 shall be construed to prevent a Carrier from utilizing additional credentialing information in selecting the Providers with which it contracts.

(4) Nothing in this 211 CMR 52.09 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 52.09 if the Carrier does not provide Benefits through a Network or does not have contracts with Participating Providers.

(7) A 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 211 CMR 51.00: *Preferred Provider Health Plans and Workers' Compensation Preferred Provider Arrangements* and 452 CMR 6.00: *Utilization Review and Quality Assessment*.

(8) Nothing in 211 CMR 52.09 shall be construed to prevent a Carrier from implementing timelines that are more stringent than otherwise provided in 211 CMR 52.09.

52.10: Preventive Health Services

(1) A Carrier's application will be reviewed for compliance with preventive services mandated by applicable law. A Carrier that is not an HMO shall be required to comply with 211 CMR 52.10 only to the extent of those Preventive Health Services mandated by its licensing or enabling statute or by any other applicable state or federal law.

(2) A Carrier that provides specified services through a workers' compensation preferred Provider arrangement shall not be required to meet the requirements of 211 CMR 52.10.

52.11: Provider Contracts

(1) Contracts between Carriers and Health Care Providers may include provisions to protect against payments that exceed the maximum allowable amount payable for such service under the applicable payment method, so long as the contracts comply with all Rules for Coordination of Benefits in 211 CMR 38.04(1) and (2).

(a) Without limiting the generality of this provision, contracts between Carriers and Health Care Providers may include provisions that allow Carriers to provide financial incentives to Health Care Providers concerning prohibiting or limiting payments or reimbursements for the following practices, which are forbidden:

1. duplicate billing, which includes the submission of multiple claims for the same service, for the same member, by the same provider or multiple providers;

2. overstating or misrepresenting services, including provider upcoding or submitting separate claims for services or procedures provided as components of a more-comprehensive service for which a single rate of payment is established; and

3. submitting inappropriate claims under an individual practitioner's provider ID/service

location number.

(2~~1~~) Contracts between Carriers and Providers shall state that a Carrier shall not refuse to contract with or compensate for covered services an otherwise eligible Health Care Provider solely because such 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 as they relate to the needs of such Provider's patients; or

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

(~~2~~3) Contracts between Carriers and Providers shall state that the Provider is not required to indemnify the 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 based on the Carrier's management decisions, Utilization Review provisions or other policies, guidelines or actions.

(~~3~~4) No contract between a Carrier and a Licensed Health Care Provider Group may contain any Incentive Plan that includes a specific payment made to a Health Care Professional as an inducement to reduce, delay or limit specific, Medically Necessary services covered by the health care contract.

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

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

(c) Nothing in 211 CMR 52.11(3) shall be construed to prohibit contracts that contain Incentive Plans that involve general payments such as Capitation payments or shared risk agreements between Carriers and Providers, so long as such contracts, which impose risk on such Providers for the costs of care, services and equipment provided or authorized by another Health Care Provider, comply with 211 CMR 52.11(4) and 211 CMR 155.00: *Risk-bearing Provider Organizations*.

(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~~5) No 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 which imposes financial risk on such Provider for the costs of care, services or equipment provided or authorized by another Provider unless such contract includes specific provisions with respect to the following:

(a) stop loss protection;

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

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

(~~5~~6) No Carrier shall enter into an agreement or contract with a Health Care Provider if the agreement or contract contains a provision that:

(a) 1. 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;

2. 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;

3. 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

4. requires a Provider to participate in a new plan subject to 211 CMR 152.00: *Health Benefit Plans Using Limited, Regional or Tiered Provider Networks* 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 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 M.G.L. c. 12C, § 10;

(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~~7) Contracts between Carriers and Health Care Providers shall state that neither the Carrier nor the Provider has the right to terminate the contract without cause.

(~~7~~8) Contracts between Carriers and Health Care Providers shall state that a Carrier shall provide a written statement to a Provider of the reason or reasons for such Provider's involuntary disenrollment.

(~~8~~9) Contracts between Carriers and Health Care Providers shall state that the Carrier shall notify Providers, either by mail or electronically, of modifications in payments, modifications in covered services or modifications in a Carrier's procedures, documents or requirements, including those associated with Utilization Review, quality management and improvement, credentialing and Preventive Health Services, that have a substantial impact on the rights or responsibilities of the Providers, and the effective date of the modifications. The notice shall be provided 60 Days before the effective date of such modification, unless such other date for notice is mutually agreed upon between the Carrier and the Provider.

(~~9~~10) Contracts between Carriers and Health Care Providers shall state that Providers shall not bill patients for charges for covered services other than for deductibles, copayments, or coinsurance.

(1~~0~~1) Contracts between Carriers and Health Care Providers shall prohibit Health Care Providers from billing patients for nonpayment by the Carrier of amounts owed under the contract due to the insolvency of the 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.

(1~~1~~2) Contracts between Carriers and Health Care Providers shall require Providers to comply with the Carrier's requirements for Utilization Review, quality management and improvement, credentialing and the delivery of Preventive Health Services.

(13~~2~~) Contracts between Carriers and Health Care Providers shall require Providers to promptly advise Carriers when their availability to see new patients changes (including when they implement a waitlist) and shall require Carriers to make changes to reflect changes to Provider availability within two business days of receiving notice of a Provider's change in status.

(14~~3~~) Nothing in 211 CMR 52.11: *Provider Contracts* shall be construed to preclude a Carrier from requiring a Health Care Provider to hold confidential specific compensation terms.

(15~~4~~) Nothing in 211 CMR 52.11: *Provider Contracts* shall be construed to restrict or limit the rights of Health Benefit Plans to include as Providers Religious Non-medical Providers or to utilize medically based eligibility standards or criteria in deciding Provider status for Religious Non-medical Providers.

(1~~5~~6) For Dental and Vision Benefit Plans, the following provisions regarding the standards for Provider contracts found at 211 CMR 51.11: *Provider Contracts*, shall apply for Dental and Vision Benefits: 211 CMR 52.11(1) through (4) and (11).

(1~~6~~7) Contracts between Carriers and Health Care Providers shall recognize Nurse Practitioners and Physician Assistants as Participating Providers and shall treat services provided by Participating Provider Nurse Practitioners and Physician Assistants to their 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 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 or Physician Assistant who is a 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 for identical services rendered by a Provider of healthcare licensed by the Commonwealth.

(1~~7~~8) Contracts between Carriers and Behavioral Health Service Providers, or between any entity that manages or administers mental health or substance use disorder benefits for the Carrier and Behavioral Health Service Providers, shall require that the Carrier will establish a base fee schedule for evaluation and management services for Behavioral Health Service

52.11: continued

Providers that is not lower than the base fee schedule used for evaluation and management services for Primary Care Providers of the same of similar licensure type in the same geographic region. For the purposes of this item, the term "base fee schedule" means the minimum rates, typically set forth in fee schedules, paid by the Carrier to an in-Network Health Care Provider who is not paid under an alternative payment arrangement for covered Health Care Services, provided, however, that final rates may be subject to negotiations or adjustments that may result in payments to in-network providers that are different from the base schedule. Carriers are expected to issue contract amendments necessary to implement this section by no later than August 10, 2023 and, when implementing this section, Carriers shall not lower their base fee schedules for Primary Care Providers in order to comply with this item.

(19) A contract between a Carrier or Provider shall provide clear notice to Providers about a Provider's responsibility to keep appropriate Medical Necessity records for at least two years in the event the Carrier does an audit of records as part of review of any potential fraud, waste, or abuse investigation.

(20) A contract between a Carrier or Provider shall provide clear notice to Providers about processes to audit a Provider's records retrospectively to question the Medical Necessity of claims or the accuracy of payments made and a Carrier's right to seek repayment of prior-made payments.

(21) A contract between a Carrier or Provider shall provide clear notice to Providers about timely filing requirements and the processes required by Carriers to consider claims that are submitted beyond those identified timely filing requirements.

52.12: 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 211 CMR 52.12, 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 52.05(3) and (4), a Carrier shall file with the Commissioner an access analysis that meets the requirements of 211 CMR 52.12 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 52.12(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 geographic areas as appropriate for the Carrier's service area, 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 use disorders who are accepting new patients;
e. The total number of Network Health Care Professionals who specialize in the treatment of Behavioral Health and substance use disorders, 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 are accepting new patients and a list of those top five types;
g. The total number of Network Health Care Professionals who specialize in the top five types of Specialty Care by volume of utilization who are not accepting new patients and a list of those top five types;
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 Professionals Practitioners:
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 Networks 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.
(j) Any other information required by the Commissioner to determine compliance with the provisions of 211 CMR 52.12.

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

52.13: Evidences of Coverage

(1) Evidences of Coverage as to a Carrier. It shall constitute delivery of an Evidence of Coverage if a Carrier chooses to, upon or after enrollment, require the Insured to designate whether the Insured wants to receive 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 refer the Insured to a resource where the information described in such Evidence of Coverage can be accessed including, but not limited to, an Internet Website. In such instance, the Evidence of Coverage must meet the requirements of 211 CMR 52.13(4).

An electronic copy of the Evidence of Coverage shall always be delivered to the group representative in the case of a group policy.

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

(a) an Evidence of Coverage;

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

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

Dental and Vision Carriers shall be exempt from the provisions of 211 CMR 52.13(3)(b), (h) through (j), (q) through (x), (z) and (aa).

(3) Evidence of Coverage Requirements. An Evidence of Coverage shall contain a clear, concise and complete statement of all of the information described at 211 CMR 52.13(3)(a) through (aa). In addition, for Limited, Regional and Tiered Network Plans, an Evidence of Coverage shall also contain any information as required by 211 CMR 152.00: *Health Benefit Plans Using Limited, Regional or Tiered Provider Networks*.

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

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

(c) The toll-free telephone number and website established by the Carrier to identify the Network status of an identified health care Provider and present Provider cost and location information and an explanation of the information that an Insured may obtain through such toll-free number and website.

(d) The limitations on the scope of:

1. Health Care Services and any other Benefits to be provided, including:
   a. an explanation of any 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-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 52.14(4).
2. Dental or Vision Care Services and any other Benefits to be provided, including an explanation of any deductible or copayment feature.

(e) 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, Dental or Vision Benefit Plan;

(f) A description of the locations where, and the manner in which, Health, Dental or Vision Care Services and other Benefits may be obtained, and, additionally, for Health Care Services:

1. the method to locate Provider directory information on a Carrier's website and the method to obtain a paper 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-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-Network Provider(s), unless the Insured has a reasonable opportunity to choose to have the service performed by a Network Provider.

(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;

(h) The criteria by which an Insured may be disenrolled or denied enrollment. 211 CMR 52.13(3)(h) shall apply to Carriers, including Dental and Vision Carriers.

(i) The involuntary disenrollment rate among Insureds of the Carrier. 211 CMR 52.13(3)(i) shall apply to Carriers, including Dental and Vision Carriers.

1. For the purposes of 211 CMR 52.13(3)(i), Carriers shall exclude all Administrative Disenrollments, Insureds who are disenrolled because they have moved out of a health plan's Service Area, Insureds whose continuation of coverage periods have expired, former dependents who no longer qualify as dependents, or Insureds who lose coverage under an employer sponsored plan because they have ceased employment or because their employer group has cancelled coverage under the plan, reduced the numbers of hours worked, become disabled, retired or died.

2. For the purposes of 211 CMR 52.13(3)(i), the term "involuntary disenrollment" means that a Carrier has terminated the coverage of the Insured due to any of the reasons contained in 211 CMR 52.13(3)(j)2. and 3.

(j) The requirement that an Insured's coverage may be canceled, or its renewal refused may arise only in the circumstances listed in 211 CMR 52.13(3)(j)1. through 5. 211 CMR 52.13(3)(j) shall apply to Carriers, including Dental and 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;
3. commission of acts of physical or verbal abuse by the Insured which pose a threat to Providers or other Insureds of the Carrier and which are unrelated to the physical or mental condition of the Insured; provided, that the Commissioner prescribes or approves the procedures for the implementation of the provisions of 211 CMR 52.13(3)(i)3.;
4. relocation of the Insured outside the Service Area of the Carrier; or
5. non-renewal or cancellation of the group contract through which the Insured receives coverage;

(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: *Health Insurance Consumer Protection*, including a description of the process for seeking expedited internal review and concurrent expedited internal and external reviews pursuant to 958 CMR 3.000;

(l) A statement telling Insureds how to obtain the report regarding Grievances pursuant to 958 CMR 3.600(1)(d) from the Office of Patient Protection;

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

(n) A summary description of the procedure, if any, for out-of-Network referrals and any additional charge for utilizing out-of-network Providers. 211 CMR 52.13(3)(n) shall apply to Carriers, including Dental and Vision Carriers;

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

(p) A statement regarding all products/plans detailing what translator and interpretation services are available to assist Insureds, including that the Carrier will provide, upon request, interpreter and translation services related to administrative procedures. The statement must appear in at least the languages identified by the Centers for Medicare & Medicaid Services as the top non-English languages in Massachusetts, 211 CMR 52.13(3)(p) shall apply to Carriers, including Dental and Vision Carriers.

(q) A list of prescription drugs excluded from any closed or restricted formulary available to Insureds under the Health Benefit Plan; provided, that the 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. A Carrier will be deemed to have met the requirements of 211 CMR 52.13(3)(q) if the Carrier does all of the following:

1. provides a complete list of prescription drugs that are included in any closed or restricted formulary;
2. clearly states that all other prescription drugs are excluded;
3. provides a toll-free number that is updated within 48 hours of any change in the closed or restricted formulary to enable Insureds to determine whether a particular drug is included in or excluded from the closed or restricted formulary;

4. provides an Internet Website that is updated as soon as practicable relative to any change in the closed or restricted formulary to enable 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 M.G.L. c. 94C, § 3, and lists each of such schedule II or III drugs.

(r) A summary description of the procedures followed by the 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 consistent with 211 CMR 38.00: *Coordination of Benefits (COB)*;

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

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

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

2. A statement that the Carrier will allow any female Insured who is in her second or third trimester of pregnancy and whose 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, consistent with the terms of the Evidence of Coverage, for the period up to and including the Insured's first postpartum Visit.

3. A statement that the Carrier will allow any Insured who is Terminally Ill and whose 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, consistent with the terms of the Evidence of Coverage, until the Insured's death.

4. A statement that the Carrier will provide coverage for Health Services for up to 30 Days from the effective date of coverage to a new Insured by a Provider who is not a Participating Provider in the Carrier's Network if:

a. the Insured's employer only offers the Insured a choice of Carriers in which said Provider is not a Participating Provider; and

b. said Provider is providing the Insured with an ongoing course of treatment or is the Insured's Primary Care Provider; and

c. With respect to an Insured in her second or third trimester of pregnancy, 211 CMR 52.13(3)(v)4. shall apply to services rendered through the first postpartum Visit. With respect to an Insured with a Terminal Illness, 211 CMR 52.13(3)(v)4. shall apply to services rendered until death;

5. A Carrier may condition coverage of continued treatment by a Provider under 211 CMR 52.13(3)(v)1. through 4. upon the Provider's agreeing as follows:

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

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

c. to adhere to the 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;

6. Nothing in 211 CMR 52.13(3)(v) shall be construed to require the coverage of Benefits that would not have been covered if the Provider involved remained a Participating Provider;

(w) If a Carrier requires an Insured to designate a Primary Care Provider, a statement that the Carrier will allow the Primary Care Provider to authorize a standing referral for Specialty health Care provided by a Health Care Provider participating in the Carrier's Network when:

1. the Primary Care Provider determines that such referrals are appropriate;
2. the Provider of Specialty Care agrees to a treatment plan for the Insured and provides the Primary Care Provider with all necessary clinical and administrative information on a regular basis; and
3. the Health Care Services to be provided are consistent with the terms of the Evidence of Coverage.

Nothing in 211 CMR 52.13(3)(v) shall be construed to permit a Provider of Specialty health Care who is the subject of a referral to authorize any further referral of an Insured to any other Provider without the approval of the Insured's Carrier;

(x) If a Carrier requires an Insured to obtain referrals or ~~prior~~ prospective ~~authorization~~ review from a Primary Care Provider for Specialty Care, a statement that the Carrier will not require an Insured to obtain a referral or ~~prior authorization~~prospective review from a 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 and that the Carrier will not require higher copayments, coinsurance, deductibles or additional Cost-Sharing features for such services provided to such Insureds in the absence of a referral from a 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 as a result of such examination;
2. maternity care; and
3. medically necessary evaluations and resultant Health Care Services for acute or emergency gynecological conditions.

Carriers may establish reasonable requirements for participating obstetricians, gynecologists, certified nurse midwives or family practitioners to communicate with an Insured's Primary Care Provider regarding the Insured's condition, treatment, and need for follow-up care; and nothing in 211 CMR 52.13(3)(x) shall be construed to permit an obstetrician, gynecologist, certified nurse midwife or family practitioner to authorize any further referral of an Insured to any other Provider without the approval of the Insured's Carrier;

(y) If a Carrier offers a Site of Service Plan, the Carrier must prominently and clearly specify on the cover of the Evidence of Coverage and related promotional materials that care delivered by certain Network Providers or at certain Network locations may only be available when deemed medically necessary for the patient's condition. In addition, prior to offering Site of Service Plans, the Carrier is to provide notice to covered members and to Network Providers prior to the Site of Service Plan being issued or renewed.

(z) A statement that the Carrier will provide coverage of pediatric Specialty Care, including, for the purposes of 211 CMR 52.13(3)(x), mental health care, by persons with recognized expertise in Specialty pediatrics to Insureds requiring such services.

(aa) If a Carrier allows or requires an Insured to designate a Primary Care Provider, a statement that the Carrier shall provide the Insured with an opportunity to select a Participating Provider Nurse Practitioner or a Participating Provider Physician Assistant as a Primary Care Provider or to change his or her Primary Care Provider to a Participating Provider Nurse Practitioner or a Participating Provider Physician Assistant at any time during the Insured's coverage period.

(bb) Evidence that the Carrier will provide coverage on a nondiscriminatory basis for covered services when delivered or arranged for by a Participating Provider Nurse Practitioner or a Participating Provider Physician Assistant. For the purposes of 211 CMR 52.13(3)(bb), nondiscriminatory basis shall mean that a Carrier's plan does not contain any annual or lifetime dollar or unit of service limitation imposed on coverage for the care provided by a Participating Provider Nurse 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 Providers, in accordance with

M.G.L. c. 176R, § 16(1) and c. 176S, § 1;

(cc) 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.

(4) Internet Websites. If the Carrier, including any Dental or Vision Carrier, refers the Insured to resources where the information described in the Evidence of Coverage can be accessed including, but not limited to, an Internet Website, such Carrier must be able to demonstrate compliance with applicable law, and with the following with respect to the Internet Website:

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

1. All necessary information and a clear explanation of the manner by which Insureds can access their specific Evidence of Coverage and any amendments thereto through such Internet Website;
2. A list of the specific information to be furnished by the Carrier through an Internet Website;
3. The significance of such information to the Insured;
4. The Insured's right to receive, free of charge, a paper copy of Evidences of Coverage and any amendments thereto at any time;
5. The manner by which the Insured can exercise the right to receive a paper copy at no cost to the Insured; and
6. A toll free number for the Insured to call with any questions or requests including, but not limited to, a request for the Carrier to provide assistance for the Insured with finding a Provider.

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

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

(5) Group Plans. A Carrier, including a Dental and Vision Carrier, shall always deliver at least one Evidence of Coverage to the group representative of a group plan, notwithstanding the provisions of 211 CMR 52.13, 52.14 or 52.15.

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

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

(a) any changes in Clinical Review Criteria; and

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

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

(9) Dates Required. Every Evidence of Coverage described in 211 CMR 52.13 must contain the effective date, date of issue and, if applicable, expiration date.

(10) Workers' Compensation. A 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 if it has met the requirements of 211 CMR 51.00: *Preferred Provider Health Plans and Workers' Compensation Preferred Provider Arrangements* and 452 CMR

52.13: continued

6.00: *Utilization Review and Quality Assessment*.

(11) Certain Requirements also Applicable to Evidences of Coverage for Dental and Vision Carriers. The following provisions of 211 CMR 52.13 shall also apply to Evidences of Coverage issued by Dental and Vision Carriers: 211 CMR 52.13(4) through (10).

52.14: Required Disclosures for Carriers and Behavioral Health Managers

(1) A Carrier shall provide to at least one adult Insured in each household upon enrollment, and to a prospective 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 criteria are developed;

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

1. For the purposes of 211 CMR 52.14(1)(c), Carriers shall exclude all Administrative Disenrollments, Insureds who are disenrolled because they have moved out of a health plan's Service Area, Insureds whose continuation of coverage periods have expired, former dependents who no longer qualify as dependents, or Insureds who lose coverage under an employer-sponsored plan because they have ceased employment or because their employer group has cancelled coverage under the plan, reduced the numbers of hours worked, retired or died.

2. For the purposes of 211 CMR 52.14(1)(c), the term "voluntary disenrollment" means that an Insured has terminated coverage with the Carrier by nonpayment of premium.

3. For the purposes of 211 CMR 52.14(1)(c), the term "involuntary disenrollment" means that a Carrier has terminated the coverage of the Insured due to any of the reasons contained in 211 CMR 52.13(3)(i)2. and 3.

(d) a notice to Insureds regarding Emergency Medical Conditions that states all of the following:

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

2. that no 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 will be denied coverage for medical and transportation expenses incurred as a result of such Emergency Medical Condition; and

4. if the Carrier requires an Insured to contact either the Carrier or its designee or the Primary Care Provider of the Insured within 48 hours of receiving emergency services, that notification already given to the Carrier, designee or Primary Care Provider by the attending emergency 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 is available to the Insured or prospective Insured from the Office of Patient Protection; and

(f) a statement:

1. that an Insured has the right to request referral assistance from a Carrier if the Insured or the Insured's Primary Care Provider has difficulty identifying Medically Necessary services within the Carrier's Network;

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

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

(2) The information required of Carriers by 211 CMR 52.14(1)(a) through (f) may be contained in the Evidence of Coverage and need not be provided in a separate document.

(3) Every disclosure required of Carriers and described in 211 CMR 52.14(1)(a) through (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:

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

2. 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 52.14(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 52.14(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 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 to the disclosures required by 211 CMR 52.14 to the Bureau at least 30 Days before their effective dates.

(7) Carriers shall submit Material Changes to the disclosures required by 211 CMR 52.14(1)(a) through (f) to at least one adult Insured in every household residing in Massachusetts at least once every two years.

(8) A 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 if it has met the requirements of 211 CMR 51.00: *Preferred Provider Health Plans and Workers' Compensation Preferred Provider Arrangements* and 452 CMR 6.00: *Utilization Review and Quality Assessment*.

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

(10) A Carrier for whom a Behavioral Health Manager is administering Behavioral Health Services shall state the name and telephone number of the Behavioral Health Manager on the Carrier's enrollment cards issued in the normal course of business.

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

(a) a notice to the Insured regarding emergency mental Health Services that states:

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

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

52.14: continued

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

(b) a summary of the process by which clinical guidelines and Utilization Review criteria are developed for Behavioral Health Services; and

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

(12) The information required of Behavioral Health Managers by 211 CMR 52.14(11) may be contained in the Carrier's Evidence of Coverage and need not be provided in a separate document. Every disclosure described in 211 CMR 52.14(11) shall contain the effective date, date of issue and, if applicable, expiration date.

(13) A Behavioral Health Manager (if applicable) or Carrier shall submit a Material Change to the information required by 211 CMR 52.14(11) to the Bureau at least 30 Days before its effective date and to at least one adult Insured in every household residing in the Commonwealth at least biennially.

(14) A Behavioral Health Manager that provides specified services through a workers' compensation preferred Provider arrangement that meets the requirements of 211 CMR 51.00: *Preferred Provider Health Plans and Workers' Compensation Preferred Provider Arrangements* and 452 CMR 6.00: *Utilization Review and Quality Assessment* shall be considered to comply with 211 CMR 52.14.

(15) A Carrier for whom a Behavioral Health Manager is administering Behavioral Health Services shall be responsible for the Behavioral Health Manager's failure to comply with the requirements of 211 CMR 52.00 in the same manner as if the Carrier failed to comply and shall be subject to the provisions of 211 CMR 52.17.

52.15: Provider Directories

All Provider directory requirements set forth in 211 CMR 52.15 shall be in addition to any applicable Provider directory requirements under 211 CMR 152.08 for insured Health Benefit Plans that use limited, regional or tiered Provider Networks:

(1) Carriers shall establish appropriate systems to collect, store, and maintain detailed information about each Health Care Provider within their Provider Network systems. The systems are to be developed in a manner that facilitates a Health Care Provider's ability to update personal and practice information to the maximum extent feasible. Carriers shall ensure that Provider directories educate persons covered by plans providing services through Networks of Providers about how they may obtain in-Network care from an out-of-Network Provider when an in-Network Provider is not available.

(2) The detailed information that the Carrier is required to collect, store and maintain about Health Care Providers who are a part of the Carrier's Network, shall include at least the following information for each Health Care Provider:

(a) Health Care Provider's primary Specialty, secondary Specialty (if applicable), tertiary Specialty (if applicable), Behavioral Health sub-Specialty (if applicable)

1. The reporting of a Specialty or sub-Specialty should be based on the Provider's actual training and experience in treatment of this Specialty or sub-Specialty in the past 24 months. ;

(b) license type, practice credentials (education, including all relevant licensure(s), professional designations, and relevant certifications, including but not limited to board certifications);

(c) Health Care Facilities with which a Health Care Provider is affiliated (*e.g.*, where a Provider has admitting privileges);

(d) if a hospital or Facility, the type of hospital\Facility and its Accreditation status;

(e) if a non-hospital behavioral health Facility, the standard services as identified by the Commissioner, that are available in the Facility;
(f) practice group affiliation;
(g) office locations for a Provider, and for each location whether the individual Provider sees patients in that location:
1. at least once per week;
2. at least once per month; or
3. as a cover/fill-in as needed;
(h) whether the Health Care Provider is:
1. is available to accept new patients covered by the Carrier;
2. is not accepting new patients covered by the Carrier; or
3. has limited availability to accept new patients covered by the Carrier with a waitlist of 4 weeks of less to schedule an appointment;
(i) operating hours for each office location, including whether the office is available for evening and weekend appointments;
(j) main phone number(s) available for members' use in setting up appointments;
(k) all languages understood and/or spoken by the Health Care Provider;
(l) whether the setting in which a Provider treats patients is ADA accessible and a description of the accommodations available to address physical, developmental, and intellectual disabilities;
(m) whether the practice specializes in the treatment of specific genders and identification of those specific genders or gender identities based upon the Provider's actual treatment of members of such populations or groups in the last 24 months.;
(n) any specific age groups treated by the Health Care Provider, if the Provider so chooses;
(o) any special populations or cultural groups that the Health Care Provider wishes to highlight that the Health Care Provider serves, as well as the Provider's race and nationality, if the Provider so chooses;
(p) whether the Health Care Provider has conditions to treating a patient, including the following:
1. requiring a patient to pay a concierge medicine fee, Facility fee, or other administrative fee in order to be treated by the Health Care Provider,
2. if a Health Care Provider practice requires that the care is limited to hospital or Facility inpatients;
3. for Health Care Providers who work in clinics or community health centers, requiring that a patient receive other health care at the clinic or community health center; or
4. for Health Care Providers who work at university or school health centers, requiring that patients are enrolled students in the university or school.
(q) if a Tiered Network Plan, the Provider's tier, an explanation of how the Carrier identifies the Provider's tier, and the impact of the tier on Cost-sharing under the health plan; and
(r) which Health Care Providers within a Facility are available for consultation via Telehealth and the modalities of Telehealth the Health Care Provider offers to patients or whether the Health Care Provider is available for consultation only via Telehealth.

(3) detailed information that the Carrier is required to display in the Provider directory shall present information about the Health Care Professionals who see patients at each office location identifying whether the Health Care Professional is limiting patients to a subset of the Carrier's members and information according to the following categories:
a. Health Care Professional sees patients at the location at least once per week;
b. Health Care Professional sees patients at the location at least once per month; and
c. Health Care Professional sees patients as a cover/fill-in or when needed.

(4) detailed information that the Carrier is required to display in the Provider directory shall include at least the following information about non-Facility Health Care Providers who are a part of the Carrier's Network:
(a) Health Care Provider's primary Specialty, secondary Specialty (if applicable), tertiary Specialty (if applicable), Behavioral Health sub-Specialty (if applicable);
(b) license type, practice credentials (education, including all relevant licensure(s), professional designations, and relevant certifications including but not limited to board certifications);

(c) Health Care Facilities with which a Health Care Provider is affiliated (*e.g.*, where a Provider has admitting privileges);
(d) whether the Health Care Provider is:
1. accepting new patients that are covered by the Carrier
2. closed to new patients covered by the Carrier; or
3. accepting new patients but with a waitlist of 4 weeks or less to schedule an appointment);
(e) group practice affiliations;
(f) office locations for a Provider where the Provider will see patients and for each location whether the Provider sees patients:
1. at least once per week; or
2. at least once per month;
(g) operating hours for each office location, including whether the office is open for evening and weekend appointments;
(h) phone number(s) or other contact information a member may use in setting up an appointment;
(i) whether the office at which a Provider treats patients is ADA accessible and a description of the accommodations available to address physical, developmental, and intellectual disabilities;
(j) languages spoken by the Health Care Provider;
(k) age groups and special populations, genders or cultural groups that the Health Care Provider treats on a regular basis, as well as the Provider's race and nationality, if the Provider so chooses;
(l) whether the Health Care Provider requires a patient to pay a concierge medicine, Facility fee, or other administrative fee in order to be treated by the Health Care Provider;
(m) if a covered member is in a Tiered Network Plan, the Carrier shall provide access to information that will identify the Provider's tier within the covered members' Tiered Network Plan, an explanation of how the Carrier identifies the Provider's tier, and the impact of the tier on Cost-sharing under the health plan; and
(n) whether the Health Care Provider is available for consultation via Telehealth and the modalities of Telehealth the Health Care Provider offers to patients.

(5) The detailed information that the Carrier is required to display in the Provider directory shall include at least the following information about Facility Health Care Providers who are a part of the Carrier's Network:
(a) the type of hospital/Facility and its Accreditation status;
(b) if a non-hospital behavioral health Facility, the standard services as identified by the Commissioner that are available in the Facility;
(c) the main phone number(s) for members to use in contacting the Facility;
(d) all languages spoken by Providers within the Facility;
(e) whether the office is ADA compliant and list a description of accommodations to address physical and intellectual disabilities;
(f) if Facilities are tiered within a Tiered Network Plan, the Provider's tier, an explanation of how the Carrier identifies the Provider's tier, and the impact of the tier on Cost-sharing under the health plan;
(g) how the Health Care Provider may be contacted by a patient, including phone numbers and internet portals; and .
(h) whether the Facility's practitioners may be available for consultation via Telehealth.

(6) A Carrier shall ensure the accuracy of the information concerning each Provider listed in the Carrier's Provider directories for each Network plan and shall review and update the entire Provider directory for each Network plan.

(7) If delivering a paper copy of the Provider directory, a Carrier shall be deemed to have met the requirements of 211 CMR 52.15(1) if the Carrier:
(a) provides to at least one adult Insured in each household, or in the case of a group policy, to the group representative, at least once per calendar year an addendum, insert, or other update to the Provider directory originally provided under 211 CMR 52.15(1);
(b) updates its toll-free number within 48 hours and Internet Website as soon as practicable, or as directed by the Commissioner.

(8) Every Provider directory described in 211 CMR 52.15 must contain the effective date, date of issue, expiration date, if applicable, and reference to any government-sponsored website(s) providing quality and cost information, as may be designated by the Commissioner.

(9) A Carrier shall deliver a Provider directory through an Internet Website A Carrier may also deliver a Provider directory via "intranet websites," "electronic mail," and "e-mail." If the Carrier refers an Insured to access directory information through an Internet Website, the Carrier must be able to demonstrate compliance with the following:

(a) The Carrier shall deliver notice of the Provider directory to at least one adult in the household of each Insured, by direct mail, or by electronic mail if the Insured has agreed to communicate electronically, that includes:

1. all necessary information and a clear explanation of the manner by which Insureds can access their specific Provider directory through an Internet Website;
2. a list of the specific information to be furnished by the Carrier through an Internet Website;
3. the Insured's right to receive, free of charge, a paper copy of the Provider directory at any time;
4. the manner by which the Insured can exercise the right to receive a paper copy at no cost to the Insured; and
5. a toll-free number for the Insured to call with any questions or requests and instructions about how the Insured can contact the Carrier if they want assistance in locating an available Provider. The Carrier shall take reasonable measures to ensure that the Provider directory information and documents furnished in an Internet Website are substantially the same as that contained in the Carrier's paper documents.

(b) The Carrier takes reasonable measures to ensure that it furnishes, upon request of an individual, a paper copy of the Provider directory.

(10) A Provider directory that is electronically available shall:

(a) be in a format which will be searchable by
1. Provider type,
2. Specialty in treating specific populations, if applicable,
3. whether the Provider is accepting new patients/is closed to new patients,
4. language spoken, and
5. distance from a geographic starting point selected by a consumer.;

(b) shall identify that it is current as of a certain date;

(c) be accessible to the general public through a clearly identifiable link or tab without requiring the general public to create or access an account, enter a policy or contract number, provide other identifying information, or demonstrate coverage or an interest in obtaining coverage with the Network plan;

(d) be updated as soon as practicable and not less often than monthly or as directed by the Commissioner; provided, however, that an electronic Network plan Provider directory shall be updated within two business days, or sooner if consistent with federal guidelines, when the Carrier is informed of and upon confirmation that:

1. a contracting Provider is no longer accepting new patients for that Network plan or an individual Provider within a Provider group is no longer accepting new patients;
2. a Provider or Provider group is no longer being under contract for a particular Network plan;
3. a Provider's practice location or other Provider directory information has changed;
4. a Provider has retired or ceased practice; or
5. any other information that affects the content or accuracy of the Provider directory has changed.

(11) A Provider directory shall include a dedicated customer service email address and telephone number and electronic link, set forth prominently in both the directory and on the Carrier's website, to assist with the Provider directory information and to provide information about a Provider's participation in the Carrier's Network, consistent with federal requirements for providing this information. The Provider directory will educate members to notify the Carrier of inaccurate Provider directory information, consistent with federal requirements.

The Carrier shall investigate reports of Provider directory inaccuracies within 30 Days of receiving notice of an inaccuracy, and the Carrier shall modify the Provider directory as soon as

practicable, but not longer than 30 Days after finding an inaccuracy. Carrier will establish a dedicated toll-free telephone number or add an option to its existing toll-free number to assist covered persons to schedule an appointment with an available and appropriate Health Care Provider when they are unable to locate or schedule an appointment with a Health Care Provider who is listed in the Carrier's Provider directory information as accepting new patients to treat the patients of a certain age or health condition Specialty.

The Carrier will also contact each of the Health Care Providers who were unavailable to schedule an appointment with the patient in order to understand the reasons that an appointment was not scheduled, and the Carrier shall modify the Provider directory information as necessary to reflect the correct availability of the Health Care Provider to treat conditions and certain age groups. Carriers shall conduct staff training regarding communications about inaccurate Provider information so as to ensure that Provider directory inaccuracies are promptly investigated and corrected. Carriers will maintain files of all such follow-up calls so that they may be reviewed by Division staff upon request.

(12) The Provider directory must contain a list of Health Care Providers in the Carrier's Network available to Insureds residing in Massachusetts, organized by Specialty, location, and distance from a starting point selected by the searching individual, and the directory shall summarize on the Carrier's Internet Website for each such Provider:

(a) the method used to compensate or reimburse such Provider;

(b) the Provider price relativity, as defined in and reported under section 10 of chapter 12C;

(c) the Provider's health status adjusted total medical expenses, as defined in and reported under said section 10 of said chapter 12C;

(d) 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 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;

(e) such information about Providers may be provided directly by Carrier or by reference to a third-party source that facilitates comparison of Providers' performance.

(13) Carriers shall display information in the Provider directory about how to access coverage for community-based Behavioral Health Service Providers that provide crisis, urgent care, and stabilization services, including but not limited to mobile crisis intervention and the emergency services program.

(14) Nothing in 211 CMR 52.15(8) shall be construed to require disclosure of the specific details of any financial arrangements between a Carrier and a Provider.

(15) If any specific Providers or type of Providers requested by an Insured are not available in said 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.

(16) Notwithstanding any general or specific law to the contrary, a Carrier shall ensure that all Participating Provider Nurse Practitioners and Participating Provider Physician Assistants with whom a member can make an appointment are included and displayed in a nondiscriminatory manner in the Carrier's Provider Directory.

(17) Carriers' new and renewing Provider contracts shall require Providers to inform the Carrier promptly when the Provider availability to see new patients changes (including whether they have a waitlist) and Carriers shall prioritize updating directories to reflect these changes within two business days of receiving notice of a Provider's change in status.

(18) Consistent with federal guidelines, Carriers shall contact Providers every 90 days, or as directed by the Commissioner, to remind Providers to check and verify their profiles so that Carriers can certify that the Provider's information is correct. As part of such reminders, Carriers shall educate Providers about the importance of making Provider changes as soon as Provider changes occur so that Carriers may make the appropriate Provider directory updates as soon as possible.

(19) Consistent with federal guidelines, Carriers that have received notice of potentially inaccurate information through a consumer, Provider, or audit and have been unable to validate the accuracy of the listing shall take the following steps:

(a) If the potential inaccuracy relates to the physical address or telephone number of the Provider, the Carrier should either immediately remove the information from the online directory until the information is updated, or designate the information as "unverified" for no longer than 90 days, after which the information must be immediately removed;

(b) If the potential inaccuracy relates to whether a Provider is accepting new patients, the Carrier shall remove the designation "accepting new patients" for that Provider until the information is updated;

(c) If the potential inaccuracy relates to whether a Provider is or continues to be an in-Network Provider, the Carrier should remove the full Provider listing from the online directory until it is updated.

(20) Carriers shall employ policies to ensure that directory information provided, updated and verified by behavioral health Providers is accurately uploaded and displayed in its directory and shall audit licensed behavioral health Providers' and licensed non-hospital behavioral health facilities' Provider directory information on a quarterly basis, including information with respect to:

(a) all licensed behavioral health Providers who have not submitted a claim within 12 months of the audit and who have not otherwise been audited or have not received an attestation in the past 12 months or for whom the Carrier has not received a written or electronic attestation certifying that all elements of the licensed behavioral health Provider's directory profile have been reviewed, updated as necessary and then confirmed as accurate has not been received in the past 12 months; and

(b) a representative sample of no less than 15% of all licensed behavioral health Providers who have not been audited in the last 12 months or for whom as a written or electronic attestation certifying that all elements of the licensed behavioral health Provider's directory profile have been reviewed, updated, as necessary, and then confirmed as accurate has not been received in the past 120 days; and

(c) Carriers should compare at least 2% of the attestations received in the prior 120 days to the related information or changes in their Provider directories to confirm that the data elements match the data elements in the directory.

(21) Quarterly behavioral health audits shall exclude licensed behavioral health Providers that have been audited in the last 12 months, or which have been removed from the Provider directory. In the event that three successive quarterly audits demonstrate that at least 85% of the auditable licensed behavioral health Providers are listed in a manner that is 100% accurate, the Carrier may shift to conducting behavioral health audits on a semi-annual basis.

(22) Non-behavioral Health Care Providers' Provider directory information should be audited to ensure accuracy of Provider directory information on at least an annual basis, or as directed by the Commissioner. Carriers shall initiate these required audits no later than the start of the second calendar quarter after these regulations are promulgated in final form.

(23) Carriers will maintain files of all Provider audits for no less than seven years from the completion of any audit so that they may be reviewed by Division staff upon request.

(24) A Carrier shall deliver a notice to at least one adult Insured in each household upon enrollment annually about how to access the Carrier's Provider directory.

(25) A Carrier shall deliver a Provider directory to an Insured or a prospective Insured upon request. The print copy of the requested Provider directory information shall be provided to the requester by mail postmarked no more than five business days after the date of the request, and the print copy may be limited to the geographic region in which the requester resides or works or intends to reside or work.

(26) In the case of a group policy, the Carrier shall deliver a Provider directory to the group representative on at least an annual basis.

52.15: continued

(27) A Carrier shall update the print copies of the Carrier's Provider directory not less frequently than annually, and a Carrier shall include a disclosure in the print format of the Provider directory that the information included in the Provider directory is accurate as of the date of printing and that an individual may consult the Carrier's electronic Provider directory on its website or call a specified customer service telephone number to obtain the most current Provider directory information;

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

(29) A 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 if it has met the requirements of 211 CMR 51.00 and 452 CMR 6.00.

(30) If a Carrier offers a Site of Service Plan, the Provider directory for this plan is to clearly and prominently specify which certain Network Providers or service locations will only be available for covered care when the care is deemed medically necessary to be provided by the Provider or a certain service location.

52.16: Access to Covered Services through Telehealth

(1) A Carrier shall provide coverage for Health Care Services delivered via Telehealth by a contracted Network Provider if:

(a) the Health Care Services are covered by way of in-person consultation or delivery; and
(b) the Health Care Services may be appropriately provided through the use of Telehealth.

(2) A Carrier shall not meet Network adequacy through significant reliance on Network Providers who deliver Health Care Services via Telehealth only and shall not be considered to have an adequate Network if patients are not able to access appropriate in-person services in a timely manner upon request. Coverage shall not be limited to services delivered by Providers who are contracted through third-party Telehealth vendors.

(3) A Carrier may undertake Utilization Review, including preauthorization, to determine the appropriateness of Telehealth as a means of delivering a Health Care Service; provided, however, that the determination shall be made in the same manner as if the service was delivered in person.

(4) A Carrier shall not be required to reimburse a Health Care Professional for a Health Care Service that is not a covered benefit under the plan. A Carrier shall not be required to reimburse a Health Care Professional not contracted under a closed Network plan except as provided for under subclause (4) of subsection (a) of section 6 of chapter 176O.

(5) A Health Care Professional shall not be required to document a barrier to an in-person Visit nor shall the type of setting where Telehealth services are provided be limited for Health Care Services provided via Telehealth; provided, however, that a patient may decline receiving services via Telehealth in order to receive in-person services.

(6) A Carrier's coverage may provide for patient Cost-sharing (copayment, coinsurance, deductible) for services delivered during a Telehealth Visit; provided that the patient Cost-sharing does not exceed the deductible, copayment, or coinsurance applicable to the same services provided during an in-person Visit with a Health Care Provider.

(7) Carriers shall ensure that the in-Network rate of reimbursement for services delivered during a Telehealth Visit with Health Care Professionals of covered Behavioral Health Services when provided via interactive audio-video technology or audio-only telephone shall be no less than the rate of payment for the same Behavioral Health Service provided via an in-person Visit with a Health Care Provider.

52.16: continued

(8) The rate of payment for services delivered during a Telehealth Visit when provided via synchronous interactive audio-video technology or audio-only telephone may be greater than the rate of payment for the same service delivered by other Telehealth modalities.

(9) Coverage that reimburses a Health Care Professional with a Global Payment shall account for the provision of Telehealth services when setting the global payment reimbursement amount.

(10) Carriers will contractually require that Health Care Professionals use Telehealth technology that conforms to applicable federal and state health information privacy and security standards as well as standards for informed consent. As long as the technology meets these standards, a Carrier shall not limit the use of a Telehealth communications platform that conforms to such standards.

(11) Carriers are to include information within Network Directories about which Providers are available to deliver services via Telehealth. A Carrier should forward its comprehensive Telehealth plan to the Division, and such plan will subsequently be forwarded as part of the biennial managed care Accreditation process. The Telehealth plan should include the following:

(a) The communications that will be used with Providers to specify the service and documentation standards that a Provider will need to meet in order for services provided by Telehealth to be covered by the Carrier;

(b) A statement that restricts covered Telehealth Visits to those that are compatible with state/federal privacy standards;

(c) A list of the services that will not be covered when provided to a covered person via Telehealth, and an explanation for why these services are not covered;

(d) An explanation of how and when Cost-sharing (copayments, coinsurance, and deductibles) will apply for Telehealth services, and if Cost-sharing is waived, a description of the exact circumstances under which the Cost-sharing will be waived.

(e) A statement of how the Carrier intends to reimburse Providers for the following Telehealth services:

1. Behavioral Health Services;
2. Primary Care Services; and
3. Chronic Disease Management services; and
4. All other services, including those provided by Asynchronous Telehealth.

(f) An identification of the billing codes, location codes or other codes that the Carrier intends to use to reimburse Providers for Telehealth services, including the following:

1. when Telehealth may be used for follow-ups that may be considered less than a Visit, a description of how the Carrier intends to reimburse Providers for these follow-up Telehealth services; and
2. physical exams, including those that have both Telehealth and in-person components.

52.17: Material to Be Provided to the Office of Patient Protection

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

(a) A copy of every Evidence of Coverage and amendments thereto offered by the Carrier.
(b) A copy of the Provider directory described in 211 CMR 52.15.
(c) A copy of the materials specified in 211 CMR 52.14.

(2) A Carrier shall provide the following to the Office of Patient Protection by no later than April 1st:

(a) A list of sources of independently published information assessing Insured satisfaction and evaluating the quality of Health Care Services offered by the Carrier.

(b) A report of the percentage of physicians and Nurse Practitioners and Physician Assistants who voluntarily and involuntarily terminated participation contracts with the Carrier during the previous calendar year for which such data has been compiled and the three most common reasons for voluntary and involuntary Provider disenrollment;

1. For the purposes of 211 CMR 52.16(2)(b), Carriers shall exclude physicians, Nurse Practitioners, and Physician Assistants who have moved from one physician and/or Nurse Practitioner or Physician Assistant group to another but are still under contract with the Carrier.

2. For the purposes of 211 CMR 52.16(2)(b), "voluntarily terminated" means that the physician, Nurse Practitioner, or Physician Assistant terminated the contract with the Carrier.

3. For the purposes of 211 CMR 52.16(2)(b), "involuntarily terminated" means that the Carrier terminated its contract with the physician, Nurse Practitioner, or Physician Assistant;

(c) The percentage of premium revenue expended by the Carrier for Health Care Services provided to Insureds for the most recent year for which information is available;

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

1. filed Grievances, Grievances that were approved internally, Grievances that were denied internally, and Grievances that were withdrawn before resolution; and

2. external appeals pursued after exhausting the internal Grievance process and the resolution of all such external appeals. The report shall identify for each such category, to the extent such information is available, the demographics of such Insureds, which shall include, but need not be limited to, race, gender and age; 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:
   a. the Insured failed to obtain pre-treatment authorization or referral for services;
   b. the service was not Medically Necessary;
   c. the service was experimental or investigational;
   d. the Insured was not covered or eligible for benefits at the time services occurred;
   e. the Carrier does not cover the service or the Provider under the Insured's plan;
   f. duplicate claims had been submitted;
   g. incomplete claims had been submitted;
   h. coding errors had occurred; or
   i. of any other specified reason.

(f) A 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(1)(a) through (c) and (2)(c) through (e).

52.18: Noncompliance with 211 CMR 52.00

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

Following notice and hearing, the Commissioner shall suspend the 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 of Neglect can be removed.

(2) Noncompliance with 211 CMR 52.00.

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

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

1. The hearing shall be held no later than 21 Days following the date of the notice specified in 211 CMR 52.17(2)(b).
2. The hearing shall be conducted pursuant to M.G.L. c. 30A.

52.18: continued

3. The hearing shall provide the Carrier with an opportunity to respond to the alleged noncompliance.

(d) Penalties. Following the hearing specified in 211 CMR 52.17(2)(c), the Bureau may issue a finding against the 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.
3. A penalty not to exceed $10,000 for each classification of violation.
4. The suspension or revocation of the Carrier's Accreditation.

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

(4) Revocation by a National Accreditation Organization. If the 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.

(5) Informal Resolutions. Nothing in 211 CMR 52.17 shall be construed to prohibit the Bureau and a Carrier from resolving compliance issues through informal means.

52.19: 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; c. 176J, § 11; c. 176O, §§ 2 and 17; c. 176R, § 6; and c. 176S, § 6.

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