MANAGED CARE CHECKLIST:
REQUIREMENTS FOR PROVIDER CONTRACTS

NOTE TO CARRIERS COMPLETING THIS CHECKLIST:
Pursuant to Bulletin 2001-05 and 2008-19, please include a completed checklist for each provider contract when submitting (1) an application for accreditation; (2) a material change to accreditation; (3) an application for an insured preferred provider plan; or (4) a material change to an insured preferred provider plan.

When completing this checklist, please indicate for each requirement the page number(s), and/or section(s), where the required information may be found in the submitted materials.

- ***For items requiring company confirmation, please place a checkmark next to the requirement acknowledging confirmation.***
- ***If a requirement is not applicable, please place "N/A" next to the requirement and explain, either within the checklist or on a separate sheet, the legal basis under which the requirement does not apply to the filed materials.***

MATERIAL CHANGES

Is this submission a material change to previously filed provider contracts?

YES [ ]   NO [ ]

If Yes, when submitting a material change to previously filed provider contracts:

- **complete only those sections of the checklist(s) specific to the submission and**
- **include red-line version(s) of the previously filed document(s).**

A FILING THAT DOES NOT INCLUDE A COMPLETED CHECKLIST AND SUPPORTING DOCUMENTATION [AS NECESSARY] WILL BE RETURNED AND NOT REVIEWED.

Carrier Name & NAIC #: ______________________________

Contact Name & Title: ______________________________

Address: ______________________________

Telephone & Fax: ______________________________

Email Address: ______________________________

Contract Name & Form #: ______________________________

Date submitted: ______________________________

Carrier Certification:

I ______________________________ a duly authorized representative of ______________________________ certify that it is my good faith belief based on the review of this checklist and submitted provider contracts and additional materials that the provider contracts and additional submitted materials comply with applicable Massachusetts law.

REQUIRED LANGUAGE IN PROVIDER CONTRACTS

Certain requirements of 211 CMR 52.00 et seq. apply to dental and vision carriers. Such provisions are 211 CMR 52.12(1) through (4) and 211 CMR 52.12(11). In addition, dental and vision provider contracts utilized within stand alone dental and vision plans should contain the requirements of the so-called "prompt payment law" under M.G.L. c. 176I §2. [see Bulletin No. 2006-03 and Filing Guidance 2009-A]

According to 211 CMR 52.12(1), "[c]ontracts between carriers and providers **shall state** that a carrier shall not refuse to contract with or compensate for covered services with an otherwise eligible health care provider solely because such provider has in good faith:

Pg#_____ (a) communicated with or advocated on behalf of one or more of his 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

Pg#_____ (b) communicated with one or more of his 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."

Pg#_____ According to 211 CMR 52.12(2), "[c]ontracts 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."

According to 211 CMR 52.12(3), "[n]o 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.

Pg#_____ (a) Health care professionals shall not profit from provision of covered services that are not medically necessary or medically appropriate.

Pg#_____ (b) Carriers shall not profit from denial or withholding of covered services that are medically necessary or medically appropriate.

Pg#_____ (c) Nothing in 211 CMR 52.12(3) shall be construed to prohibit contracts that contain incentive plans that involve general payments such as capitation payments or shared risk agreements that are made with respect to providers or which are made with respect to groups of insureds if 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 52.12(4)."

Confirm carrier complies with this requirement & reference the section(s) of the provider contracts that address this requirement.

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According to 211 CMR 52.12(4), "[n]o 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:

Pg#_____ (a) stop loss protection;

Pg#_____ (b) minimum patient population size for the provider group; and

Pg#_____ (c) identification of the health care services for which the provider is at risk."

Please provide a statement that advises whether the carrier has issued new contracts as described above, and if so, reference the section(s) of the provider contract that address 211 CMR 52.12(4)(a)-(c).

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Pg#_____ According to 211 CMR 52.12(5), "[c]ontracts between carriers and health care providers **shall state** that neither the carrier nor the provider has the right to terminate the contract without cause."

Pg#_____ According to 211 CMR 52.12(6), "[c]ontracts 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."

Pg#_____ According to 211 CMR 52.12(7), "[c]ontracts between carriers and health care providers **shall state** that the carrier shall notify providers in writing 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."

Pg#_____ According to 211 CMR 52.12(8), "[c]ontracts 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."

Pg#_____ According to 211 CMR 52.12(9), "[c]ontracts 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."

Pg#_____ According to 211 CMR 52.12(10), "[c]ontracts 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."

According to 211 CMR 52.12(11), "[n]othing in 211 CMR 52.12 shall be construed to preclude a carrier from requiring a health care provider to hold confidential specific compensation terms.

Confirm carrier complies with this requirement.

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According to 211 CMR 52.12(12), "[n]othing in 211 CMR 52.12 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."

Confirm carrier complies with this requirement.

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According to 211 CMR 52.12(14), "[a] participating provider nurse practitioner practicing within the scope of his or her license, including all regulations requiring collaboration with a physician under M.G.L. c. 112, §80B, shall be considered qualified within the carrier's definition of primary care provider to an insured."

Confirm carrier complies with this requirement & reference the section(s) of the provider contract(s) that address this requirement.

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Pg#_____ According to 211 CMR 52.12(15), "[c]ontracts between carriers and health care providers shall recognize nurse practitioners as participating providers and shall treat services provided by participating provider nurse practitioners 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 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."

Confirm carrier complies with this requirement & reference the section(s) of the provider contract(s) that address this requirement.

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According to M.G.L. c. 176O §9A [Section 39 of Chapter 288 of the Acts of 2010], "[a] carrier shall not enter into an agreement or contract with a health care provider if the agreement or contract contains a provision that:

Pg#_____ (a) (i) limits the ability of the carrier to introduce or modify a select network plan or tiered network plan by granting the health care provider a guaranteed right of participation; (ii) requires the carrier to place all members of a provider group, whether local practice groups or facilities, in the same tier of a tiered network plan; (iii) requires the carrier to include all members of a provider group, whether local practice groups or facilities, in a select network plan on an all-or-nothing basis; or (iv) requires a provider to participate in a new select network or tiered network plan 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

Pg#_____ (b) requires or permits the carrier or the health care provider to alter or terminate a contract or agreement, in whole or in part, to affect parity with an agreement or contract with other carriers or health care providers or based on a decision to introduce or modify a select network plan or tiered network plan; or

Pg#_____ (c) requires or permits the carrier to make any form of supplemental payment unless each supplemental payment is publicly disclosed to the commissioner as a condition of

accreditation, including the amount and purpose of each payment and whether or not each payment is included within the provider's reported relative prices and health status adjusted total medical expenses under section 6 of chapter 118G.

Confirm that the filed contract(s) comply with the above noted statutory requirement.

According to M.G.L. c. 176O §9A [Section 197 of Chapter 224 of the Acts of 2012], "[a] carrier shall not enter into an agreement or contract with a health care provider if the agreement or contract contains a provision that:

Pg#_____ (d) limits the ability of either the carrier or the health care provider from disclosing the allowed amount and fees of services to an insured or insured's treating health care provider.

Pg#_____ (e) limits the ability of either the carrier or the health care provider from disclosing out-of-pocket costs to an insured.

Confirm that the filed contract(s) comply with the above noted statutory requirement and highlight the section that addresses the above.

Pg#_____ According to M.G.L. c. 176O §9B [Section 198 of Chapter 224 of the Acts of 2012], "[c]arriers shall not be permitted to enter into or continue alternate payment arrangements involving downside risk with provider organizations that have not received a risk certificate under chapter 176U.

Confirm that the filed contract(s) comply with the above noted statutory requirement and highlight the section that addresses the above.

Pg#_____ According to M.G.L. c. 176I §2 (or M.G.L. c. 176G §6), contracts must contain a provision requiring that within 45 days after the receipt by the carrier of completed forms for reimbursement, the carrier shall (i) make payment, (ii) notify the provider in writing of the reason or reasons for nonpayment, or (iii) notify the provider in writing of what additional information or documentation is necessary to complete the forms for reimbursement. If the carrier fails to comply with these requirements for any claims related to the provision of health care services, the carrier shall pay, in addition to any reimbursement for health care services provided, interest on such benefits, which shall accrue beginning 45 days after the carrier's receipt of request for reimbursement at the rate of 1.5 per cent per month, not to exceed 18 per cent per year. The provisions relating to interest payments shall not apply to a claim that the carrier is investigating because of suspected fraud. (See also M.G.L. c. 175, § 110(G); M.G.L. c. 176A, § 8(e); M.G.L. c. 176B, § 7; and Bulletin 00-13)

Pg#_____ Early in 2002, the Division became aware that certain providers in the Massachusetts market intended to modify their practices in April 2002 by charging an annual fee to members as a condition to continue to be part of the providers' panel of patients. The Division was formally requested by certain carriers to opine as to whether carriers would be permitted to continue to include providers within their managed care networks if those providers required such fees as a condition for treatment. As is noted in a letter dated March 6, 2002 to Tufts Health Plan, the Division's General Counsel indicated that it does not believe that the providers' annual fee proposal "violates the current statutory and regulatory framework governing contracts between carriers and providers." The Division's General Counsel's letter of March 6, 2002 instructs all carriers to "incorporate provisions into their contracts with providers, provider groups or networks that require advance disclosure or notification by the provider to the carrier of any such arrangements [to charge an annual fee to members as a condition to continue to be a part of a providers' panel of patients]."

MISCELLANEOUS

According to M.G.L. c. 176O §2(d), "[a] carrier that contracts with another entity to perform some or all of the functions governed by this chapter shall be responsible for ensuring compliance by said entity with the provisions of this chapter. Any failure by said entity to meet the requirements of this chapter shall be the responsibility of the carrier to remedy and shall subject the carrier to any and all enforcement actions, including financial penalties, authorized under this chapter."

Please confirm that the carrier is aware of this requirement and that the carrier has submitted, as applicable, all contracts between (1) the carrier and any delegated entity and (2) the delegated entity and providers.

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DEFINITIONS [**M.G.L. c. 176O, § 1 and 211 CMR 52.03 (if used within contract)**]

Pg#______ **Adverse determination**, "a determination, based upon 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."

Pg#______ **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 the 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 section 1867(e)(1)(B) of the Social Security Act, 42 U.S.C. section 1395dd(e)(1)(B)." [**Section 185 of Chapter 224 of the Acts of 2012 effective November 4, 2012**]"

Pg#______ **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."

Pg#______ **Participating provider**, "a provider who, under a contract with the carrier or with its contractor or subcontractor, has agreed to provide health care services to insureds with an expectation of receiving payment, other than coinsurance, copayments or deductibles, directly or indirectly from the carrier."

Pg#______ **Utilization review**, "a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, 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."

Requirements that may either be in provider contracts or otherwise distributed to providers

If distributed in another format, please forward copies of the applicable documents and identify the pages and/or sections that address the following requirements.

Pg#_____ According to M.G.L. c. 175 §47U(b) (or M.G.L. c. 176G §5(b), M.G.L. c. 176A §8U(b) and M.G.L. c. 176B §4U(b)), carriers shall provide coverage for emergency services provided to insureds for emergency medical conditions. After an insured has been stabilized for discharge or transfer, a carrier may require a hospital emergency department to contact a physician on-call designated by the carrier or its designee for authorization of post-stabilization services. The hospital emergency department shall take all reasonable steps to initiate contact with the carrier or its designee within 30 minutes of stabilization. However, such authorization shall be deemed granted if the carrier or its designee has not responded to the call within 30 minutes. In the event the attending physician and the on-call physician do not agree on what constitutes appropriate medical treatment, the opinion of the attending physician shall prevail and such treatment shall be considered appropriate treatment for an emergency medical condition, provided that such treatment is consistent with generally accepted principles of professional medical practice and is a covered benefit under the policy or contract.

Pg#_____ According to M.G.L. c. 175 §47U(c) (or M.G.L. c. 176G §5(c), M.G.L. c. 176A §8U(c) or M.G.L. c. 176B §4U(c)), a carrier may require an insured to contact either the carrier or its designee or the primary care physician of the insured within 48 hours of receiving emergency services, but notification already given to the carrier, designee or primary care physician by the attending physician shall satisfy this requirement.

Pg#_____ According to M.G.L. c. 176O §10(c), "[a] carrier or utilization review organization shall conduct an annual survey of insureds to assess satisfaction with access to specialist services, ancillary services, hospitalization services, durable medical equipment and other covered services . . . [and c]arriers 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."

Pg#_____ According to M.G.L. c. 176O §12(b), "[a] carrier or utilization review organization shall make an initial determination regarding a proposed admission, procedure or service that requires such a determination within two working days of obtaining all necessary information . . . [and i]n 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 provide written or electronic confirmation of the telephone notification to the insured and the provider within two working days thereafter. 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 provide written or electronic confirmation of the telephone notification to the insured and the provider within one working day thereafter."

Pg#_____ According to M.G.L. c. 176O §12(c), "[a] carrier or utilization review organization shall make a concurrent review determination within one working day of obtaining all necessary information. In the case of a determination to approve an extended stay or additional services, the carrier or utilization review organization shall notify by telephone the provider rendering the service within one working day, and shall provide 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. In the case of an adverse determination, the carrier or utilization review organization shall notify by telephone the provider rendering the service within 24 hours, and shall provide written or

electronic notification to the insured and the provider within one working day thereafter. The service shall be continued without liability to the insured until the insured has been notified of the determination."

Pg#_____ According to 211 CMR 52.08(6), "[t]he written notification of an adverse determination shall include a substantive clinical justification therefor that is consistent with generally accepted principles of professional medical practice, and shall, at a minimum: (a) identify the specific information upon which the adverse determination was based; (b) discuss the insured's presenting symptoms or condition, diagnosis and treatment interventions and the specific reasons such medical evidence fails to meet the relevant medical review criteria; (c) specify any alternative treatment option offered by the carrier, if any; (d) reference and include applicable clinical practice guidelines and review criteria; and (e) include a clear, concise and complete description of the carrier's formal internal grievance process and the procedures for obtaining external review pursuant to 105 CMR 128.400."

Pg#_____ According to M.G.L. c. 176O §12(e),"[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. Said 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 said reviewer cannot be available within one working day. 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 [M.G.L. c. 176O, §§] 13 and 14. The reconsideration process allowed herein shall not be a prerequisite to the formal internal grievance process or an expedited appeal required by [M.G.L. c. 176O, §] 13."

Pg#_____ According to M.G.L. 176O §16(a) "[t]he physician treating an insured, shall, consistent with generally accepted principles of professional medical practice and in consultation with the insured, make all clinical decisions regarding medical treatment to be provided to the insured, including the provision of durable medical equipment and hospital lengths of stay. Nothing in this section shall be construed as altering, affecting or modifying either the obligations of any third party or the terms and conditions of any agreement or contract between either the treating physician or the insured and any third party."

Pg#_____ According to M.G.L. 176O §16(b) "[a] carrier shall be required to pay for health care services ordered by a treating physician if (1) the services are a covered benefit under the insured's health benefit plan; and (2) the services are medically necessary. A carrier may develop guidelines to be used in applying the standard of medical necessity, as defined herein. Any such medical necessity guidelines utilized by a carrier in making coverage determinations shall be: (i) developed with input from practicing physicians in the carrier's or utilization review organization's service area; (ii) developed in accordance with the standards adopted by national accreditation organizations; (iii) updated at least biennially or more often as new treatments, applications and technologies are adopted as generally accepted professional medical practice; and (iv) evidence-based, if practicable. In applying such guidelines, a carrier shall consider the individual health care needs of the insured."

Pg#_____ According to M.G.L. 176O §16(c) "[w]ith respect to an insured enrolled in a health benefit plan under which the carrier or utilization review organization only provides administrative services, the obligations of a carrier or utilization review organization created by this section and related to payment shall be limited to recommending to the third party payor that coverage should be authorized."

NURSE PRACTITIONERS RECOGNIZED AS PARTICIPATING PROVIDERS

As you know, M.G.L. c. 176R, which took effect on January 1, 2009, was enacted as part of chapter 305 of the Acts of 2008 (chapter 305) requiring insurers to recognize nurse practitioners, defined as registered nurses who hold authorization in advance nursing practice under section 80B of chapter 112, as participating providers. Although chapter 176R did not amend any section of M.G.L. c. 176O (chapter 176O), under which the Office of Patient Protection operates, there are several sections of 105 CMR 128.000 that are indirectly affected by the passage of chapter 176R.

Pg#_____ According to 105 CMR 128.501, "[c]arriers shall allow any female insured who is in her second or third trimester of pregnancy and whose provider in connection with said pregnancy is involuntarily disenrolled for reasons other than those related to quality or fraud, to continue treatment with said provider, consistent with the carrier's evidence of coverage, for a period up to and including the insured's first postpartum visit."

Pg#_____ According to 105 CMR 128.502, "[c]arriers shall allow any insured who is terminally ill, and whose provider in connection with the treatment of the insured's terminal illness is involuntarily disenrolled for reasons other than those related to quality or fraud, to continue treatment with said provider, consistent with the terms of the carrier's evidence of coverage, until the insured's death."

According to 105 CMR 128.503(A), "[a] carrier provide coverage for health services to a newly insured provided by a physician or nurse practitioner who is not a participating provider in the carrier's network for up to 30 days from the effective date of coverage if:

Pg#_____ (1) the insured's employer only offers the insured a choice of carriers in which said provider is not a participating provider; and

Pg#_____ (2) said provider is providing the insured with an ongoing course of treatment or is the insured's primary care provider"

Pg#_____ According to 105 CMR 128.503(B), "[w]ith respect to an insured pregnant woman who is in her second or third trimester, coverage pursuant to 105 CMR 128.503(A) shall apply to services rendered through the insured's first postpartum visit."

Pg#_____ According to 105 CMR 128.503(C), "[w]ith respect to an insured with a terminal illness, coverage pursuant to 105 CMR 128.503(A) shall apply to services rendered until the insured's death."

According to 105 CMR 128.504(A), "[a] carrier may condition coverage of continued treatment by a provider under 105 CMR 128.500 through 128.502, upon the provider's agreeing:

Pg#_____ (1) to accept reimbursement from the carrier at the rates applicable prior to the notice of disenrollment as payment in full;

Pg#_____ (2) to not 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;

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Pg#_____ (3) 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,

Pg#_____ (4) to adhere to such carrier's policies and procedures, including procedures regarding referrals, obtaining prior authorization and providing treatment pursuant to a treatment plan, if any, approved by the carrier."

According to 105 CMR 128.504(B), "[a] carrier may condition coverage of treatment by a physician or nurse practitioner under 105 CMR 128.503 upon the provider's agreeing:

Pg#_____ (1) to accept reimbursement from the carrier at the rates applicable to participating providers as payment in full;

Pg#_____ (2) to not 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 participated in the carrier's network;

Pg#_____ (3) 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

Pg#_____ (4) to adhere to the carrier's policies and procedures, including procedures regarding referrals, obtaining prior authorization and providing treatment pursuant to a treatment plan, if any, approved by the carrier."

According to 105 CMR 128.505(A), "[a] carrier that requires an insured to designate a primary care provider shall allow such a primary care provider to authorize a standing referral for specialty health care, including mental health care, provided by a health care provider participating in such carrier's network when:

Pg#_____ (1) the primary care provider determines that such referrals are appropriate;

Pg#_____ (2) the provider of specialty health 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

Pg#_____ (3) the health care services to be provided are consistent with the terms of the carrier's evidence of coverage.

Pg#_____ According to 105 CMR 128.505 (B), "[n]othing in 105 CMR 128.505 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."

According to 105 CMR 128.506(A), "[n]o carrier that requires an insured to obtain referrals or prior authorizations from a primary care provider for specialty care shall require an insured to obtain a referral or prior authorization 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:

Pg#_____ (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;

Pg#_____ (2) maternity care; and,

Pg#_____ (3) medically necessary evaluations and resultant health care services for acute or emergency gynecological conditions."

Pg#_____ According to 105 CMR 128.506(B), "[n]o No carrier shall require higher copayments, coinsurance, deductibles or additional cost sharing arrangements for such services provided to such insureds in the absence of a referral from a primary care provider

Pg#_____ According to 105 CMR 128.506(C), "[c]arriers 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."

Pg#_____ According to 105 CMR 128.506 (D), "[n]othing in 105 CMR 128.506 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."

Pg#_____ According to 105 CMR 128.506(E), "[f]or the purposes of 105 CMR 128.506, the term "specialty care" is limited to those services that are medically necessary and consistent with the terms of the carrier's evidence of coverage."

PHARMACISTS AND PHARMACIES

The definitions of "health care provider" and "health care services" under M.G.L. c. 176O, § 1 are broad enough to include pharmacists and pharmacy services. Pharmacists and pharmacies clearly fall within the definition of a "health care provider" as they must obtain certification or registration under M.G.L. c. 112. Further, pharmacists and pharmacies are certified or registered to dispense drugs, which clearly falls within the definition of "health care services" as a service for the "prevention, treatment, cure or relief of a health condition, illness, injury or disease." Pharmacist and pharmacy provider contracts have an impact on consumers and as such, the Bureau should be considered to be authorized by statute to review pharmacist and pharmacy provider contracts under its M.G.L. c. 176O authority.

Therefore, in order to satisfy the requirements of M.G.L. c. 176O, please review your pharmacist and pharmacy provider contracts, as applicable, and forward a completed checklist highlighting the following requirements under 211 CMR 52.12:

- 211 CMR 52.12(1) (regarding health care providers' rights to discuss coverage and compensation with patients);
- 211 CMR 52.12(2) (regarding indemnification against liabilities);
- 211 CMR 52.12(5) (prohibiting contract terminations that are not "for-cause");
- 211 CMR 52.12(6) (regarding providers' rights in case of involuntary disenrollment);
- 211 CMR 52.12(7) (regarding providers' rights to written notice of modifications);
- 211 CMR 52.12(8) (prohibiting "balance-billing");
- 211 CMR 52.12(9) (regarding patients' "hold harmless" rights in case of the carrier's insolvency); and
- 211 CMR 52.12(10)(regarding providers' compliance with managed care standards).

In addition, pharmacist and pharmacy provider contracts should contain the requirements of the so-called "prompt payment law" under M.G.L. c. 175, § 110(G). (These requirements also apply to nonprofit hospital and medical service corporations, HMOs and Preferred Provider Plans, as well as to commercial insurers, pursuant to M.G.L. c. 176A §8(e); M.G.L. c. 176B §7; M.G.L. c. 176G §6; and M.G.L. c. 176I §2.).