connecticut Addendum

State Specific Provider Requirements

# **General Terms.**

## *Relationship to Master Provider Agreement*.In the event that a provision of this Addendum conflicts with a provision of the Agreement, the provisions of this Addendum shall supersede, govern and control to the extent required by law and to the extent Contigo Health, Provider, Customers, Downstream Clients or Payors are subject to such law.

## *Applicability*. Provisions included herein which are not otherwise addressed by the Agreement shall be considered additional obligations upon the Parties for purposes of Covered Services provided in this State. Provisions included herein which specifically contradict an obligation under a provision of the Agreement shall replace that specific Agreement provision for purposes of Covered Services provided in this State, to the extent necessary to comply with applicable law. The provisions of this Addendum apply only to the entities covered by the referenced law and only for purposes of Covered Services provided in this State, unless otherwise required by the terms of the applicable law.

## *Definitions*. Capitalized terms used herein but not defined shall have the meaning assigned in the Agreement or assigned in the applicable law.

## *Citations*. The citations in this Addendum are current as of the date of this Addendum. Renumbering or recodification of statutes or regulations does not nullify the intent of the applicable provision provided herein.

## *Compliance with Law; Change of Law*. Any ambiguity in this Addendum shall be resolved in favor of a meaning that complies and is consistent with applicable law. To the extent a law cited herein is modified in a manner impacting this Addendum, any required revisions shall be automatically incorporated herein and any provisions which are no longer applicable shall be considered severed from this Addendum effective as of the date of the change in law. Contigo Health will update this Addendum after a change in law when reasonably practicable.

# **Network Arranger Laws**

# As required by Conn. Gen. Stat. § 38a-479aa(l), if the Preferred Provider Network fails to pay for health care services as set forth in the Agreement, the enrollee shall not be liable to the Provider for any sums owed by the Preferred Provider Network or any sums owed by the MCO or insurer because of nonpayment by the MCO or insurer, insolvency of the MCO or insurer or breach of contract between the MCO or insurer and the Preferred Provider Network.

# **General Insurance Laws**

# As required by Conn. Gen. Stat. § 38a-472f(g)(1)(C), if Provider is a hospital, as defined in section 38a-493, or a parent corporation of a hospital, and the Agreement is not renewed or is terminated by either the health carrier or the Provider, the health carrier and the Provider shall continue to abide by the terms of such Agreement, including reimbursement terms, for a period of 60 days from the date of termination or, in the case of a nonrenewal, from the end of the Agreement term. Except as otherwise agreed between such health carrier and such Provider, the reimbursement terms of any contract entered into by such health carrier and such Provider during said 60-day period shall be retroactive to the date of termination or, in the case of a nonrenewal, the end date of the Agreement term. This subparagraph shall not apply if the health carrier and Provider agree, in writing, to the termination or nonrenewal of the Agreement and the health carrier and Provider provide the notices required under Conn. Gen. Stat. § 38a-472f(g)(1) (A) and (B).

# As required by Conn. Gen. Stat § 38a-477g(b)(1)(A), the following language is included in the Agreement:

# Provider agrees that in no event, including, but not limited to, nonpayment by the health carrier or intermediary, the insolvency of the health carrier or intermediary, or a breach of this Agreement, shall the Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a covered person or a person (other than the health carrier or intermediary) acting on behalf of the covered person for services provided pursuant to this Agreement. This Agreement does not prohibit the Provider from collecting coinsurance, deductibles or copayments, as specifically provided in the evidence of coverage, or fees for uncovered services delivered on a fee-for-service basis to covered persons. Nor does this Agreement prohibit a Provider (except for a health care provider who is employed full-time on the staff of a health carrier and has agreed to provide services exclusively to that health carrier’s covered persons and no others) and a covered person from agreeing to continue services solely at the expense of the covered person, as long as the Provider has clearly informed the covered person that the health carrier does not cover or continue to cover a specific service or services. Except as provided herein, this Agreement does not prohibit the Provider from pursuing any available legal remedy.

# As required by Conn. Gen. Stat § 38a-477g(b)(1)(B), in the event of a health carrier or intermediary insolvency or other cessation of operations, the Provider’s obligation to deliver covered health care services to covered persons without requesting payment from a covered person other than a coinsurance, copayment, deductible or other out-of-pocket expense for such services will continue until the earlier of (i) the termination of the covered person’s coverage under the network plan, including any extension of coverage provided under the Agreement terms or applicable state or federal law for covered persons who are in an active course of treatment, as set forth in § 38a-472f(2)(g), or are totally disabled, or (ii) the date the Agreement between the health carrier and the Provider would have terminated if the health carrier or intermediary had remained in operation, including any extension of coverage required under applicable state or federal law for covered persons who are in an active course of treatment or are totally disabled.

# As required by Conn. Gen. Stat § 38a-477g(b)(1)(C), Provider shall make health records available to appropriate state and federal authorities involved in assessing the quality of care provided to, or investigating grievances or complaints of, covered persons. Provider shall comply with applicable state and federal laws related to the confidentiality of medical and health records and a covered person’s right to view, obtain copies of or amend such covered person’s medical and health records.

# As required by Conn. Gen. Stat § 38a-477g(b)(1)(D), (c), health carrier shall provide to a Provider at least 90 days' advance written notice of any change to the provisions or other documents specified under Conn. Gen. Stat § 38a-477g, and any change to the provider manuals and policies specified under Conn. Gen. Stat § 38a-477g that will result in a material change to such Agreement or the procedures that a Provider must follow pursuant to such Agreement.

# As required by Conn. Gen. Stat § 38a-477g(b)(1)(D), (c), at the time an agreement is signed, the health carrier or such health carrier's intermediary shall disclose to the Provider (A) all provisions and other documents incorporated by reference in such Agreement; and (B) all provider manuals and policies incorporated by reference in such Agreement, if any.

# At the time the Agreement is signed, the health carrier or such health carrier's intermediary shall disclose to a Provider all documents required by Conn. Gen. Stat § 38a-477g(c)(1).

# As required by Conn. Gen. Stat § 38a-477g(j), in the event of the failure, for any reason, of a preferred provider network, the MCO shall provide coverage for the enrollee to continue covered treatment with the Provider who treated the enrollee under the preferred provider network Agreement regardless of whether the Provider participates in any plan operated by the MCO. In the event of such failure, the MCO shall continue coverage until the earlier of (1) the date the enrollee's treatment is completed under a treatment plan that was authorized and in effect on the date of the failure, or (2) the date the Agreement between the enrollee and the MCO terminates. The MCO shall compensate a Provider for such continued treatment at the rate due the Provider under the Agreement with the failed preferred provider network.

# As required by Conn. Gen. Stat. §38a-478h,38a-472f(g)(1)(A) and Conn. Agencies Regs. § 38a-472f-2, the health carrier and Provider shall provide at least 90 days' written notice to each other before the health carrier removes a Provider from the network or the Provider leaves the network. Each Provider that receives a notice of removal or issues a departure notice shall provide to the health carrier, not later than 30 days after receipt of the notice of termination, a list of such Provider's patients who are covered persons under a network plan of such health carrier.

# As required by Conn. Gen. Stat. § 38a-479aa(l), if the Preferred Provider Network fails to pay for health care services as set forth in the Agreement, the enrollee shall not be liable to the Provider for any sums owed by the Preferred Provider Network or any sums owed by the MCO because of nonpayment by the MCO, insolvency of the MCO or breach of contract between the MCO and the Preferred Provider Network.

# As required by Conn. Gen. Stat. § 38a-479bb(d)(1), the Preferred Provider Network shall provide to the MCO at the time the Agreement is entered into, annually, and upon request of the MCO, (A) the financial statement completed in accordance with sections 38a-53 and 38a-54, as applicable, and section 38a-479aa; (B) documentation that satisfies the MCO that the Preferred Provider Network has sufficient ability to accept financial risk; (C) documentation that satisfies the MCO that the Preferred Provider Network has appropriate management expertise and infrastructure; (D) documentation that satisfies the MCO that the Preferred Provider Network has an adequate provider network taking into account the geographic distribution of enrollees and Providers and whether Providers are accepting new patients; (E) an accurate list of Providers; and (F) documentation that satisfies the MCO that the Preferred Provider Network has the ability to ensure the delivery of health care services as set forth in the Agreement.

# As required by Conn. Gen. Stat. § 38a-479bb(d)(2), the Preferred Provider Network shall provide to the MCO a quarterly status report that includes (A) information updating the financial statement completed in accordance with sections 38a-53 and 38a-54, as applicable, and section 38a-479aa; (B) a report showing amounts paid to those Providers who provide health care services on behalf of the MCO; (C) an estimate of payments due Providers but not yet reported by Providers; (D) amounts owed to Providers for that quarter; and (E) the number of utilization review determinations not to certify an admission, service, procedure or extension of stay made by or on behalf of the Preferred Provider Network and the outcome of such determination on appeal.

# As required by Conn. Gen. Stat. § 38a-479bb(d)(3), the Preferred Provider Network shall provide notice to the MCO not later than 5 business days after (A) any change involving the ownership structure of the Preferred Provider Network; (B) financial or operational concerns arise regarding the financial viability of the Preferred Provider Network; or (C) the Preferred Provider Network's loss of a license in this or any other state.

# As required by Conn. Gen. Stat. § 38a-479bb(d)(4), if the MCO fails to pay for health care services as set forth in the Agreement, the enrollee will not be liable to the Provider or Preferred Provider Network for any sums owed by the MCO or Preferred Provider Network.

# As required by Conn. Gen. Stat. § 38a-479bb(d)(5), the Preferred Provider Network shall include in all agreements between the Preferred Provider Network and Providers a provision that if the Preferred Provider Network fails to pay for health care services as set forth in the Agreement, for any reason, the enrollee shall not be liable to the Provider or Preferred Provider Network for any sums owed by the Preferred Provider Network or any sums owed by the MCO because of nonpayment by the MCO, insolvency of the MCO or breach of contract between the MCO and the Preferred Provider Network.

# As required by Conn. Gen. Stat. § 38a-479bb(d)(6), the Preferred Provider Network is required to provide information to the MCO, satisfactory to the MCO, regarding the Preferred Provider Network's reserves for financial risk.

# As required by Conn. Gen. Stat. § 38a-479bb(d)(7), the Preferred Provider Network or MCO shall post and maintain a letter of credit, bond, surety, reinsurance, reserve or other financial security acceptable to the commissioner, in order to satisfy the risk accepted by the Preferred Provider Network pursuant to the contract, in an amount calculated in accordance with subsection (i) of section 38a-479aa. The MCO shall determine who posts and maintains the security required. In the event of insolvency or nonpayment, such security shall be used by the Preferred Provider Network, or other entity designated by the Commissioner, solely for the purpose of paying any outstanding amounts owed Providers, except that any remaining security may be used for the purpose of reimbursing the MCO for any payments made by the MCO to Providers on behalf of the Preferred Provider Network.

# As required by Conn. Gen. Stat. § 38a-479bb(d)(8), at the discretion of the MCO and to the extent the MCO is permitted, MCO will pay Providers directly and in lieu of the Preferred Provider Network in the event of insolvency or mismanagement by the Preferred Provider Network and that payments made pursuant to this subdivision may be made or reimbursed from the security posted pursuant to Conn. Gen. Stat. Ann. § 38a-479bb(b).

# As required by Conn. Gen. Stat. § 38a-479bb(d)(9), agreements between the Preferred Provider Network and Providers shall be transferred and assigned to the MCO for the provision of future services by Providers to enrollees, at the discretion of the MCO, in the event the Preferred Provider Network (A) becomes insolvent, (B) otherwise ceases to conduct business, as determined by the commissioner, or (C) demonstrates a pattern of nonpayment of authorized claims, as determined by the commissioner, for a period in excess of 90 days.

# As required by Conn. Gen. Stat. § 38a-479bb(d)(10), each contract between a Preferred Provider Network and Provider shall include a provision transferring and assigning such contracts to the MCO for the provision of future health care services by Providers to enrollees, at the discretion of the MCO, in the event the Preferred Provider Network (A) becomes insolvent, (B) otherwise ceases to conduct business, as determined by the commissioner, or (C) demonstrates a pattern of nonpayment of authorized claims, as determined by the commissioner, for a period in excess of ninety days.

# As required by Conn. Gen. Stat. § 38a-479bb(d)(11), the Preferred Provider Network shall pay for the delivery of health care services and operate or maintain arrangements or contracts with Providers in a manner consistent with the provisions of law that apply to the MCO's contracts with enrollees and providers.

# As required by Conn. Gen. Stat. § 38a-479bb(d)(12), the Preferred Provider Network shall ensure that utilization review determinations are made in accordance with section 38a-591d.

# As required by Conn. Gen. Stat. § 38a-479bb(e), each MCO that contracts with a Preferred Provider Network shall have adequate procedures in place to notify the Commissioner that a Preferred Provider Network has experienced an event that may threaten the Preferred Provider Network’s ability to materially perform under its Agreement with the MCO. The MCO shall provide such notice to the Commissioner not later than 5 days after it discovers that the Preferred Provider Network has experienced such an event.

# As required by Conn. Gen. Stat. § 38a-479bb(f), each MCO that contracts with a Preferred Provider Network shall monitor and maintain systems and controls for monitoring the financial health of the Preferred Provider Networks with which it contracts.

# **Health Maintenance Organization (HMO) /Managed Care Organization (MCO) Specific Laws**

## As of the date of this Addendum, there are no applicable laws of this type.