Massachusetts 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impacting this Addendum, any required revisions shall be automatically incorporated herein and any provisions which are no longer applicable shall be considered severed from this Addendum effective as of the date of the change in law.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**

* 1. Any information which is required to be included in the Agreement under Mass. Gen. Laws ch. 176I, § 2 and which is not already included in the body of the Agreement but has been provided to the Provider by the Organization separately shall be considered incorporated into the Agreement.
	2. Any information which is required to be included in the Agreement under 940 Mass. Code Regs. 26.06 and which is not already included in the body of the Agreement but has been provided to the Provider by the Plan separately shall be considered incorporated into the Agreement.

# **General Insurance Laws**

## As required by Mass. Gen. Laws ch. 176O, § 15, any provision of the Agreement which allows the plan to terminate the Agreement without cause is removed in relation to this Addendum.  In addition, carrier will provide a written statement to the Provider of the reason or reasons for such Provider's involuntary disenrollment.

## As required by Mass. Gen. Laws Ann. ch. 176O, § 22, carrier requires, as a condition of participation in the carrier's provider network that the Provider also apply to participate in the medical assistance program.

## As required by 211 Mass. Code Regs. 52.11(1), carrier will not refuse to contract with or compensate for covered services an otherwise eligible Provider solely because the Provider has in good faith (a) communicated with or advocated on behalf of one or more prospective, current or former patients regarding the provisions, terms or requirements of the plans as they relate to the needs of such Provider's patients; or (b) communicated with one or more 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.

## As required by 211 Mass. Code Regs. 52.11(2), 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.

## As required by 211 Mass. Code Regs. 52.11(6), any provision of the Agreement which allows the plan or Provider to terminate the Agreement without cause is removed in relation to this Addendum.

## As required by 211 Mass. Code Regs. 52.11(7), carrier shall provide a written statement to a Provider of the reason or reasons for such Provider's involuntary disenrollment.

## As required by 211 Mass. Code Regs. 52.11(8), 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 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.

## As required by 211 Mass. Code Regs. 52.11(9), Provider shall not bill patients for charges for covered services other than for deductibles, copayments, or coinsurance.

## As required by 211 Mass. Code Regs. 52.11(10), Provider shall not bill patients for nonpayment by the carrier of amounts owed under the Agreement due to the insolvency of the carrier. This requirement shall survive the termination of the Agreement for services rendered prior to the termination of the Agreement, regardless of the cause of the termination.

## As required by 211 Mass. Code Regs. 52.11(11), Provider shall comply with the carrier's requirements for utilization review, quality management and improvement, credentialing and the delivery of preventive health services.

## As required by 211 Mass. Code Regs. 52.11(15), nurse practitioners and physician assistants acting within the scope of their professional license are recognized as Providers under applicable terms of this Agreement.

## As required by 211 Mass. Code Regs. 152.05, prior to implementing a plan with a limited, regional or tiered provider network, a carrier shall have signed agreements with those Providers that will be in that provider network which are in compliance with the requirements of 211 Mass. Code Regs. 52.12. Any information which is required to be included in the Agreement under 211 Mass. Code Regs. 152.05 and which is not already included in the body of the Agreement but has been provided to the Provider by the carrier separately shall be considered incorporated into the Agreement. The Provider has the right to opt out of any new plan that uses a limited provider network or a tiered provider network at least 60 days before the health benefit plan is submitted to the Commissioner for approval.

## As required by 211 Mass. Code Regs. 152.05, as applicable to agreements for tiered provider networks, carrier will notify the provider, in writing, at least 60 days before the effective date of the following modifications. The Provider and the carrier may agree, in writing, on an alternative date for notice of such modifications in the Agreement.

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

## As required by Mass. Gen. Laws ch. 176G, § 6, within 45 days after the receipt by the organization of completed forms for reimbursement to the Provider of health care services, the HMO shall (i) make payments for such services provided, (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 said forms for such reimbursement. If the HMO fails to comply with this paragraph for any claims related to the provision of health care services, the HMO shall pay, in addition to any reimbursement for health care services provided, interest on such benefits, which shall accrue beginning 45 days after the HMO'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 of this paragraph relating to interest payments shall not apply to a claim that the HMO is investigating because of suspected fraud.

## As required by Mass. Gen. Laws ch. 176G, § 21 (b)-(d), the Provider agrees that in no event, including but not limited to nonpayment by the HMO of amounts due the Provider under this contract, insolvency of the HMO or any breach of this Agreement by the HMO, shall the Provider or its assignees or subcontractors have a right to seek any type of payment from, bill, charge, collect a deposit from, or have any recourse against, the member, persons acting on the member's behalf, other than the HMO, the employer or the group health maintenance contract holder for services provided pursuant to this contract except for the payment of applicable co-payment, co-insurance or deductibles for services covered by the HMO. The requirements of this provision shall survive any termination of this Agreement for services rendered prior to the termination, regardless of the cause of such termination. The HMO's members, any persons acting on the member's behalf, other than the HMO, and the employer or group health maintenance contract-holder shall be third-party beneficiaries of this clause. This provision supersedes any oral or written agreement hereafter entered into between the provider and the member, persons acting on the member's behalf, other than the HMO, and the employer or group health maintenance contract holder.