HOUSE BILL 1318

C3 6lr2562
CF SB 929

By: **Delegates Kelly, Angel, Cullison, Hill, Pena–Melnyk, Sample–Hughes, and West**

Introduced and read first time: February 12, 2016
Assigned to: Health and Government Operations

A BILL ENTITLED

AN ACT concerning

Health Benefit Plans – Network Access Standards and Provider Network Directories

FOR the purpose of requiring certain carriers to maintain or adhere to certain standards that ensure that certain enrollees have certain access to certain health care providers and covered services; requiring certain carriers to file with the Maryland Insurance Commissioner, on or before a certain date and then annually, a certain plan for a certain review and approval; requiring certain carriers to notify the Commissioner of a certain change within a certain time period under certain circumstances; requiring a certain notice to include certain information; authorizing certain carriers to request that the Commissioner deem certain information as confidential information; requiring certain carriers to make a certain plan available to the public in a certain manner; requiring a certain plan to include certain information; requiring certain carriers to monitor a certain clinical capacity of certain providers in a certain manner; requiring the Commissioner, in consultation with certain persons, to adopt certain regulations on or before a certain date; establishing that certain carriers meet certain requirements by developing and making available to certain individuals a certain network directory; requiring certain carriers to develop and make available to certain individuals a certain network directory on the Internet and in printed form under certain circumstances; requiring a certain network directory to meet certain requirements and include certain information; requiring certain carriers to update a certain network directory within a certain time period under certain circumstances; requiring certain carriers, at certain occurrences, to notify enrollees how to access or obtain certain information; requiring certain information to be updated at certain intervals; requiring certain carriers to contact certain providers to make a certain determination under certain circumstances; requiring certain carriers to treat certain services in a certain manner for a certain purpose under certain circumstances; altering a certain requirement on certain carriers to update certain information; requiring certain procedures established by certain carriers to ensure that certain requests are addressed in a certain manner;

EXPLANATION: **CAPITALS INDICATE MATTER ADDED TO EXISTING LAW.**
[Brackets**]** indicate matter deleted from existing law.

prohibiting a certain procedure established by certain carriers from being used for a certain purpose; requiring certain carriers to have a certain system in place for a certain purpose and to provide certain information to the Commissioner under certain circumstances; requiring certain carriers to file with the Commissioner a copy of certain procedures that includes certain information; requiring certain carriers to make a copy of certain procedures available to certain individuals in a certain manner and under certain circumstances; defining certain terms; making conforming changes; providing for the application of this Act; and generally relating to health benefit plans, network access standards, and provider network directories.

BY repealing and reenacting, with amendments,
Article – Insurance
Section 15–112 and 15–830
Annotated Code of Maryland
(2011 Replacement Volume and 2015 Supplement)

SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND, That the Laws of Maryland read as follows:

Article – Insurance

15–112.

(a) (1) In this section the following words have the meanings indicated.

(2) "Accredited hospital" has the meaning stated in § 19–301 of the Health – General Article.

(3) "Ambulatory surgical facility" has the meaning stated in § 19–3B–01 of the Health – General Article.

(4) (i) "Carrier" means:

1. an insurer;

2. a nonprofit health service plan;

3. a health maintenance organization;

4. a dental plan organization; or

5. any other person that provides health benefit plans subject to regulation by the State.

(ii) "Carrier" includes an entity that arranges a provider panel for a carrier.

(5) "Credentialing intermediary" means a person to whom a carrier has delegated credentialing or recredentialing authority and responsibility.

(6) "Enrollee" means a person entitled to health care benefits from a carrier.

(7) "HEALTH BENEFIT PLAN":

(I) FOR A GROUP OR BLANKET PLAN IN THE LARGE GROUP MARKET, HAS THE MEANING STATED IN § 15–1401 OF THIS TITLE;

(II) FOR A GROUP IN THE SMALL GROUP MARKET, HAS THE MEANING STATED IN § 31–101 OF THIS ARTICLE; AND

(III) FOR AN INDIVIDUAL PLAN, HAS THE MEANING STATED IN § 15–1301 OF THIS TITLE.

(8) "HEALTH CARE FACILITY" MEANS A FIXED OR MOBILE FACILITY AT WHICH DIAGNOSTIC OR TREATMENT SERVICES OR INPATIENT OR AMBULATORY CARE ARE OFFERED TO TWO OR MORE UNRELATED INDIVIDUALS.

[(7)**] (9)** "Hospital" has the meaning stated in § 19–301 of the Health – General Article.

[(8)**] (10)** "Participating provider" means a provider on a carrier's provider panel.

[(9)**] (11)** "Online credentialing system" means the system through which a provider may access an online provider credentialing application that the Commissioner has designated as the uniform credentialing form under § 15–112.1(e) of this subtitle.

[(10)**] (12)** "Provider" means a health care practitioner or group of health care practitioners licensed, certified, or otherwise authorized by law to provide health care services.

[(11)**] (13)** (i) "Provider panel" means the providers that contract either directly or through a subcontracting entity with a carrier to provide health care services to the carrier's enrollees under the carrier's health benefit plan.

(ii) "Provider panel" does not include an arrangement in which any provider may participate solely by contracting with the carrier to provide health care services at a discounted fee–for–service rate.

(b) (1) **[**A**] SUBJECT TO PARAGRAPH (3) OF THIS SUBSECTION, A** carrier that uses a provider panel shall:

(i) 1. if the carrier is an insurer, nonprofit health service plan, or dental plan organization, maintain standards in accordance with regulations adopted by the Commissioner for availability of health care providers to meet the health care needs of enrollees;

2. if the carrier is a health maintenance organization, adhere to the standards for accessibility of covered services in accordance with regulations adopted under § 19–705.1(b)(1)(i)2 of the Health – General Article; and

3. if the carrier is an insurer or nonprofit health service plan that offers a preferred provider insurance policy that conditions the payment of benefits on the use of preferred providers, adhere to the standards for accessibility of covered services in accordance with regulations adopted under § 19–705.1(b)(1)(i)2 of the Health – General Article and as enforced by the Secretary of Health and Mental Hygiene; and

(ii) establish procedures to:

1. review applications for participation on the carrier's provider panel in accordance with this section;

2. notify an enrollee of:

A. the termination from the carrier's provider panel of the primary care provider that was furnishing health care services to the enrollee; and

B. the right of the enrollee, on request, to continue to receive health care services from the enrollee's primary care provider for up to 90 days after the date of the notice of termination of the enrollee's primary care provider from the carrier's provider panel, if the termination was for reasons unrelated to fraud, patient abuse, incompetency, or loss of licensure status;

3. notify primary care providers on the carrier's provider panel of the termination of a specialty referral services provider;

4. verify with each provider on the carrier's provider panel, at the time of credentialing and recredentialing, whether the provider is accepting new patients and update the information on participating providers that the carrier is required to provide under subsection **[**(j)**]** **(M)** of this section; and

5. notify a provider at least 90 days before the date of the termination of the provider from the carrier's provider panel, if the termination is for reasons unrelated to fraud, patient abuse, incompetency, or loss of licensure status.

(2) The provisions of paragraph (1)(ii)4 of this subsection may not be construed to require a carrier to allow a provider to refuse to accept new patients covered by the carrier.

(3) FOR A CARRIER THAT IS AN INSURER, A NONPROFIT HEALTH SERVICE PLAN, OR A HEALTH MAINTENANCE ORGANIZATION, THE STANDARDS REQUIRED UNDER PARAGRAPH (1)(I) OF THIS SUBSECTION SHALL:

(I) ENSURE THAT ALL ENROLLEES, INCLUDING ADULTS AND CHILDREN, HAVE ACCESS TO PROVIDERS AND COVERED SERVICES WITHOUT UNREASONABLE TRAVEL OR DELAY; AND

(II) INCLUDE STANDARDS THAT ENSURE ACCESS TO PROVIDERS THAT SERVE PREDOMINANTLY LOW–INCOME AND MEDICALLY UNDERSERVED INDIVIDUALS.

(C) (1) THIS SUBSECTION APPLIES TO A CARRIER THAT:

(I) IS AN INSURER, A NONPROFIT HEALTH SERVICE PLAN, OR A HEALTH MAINTENANCE ORGANIZATION; AND

(II) USES A PROVIDER PANEL FOR A HEALTH BENEFIT PLAN OFFERED BY THE CARRIER.

(2) (I) ON OR BEFORE JULY 1, 2018, AND ANNUALLY THEREAFTER, A CARRIER SHALL FILE WITH THE COMMISSIONER FOR REVIEW AND APPROVAL BY THE COMMISSIONER AN ACCESS PLAN THAT MEETS THE REQUIREMENTS OF SUBSECTION (B) OF THIS SECTION AND ANY REGULATIONS ADOPTED BY THE COMMISSIONER UNDER SUBSECTIONS (B) AND (D) OF THIS SECTION.

(II) IF THE CARRIER MAKES A MATERIAL CHANGE TO THE PROVIDER NETWORK, THE CARRIER SHALL:

1. NOTIFY THE COMMISSIONER OF THE CHANGE WITHIN 15 BUSINESS DAYS AFTER THE CHANGE OCCURS; AND

2. INCLUDE IN THE NOTICE REQUIRED UNDER ITEM 1 OF THIS SUBPARAGRAPH A REASONABLE TIMEFRAME WITHIN WHICH THE CARRIER WILL FILE WITH THE COMMISSIONER AN UPDATE TO THE EXISTING ACCESS PLAN FOR REVIEW AND APPROVAL BY THE COMMISSIONER.

(3) (I) A CARRIER MAY REQUEST THAT THE COMMISSIONER DEEM INFORMATION IN THE ACCESS PLAN FILED UNDER THIS SUBSECTION AS CONFIDENTIAL INFORMATION UNDER § 4–335 OF THE GENERAL PROVISIONS ARTICLE.

(II) A CARRIER SHALL MAKE THE ACCESS PLAN FILED UNDER THIS SUBSECTION AVAILABLE TO THE PUBLIC ON THE CARRIER'S WEB SITE AFTER REDACTION OF ANY INFORMATION DEEMED CONFIDENTIAL INFORMATION BY THE COMMISSIONER.

(4) AN ACCESS PLAN FILED UNDER THIS SUBSECTION SHALL INCLUDE A DESCRIPTION OF:

(I) THE CARRIER'S NETWORK, INCLUDING HOW TELEMEDICINE, TELEHEALTH, OR OTHER TECHNOLOGY MAY BE USED TO MEET NETWORK ACCESS STANDARDS REQUIRED UNDER SUBSECTION (B) OF THIS SECTION;

(II) THE CARRIER'S PROCESS FOR MONITORING AND ENSURING, ON AN ONGOING BASIS, THE SUFFICIENCY OF THE NETWORK TO MEET THE HEALTH CARE NEEDS OF ENROLLEES;

(III) THE FACTORS USED BY THE CARRIER TO BUILD ITS PROVIDER NETWORK, INCLUDING:

1. IN PLAIN LANGUAGE, THE CRITERIA USED TO SELECT PROVIDERS FOR PARTICIPATION IN THE NETWORK AND PLACE PROVIDERS IN NETWORK TIERS; AND

2. DEMONSTRATION BY THE CARRIER THAT THE CRITERIA COMPLY WITH THE MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT;

(IV) THE CARRIER'S EFFORTS TO ADDRESS THE NEEDS OF BOTH ADULT AND CHILD ENROLLEES, INCLUDING ADULTS AND CHILDREN WITH:

1. LIMITED ENGLISH PROFICIENCY OR ILLITERACY;

2. DIVERSE CULTURAL OR ETHNIC BACKGROUNDS;

3. PHYSICAL OR MENTAL DISABILITIES; AND

4. SERIOUS, CHRONIC, OR COMPLEX HEALTH CONDITIONS;

(V) THE CARRIER'S EFFORTS TO INCLUDE PROVIDERS IN ITS NETWORK WHO SERVE PREDOMINATELY LOW–INCOME, MEDICALLY UNDERSERVED INDIVIDUALS; AND

(VI) THE CARRIER'S METHODS FOR ASSESSING THE HEALTH CARE NEEDS OF ENROLLEES AND ENROLLEE SATISFACTION WITH HEALTH CARE SERVICES PROVIDED TO THEM.

(5) EACH CARRIER SHALL MONITOR, ON AN ONGOING BASIS AND AT LEAST QUARTERLY, THE CLINICAL CAPACITY OF ITS PARTICIPATING PROVIDERS TO PROVIDE COVERED SERVICES TO ITS ENROLLEES.

(D) ON OR BEFORE DECEMBER 31, 2017, THE COMMISSIONER SHALL, IN CONSULTATION WITH INTERESTED STAKEHOLDERS, ADOPT REGULATIONS TO ESTABLISH QUANTITATIVE AND, IF APPROPRIATE, NONQUANTITATIVE CRITERIA TO EVALUATE THE NETWORK SUFFICIENCY OF HEALTH BENEFIT PLANS SUBJECT TO THE REQUIREMENTS OF SUBSECTION (C) OF THIS SECTION, INCLUDING CRITERIA RELATING TO:

(1) GEOGRAPHIC ACCESSIBILITY OF PRIMARY CARE AND SPECIALTY PROVIDERS, INCLUDING MENTAL HEALTH AND SUBSTANCE USE DISORDER PROVIDERS;

(2) WAITING TIMES FOR AN APPOINTMENT WITH PARTICIPATING PRIMARY CARE AND SPECIALTY PROVIDERS, INCLUDING MENTAL HEALTH AND SUBSTANCE USE DISORDER PROVIDERS;

(3) PRIMARY CARE PROVIDER–TO–ENROLLEE RATIOS;

(4) PROVIDER–TO–ENROLLEE RATIOS, BY SPECIALTY;

(5) GEOGRAPHIC VARIATION AND POPULATION DISPERSION;

(6) HOURS OF OPERATION;

(7) THE ABILITY OF THE NETWORK TO MEET THE NEEDS OF ENROLLEES, WHICH MAY INCLUDE:

(I) LOW–INCOME INDIVIDUALS;

(II) ADULTS AND CHILDREN WITH:

1. SERIOUS, CHRONIC, OR COMPLEX HEALTH CONDITIONS; OR

2. PHYSICAL OR MENTAL DISABILITIES; AND

(III) INDIVIDUALS WITH LIMITED ENGLISH PROFICIENCY OR ILLITERACY;

(8) OTHER HEALTH CARE SERVICE DELIVERY SYSTEM OPTIONS, INCLUDING TELEMEDICINE, TELEHEALTH, MOBILE CLINICS, AND CENTERS OF EXCELLENCE; AND

(9) THE VOLUME OF TECHNOLOGICAL AND SPECIALTY CARE SERVICES AVAILABLE TO SERVE THE NEEDS OF ENROLLEES REQUIRING TECHNOLOGICALLY ADVANCED OR SPECIALTY CARE SERVICES.

[(c)**] (E)** A carrier that uses a provider panel:

(1) on request, shall provide an application and information that relates to consideration for participation on the carrier's provider panel to any provider seeking to apply for participation;

(2) shall make publicly available its application; and

(3) shall make efforts to increase the opportunity for a broad range of minority providers to participate on the carrier's provider panel.

[(d)**] (F)** (1) A provider that seeks to participate on a provider panel of a carrier shall submit an application to the carrier.

(2) (i) Subject to paragraph (3) of this subsection, the carrier, after reviewing the application, shall accept or reject the provider for participation on the carrier's provider panel.

(ii) If the carrier rejects the provider for participation on the carrier's provider panel, the carrier shall send to the provider at the address listed in the application written notice of the rejection.

(3) (i) Subject to paragraph (4) of this subsection, within 30 days after the date a carrier receives a completed application, the carrier shall send to the provider at the address listed in the application written notice of:

1. the carrier's intent to continue to process the provider's application to obtain necessary credentialing information; or

2. the carrier's rejection of the provider for participation on the carrier's provider panel.

(ii) The failure of a carrier to provide the notice required under subparagraph (i) of this paragraph is a violation of this article and the carrier is subject to the penalties provided by § 4–113(d) of this article.

(iii) Except as provided in subsection **[**(o)**]** **(U)** of this section, if, under subparagraph (i)1 of this paragraph, a carrier provides notice to the provider of its intent to continue to process the provider's application to obtain necessary credentialing information, the carrier, within 120 days after the date the notice is provided, shall:

1. accept or reject the provider for participation on the carrier's provider panel; and

2. send written notice of the acceptance or rejection to the provider at the address listed in the application.

(iv) The failure of a carrier to provide the notice required under subparagraph (iii)2 of this paragraph is a violation of this article and the carrier is subject to the provisions of and penalties provided by §§ 4–113 and 4–114 of this article.

(4) (i) 1. Except as provided in subsubparagraph 4 of this subparagraph, a carrier that receives a complete application shall notify the provider that the application is complete.

2. If a carrier does not accept applications through the online credentialing system, notice shall be given to the provider at the address listed in the application within 10 days after the date the application is received.

3. If a carrier accepts applications through the online credentialing system, the notice from the online credentialing system to the provider that the carrier has received the provider's application shall be considered notice that the application is complete.

4. This subparagraph does not apply to a carrier that arranges a dental provider panel until the Commissioner certifies that the online credentialing system is capable of accepting the uniform credentialing form designated by the Commissioner for dental provider panels.

(ii) 1. A carrier that receives an incomplete application shall return the application to the provider at the address listed in the application within 10 days after the date the application is received.

2. The carrier shall indicate to the provider what information is needed to make the application complete.

3. The provider may return the completed application to the carrier.

4. After the carrier receives the completed application, the carrier is subject to the time periods established in paragraph (3) of this subsection.

(5) A carrier may charge a reasonable fee for an application submitted to the carrier under this section.

[(e)**] (G)** A carrier may not deny an application for participation or terminate participation on its provider panel on the basis of:

(1) gender, race, age, religion, national origin, or a protected category under the federal Americans with Disabilities Act;

(2) the type or number of appeals that the provider files under Subtitle 10B of this title;

(3) the number of grievances or complaints that the provider files on behalf of a patient under Subtitle 10A of this title; or

(4) the type or number of complaints or grievances that the provider files or requests for review under the carrier's internal review system established under subsection **[**(h)**] (K)** of this section.

[(f)**] (H)** (1) A carrier may not deny an application for participation or terminate participation on its provider panel solely on the basis of the license, certification, or other authorization of the provider to provide health care services if the carrier provides health care services within the provider's lawful scope of practice.

(2) Notwithstanding paragraph (1) of this subsection, a carrier may reject an application for participation or terminate participation on its provider panel based on the participation on the provider panel of a sufficient number of similarly qualified providers.

(3) A violation of this subsection does not create a new cause of action.

[(f–1)**] (I)** (1) Subject to the provisions of this subsection, a carrier may not require a provider participating on its provider panel to be recredentialed based on:

(i) a change in the federal tax identification number of the provider;

(ii) a change in the federal tax identification number of a provider's employer; or

(iii) a change in the employer of a provider, if the new employer is:

1. a participating provider on the carrier's provider panel; or

2. the employer of providers that participate on the carrier's provider panel.

(2) A provider that participates on a carrier's provider panel or the provider's employer shall give written notice to the carrier of a change in the federal tax identification number of the provider or the provider's employer not less than 45 days before the effective date of the change.

(3) The notice required under paragraph (2) of this subsection shall include:

(i) a statement of the intention of the provider or the provider's employer to continue to provide health care services in the same field of specialization, if applicable;

(ii) the effective date of the change in the federal tax identification number of the provider or the provider's employer;

(iii) the new federal tax identification number of the provider or the provider's employer and a copy of U.S. Treasury Form W–9, or any successor or replacement form; and

(iv) the following information about a new employer of the provider:

1. the employer's name;

2. the name of the employer's contact person for carrier questions about the provider; and

3. the address, telephone number, facsimile transmission number, and electronic mail address of the contact person for the employer.

(4) If the new federal tax identification number or the form required to be included in the notice under paragraph (3)(iii) of this subsection is not available at the time the notice is given to a carrier, it shall be provided to the carrier promptly after it is received by the provider or the provider's employer.

(5) Within 30 business days after receipt of the notice required under paragraph (2) of this subsection, a carrier:

(i) shall acknowledge receipt of the notice to the provider or the provider's employer; and

(ii) if the carrier considers it necessary to issue a new provider number as a result of a change in the federal tax identification number of a provider or a provider's employer or a change in the employer of a provider, shall issue a new provider number, by mail, electronic mail, or facsimile transmission, to:

1. the provider or the provider's employer; or

2. the representative of the provider or the provider's employer designated in writing to the carrier.

(6) A carrier may not terminate its existing contract with a provider or a provider's employer based solely on a notice given to the carrier in accordance with this subsection.

[(g)**] (J)** A carrier may not terminate participation on its provider panel or otherwise penalize a provider for:

(1) advocating the interests of a patient through the carrier's internal review system established under subsection **[**(h)**] (K)** of this section;

(2) filing an appeal under Subtitle 10B of this title; or

(3) filing a grievance or complaint on behalf of a patient under Subtitle 10A of this title.

[(h)**] (K)** Each carrier shall establish an internal review system to resolve grievances initiated by providers that participate on the carrier's provider panel, including grievances involving the termination of a provider from participation on the carrier's provider panel.

[(i)**] (L)** (1) For at least 90 days after the date of the notice of termination of a primary care provider from a carrier's provider panel for reasons unrelated to fraud, patient abuse, incompetency, or loss of licensure status, the primary care provider shall furnish health care services to each enrollee:

(i) who was receiving health care services from the primary care provider before the notice of termination; and

(ii) who, after receiving notice under subsection (b) of this section of the termination of the primary care provider, requests to continue receiving health care services from the primary care provider.

(2) A carrier shall reimburse a primary care provider that furnishes health care services under this subsection in accordance with the primary care provider's agreement with the carrier.

[(j)**] (M)** (1) **[**A**] SUBJECT TO PARAGRAPH (2) OF THIS SUBSECTION, A** carrier shall make available to prospective enrollees on the Internet and, on request of a prospective enrollee, in printed form:

(i) a list of providers on the carrier's provider panel; and

(ii) information on providers that are no longer accepting new patients.

(2) A CARRIER THAT DEVELOPS AND MAKES AVAILABLE TO ENROLLEES AND PROSPECTIVE ENROLLEES A NETWORK DIRECTORY IN ACCORDANCE WITH SUBSECTION (N) THIS SECTION MEETS THE REQUIREMENTS OF PARAGRAPH (1) OF THIS SUBSECTION.

(N) (1) THIS SUBSECTION APPLIES TO A CARRIER THAT:

(I) IS AN INSURER, A NONPROFIT HEALTH SERVICE PLAN, OR A HEALTH MAINTENANCE ORGANIZATION; AND

(II) USES A PROVIDER PANEL FOR A HEALTH BENEFIT PLAN OFFERED BY THE CARRIER.

(2) A CARRIER SHALL DEVELOP AND MAKE AVAILABLE TO ENROLLEES AND PROSPECTIVE ENROLLEES ON THE INTERNET AND, ON REQUEST OF AN ENROLLEE OR A PROSPECTIVE ENROLLEE, IN PRINTED FORM, AN UP–TO–DATE AND ACCURATE PROVIDER NETWORK DIRECTORY FOR A HEALTH BENEFIT PLAN OFFERED BY THE CARRIER TO ENROLLEES AND PROSPECTIVE ENROLLEES.

(3) THE NETWORK DIRECTORY MADE AVAILABLE TO ENROLLEES AND PROSPECTIVE ENROLLEES ON THE INTERNET UNDER PARAGRAPH (2) OF THIS SUBSECTION:

(I) SHALL BE ACCESSIBLE THROUGH A CLEARLY IDENTIFIABLE LINK OR TAB ON THE CARRIER'S WEB SITE;

(II) MAY NOT REQUIRE AN ENROLLEE OR A PROSPECTIVE ENROLLEE TO CREATE OR ACCESS AN ACCOUNT ON THE CARRIER'S WEB SITE; AND

(III) SHALL INCLUDE, IN A SEARCHABLE FORMAT, THE INFORMATION REQUIRED UNDER PARAGRAPH (4) OF THIS SUBSECTION.

(4) THE NETWORK DIRECTORY REQUIRED UNDER PARAGRAPH (2) OF THIS SUBSECTION SHALL:

(I) FOR EACH PARTICIPATING HEALTH CARE PRACTITIONER, INCLUDE:

1. THE HEALTH CARE PRACTITIONER'S NAME AND GENDER;

2. FOR EACH OFFICE OR HEALTH CARE FACILITY AT WHICH THE HEALTH PRACTITIONER PROVIDES SERVICES TO PATIENTS:

A. THE LOCATION OF THE OFFICE OR HEALTH CARE FACILITY, INCLUDING THE ADDRESS OF THE OFFICE OR HEALTH CARE FACILITY;

B. CONTACT INFORMATION FOR THE HEALTH CARE PRACTITIONER; AND

C. WHETHER THE HEALTH CARE PRACTITIONER IS ON THE PROVIDER PANEL AT THE OFFICE OR HEALTH CARE FACILITY;

3. THE SPECIALTY AREA OR AREAS OF THE HEALTH CARE PRACTITIONER, IF APPLICABLE;

4. THE MEDICAL GROUP AFFILIATIONS OF THE HEALTH CARE PRACTITIONER, IF APPLICABLE;

5. THE LANGUAGES SPOKEN BY THE HEALTH CARE PRACTITIONER OTHER THAN ENGLISH, IF APPLICABLE; AND

6. WHETHER THE HEALTH CARE PRACTITIONER IS ACCEPTING NEW PATIENTS;

(II) FOR EACH PARTICIPATING HOSPITAL, INCLUDE:

1. THE HOSPITAL NAME AND TYPE;

2. THE LOCATION OF THE HOSPITAL, INCLUDING THE ADDRESS OF THE HOSPITAL;

3. CONTACT INFORMATION FOR THE HOSPITAL, INCLUDING A TELEPHONE NUMBER FOR THE HOSPITAL; AND

4. THE ACCREDITATION STATUS OF THE HOSPITAL; AND

(III) FOR HEALTH CARE FACILITIES AND PROGRAMS LICENSED UNDER TITLE 7.5 OF THE HEALTH – GENERAL ARTICLE AT WHICH HEALTH CARE SERVICES ARE PROVIDED, OTHER THAN HOSPITALS, INCLUDE:

1. THE NAME AND TYPE OF THE HEALTH CARE FACILITY OR PROGRAM;

2. THE TYPES OF HEALTH CARE SERVICES PROVIDED AT THE HEALTH CARE FACILITY OR PROGRAM;

3. THE LOCATION OF THE HEALTH CARE FACILITY OR PROGRAM, INCLUDING THE ADDRESS OF THE HEALTH CARE FACILITY OR PROGRAM; AND

4. CONTACT INFORMATION FOR THE HEALTH CARE FACILITY OR PROGRAM, INCLUDING A TELEPHONE NUMBER FOR THE HEALTH CARE FACILITY OR PROGRAM.

(5) THE NETWORK DIRECTORY REQUIRED UNDER PARAGRAPH (2) OF THIS SUBSECTION SHALL, IN PLAIN LANGUAGE:

(I) INCLUDE A DESCRIPTION OF:

1. THE CRITERIA USED BY THE CARRIER TO:

A. SELECT PROVIDERS FOR PARTICIPATION IN THE NETWORK; AND

B. PLACE PROVIDERS IN NETWORK TIERS, IF APPLICABLE; AND

2. HOW THE CARRIER DESIGNATES DIFFERENT PROVIDER TIERS OR LEVELS IN THE NETWORK, IF APPLICABLE;

(II) FOR EACH HEALTH CARE PRACTITIONER, HOSPITAL, HEALTH CARE FACILITY, AND LICENSED PROGRAM IN THE NETWORK, IDENTIFY THE PROVIDER TIER OR LEVEL IN THE NETWORK IN WHICH THE HEALTH CARE PRACTITIONER, HOSPITAL, HEALTH CARE FACILITY, OR LICENSED PROGRAM IS PLACED;

(III) INDICATE THAT AUTHORIZATION OR REFERRAL MAY BE REQUIRED TO ACCESS PROVIDERS IN THE NETWORK, IF APPLICABLE; AND

(IV) IF APPLICABLE, IDENTIFY THE HEALTH BENEFIT PLAN TO THE WHICH THE NETWORK DIRECTORY APPLIES.

(6) THE NETWORK DIRECTORY REQUIRED UNDER PARAGRAPH (2) OF THIS SUBSECTION SHALL:

(I) ACCOMMODATE THE COMMUNICATION NEEDS OF INDIVIDUALS WITH DISABILITIES;

(II) INCLUDE INFORMATION, OR A LINK TO INFORMATION, REGARDING AVAILABLE ASSISTANCE FOR INDIVIDUALS WITH LIMITED ENGLISH PROFICIENCY;

(III) INCLUDE A CUSTOMER SERVICE PHONE NUMBER AND, IN THE NETWORK DIRECTORY MADE AVAILABLE ON THE INTERNET, AN E–MAIL LINK THAT ENROLLEES, PROSPECTIVE ENROLLEES, AND MEMBERS OF THE PUBLIC MAY USE TO NOTIFY THE CARRIER OF INACCURATE INFORMATION IN THE NETWORK DIRECTORY; AND

(IV) INCLUDE A NOTICE STATING THAT AN ENROLLEE:

1. HAS A RIGHT TO AN ACCURATE NETWORK DIRECTORY; AND

2. MAY DIRECT A COMPLAINT TO THE COMMISSIONER IF THERE IS AN INACCURATE LISTING IN THE NETWORK DIRECTORY.

(7) IF NOTIFIED OF A POTENTIAL INACCURACY IN A NETWORK DIRECTORY, A CARRIER SHALL INVESTIGATE THE INACCURACY AND TAKE CORRECTIVE ACTION, IF NECESSARY, TO UPDATE THE NETWORK DIRECTORY WITHIN 15 WORKING DAYS AFTER RECEIVING NOTIFICATION OF THE POTENTIAL INACCURACY.

[(2)**] (O) (1)** A carrier shall notify each enrollee at the time of initial enrollment and renewal about how to **ACCESS OR** obtain the **[**following information on the Internet and in printed form:

(i) a list of providers on the carrier's provider panel; and

(ii) information on providers that are no longer accepting new patients**] INFORMATION REQUIRED UNDER SUBSECTIONS (M) AND (N) OF THIS SECTION**.

[(3)**] (2)** (i) Information provided in printed form under **[**paragraphs (1) and (2)**] SUBSECTIONS (M) AND (N)** of this **[**subsection**] SECTION** shall be updated at least once a year.

(ii) Subject to subsection **[**(m)**]** **(S)** of this section, information provided on the Internet under **[**paragraphs (1) and (2)**]** **SUBSECTIONS (M) AND (N)** of this **[**subsection**]** **SECTION** shall be updated at least once every 15 days.

(III) IF A PROVIDER LISTED IN A NETWORK DIRECTORY AS A PARTICIPATING PROVIDER HAS NOT SUBMITTED A CLAIM IN THE LAST 6 MONTHS, A CARRIER SHALL CONTACT THE PROVIDER TO DETERMINE IF THE PROVIDER INTENDS TO REMAIN IN THE NETWORK AND UPDATE THE NETWORK DIRECTORY ACCORDINGLY.

(3) IF AN ENROLLEE RELIES ON MATERIALLY INACCURATE INFORMATION IN A NETWORK DIRECTORY INDICATING THAT A PROVIDER IS IN–NETWORK AND THEN RECEIVES HEALTH CARE SERVICES FROM THAT PROVIDER, A CARRIER SHALL TREAT THE HEALTH CARE SERVICES AS IF THEY WERE RENDERED BY A PROVIDER ON THE CARRIER'S PROVIDER PANEL FOR THE PURPOSE OF CALCULATING ANY OUT–OF–POCKET MAXIMUM, DEDUCTIBLE, COPAYMENT AMOUNT, OR COINSURANCE AMOUNT PAYABLE BY THE ENROLLEE FOR THE HEALTH CARE SERVICES.

[(4)**]** **(P)** A policy, certificate, or other evidence of coverage shall:

[(i)**]** **(1)** indicate clearly the office in the Administration that is responsible for receiving and responding to complaints from enrollees about carriers; and

[(ii)**]** **(2)** include the telephone number of the office and the procedure for filing a complaint.

[(k)**]** **(Q)** The Commissioner:

(1) shall adopt regulations that relate to the procedures that carriers must use to process applications for participation on a provider panel; and

(2) in consultation with the Secretary of Health and Mental Hygiene, shall adopt strategies to assist carriers in maximizing the opportunity for a broad range of minority providers to participate in the delivery of health care services.

[(l)**]** **(R)** A carrier may not include in a contract with a provider, ambulatory surgical facility, or hospital a term or condition that:

(1) prohibits the provider, ambulatory surgical facility, or hospital from offering to provide services to the enrollees of another carrier at a lower rate of reimbursement;

(2) requires the provider, ambulatory surgical facility, or hospital to provide the carrier with the same reimbursement arrangement that the provider,

ambulatory surgical facility, or hospital has with another carrier if the reimbursement arrangement with the other carrier is for a lower rate of reimbursement; or

(3) requires the provider, ambulatory surgical facility, or hospital to certify to the carrier that the reimbursement rate being paid by the carrier to the provider, ambulatory surgical facility, or hospital is not higher than the reimbursement rate being received by the provider, ambulatory surgical facility, or hospital from another carrier.

[(m)**] (S)** **[**(1)**]** A carrier shall update **[**its provider information**]** **THE INFORMATION THAT MUST BE MADE AVAILABLE ON THE INTERNET** under **[**subsection (j)(3)(ii)**] SUBSECTIONS (M) AND (N)** of this section within 15 working days after receipt of **[**written**]** notification from the participating provider of a change in the applicable information.

[(2) Notification is presumed to have been received by a carrier:

(i) 3 working days after the date the participating provider placed the notification in the U.S. mail, if the participating provider maintains the stamped certificate of mailing for the notice; or

(ii) on the date recorded by the courier, if the notification was delivered by courier.**]**

[(n)**] (T)** (1) A carrier may not require a provider that provides health care services through a group practice or health care facility that participates on the carrier's provider panel under a contract with the carrier to be considered a participating provider or accept the reimbursement fee schedule applicable under the contract when:

(i) providing health care services to enrollees of the carrier through an individual or group practice or health care facility that does not have a contract with the carrier; and

(ii) billing for health care services provided to enrollees of the carrier using a different federal tax identification number than that used by the group practice or health care facility under a contract with the carrier.

(2) A nonparticipating provider shall notify an enrollee:

(i) that the provider does not participate on the provider panel of the enrollee's carrier; and

(ii) of the anticipated total charges for the health care services.

[(o)**] (U)** The provisions of subsection **[**(d)(3)(iii)**] (F)(3)(III)** of this section do not apply to a carrier that uses a credentialing intermediary that:

(1) is a hospital or academic medical center;

(2) is a participating provider on the carrier's provider panel; and

(3) acts as a credentialing intermediary for that carrier for health care practitioners that:

(i) participate on the carrier's provider panel; and

(ii) have privileges at the hospital or academic medical center.

[(p)**] (V)** (1) Notwithstanding subsection **[**(n)(1)**] (T)(1)** of this section, a carrier shall reimburse a group practice on the carrier's provider panel at the participating provider rate for covered services provided by a provider who is not a participating provider if:

(i) the provider is employed by or a member of the group practice;

(ii) the provider has applied for acceptance on the carrier's provider panel and the carrier has notified the provider of the carrier's intent to continue to process the provider's application to obtain necessary credentialing information;

(iii) the provider has a valid license issued by a health occupations board to practice in the State; and

(iv) the provider:

1. is currently credentialed by an accredited hospital in the State; or

2. has professional liability insurance.

(2) A carrier shall reimburse a group practice on the carrier's provider panel in accordance with paragraph (1) of this subsection from the date the notice required under subsection **[**(d)(3)(i)1**] (F)(3)(I)1** of this section is sent to the provider until the date the notice required under subsection **[**(d)(3)(iii)2**] (F)(3)(III)2** of this section is sent to the provider.

(3) A carrier that sends written notice of rejection of a provider for credentialing under subsection **[**(d)(3)(iii)2**] (F)(3)(III)2** of this section shall reimburse the provider as a nonparticipating provider for covered services provided on or after the date the notice is sent.

(4) A health maintenance organization may not deny payment to a provider under this subsection solely because the provider was not a participating provider at the time the services were provided to an enrollee.

(5) A provider who is not a participating provider of a carrier and whose group practice is eligible for reimbursement under paragraph (1) of this subsection may not hold an enrollee of the carrier liable for the cost of any covered services provided to the enrollee during the time period described in paragraph (2) of this subsection, except for any deductible, copayment, or coinsurance amount owed by the enrollee to the group practice or provider under the terms of the enrollee's contract or certificate.

(6) A group practice shall disclose in writing to an enrollee at the time services are provided that:

(i) the treating provider is not a participating provider;

(ii) the treating provider has applied to become a participating provider;

(iii) the carrier has not completed its assessment of the qualifications of the treating provider to provide services as a participating provider; and

(iv) any covered services received must be reimbursed by the carrier at the participating provider rate.

15–830.

(a) (1) In this section the following words have the meanings indicated.

(2) "Carrier" means:

(i) an insurer that offers health insurance other than long–term care insurance or disability insurance;

(ii) a nonprofit health service plan;

(iii) a health maintenance organization;

(iv) a dental plan organization; or

(v) except for a managed care organization as defined in Title 15, Subtitle 1 of the Health – General Article, any other person that provides health benefit plans subject to State regulation.

(3) (i) "Member" means an individual entitled to health care benefits under a policy or plan issued or delivered in the State by a carrier.

(ii) "Member" includes a subscriber.

(4) "Nonphysician specialist" means a health care provider who:

(i) is not a physician;

(ii) is licensed or certified under the Health Occupations Article; and

(iii) is certified or trained to treat or provide health care services for a specified condition or disease in a manner that is within the scope of the license or certification of the health care provider.

(5) "Provider panel" has the meaning stated in § 15–112(a) of this title.

(6) "Specialist" means a physician who is certified or trained to practice in a specified field of medicine and who is not designated as a primary care provider by the carrier.

(b) (1) Each carrier that does not allow direct access to specialists shall establish and implement a procedure by which a member may receive a standing referral to a specialist in accordance with this subsection.

(2) The procedure shall provide for a standing referral to a specialist if:

(i) the primary care physician of the member determines, in consultation with the specialist, that the member needs continuing care from the specialist;

(ii) the member has a condition or disease that:

1. is life threatening, degenerative, chronic, or disabling; and

2. requires specialized medical care; and

(iii) the specialist:

1. has expertise in treating the life–threatening, degenerative, chronic, or disabling disease or condition; and

2. is part of the carrier's provider panel.

(3) Except as provided in subsection (c) of this section, a standing referral shall be made in accordance with a written treatment plan for a covered service developed by:

(i) the primary care physician;

(ii) the specialist; and

(iii) the member.

(4) A treatment plan may:

(i) limit the number of visits to the specialist;

(ii) limit the period of time in which visits to the specialist are authorized; and

(iii) require the specialist to communicate regularly with the primary care physician regarding the treatment and health status of the member.

(5) The procedure by which a member may receive a standing referral to a specialist may not include a requirement that a member see a provider in addition to the primary care physician before the standing referral is granted.

(c) (1) Notwithstanding any other provision of this section, a member who is pregnant shall receive a standing referral to an obstetrician in accordance with this subsection.

(2) After the member who is pregnant receives a standing referral to an obstetrician, the obstetrician is responsible for the primary management of the member's pregnancy, including the issuance of referrals in accordance with the carrier's policies and procedures, through the postpartum period.

(3) A written treatment plan may not be required when a standing referral is to an obstetrician under this subsection.

(d) (1) Each carrier shall establish and implement a procedure by which a member may request a referral to a specialist or nonphysician specialist who is not part of the carrier's provider panel in accordance with this subsection.

(2) The procedure shall provide for a referral to a specialist or nonphysician specialist who is not part of the carrier's provider panel if:

(i) the member is diagnosed with a condition or disease that requires specialized health care services or medical care; and

(ii) 1. the carrier does not have in its provider panel a specialist or nonphysician specialist with the professional training and expertise to treat or provide health care services for the condition or disease; or

2. the carrier cannot provide reasonable access to a specialist or nonphysician specialist with the professional training and expertise to treat or provide health care services for the condition or disease without unreasonable delay or travel.

(3) THE PROCEDURE SHALL ENSURE THAT A REQUEST TO OBTAIN A REFERRAL TO A SPECIALIST OR NONPHYSICIAN SPECIALIST WHO IS NOT PART OF THE CARRIER'S PROVIDER PANEL IS ADDRESSED IN A TIMELY MANNER THAT IS:

(I) APPROPRIATE FOR THE MEMBER'S CONDITION; AND

(II) CONSISTENT WITH THE REQUIREMENTS FOR DETERMINATIONS MADE BY PRIVATE REVIEW AGENTS UNDER § 15–10B–06 OF THIS TITLE.

(4) THE PROCEDURE MAY NOT BE USED BY A CARRIER AS A SUBSTITUTE FOR ESTABLISHING AND MAINTAINING A SUFFICIENT PROVIDER NETWORK IN ACCORDANCE WITH § 15–112 OF THIS TITLE; OR

(5) EACH CARRIER SHALL:

(I) HAVE A SYSTEM IN PLACE THAT DOCUMENTS ALL REQUESTS TO OBTAIN A REFERRAL TO RECEIVE A COVERED SERVICE FROM A SPECIALIST OR NONPHYSICIAN SPECIALIST WHO IS NOT PART OF THE CARRIER'S PROVIDER PANEL; AND

(II) PROVIDE THE INFORMATION DOCUMENTED UNDER ITEM (I) OF THIS PARAGRAPH TO THE COMMISSIONER ON REQUEST.

(e) For purposes of calculating any deductible, copayment amount, or coinsurance payable by the member, a carrier shall treat services received in accordance with subsection (d) of this section as if the service was provided by a provider on the carrier's provider panel.

(f) A decision by a carrier not to provide access to or coverage of treatment or health care services by a specialist or nonphysician specialist in accordance with this section constitutes an adverse decision as defined under Subtitle 10A of this title if the decision is based on a finding that the proposed service is not medically necessary, appropriate, or efficient.

(g) **(1)** Each carrier shall file with the Commissioner a copy of each of the procedures required under this section**, INCLUDING:**

(I) STEPS THE CARRIER REQUIRES OF A MEMBER TO REQUEST A REFERRAL;

(II) THE CARRIER'S TIMELINE FOR DECISIONS; AND

(III) THE CARRIER'S GRIEVANCE PROCEDURES FOR DENIALS.

(2) EACH CARRIER SHALL MAKE A COPY OF EACH OF THE PROCEDURES FILED UNDER PARAGRAPH (1) OF THIS SUBSECTION AVAILABLE TO ITS MEMBERS:

(I) IN THE CARRIER'S ONLINE NETWORK DIRECTORY REQUIRED UNDER § 15–112(M)(1) OF THIS TITLE; AND

(II) ON REQUEST.

SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall apply to health benefit plans issued, delivered, or renewed in the State on and after January 1, 2019.

SECTION 3. AND BE IT FURTHER ENACTED, That this Act shall take effect June 1, 2016.