Revised 08/02/17

HMO PROVIDER CONTRACT CHECKLIST

COMPANY:	NAIC Code:
FORM(S):	
DATE:	
SERFF TRACKING NO.:	

The items listed below may paraphrase the law or regulation. **The checklist is not required to be included with a form filing.** It should be used as a guide in determining which laws and regulations apply to the contract. **Refer to COMAR, The Insurance Article or Health-General Article, as amended to date, for the exact wording.**

Brief Description & Law/Regulation Cite	**"X" Means Applicable**	**Form/ Page**

A. General Requirements

A1.	Forms should be submitted in duplicate – COMAR 31.12.02.13C(1) *Required for paper filings only*		
A2.	Forms should have unique form number in lower left corner of first page – COMAR 31.12.02.13C(3)		
A3.	Contract governed by Maryland law – COMAR 31.12.02.13C(4)(k)		

B. Provisions Required to be Included in Contract

B1.	Definition of Experimental Medical Care – §15-123(d), Insurance		
B2.	Hold Harmless Clause – §19-710(i), Health-General		
B3.	Disclosure of the carriers comprising the provider panel (does not apply to dental)– §15-112.2(c), Insurance		
B4.	Disclosure informing provider of the right to elect not to serve on panel for workers' compensation services – §15-125(c)(3), Insurance		
B5.	Description of bonus payments to primary care providers for providing services after 6 p.m. and before 8 a.m., or on weekends and holidays (PCP only) – §15-136(c)(2), Insurance		

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C. Claims Procedures and Reimbursement Policies

C1.	"Most Favored Nation" clause prohibited – §15-112(s), Insurance		
C2.	If contract includes more than one fee schedule, may not require as a condition of participation that the provider accept each schedule of applicable fees included in the provider contract – §15-112.2(d), Insurance		
C3.	Member of participating group practice or health care facility providing services through non-participating individual or group practice or health care facility and billing using federal tax ID number of non-participating provider – §15-112(u), Insurance		
C4.	Dental provider contract may not include a provision requiring dental provider to provide non-covered services at fees set by the HMO – §15-112.2(g), Insurance		
C5.	Vision provider contract may not require vision provider to provide non-covered services at fees set by HMO - § 15-112.2(h)(2)(i)		
C6.	Vision provider contract may not require vision provider to provide discounts on materials that are not covered benefits - § 15-112.2(h)(2)(ii)		
C7.	Withholds prohibited – §15-113(b), Insurance		
C8.	Certain bonuses permitted – §15-113(c), Insurance		
C9.	Payment of capitation fees to health care provider within 45 days after initial care is given – §15-113(e), Insurance		
C10.	Reimbursement to group practice while non-participating provider being credentialed – §15-112(w), Insurance		
C11.	HMO required to provide certain information at the time of contract execution or 30 days prior to a change – §15-113(d), Insurance		
C12.	HMO providing pharmaceutical benefits must notify all contracting pharmacies in writing of certain changes at least 30 days before the effective date of the changes – §19-712.2, Health-General		
C13.	HMO required to provide and update claims filing procedures – §15-1004(d)(1), Insurance		

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C14.	Certain retroactive denials of reimbursement are prohibited – §15-1008(c), Insurance		
C15.	Denial of reimbursement for pre-authorized care prohibited except for limited reasons – §15-1009, Insurance		
C15.	May not require providers to file claims sooner than 180 days from date of service – §15-1005(e)(1), Insurance		
C16.	HMO required to pay claims within 30 days or send appropriate notice – §15-1005(c), Insurance		
C17.	HMO must permit provider a minimum of 90 working days after a claim denial to appeal – §15-1005(e)(2), Insurance		

D. Termination

D1.	HMO must give provider 90-day minimum notice of termination from provider panel – §15-112(b)(1)(ii)5., Insurance		
D2.	Primary care provider required to continue services for care in progress for 90 days after receiving notice of termination from HMO (PCP only) – §15-112(m), Insurance		
D3.	Provider must give HMO 90-day minimum notice of termination from provider panel – §15-112.2(e)(1), Insurance		
D4.	Provider required to continue to furnish health care services for 90 days after provider gives notice to HMO of termination – §15-112.2(e)(2), Insurance		

E. Prohibited Provisions

E1.	HMO may not require provider to hold HMO harmless for coverage decision or negligent act of HMO – §19-710(t), Health-General		
E2.	Prohibition against limiting communications between provider and patient – §15-116, Insurance		

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E3.	May not require provider to participate on the HMO panel, as a condition of participating on a non-HMO panel – §15-112.2(b), Insurance		
E4.	May not require the provider to serve on panel for workers' compensation services – §15-125(c)(1), Insurance		
E5.	Assignment, transfer, or subcontracting of health care providers' contracts to a PIP insurer prohibited without provider's written consent – §15-125(b), Insurance		

F. Other

F1.	Coordination of benefits clause contradicts benefit contract – COMAR 31.12.02.13C(4)(b)		
F2.	Required disclosures related to practice profiles – §19-710(s), Health-General		
F3.	HMO may pay claim by credit card with advance notice that fee applies, offer provider alternative method that doesn't impose a fee, and provider elects to accept payment of claim by credit card - § 15-1005(d), Insurance		
F3.	Administrative Service Provider Contracts – If provider accepts payments from HMO and administers those payments to external providers for health care services to be provided to HMO members, HMO must file the plan required by §19-713.2(c), Health-General		
a.	Required contents of plan – §19-713.2(d), Health-General		
b.	Ultimate responsibility for payment of claims for covered health services remains with HMO – §19-712(b) and (c), Health-General		
c.	Prior to contract approval, form and amount of segregated fund must be approved by MIA's Examination and Auditing Unit – §19-713.2(d), Health-General		
d.	Provider must register with MIA as a contracting provider (HMO must be listed on contracting provider application form) – §19-713.3, Health-General		

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F4. Pharmacy Benefits Managers – Title 15, Subtitle 16, Insurance		
a. Required disclosures from PBM to HMO – §15-1623, Insurance		
b. PBM requirements if HMO has rebate sharing contract – §15-1624, Insurance		
c. PBM required to provide certain information to participating pharmacy or pharmacist at the time of contract execution or 30 working days prior to a change – §15-1628, Insurance		
d. Information about maximum allowable cost pricing required to be included in contract between PBM and participating pharmacy – §15-1628.1, Insurance		
e. Audits by pharmacy benefits manager – §15-1629, Insurance		
f. PBM must establish internal review process – §15-1630, Insurance		
g. Retroactive denial or modification of reimbursement for approved claim prohibited except for limited reasons – §15-1631, Insurance(*applicable instead of §15-1009 for contracts between PBM and participating pharmacy or pharmacist)*		
h. Requirements for therapeutic interchanges - §§15-1633 – 15-1639, Insurance		