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By: **Leave Blank (By Request – Departmental – Maryland Insurance Administration)**

A BILL ENTITLED

AN ACT concerning

Health Insurance – Provider Panels – Definitions of Provider and Health Care Services

FOR the purpose of defining the term "health care services" and altering the definition of "provider" for purposes of certain provisions of law governing provider panels of certain health insurance carriers; and generally relating to provider panels of health insurance carriers.

BY repealing and reenacting, with amendments,
Article – Insurance
Section 15–112
Annotated Code of Maryland
(2017 Replacement Volume and 2019 Supplement)

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

Article – Insurance

15–112.

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

(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) "Behavioral health care services" has the meaning stated in § 15–127 of this subtitle.

(5) (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.

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

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

(8) "Group model health maintenance organization" has the meaning stated in § 19–713.6(a) of the Health – General Article.

(9) "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.

(10) (i) "Health care facility" means a health care setting or institution providing physical, mental, or substance use disorder health care services.

(ii) "Health care facility" includes:

1. a hospital;

2. an ambulatory surgical or treatment center;

3. a skilled nursing facility;

4. a residential treatment center;

5. an urgent care center;

6. a diagnostic, laboratory, or imaging center;

7. a rehabilitation facility; and

8. any other therapeutic health care setting.

(11) "HEALTH CARE SERVICES" HAS THE MEANING STATED IN § 15–121 OF THIS SUBTITLE.

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

[(12)**] (13)** "Network" means a carrier's participating providers and the health care facilities with which a carrier contracts to provide health care services to the

carrier's enrollees under the carrier's health benefit plan.

[(13)**] (14)** "Network directory" means a list of a carrier's participating providers and participating health care facilities.

[(14)**] (15)** "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.

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

[(16)**] (17)** "Provider" **[**means a health care practitioner or group of health care practitioners licensed, certified, or otherwise authorized by law to provide health care services**] HAS THE MEANING STATED IN § 15–121 OF THIS SUBTITLE**.

[(17)**] (18)** (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) Subject to paragraph (3) of this subsection, a carrier that uses a provider panel shall:

(i) if the carrier is an insurer, nonprofit health service plan, health maintenance organization, 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; 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 (n) 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;

(ii) 1. include standards that ensure access to providers, including essential community providers, that serve predominantly low–income and medically underserved individuals; or

2. for a carrier that provides a majority of covered

professional services through physicians employed by a single contracted medical group and through health care providers employed by the carrier, include alternative standards for addressing the needs of low–income, medically underserved individuals; and

(iii) except for a carrier that is a group model health maintenance organization, ensure that all enrollees have access to local health departments and covered services provided through local health departments, including behavioral health care services, to the extent that local health departments are willing to participate on a carrier's provider panel.

(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 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 access plan, 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 by the Commissioner.

(iii) The Commissioner may order corrective action if, after review, the access plan is determined not to meet the requirements of this subsection.

(3) (i) In accordance with § 4–335 of the General Provisions Article, the Commissioner shall deny inspection of the parts of the access plan filed under this

subsection that contain confidential commercial information or confidential financial information.

(ii) The regulations adopted by the Commissioner under subsection (d) of this section shall identify the parts of the access plan that may be considered confidential by the carrier.

(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 the criteria used to select providers for participation in the network and, if applicable, place providers in network tiers;

(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) 1. the carrier's efforts to include providers, including essential community providers, in its network who serve predominantly low–income, medically underserved individuals; or

2. for a carrier that provides a majority of covered professional services through physicians employed by a single contracted medical group and through health care providers employed by the carrier, the carrier's efforts to address

the needs of low–income, medically underserved individuals;

(vi) except for an access plan filed by a group model health maintenance organization, the carrier's efforts to include local health departments in its network; and

(vii) 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, the clinical capacity of its participating providers to provide covered services to its enrollees.

(d) (1) 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.

(2) In adopting the regulations, the Commissioner may take into consideration:

(i) geographic accessibility of primary care and specialty providers, including mental health and substance use disorder providers;

(ii) waiting times for an appointment with participating primary care and specialty providers, including mental health and substance use disorder providers;

(iii) primary care provider–to–enrollee ratios;

(iv) provider–to–enrollee ratios, by specialty;

(v) geographic variation and population dispersion;

(vi) hours of operation;

(vii) the ability of the network to meet the needs of enrollees, which may include:

1. low–income individuals;

2. adults and children with:

A. serious, chronic, or complex health conditions; or

B. physical or mental disabilities; and

3. individuals with limited English proficiency or illiteracy;

(viii) other health care service delivery system options, including telemedicine, telehealth, mobile clinics, and centers of excellence;

(ix) the volume of technological and specialty care services available to serve the needs of enrollees requiring technologically advanced or specialty care services;

(x) any standards adopted by the federal Centers for Medicare and Medicaid Services or used by the Federally Facilitated Marketplace; and

(xi) any standards adopted by another state.

(e) (1) On or before December 31, 2017, for a carrier that is a dental plan organization or an insurer or nonprofit health service plan that provides coverage for dental services, the Commissioner, in consultation with appropriate stakeholders, shall adopt regulations to specify the standards under subsection (b)(1)(i) of this section for dental services.

(2) The regulations shall:

(i) ensure that all enrollees, including adults and children, have access to providers and covered services without unreasonable delay and travel;

(ii) ensure access to providers, including essential community providers, that serve predominantly low–income, medically underserved individuals; and

(iii) require the carrier to specify how the carrier will monitor, on an ongoing basis, the ability of its participating providers to provide covered services to its enrollees.

(3) In establishing the standards for dental services, the Commissioner may consider the appropriateness of quantitative and nonquantitative criteria.

(f) 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.

(g) (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 subparagraph (ii) of this paragraph and 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) A carrier may not reject a provider who provides community–based health services for a program accredited under COMAR 10.63.02 for participation on the carrier's provider panel solely because the provider is:

1. a licensed graduate social worker or a licensed master social worker, as those terms are defined in § 19–101 of the Health Occupations Article; or

2. a licensed graduate alcohol and drug counselor, a licensed graduate marriage and family therapist, a licensed graduate professional art therapist, or a licensed graduate professional counselor as those terms are defined in § 17–101 of the Health Occupations Article.

(iii) 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 (v) 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.

(h) 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 (l) of this section.

(i) (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.

(j) (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.

(k) 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 (l) 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.

(l) 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.

(m) (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.

(n) (1) A carrier shall make the carrier's network directory available to prospective enrollees on the Internet and, on request of a prospective enrollee, in printed form.

(2) The carrier's network directory on the Internet shall be available:

(i) through a clear link or tab; and

(ii) in a searchable format.

(3) The network directory shall include:

(i) for each provider on the carrier's provider panel:

1. the name of the provider;

2. the specialty areas of the provider;

3. whether the provider currently is accepting new patients;

4. for each office of the provider where the provider participates on the provider panel:

A. its location, including its address; and

B. contact information for the provider;

5. the gender of the provider, if the provider notifies the carrier or the multi–carrier common online provider directory information system designated under § 15–112.3 of this subtitle of the information; and

6. any languages spoken by the provider other than English, if the provider notifies the carrier or the multi–carrier common online provider directory information system designated under § 15–112.3 of this subtitle of the information;

(ii) for each health care facility in the carrier's network:

1. the health care facility's name;

2. the health care facility's address;

3. the types of services provided by the health care facility; and

4. contact information for the health care facility; and

(iii) a statement that advises enrollees and prospective enrollees to contact a provider or a health care facility before seeking treatment or services, to confirm the provider's or health care facility's participation in the carrier's network.

(o) (1) A carrier shall have a customer service telephone number, e–mail address link, or other electronic means by which enrollees and prospective enrollees may notify the carrier of inaccurate information in the carrier's network directory.

(2) If notified of a potential inaccuracy in a network directory by a person other than the provider, a carrier shall investigate the reported inaccuracy and take corrective action, if necessary, to update the network directory within 45 working days after receiving the notification.

(p) (1) A carrier shall notify each enrollee at the time of initial enrollment and renewal about how to access or obtain the information required under subsection (n) of this section.

(2) (i) 1. Information provided in printed form under subsection (n) of this section shall be accurate on the date of publication.

2. A carrier shall update the information provided in printed form at least once a year.

(ii) 1. Information provided on the Internet under subsection (n) of this section shall be accurate on the date of initial posting and any update.

2. In addition to the requirement to update its provider information under subsection (t)(1) of this section, a carrier shall update the information provided on the Internet at least once every 15 days.

(3) A carrier shall:

(i) 1. periodically review at least a reasonable sample size of its network directory for accuracy; and

2. retain documentation of the review and make the review available to the Commissioner on request; or

(ii) contact providers listed in the carrier's network directory who have not submitted a claim in the last 6 months to determine if the providers intend to remain in the carrier's provider network.

(4) A carrier shall demonstrate the accuracy of the information provided under paragraph (3) of this subsection on request of the Commissioner.

(5) Before imposing a penalty against a carrier for inaccurate network directory information, the Commissioner shall take into account, in addition to any other factors required by law, whether:

(i) the carrier afforded a provider or other person identified in § 15–112.3(c) of this subtitle an opportunity to review and update the provider's network directory information:

1. through the multi–carrier common online provider directory information system designated under § 15–112.3 of this subtitle; or

2. directly with the carrier;

(ii) the carrier can demonstrate the efforts made, in writing, electronically, or by telephone, to obtain updated network directory information from a provider or other person identified in § 15–112.3(c) of this subtitle;

(iii) the carrier has contacted a provider listed in the carrier's network directory who has not submitted a claim in the last 6 months to determine if the provider intends to remain on the carrier's provider panel;

(iv) the carrier includes in its network directory the last date that a provider updated the provider's information;

(v) the carrier has implemented any other process or procedure to:

1. encourage providers to update their network directory information; or

2. increase the accuracy of its network directory; and

(vi) a provider or other person identified in § 15–112.3(c) of this subtitle has not updated the provider's network directory information, despite opportunities to do so.

(q) A policy, certificate, or other evidence of coverage shall:

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

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

(r) 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, 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.

(s) 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.

(t) (1) A carrier shall update the information that must be made available on the Internet under subsection (n) of this section within 15 working days after receipt of electronic notification or notification by first–class mail tracking method 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.

(u) (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.

(v) The provisions of subsection (g)(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.

(w) (1) Notwithstanding subsection (u)(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 (g)(3)(i)1 of this section is sent to the provider until the date the notice required under subsection (g)(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 (g)(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.

(x) A carrier may not impose a limit on the number of behavioral health providers at a health care facility that may be credentialed to participate on a provider panel.

SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall take effect October 1, 2020.