HEALTH MAINTENANCE ORGANIZATION AND DENTAL PLAN ORGANIZATION
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 contract 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. Unless otherwise specified, all section references are to the Insurance Article of the Annotated Code of Maryland.

A. General Requirements for HMO Provider Contracts

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

B. Provisions Required to be Included in Contract

	Citation	**Description**	**"X" Means Applicable**	**Form/ Page**
B1.	§15-123(d)	Definition of Experimental Medical Care		
B2.	HMO: §19-710(i), Health-General DPO: COMAR 31.12.04.08C	Hold Harmless Clause		
B3.	§15-112.2(c)	Disclosure of the carriers comprising the provider panel (HMO only, does not apply to dental).		
B4.	§15-125(c)(3)	Disclosure informing provider of the right to elect not to serve on panel for workers' compensation services.		

	Citation	Description	"X" Means Applicable	Form/ Page
B5.	§15-136(c)(2)	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 (HMO PCP only)		
B6.	COMAR 31.12.04.08B	Twelve Month Initial Commitment (DPO Only)		
B7.	COMAR 31.12.04.08D	Effective Date (DPO Only)		
B8.	COMAR 31.12.04.08E	Termination Date (DPO Only)		
B9.	COMAR 31.12.04.08F	Renewal Provision (DPO Only)		
B10.	COMAR 31.12.04.08G(1)	Benefits provided in exchange for copayments (DPO Only)		

C. Claims Procedures and Reimbursement Policies

	Citation	Description	"X" Means Applicable	Form/ Page
C1.	§15-112(s)	"Most Favored Nation" clause prohibited.		
C2.	§15-112(u)	Carrier may not require a provider in a group practice or health care facility to participate on carrier's panel or accept reimbursement		
C3.	§15-112(w)	Reimbursement to group practice while non-participating provider being credentialed.		
C4.	§15-112.2(d)	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 (HMO only)		
C5.	§15-112.2(f)	Dental provider contract may not require a participating dentist as a condition of participating in a capitated dental provider panel or fee-for-service dental provider panel, to accept an added, revised, or amended fee schedule that contains a lower fee		

	Citation	Description	"X" Means Applicable	Form/ Page
C6.	§15-112.2(g)	Dental provider contract may not include a provision requiring dental provider to provide non-covered services at fees set by the HMO or DPO.		
C7.	§ 15-112.2(h)(2)(i)	Vision provider contract may not require vision provider to provide non-covered services at fees set by HMO.		
C8.	§ 15-112.2(h)(2)(ii)	Vision provider contract may not require vision provider to provide discounts on materials that are not covered benefits.		
C9.	§15-113(b)	Withholds prohibited		
C10.	§15-113(c)	Certain bonuses permitted		
C11.	§15-113(d)	HMO required to provide certain information at the time of contract execution or 30 days before a change.		
C12.	§15-113(e)	Payment of capitation fees to health care provider within 45 days after initial care is given.		
C13.	§15-113(f) Senate Bill 834, Chpt 298, 2022 Legislative Session effective 10/1/2022	Two-Sided Incentive Arrangement		
	§15-113(f)(1)	1. Requirements of Arrangement		
	§15-113(f)(1)(i)	a. Contract must explain and specify the methodology for calculating the target budget		
	§15-113(f)(1)(ii)	b. Contract must include the recoupment limit		
	§15-113(f)(1)(iii)	c. Contract must include maximum liability for total recoupments, and demonstrate compliance with the 10% cap		
	§15-113(f)(1)(iv)	d. Carrier must provide explanation of opportunity for gains		

	Citation	Description	"X" Means Applicable	Form/ Page
	§15-113(f)(1)(v)	e. Contract must be clear that independent audits and third-party dispute resolution process is available		
	§15-113(f)(1)(vi)	f. Contract must include statement about good faith adjustments to target budget		
	§15-113(f)(1)(vii)	g. Contract must include statement about prompt payments/recoupments		
	§15-113(f)(2)	2. May not allow recoupment by carrier during the first 12 months of the arrangement, unless mutually agreed to by provider and carrier		
	§15-113(f)(3)	3. Information when payment is determined on the total cost of care of population or episodes of care must be disclosed quarterly		
	§15-113(f)(4)	4. May not be amended during term of contract unless mutually agreed to by provider and carrier		
	§15-113(f)(5)	5. Independent dispute resolution may not be required to be exhausted before filing appeal		
C14.	§19-712.2, Health-General	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 (HMO only).		
C15.	§15-1004(d)(1)	HMO required to provide and update claims filing procedures (HMO only).		
C16.	§15-1008(c)	Certain retroactive denials of reimbursement are prohibited.		
C17.	§15-1009	Denial of reimbursement for pre-authorized care prohibited except for limited reasons.		
C18.	§15-1005(c)	HMO required to pay claims within 30 days or send appropriate notice (HMO Only).		

	Citation	Description	"X" Means Applicable	Form/ Page
C19.	§15-1005(e)(1)	May not require providers to file claims sooner than 180 days from date of service.		
C20.	§15-1005(e)(2)	Must permit provider a minimum of 90 working days after a claim denial to appeal.		

D. Termination

	Citation	Description	"X" Means Applicable	Form/ Page
D1.	§15-112(b)(1)(ii)5	HMO or DPO must give provider 90-day minimum notice of termination from provider panel.		
D2.	§15-112(m)	Primary care provider required to continue services for care in progress for 90 days after receiving notice of termination from HMO or DPO (PCP only).		
D3.	§15-112.2(e)(1)	Provider must give HMO or DPO 90-day minimum notice of termination from provider panel.		
D4.	§15-112.2(e)(2)	Provider required to continue to furnish health care services for 90 days after provider gives notice to HMO or DPO of termination.		

E. Prohibited Provisions

	Citation	Description	"X" Means Applicable	Form/ Page
E1.	§19-710(t)	HMO may not require provider to hold HMO harmless for coverage decision or negligent act of HMO (HMO only).		
E2.	§15-116	Prohibition against limiting communications between provider and patient.		
E3.	§15-112.2(b)(1)(i)	May not require provider to participate on the HMO panel, as a condition of participating on a non-HMO panel (HMO Only)		
E4.	§15-112.2(b)(1)(ii)	May not require dental provider to participate on a capitated provider panel, as a condition of participating on a fee-for-service provider panel		

	Citation	Description	"X" Means Applicable	Form/ Page
E5.	§15-125(b)	Assignment, transfer, or subcontracting of health care providers' contracts to a PIP insurer prohibited without provider's written consent.		
E6.	§15-125(c)(1)	May not require the provider to serve on panel for workers' compensation services.		
E7.	§15-112(j)(1)	HMO or DPO may not require provider to be recredentialed based on: • Change in federal tax ID number of the provider • Change in the federal tax ID number of a provider's employer, or • Change in the employer of a provider		
E8.	§15-112(x)	HMO may not close their network to new behavioral health providers at a facility, even if the HMO believes it already has a sufficient number of providers in the network (HMO Only).		

F. Other – HMO ONLY

	Citation	Description	"X" Means Applicable	Form/ Page
F1.	COMAR 31.12.02.13C(4)(b)	Coordination of benefits clause contradicts benefit contract		
F2.	§19-710(s), Health-General	Required disclosures related to practice profiles		
F3.	§ 15-1005(d)	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.		
F4.	§19-713.2(c), Health-General	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		
	§19-713.2(d), Health-General	a. Required contents of plan		

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	§19-712(b) and (c), Health-General	b. Ultimate responsibility for payment of claims for covered health services remains with HMO		
	§19-713.2(d), Health-General	c. Prior to contract approval, form and amount of segregated fund must be approved by MIA's Examination and Auditing Unit		
	§19-713.3, Health-General	d. Provider must register with MIA as a contracting provider (HMO must be listed on contracting provider application form)		
F5.	42 USC §300gg-139(a)	Provider required to submit provider directory information to the HMO during certain times and circumstances		