Application For Modification of Licensure Service Area Expansion & Guide

June - 2006

North Carolina Department of Insurance
Life and Health Division
1201 Mail Service Center
Raleigh, NC 27699-1201
(919) 733-5060

Special points of interest:

* All Checklists and required formats are available on-line at the Department's web page
* Paperless Filing
* Life and Health performs the review and approval of HMO Certificate of Authority and modifications, member materials, and rates.

Contents:

Application Process 1
Pre-Application Meeting 1
General Instructions 2
Down Loadable Checklists 4
Flow Chart 4
General Filing Requirements 2
Exhibits 6

About The Modification to HMO Certificate of Authority Process

The North Carolina Department of Insurance (Department) is the only agency in North Carolina responsible for the regulation of Health Maintenance Organizations.

Many separate Divisions within the Department play a role in the ongoing regulation. In some instances, more than one Division will be involved in a particular regulatory issue, but in other instances, you may deal with only one Division.

The Life and Health Division is responsible for coordinating the reviewing the Certificate of Authority application or modification, including member forms and benefit design, including the proposed Master Group Contract, Evidence (Certificate) of Coverage, Benefit Riders, Enrollment Forms, Change Forms, rates and marketing, and advertising materials.

The Life and Health Division will coordinate the Modification with the Financial Evaluation Division. This Division responses to financial solvency. financial feasibility plans, insolvency plans, financial statements, and, working capital and reserves.

The Life and Health Division will also coordinate the Modification with the Actuarial Services Division. This Division responses to premium rate methodologies and rating assumptions.

Pre-Application Meeting

If the applicant has not scheduled and/or already participated in a pre-application meeting with the NCDOI Please contact the Life and Health Division at (919) 733-5060 to arrange the meeting; ask to speak with the Supervising Analyst to review the service area expansion process and requirements. This meeting is essential for the successful completion of the application. This meeting is most productive when scheduled once you have begun to complete the application, but well prior to submission, in order that you may have prepared specific and informed questions. The application may be impacted by the answers received during the meeting.

If the HMO has current issues open with the Department, they may impact the review of this application.

- The issues to be discussed at this meeting include but are not limited to:
- What information must be included in the application
- Additional information that may be included in the application
- Financial requirements
- Accessibility and availability requirements
- Requesting the service area
- Regulatory changes which may effect the application

Instructions -Filing Service Area Expansion

In an effort to reduce the processing time for the approval of an expansion of service area request, the North Carolina Department of Insurance (NCDOI) has prepared these guidelines which may be used to assist the applicant in completion of a Service Area Expansion Application.

The application references North Carolina statutes and regulations, which must be met by the applicant in order to receive approval to modify the HMO certificate of authority.

Please be advised this list is not all-inclusive and it recommended the applicant contact the publisher for a complete reference of applicable statutes and regulations.

General Statutes of North Carolina - Insurance, Chapters 58 and 58A - The Michie Company
(800) 446-3410

North Carolina Regulations - National Insurance Law Service
(800) 423-5910

The North Carolina Department of Insurance

Expansion Area Modification

Application Review Process

Copies of the application will be distributed to each of the above listed Divisions. One copy is placed in the Life and Health library, for public review. Once received by each Division, the application will be assigned to a particular analyst in each Division.

Within the Life and Health Division, an application will be assigned to an reviewing Analyst, who will then become the primary point of contact for routine matters relating to the review.

The Life and Health Division and the Actuarial Services Division will concurrently review applications. The applicant will receive correspondence from each Division and at this point responses should be addressed directly to the particular Division regarding its questions and concerns. The Financial Evaluation Division conducts a preliminary review of the application, however this review cannot be completed until rating methodologies and projections are secured and finalized by the Actuarial Services Division.

Applicants are required to respond within 90 days of receiving correspondence from any Division. All Divisions should be copied on the response. If the response is not received within this time frame, the application will be closed.

The entire application will be approved at one time. Approval for use of all submitted items is granted through receipt of a Certificate of Authority. Rates, member forms, provider contracts, etc. are not separately approved prior to the date the applicant receives its Certificate of Authority. Applicants may not contract with employer groups prior to receiving its Certificate of Authority.

General Filing Requirements

The North Carolina Department of Insurance (NCDOI) has prepared this guideline and checklist to help applicants prepare their applications in a manner that promotes prompt and thorough review by the NCDOI. **This guideline is not all-inclusive.** Each Exhibit or sections submitted to the NCDOI must be accompanied by the appropriate supporting documentation, in the order requested. All forms should be filled out completely unless otherwise stated. The NCDOI will not accept an incomplete application. The application cannot be amended once submitted, except for specific changes requested by the NCDOI.

The application and all of its contents will become public information immediately upon submission. The NCDOI is authorized to protect only legitimate trade secrets from public view. The NCDOI approves trade secret, confidential information on a section by section basis, rather than entire documents. Therefore, written information must be submitted that identifies the specific areas to be classified as confidential. In order to have material classified as trade secret and thereby confidentially maintained by the Department, an applicant must:

Indicate clearly the specific information to be treated as a trade secret;
Submit a written memorandum to the Life and Health Division explaining why this information qualifies as a trade secret pursuant to North Carolina General Statute (NCGS) Chapter 24, Article 66, Section 152 and Article 132 Section 1.2. This information must include specific explanations as to how and why the area meets the definition of trade secret and not a restatment of the definition itself (e.g. how economic value could be obtained)

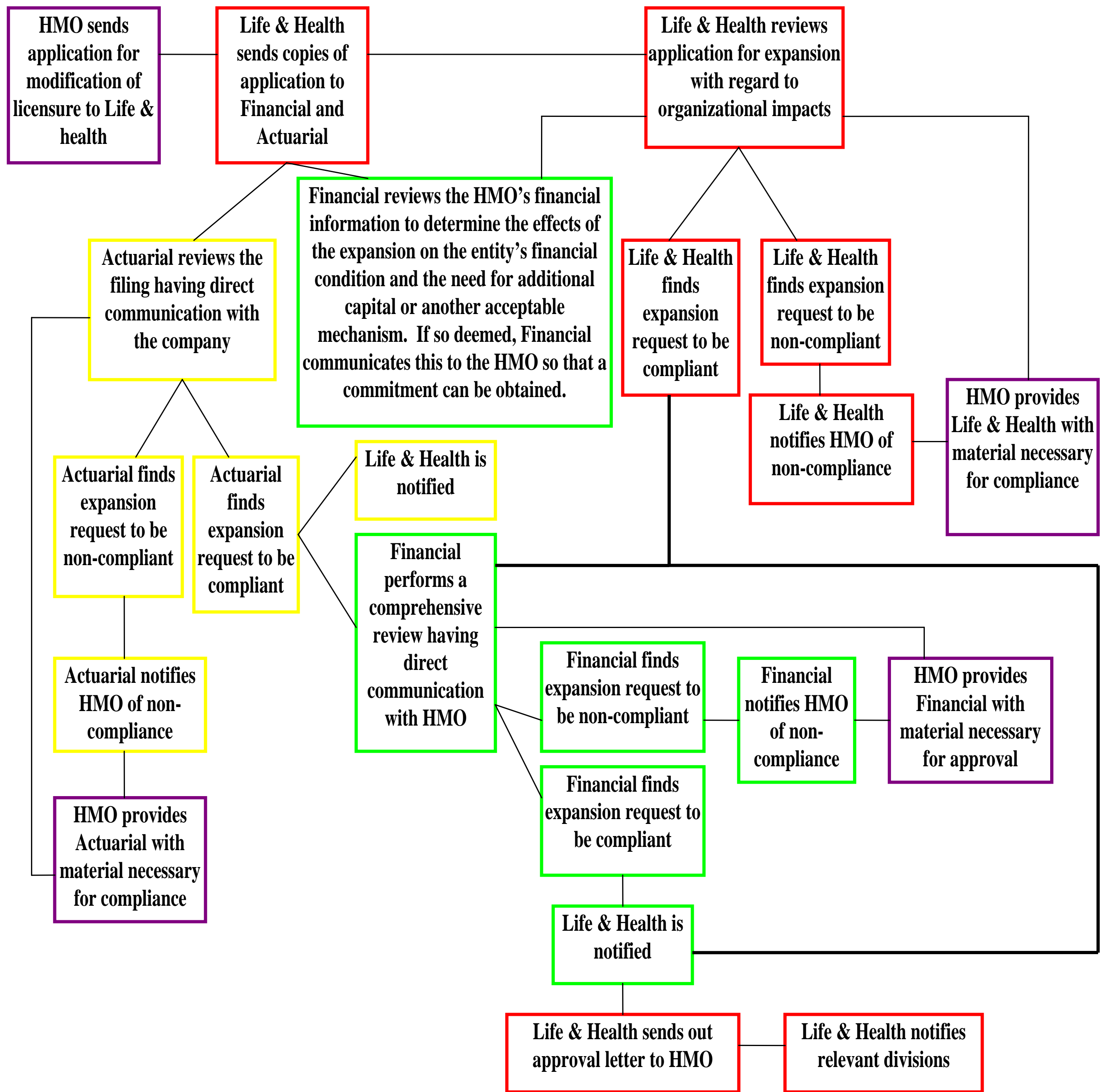
The explanation and the indicated materials will be reviewed by the Life and Health Division and legal counsel to determine if it meets the criteria as outlined in NCGS 24-66-152 and 132-1.2. The applicant will be notified of the decision rendered.

Historically, little information included in the application has been determined to qualify as a trade secret.

The application must be prepared as follows:

One original and eight copies must be submitted
Filing fee of $250.00 must accompany the application
The application must be contained in 3 ring binders (if multiple binders, each must be labeled properly with the applicant's name)
A cover letter must be submitted with the application
Binders must be tabbed to identify the 19 separate exhibits describing the contents of the application
Identical items should be cross-referenced, rather than duplicated throughout the document
The original copy has all signed documents with original signature. (no photocopies)

MODIFICATION OF LICENSURE: EXPANSION OF SERVICE AREA FLOWCHART (90 days)



*If the HMO is found to be incapable of expanding, Financial can decide to end the process of evaluating the application in all divisions. At that point, HMO would be given the opportunity to provide satisfactory evidence of financial capability that would support an expansion of service.

APPLICATION FOR MODIFICATION OF LICENSURE
SERVICE AREA EXPANSION

Life and Health Division
North Carolina Department of Insurance
1201 Mail Service Center
Raleigh, NC 27699-1201

Assigned to (internal use only):	Date Received:
	Returned:
Qualified and accepted:	Application Fee Received:
	Date Distributed to Divisions:

APPLICANT INFORMATION

Applicant's Name**:** ____________________

Applicant's Address:____________________

____

Counsel Name, Address, Phone Number:____________________

____

Name of Contact Person Responsible for Application ,Address, Phone Number:

____

____

Proposed Date of Expansion : ____________________
(Date)

The following exhibits are required pursuant to North Carolina General Statutes (NCGS) Chapter 58, Article 67, Section 10 (d)(1) and Title 11 of the North Carolina Administrative Code (NCAC) Chapter 20, Section 0600. The exhibits should be clearly labeled as Exhibit 1, 2, 3 etc. Any attachments to the Exhibit should be labeled 1a, 1b, 1c etc., and referenced accordingly.

EXHIBIT 1: BASIC ORGANIZATIONAL DOCUMENT

This exhibit should contain any amendments to the basic organizational documents including the articles of incorporation or associations, partnership agreement, or other applicable documents and articles of amendments from the Secretary of State, which will result from modifying the existing service area.

If there is no change to existing documents on file, please so indicate.

EXHIBIT 2: BYLAWS, RULES, REGULATIONS, ETC.

This exhibit typically includes amended bylaws or rules and regulations or similar documents regulating the conduct of the internal affairs of the applicant which have been made as a result of this expansion request. The documents should be certified copies.

If there is no change to existing documents, please so indicate.

EXHIBIT 3: NAMES, ADDRESSES AND POSITIONS OF OFFICERS AND

This exhibit should list the names, addresses, and official positions of persons who are to be responsible for the conduct of the affairs of the applicant, including all members of the board of directors, board of trustees, executive committee, or other governing board or committee, the principal officers in the case of a corporation, and the partners or members in the case of a partnership or association **if not already on file**. **Label Exhibit 3a**

A biographical affidavit has been supplied with this exhibit. Application Forms must be completed and signed for each of the officers and directors **not already on file** with the Department. All questions must be answered and if the question is not applicable, or the answer is none, please so indicate. **Label Exhibit 3b**

The list of Officers and Board members should be consistent with the Company’s current bylaws, including number of board members and number and title of officers.

Throughout the process, provide the Department with updates, including applicable biographical affidavits, as officers and board members change or are added.

If there is no change to existing documents, please so indicate.

EXHIBIT 4: PROVIDER CONTRACTS / ADMINISTRATIVE CONTRACTS

This exhibit must contain a copy of any contract form made or to be made between any class of providers and the HMO and a copy of any contract form made or to be made between third party administrators, marketing consultants, or persons listed in Exhibit 3, **which will result from submission of this expansion request**. **All contracts must be submitted to the Department for review and approval.**

Any management or administrative agreements entered into pursuant to NCGS-58-67-30 and/or NCGS 58-19 must be submitted for review and approval prior to use, **which will result from submission of this expansion request**. Such contracts should clearly outline the obligations of both parties including the services to be provided to the HMO and the fee to be paid by the HMO. Services to be provided to the HMO should be outlined in terms of operational areas, support staff, etc.

Review the regulations provided with this exhibit which outline the provisions which must be included in all provider contracts

Review the regulations provided with this exhibit which outline the provisions which must be included in all intermediary contracts

Provider contracts must be secured prior to the Department granting approval of a service area expansion request.

If there is no change to existing documents, please so indicate.

PROVIDER CONTRACT PROVISIONS

. The following provisions should be included in provider agreements:

Definitions of all technical insurance and managed care terms used in the contract such as:
- all terms with specific insurance or managed care meanings
- clinical peer, if used in the contract
- covered person, if used in the contract
- emergency medical condition, if used in the contract
- emergency services, if used in the contract
- grievance, if used in the contract
- medical necessity, if used in the contract
- stabilize, if used in the contract
- urgent care, if used in the contract
- terms with member payment implications (deductible, coinsurance, copayment, covered services, etc.)
- terms with provider payment implications (capitation, withhold, etc.)

General Provisions, including:
- Term of contract
- Requirements for written notice of termination and each party's grounds for termination
- Provider's continuing obligations after termination of the provider contract or in the case of the carrier or intermediary's insolvency. The obligations should address:

- transition of administrative duties and records
- continuation of care, when inpatient care is on going.

Contract and specified amendments, exhibits, attachments or addendums constitute the entire contract between the parties

Contract not assignable by provider, or not assignable by provider without written consent of the HMO

Nondiscrimination provision

North Carolina governing law

Provider Representations and Warranties:

Current unrestricted license

Requirement to notify the HMO of changes in the status of license

Unrestricted hospital privileges, at a minimum of one HMO contracted hospital, if applicable

Requirement to notify the HMO of changes in the status of hospital privileges, if applicable

Professional liability insurance coverage of specified per occurrence and per annum amounts

Requirement to notify the HMO of changes in the status of professional liability insurance

Current unrestricted DEA Registration Certificate, if applicable

Requirement to notify the HMO of changes in the status of narcotic prescribing privileges, if applicable

Facility accredited by the Joint Commission on Accreditation of Healthcare Organizations, if applicable

Requirement to notify the HMO of revocation or suspension of JCAHO accreditation, if applicable

Certified to participate in the Medicare/Medicaid program, if applicable

Requirement to notify the HMO of any sanctions imposed by the Medicare Program, if applicable

Provider Obligations:

Provider's obligation to maintain licensure, accreditation, and credentials sufficient to meet the carrier's credential verification program requirements and to notify the carrier of subsequent changes in status of any information relating to the provider's professional credentials

Provider's obligation to maintain professional liability insurance coverage in an amount acceptable to the carrier and notify the carrier of subsequent changes in status of such.

Provider shall not bill any network plan member for covered services, except for specified coinsurance, copayments, and applicable deductibles (prepaid basis only)

Provider's responsibility to collect applicable member deductibles, copayments, coinsurance, and fees for noncovered services

Provider's obligation to arrange for call coverage or other back-up to provide service in accordance with the carrier's standards for provider accessibility

to participate in the Medicare/Medicaid program, if applicable

Requirement to notify the HMO of any sanctions imposed by the Medicare Program, if applicable

For capitated programs, provision or attachment describing the specific health care services to be provided

Member hold harmless provision

Requirement to practice in accordance with professionally recognized standards of care

Emergency service/admission notification requirements, if applicable

Provider required to participate in and cooperate with the HMO's:

- utilization review program
- quality assurance program
- credentialing program
- sanctions program, if separate from utilization review, quality assurance and/or credentialing program
- member grievance program
- practice site visits
- coordination of benefits program

claims submission requirements
procedures and requirements for referrals
Maintain medical records of members in accordance with industry standards or specific standards developed or adopted by the HMO
Make medical records available for review by the HMO
Maintain the confidentiality of member medical records and other personal information
Provide 24 hour per day, seven day per week call coverage, if applicable
Continuing obligation after termination of contract
Collect applicable member deductibles, copayment, coinsurance and fees for noncovered services

HMO Obligations:
Detailed description of payment methodology and risk arrangements, if any
Provide information on benefit plans, administrative and utilization management requirements and timely notification of changes in such requirements (i.e., practice administrative manual)
Provide member identification cards and a mechanism for verifying member coverage
Provider dispute resolution mechanism
Provide performance feedback reports/information if fees are related to efficiency criteria
List provider in Provider Directory (when authorized by provider) and make the directory available to members

Please also note the following:
Mandatory, binding arbitration for members is prohibited by NCGS 58-3-35. Therefore, binding arbitration for members should not be referenced in provider contracts.
Because the Department strongly discourages HMOs from practicing subrogation, provider contracts should not reference it either.
HMOs are discouraged from filing for bankruptcy under federal code in North Carolina, pursuant to NCGS 58-67-5 (f) which defines an HMO as a domestic insurance company for purposes of USC 11, the federal bankruptcy code. This statute places HMOs under the jurisdiction of the Commissioner of Insurance. In addition, NCGS 58-67-145 outlines provisions for rehabilitation, liquidation or conservation of HMOs. Therefore, provider contracts should reference the more general term "insolvency," rather than bankruptcy.
Contracts should be in the true, legal name of the Company, as provided by NCGS 58-3-50.
No language that has the potential to be interpreted as limiting physician actions or communications with members that is consistent with their professional or ethical responsibilities will be permitted. In addition, program requirements for credentialing, utilization management, etc. may not contain such provisions.
If provider administrative manuals or provider handbooks are referenced within and made a part of the provider contracts, these documents must be submitted for review.
All exhibits and addendums referenced in the contracts should be submitted for review.

EXHIBIT 5: DESCRIPTION OF HMO OPERATIONS

This exhibit should contain a detailed description of how this significant modification will change existing HMO operations. The description should include, but is not limited to the following information:

A description of proposed operational changes including claims processing and payment, utilization management, quality management, enrollment and billing, customer service, provider relations, etc.
The city and state where each operation will be performed (i.e. claims will be paid in Jacksonville, Fl)
Changes to any affiliates and/or intermediary relationships who will perform operations on behalf of the applicant if known
Additional Management Information Systems to be employed and location of these systems

EXHIBIT 6: FINANCIAL STATEMENTS

This exhibit should include current financial statements showing the applicant's assets, liabilities, and sources of financial support. If the applicant's financial affairs are audited by independent certified public accountants, a copy of the applicant's most recent regular certified financial statements may satisfy this requirement unless the Financial Evaluation Division directs that additional or more recent financial information is required. Please be advised of the following:

The financial statements and projections filed must be on a statutory accounting basis based upon North Carolina law.

In accordance with 11 NCAC 11C .0311, applications for expansion of service area must demonstrate at least a minimum of one year of net operational gains by the applicant in the current approved service area.

The aforementioned requirement may be waived by the Commissioner if additional capital as determined by the Commissioner is placed in the HMO, or if a guaranty agreement approved in writing by the Commissioner, to pay for any loss to enrollees claiming reimbursement due to insolvency of the HMO is made. In order to qualify, the guaranteeing organization must:
submit to the jurisdiction of this State for actions arising under the guarantee;
submit certified, audited annual financial statements to the Commissioner; and
appoint the Commissioner to receive service of process in this State.