**STATE OF WEST VIRGINIA**
**Offices of the Insurance Commissioner**
**Financial Conditions Division**

Mailing Address:
Financial Conditions
PO Box 50540
Charleston, WV 25305-0540

Telephone: (304) 558-2100
Facsimile: (304) 558-1365
Email: financial.conditions@wvinsurance.gov
www.wvinsurance.gov

Location:
Financial Conditions
1124 Smith Street, Rm 102
Charleston, WV 25301

# Foreign Health Maintenance Organization
# Application and Checklist for a
# Certificate of Authority
# Chapter 33, Article 25A of the West Virginia Code

Mail completed application to:

West Virginia Offices of the Insurance Commissioner
Financial Conditions Division
PO Box 50540
Charleston, WV 25305-0540

Pursuant to Chapter 33, Article 25A, of the West Virginia Code, the application is hereby submitted to form and operate a Health Maintenance Organization ("HMO").

Name, trade name and address of the Health Maintenance Organization Applicant:

Name: _____

Trade Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____

Attorney or Principal filing this application on behalf of the HMO applicant:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____

E-mail requests to: financial.conditions@wvinsurance.gov

Important Links:
W. Va. Code
Insurance Rules
Informational Letters

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## INTRODUCTION

A Health Maintenance Organization (HMO) is a public or private organization which provides or otherwise makes available basic health care services to enrollees. Factors to consider in determining if an organization is an HMO include, but are not limited to, whether it: (1) receives premiums for the provision of basic health care services to enrollees on a prepaid per capita or prepaid aggregate fixed sum basis excluding copayments; (2) provides physician services through doctors who are either employees or partners of the organization and/or through arrangements with individual or group practice doctors; (3) assures the availability, accessibility, quality and effective utilization of the health care services which it provides; and (4) offers services through an organized delivery system in which a primary care physician is designated for each subscriber upon enrollment.

To operate in West Virginia, an HMO must apply for and receive a Certificate of Authority from the Insurance Commissioner. Each application must set forth and be accompanied by the information and documentation requested. The Commissioner shall issue or deny a Certificate of Authority to any person filing an application within one hundred twenty days after receipt of the completed application. IMPORTANTLY: An application will not be considered complete until all information and documentation requested have been submitted to the Commissioner, and the applicant has fully complied with all provisions or requirements of these guidelines or applicable laws. Prior to receiving a Certificate of Authority, an applicant will be contacted by the Insurance Commission to initiate the depositing of cash or government securities with the West Virginia Treasurer's Office in compliance with W. Va. Code §33-25A-4(2)(h).

## INSTRUCTIONS

1. A completed application checklist and appropriate verification must be submitted.

2. All information provided should be placed in three-inch binder(s) and be separated by numbered tabs which correspond to the numbered requests in the application checklist. For example: Application Question No. 5 asks for a copy of the Articles of Incorporation. The copy should be placed under Tab No. 5 in the binder.

3. Documents must have page numbers which should begin with the corresponding Tab No. and a dash (-). For Example: If the Articles of Incorporation are four pages long, each page should be numbered 5-1, 5-2, 5-3 and 5-4.

4. Replacement pages should specifically note what pages are being replaced. For example: If the Articles of Incorporation were incorrect and had to be replaced, they should be numbered Replacement 5-1, Replacement 5-2, etc. If the documents merely supplement existing documents, they should be marked Supplemental and should use a letter of the alphabet. For example: If page 5-1 of the Articles of Incorporation is being supplemented it should be numbered Supplemental 5-1(a).

5. Each application box should be check-marked (1) if the information requested has been provided. REMEMBER: Each application must be verified to make sure that the documents and information have been provided before completing and sending the checklist and verification.

6. Page numbers indicating the information and/or document location(s) must be clearly marked on the space provided.

**NOTE:** The information requested by the Application Checklist constitutes the minimum necessary to begin the 120-day Certificate of Authority review cycle. The Commissioner reserves the right to ask for and obtain additional information and/or documents from an applicant at any time prior to the deemer date in order to determine whether to grant a Certificate of Authority.

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## I. CERTIFICATE OF AUTHORITY

Page(s)
Location

☐ ____ 1. Each application for a Certificate of Authority must be verified by an officer or authorized representative of the applicant.

☐ ____ a. A verification form entitled "CERTIFICATION" is included with this application packet and must be completed and filed with each application.

☐ ____ b. Attach a copy of the corporate resolution appointing the individual as the authorized representative of the HMO.

☐ ____ 2. Attach a check in the amount of $200 made payable to the "Insurance Commissioner of West Virginia."

☐ ____ 3. File an original and two copies of the application with the West Virginia Insurance Commissioner. The Commissioner may request additional copies.

☐ ____ 4. File a copy of the cover page of this application with:

Health Care Cost Review Authority
100 Dee Drive, Suite 201
Charleston, WV 25311-1692

## II. ORGANIZATIONAL/MANAGERIAL

☐ ____ 5. Submit Articles of Incorporation and all amendments certified by the Secretary of State.

☐ ____ a. The Articles of Incorporation must state that the applicant will operate as a Health Maintenance Organization.

☐ ____ b. The Secretary of State's certificate must be dated no later than thirty (30) days before the first submission of this application.

☐ ____ c. Certificate of Authority from the domiciliary insurance regulator indicating that the company is an authorized HMO in its state of domicile.

☐ ____ 6. List and submit a copy of each type of security issued by the applicant to acquire necessary start-up capital.

☐ ____ 7. State the amount of applicant's capital and/or surplus:

☐ ____ a. For profit stock corporation:

☐ Fully paid-in capital stock (at least $1,000,000) $_____

☐ Additional surplus (at least $1,000,000) $_____

☐ ____ b. For non-profit corporation:

☐ Statutory surplus (at least $1,000,000) $_____

☐ Additional surplus (at least $1,000,000) $_____

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☐ ____ 8. Submit in chronological order a legal history listing predecessor corporations and/or organizations, mergers, reorganizations and changes of ownership. Be specific as to dates and parties involved.

☐ ____ 9. Submit the names, addresses and official capacities of all officers, directors, managers, administrators and persons holding 5% or more of the common stock of the organization responsible for the applicant's conduct.

☐ ___ a. Include a completed BIOGRAPHICAL STATEMENT AND AFFIDAVIT for each name listed above.

☐ ___ b. Each individual named above must fully disclose to the Insurance Commissioner and the applicant's Board of Directors the nature and extent of all contracts or arrangements with the applicant. The disclosure shall include any and all possible conflicts of interest.

☐ ___ c. Persons holding 5% or more of the applicant's common stock must disclose the nature and extent of any ownership interest in all parent organizations, subsidiaries and affiliated companies. The disclosure must include an organizational chart depicting all levels of ownership including all subsidiaries and parent organizations along with all affiliated companies and corresponding percentages of ownership.

☐ ___ d. Submit independent investigation reports on all individuals identified above.

1. The reports must be forwarded directly to the Financial Conditions Division of the Offices of the West Virginia Insurance Commissioner from the independent investigators.

2. Person(s) required to furnish an investigation report may use:

☐ Equifax Services, Inc.
PO Box 2729
Jacksonville, FL 32203
(904) 733-7550

☐ Another investigative organization approved by the Insurance Commissioner prior to the filing of the application.

☐ ____ 10. Submit a statement describing:

☐ ____ a. Proposed operations.

☐ ____ 1. State whether the applicant will be a Staff Model, IPA Model or Combination Model HMO.

☐ ____ 2. Describe the method of compensation for providers, e.g. fee-for-service, capitated, etc.

☐ ____ b. The proposed service area(s). "Service area" means the county or counties to be approved by the Commissioner within which the applicant may provide or arrange for health care services for its subscribers.

**III. <u>MARKETING</u>**

☐ ____ 11. Describe the marketing strategy for each major category of enrollment:

☐ ____ Group

☐ Criteria for selection of primary and secondary targets;

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☐ Use of underwriting guidelines;

☐ Plans for community education and public relations.

☐ ____ Small Group

☐ Criteria for selection of primary and secondary targets;

☐ Use of underwriting guidelines;

☐ Plans for community education and public relations.

☐ ____ Individual

☐ Criteria for selection of primary and secondary targets;

☐ Use of underwriting guidelines;

☐ Plans for community education and public relations.

☐ _____ Medicare

☐ Use of underwriting guidelines;

☐ Plans for community education and public relations.

☐ _____ Medicaid

☐ Use of underwriting guidelines;

☐ Plans for community education and public relations.

☐ ____ Public Employees Insurance Agency

☐ Use of underwriting guidelines;

☐ Plans for community education and public relations.

☐ Other

☐ Criteria for selection of primary and secondary targets;

☐ Use of underwriting guidelines;

☐ Plans for community education and public relations.

**IV. <u>INSURANCE</u>**

☐ ____ 12. Describe any limitation of the applicant's financial risk. An HMO may either obtain reinsurance or make other arrangements acceptable to the Commissioner:

☐ ____ For the cost of providing to any enrollee health care services the aggregate value of which exceeds $4,000.00 in any year;

☐ ____ For the cost of providing health care services on a non-elective emergency basis or for coverage outside the service area; or

☐ ____ For not more than 95% of the amount by which the applicant's costs for any of its fiscal years exceed 105% of its income for those fiscal years.

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☐ Other

☐ ____ 13. Describe any risk sharing arrangements with provider(s) or other parties. Provide a copy of and reference the applicable sections of each provider contract pertaining to the risk- sharing arrangements. See WV CSR §114-43.

☐ ____ 14. All directors, officers, administrators, persons holding 5% or more common stock of the organization and employees who receive, collect, disburse or invest funds in connection with the HMO must be appropriately bonded.

☐ ____ Submit the enclosed "FIDELITY BOND WORKSHEET" (Form HM0-FID-1).

☐ ____ Obtain fidelity bond(s) in the amount prescribed by the worksheet.

☐ ____ Submit a copy of each fidelity bond obtained. Each bond must be current and must be relevant to applicant's proposed operations.

☐ ____ 15. Describe any arrangements to guarantee the continuation of benefits and payments to providers of services rendered to and after insolvency for the duration of the contract period for which premiums have been paid or until their discharge for members confined to an inpatient facility on the date of insolvency.

**V. <u>FEASIBILITY STUDY and FINANCIAL</u>**

☐ ____ 16. Submit a comprehensive feasibility study:

☐ ____ a. Performed by a qualified independent actuary in conjunction with a certified public accountant;

☐ ____ b. Containing certification by the qualified actuary as to the feasibility of the proposed organization;

☐ ____ c. Containing an opinion by the certified public accountant as to the feasibility of the proposed organization;

☐ ____ d. Covering the greater of three years or until the HMO has been projected to be profitable for twelve consecutive months;

☐ ____ e. Demonstrating that the HMO would not, at the end of any month of the projection period, have less than the minimum capital and surplus;

☐ ____ f. Stating that the rates are not inadequate, excessive or unfairly discriminatory;

☐ ____ g. Demonstrating that the rates are appropriate for the classes of risk for which they have been computed;

☐ ____ h. Outlining the appropriate rating methodology;

☐ ____ i. Demonstrating the HMO is actuarially sound:

☐ ____ 1. The certification shall consider the rates, benefits and expenses of the organization.

☐ ____ 2. The rates that are or will be charged are actuarially adequate to the end of the period for which rates have been guaranteed.

☐ ____ 3. Incurred but not reported claims and claims reported but not fully paid have been adequately provided; and

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☐ ____ j. Indicating that the HMO is knowledgeable about the competitors, market and service areas for the geographic location(s) where it will operate.

☐ ____ 17. Submit the latest CPA Audit, Quarterly and Annual Financial Statements filed with the NAIC.

☐ ____ 18. Submit a statement declaring all investments have been valued for asset purposes on a basis currently approved by the National Association of Insurance Commissioners (NAIC). If any investments have been valued for asset purposes in a manner other than one currently approved by the NAIC, describe each item so valued and the basis of value indicated on the "Asset Page" of the balance sheet.

**VI. ENROLLMENT**

☐ ____ 19. Submit a description of the following assumptions underlying enrollment projections:

- ☐ ____ A projection of enrollment;
- ☐ ____ Number of eligible persons residing within the service area;
- ☐ ____ Contract size assumptions (contract distribution and content);
- ☐ ____ Penetration assumptions and rationale, including initial and re-enrollments;
- ☐ ____ Allowance for voluntary/involuntary disenrollment and group contract additions during the year;
- ☐ ____ Projection by month and year of the break-even date; and
- ☐ ____ A plan outlining the provisions made for emergency and out-of-area health care.

**VII. CONTRACTUAL**

☐ ____ 20. Submit copies of all:

- ☐ ____ Enrollment contracts.
- ☐ ____ Member handbooks.
- ☐ ____ Benefit packages, riders and endorsements. At a minimum, benefits shall include:
  - ☐ ____ TMJ
  - ☐ ____CMD
  - ☐ ____ Mammography
  - ☐ ____ Pap Smears
  - ☐ ____ Rehabilitation
  - ☐ ____ Child Immunizations
  - ☐ ____ Basic Health Care Services as defined in W. Va. Code §33-25A- 2(1).

☐ ____ 21. Submit a copy of each type of provider contract utilized by the applicant. The contracts must include:

- ☐ ____ Hold Harmless Clause (see recommended HMO Hold Harmless language attached hereto).
- ☐ ____ Sixty-day notification to the HMO and Insurance Commissioner prior to termination of the contract.
- ☐ ____ All provider contracts must include provisions required by W. Va. Code §33-45-2.

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☐ ____ Note: If documents are intermediary contracts, provide evidence that the HMO has met all other requirements contained in WV CSR §114-43-3.

☐ ____ 22. Submit a list of all physicians, hospitals and other providers with whom the applicant has contracted for services and the corresponding signature pages from each executed provider contract. The list and the corresponding signature pages must be alphabetized and sorted by county and specialty.

**VII. GRIEVANCES & APPEALS**

☐ ____ 23. Submit a detailed description of applicant's subscriber grievance and appeal procedures and include a statement that the HMO shall have someone with decision-making authority at each level of the process.

☐ ____ 24. Provide samples of group and individual contracts and certificate or member handbooks given to subscribers. Each shall include:

☐ ____ a. Formal and informal steps to resolve grievances;

☐ ____ b. Toll-free telephone numbers for the subscriber to call to present an informal grievance or to contact the grievance coordinator;

☐ ____ c. An address for written grievances;

☐ ____ d. A detailed description of the appeal process;

☐ ____ e. A description of the statute of limitations for filing grievances;

☐ ____ f. A statement outlining the time frame in which grievances shall be processed;

☐ ____ g. A statement that there is physician involvement in the review of medically-related grievances; and

☐ ____ h. A statement that time sensitive grievances will be handled on an expedited basis.

☐ ____ 25. Submit a copy of the policies and procedures for administering formal and informal grievances.

☐ ____ 26. Provide the name, address and telephone number of the grievance coordinator(s) who is/are responsible for the implementation of the grievance procedure.

**IX. QUALITY ASSURANCE**

☐ ___ 27. For health maintenance organizations that have been in existence at least three (3) years:

☐ ____ a. A copy of the current quality assurance report submitted to the HMO by a nationally recognized accreditation and review organization approved by the commissioner; or

☐ ____ b. Proof sufficient to demonstrate that the HMO has timely applied for and reasonably pursued a review of its quality assurance program; or

☐ ____ c. Indicate date the last quality assurance report was filed with and approved by the Commissioner:_____

(mm/dd/yyyy)

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**Important Note:**

• If the HMO has not been in existence at least three (3) years, documentation as required by the standards set forth in this section must be submitted to verify compliance.

• If the HMO has been in existence three (3) years or more, a copy of an Accreditation Report performed by a nationally recognized accreditation and review organization may be submitted to verify compliance. That report must, however, contain evidence that the quality assurance standards listed below in this section have been met. When necessary, separate documentation, as required by those standards, may be submitted to supplement the quality assurance report.

• If the HMO has undergone a pre-accreditation review (PAR), the PAR report may be submitted and supplemented, if necessary, by separate documentation as required by the standards set forth in this section. The PAR report and any additional documentation must verify compliance with the quality assurance standards.

• Please check those standards listed below which have been met by the quality assurance program and indicate where in the quality assurance report or in separate documentation those standards can be found. Subsequent to approval of the quality assurance program, any modification of the program must be immediately filed with and approved by the Commissioner.

☐ ___ 28. To establish quality management and improvement provide:

- ☐ ____ a. Written description of the Quality Improvement (QI) program that outlines program structure and design.
- ☐ ____ b. Statement that description is reviewed annually and updated as necessary.
- ☐ ____ c. Name, address and telephone number of senior executive responsible for program implementation.
- ☐ ____ d. Name, address and telephone number of the Medical Director.
- ☐ ____ e. Is Medical Director full time or part time?
- ☐ ____ f. Evidence that medical director has substantial involvement in QI activities.
- ☐ ____ g. Evidence of a committee that oversees and is involved in QI activities.
- ☐ ____ h. Description of the role, structure and function, including frequency of meetings, of the QI Committee.
- ☐ ____ i. Evidence that providers participate actively in the QI committee.
- ☐ ____ j. Evidence of contemporaneous records reflecting actions of the committee.
- ☐ ____ k. A copy of the annual QI work plan, or schedule of activities, that includes the following:
  - ☐ ____ 1. Objectives, scope, and planned projects or activities for the year;
  - ☐ ____ 2. Planned monitoring of previously identified issues, including tracking thereof over time; and
  - ☐ ____ 3. Planned evaluation of the QI program.

☐ ___ 29. To establish accountability to the governing body provide:

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☐ ____ a. Documentation that the governing body has approved the QI Committee's overall QI program and the annual QI work plan.

☐ ____ b. Evidence that the governing body or designated committee receives regular written reports from the QI program delineating actions taken and improvements made.

☐ ____ c. Evidence that the governing body reviews a written annual report on the QI program.

☐ ____ d. Evidence that QI information is used in recredentialing, recontracting, and/or annual performance evaluations.

☐ ___ 30. To establish coordination with other management activities provide:

☐ ____ a. Evidence that QI activities are coordinated with other performance monitoring activities, including utilization management, risk management and resolution and monitoring of member complaints and grievances.

☐ ____ b. Evidence of linkage between QI and other management functions of the managed care organization, e.g. network changes, benefits redesign, medical management systems, practice feedback to providers and patient education.

☐ ___ 31. Provider contracts should contain or include:

☐ ____ a. Requirements to participate in QI activities are incorporated into all provider contracts and employment agreements.

☐ ____ b. A specification the hospitals and other contractors will allow the managed care organization access to the medical records of their members.

☐ ____c. A provision that the health maintenance organization allows open provider-patient communication regarding appropriate treatment alternatives and that it does not penalize the provider for discussing medically necessary or appropriate care for the patient.

☐ ___ 32. To establish that the quality assurance program is designed to objectively and systematically monitor and evaluate the quality and appropriateness of care provide:

☐ ____ a. Evidence of member participation in QI.

☐ ____ b. Evidence that the monitoring and evaluation of clinical issues reflect the population served by the managed care organization in terms of age groups, disease categories, and special risk status. Identify the following:

☐ ____ 1. Services provided in institutional settings;

☐ ____ 2. Services provided in noninstitutional settings, including but not limited to, practitioner offices and home care.

☐ ____ 3. Primary care and major specialty services, including mental health.

☐ ____ 4. High-volume, high-risk services, and the care of acute and chronic conditions.

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☐ ___ 33. To establish important aspects of care and service provide:

☐ ____ a. The process for periodically updating the practice guidelines.

☐ ____ b. The mechanism for communicating the practice guidelines to managed care organization providers has been implemented.

☐ ____ c. How performance is assessed against the practice guidelines.

☐ ____ d. A description of the evaluation process for member continuity and coordination of care.

☐ ____ e. A description of mechanisms to detect under and over utilization.

☐ ____ f. A description of mechanisms used to assess patient outcomes.

☐ ___ 34. To establish access to care and service provide:

☐ ____ a. A copy of the standards for the availability of or access to primary care providers, e.g., routine, urgent and emergency care.

☐ ____ b. A description of the process for identifying members with chronic/high-risk illnesses and implementing appropriate programmatic responses.

☐ ____c. A description of the procedures for handling/scheduling appointments by telephone and the use of advice and member service lines.

☐ ___ 35. To establish quality measurement and improvement provide evidence that HMO has developed quality indicators that are objective, measurable and based on current knowledge and clinical experience and are used to monitor and evaluate each important aspect of care and service identified.

☐ ____ a. Identify performance goals and/or a bench-marking process for each indicator.

☐ ____ b. Identify the appropriate methods and frequency of data collection for each indicator.

☐ ____ c. Evidence that results of evaluations are used to improve clinical care and service.

☐ ____ d. The method of tracking areas for improvement to assure that appropriate action is taken and improvements are effective.

☐ ___ 36. To establish utilization management provide:

☐ ____ a. Description of the UM program including policies and procedures to evaluate medical necessity, criteria used, information sources, and the process used to review and approve the provision of medical services.

☐ ____ b. Mechanism for updating the UM program description on a periodic basis.

☐ ____ c. Evidence that qualified medical professionals supervise review decisions where procedures are used for preauthorization and concurrent review.

☐ ____ d. Evidence that a duly licensed physician conducts a review for medical appropriateness on any denial.

☐ ____ e. Evidence that the managed care organization utilizes, as needed, licensed physician consultants from appropriate specialty areas of medicine.

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☐ ____ f. Written utilization review decision protocols.

☐ ____ g. The mechanism for checking the consistency of application of criteria across reviewers.

☐ ____ h. The mechanism for periodically updating review criteria.

☐ ____ i. Description of information intake including pertinent clinical information and consultation with the treating physician.

☐ ____ j. Evidence that reasons for denial notification of appeal process are clearly documented and available to the member.

☐ ____ k. Written policies and procedures to evaluate the appropriate use of new medical technologies or new applications of established technologies, including medical procedures, drugs and devices.

☐ ____ 1. Written policies and procedures for evaluating the effects of the program using member satisfaction data, provider satisfaction data, and/or other appropriate means.

☐ ____ m. If any delegation of QI or UM activities to contractors, provide evidence of oversight of the contracted activity including:

☐ _____ 1. the delegated activities;

☐ _____ 2. the delegate's accountability for these activities;

☐ _____ 3. the frequency of reporting to the HMO;

☐ _____ 4. the process by which delegation will be evaluated;

☐ _____ 5. approval of the delegate's UM program; and

☐ _____ 6. evaluation of the regularly specified reports.

☐ ___ 37. To establish that a system of credentialing is in place provide:

☐ ____ a. A copy of the written policies and procedures for the credentialing process.

☐ ____ b. Evidence of a credentialing committee or other peer review body that makes recommendations regarding credentialing decisions.

☐ _____ c. Evidence that provider doctors serve as voting members of the credentialing committee.

☐ _____ d. The name, address, telephone number and area(s) of practice of each practitioner who falls under the HMO' s scope of authority and action.

☐ _____ e. Evidence that the initial credentialing process is ongoing and up-to-date and that HMO obtains review verification of the following:

☐ _____ 1. A current valid license to practice;

☐ _____ 2. When applicable clinical privileges in good standing at the hospital designated by the practitioner as the primary admitting facility;

☐ _____ 3. A valid DEA certificate, as applicable;

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☐ _____ 4. Graduation from medical school or appropriate graduate school and completion of a residency, specialty training or board certification, as applicable;

☐ _____ 5. Complete work history;

☐ _____ 6. Current adequate malpractice insurance according to the HMO's policy; and

☐ _____ 7. Complete professional liability claims history.

☐ ____ f. A copy of the form application for membership including a statement by the applicant regarding:

☐ ____ 1. Reasons for any inability to perform the essential functions of the position with or without accommodation;

☐ ____ 2. Lack of present illegal drug use and alcohol abuse;

☐ ____ 3. History of loss of license and/or felony convictions;

☐ ____ 4. History of loss or limitation of privileges or disciplinary activity; and

☐ ____ 5. An attestation to the correctness/completeness of the application.

☐ ____ g. Evidence that the HMO requests information on the practitioner during credentialing and re-credentialing from the following recognized monitoring organizations:

☐ ____ 1. National Practitioner Data Bank;

☐ ____ 2. The appropriate State licensing boards such as the Board of Medicine, Chiropractic Board, Osteopathic Board and/or Dental Board; and

☐ ____ 3. Medicare/Medicaid sanctioning.

☐ ____ h. Evidence of an initial visit to each potential primary care practitioner's office and to the offices of obstetricians/gynecologists and other high-volume specialists resulting in documentation of a structured review of the site and of medical record keeping practices to ensure conformance with HMO's standards.

☐ ____ i. Evidence of the periodic verification of credentials that is ongoing and up-to-date and implemented at least every two years.

☐ ____ j. Evidence that recredentialing, recertification, or reappointment process includes verification from primary sources of:

☐ ____ 1. Current valid license to practice;

☐ ____ 2. When applicable, clinical privileges in good standing at the hospital designated by the practitioner as the primary admitting facility;

☐ ____ 3. A valid DEA certificate, as applicable;

☐ ____ 4. Board certification, as applicable;

☐ ____ 5. Current, adequate malpractice insurance according to the HMO's policy; and

☐ ____ 6. Professional liability claims history.

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☐ ____ k. Evidence that the recredentialing process includes a current statement by the applicant regarding:

☐ ____ 1. Inability to perform the essential functions of the position, with or without accommodation; and

☐ ____ 2. Lack of present illegal drug use or alcohol abuse.

☐ ____ 1. Evidence that the recredentialing, recertification or performance appraisal process includes review data from:

☐ ____ 1. member complaints and grievances;

☐ ____ 2. results of quality reviews;

☐ ____ 3. utilization management;

☐ ____ 4. member satisfaction surveys

☐ ____ 5. medical record reviews; and

☐ _____ m. Evidence that the recredentialing process includes an on-site visit to the offices of all primary care providers and OB/GYNs.

☐ ____ n. Copies of policies and procedures for reducing, suspending or terminating practitioner privileges which shall include:

☐ ____ 1. a mechanism for reporting to the appropriate authorities serious quality deficiencies resulting in suspension or termination; and

☐ ____ 2. an appeal process for and notice thereof to the provider.

☐ _____ o. Copies of written policies and procedures for the initial quality assessment of all health delivery organizations including but not limited to hospitals, home health agencies, behavioral health agencies, nursing homes, skilled nursing facilities and free-standing surgical centers with which the HMO intends to contract.

☐ ____ 1. When applicable, confirmation that health delivery organizations have been reviewed and approved by a recognized accrediting body and are in good standing with state and federal regulatory bodies.

☐ ____ 2. A copy of the standards of participation for health delivery organizations who have not been approved by a recognized accrediting body.

☐ _____ p. Evidence of oversight of any delegated credentialing/re-recredentialing activity to contractors including a written description of:

☐ ____ 1. the delegated activities; and

☐ ____ 2. the delegate's accountability for these activities.

☐ ____ q. Evidence that HMO monitors the effectiveness of the delegate's credentialing and reappointment or recertification processes at least annually.

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☐ ___ 38. To establish that members' rights and responsibilities are delineated in the quality process provide:

☐ ____ a. A copy of the HMO's written policy recognizing the right of members to:

☐ ____ 1. voice grievances about the HMO or care provided;

☐ ____ 2. have information concerning the HMO, its services, the practitioners providing care, and members' rights and responsibilities;

☐ ____ 3. participate in decision-making regarding health care; and

☐ ____ 4. be treated with respect and recognition of their dignity and need for privacy.

☐ ____ b. A copy of the HMO's written policy addressing members' responsibilities for cooperating with those health care providers by:

☐ ____ 1. giving needed information to professional staff to ensure appropriate care; and

☐ ____ 2. following instructions and guidelines given by health care providers.

☐ ____ c. A statement that the HMO provides a copy of policies on members' rights and responsibilities to all participating providers and directly to members.

☐ ____ d. Evidence that members are given written statements that are clear and concise and at a minimum address:

☐ ____ 1. how to submit a claim for covered services;

☐ ____ 2. how to obtain primary and specialty care, behavioral health services and hospital services;

☐ ____ 3. after-hours and emergency coverage including the HMO' s policy on when to directly access emergency care or use 911 type services:

☐ ____ 4. benefits and services included and excluded from membership;

☐ _____ 5. obtaining out of area coverage;

☐ ____ 6. special benefit provisions such as co-payment, higher deductibles and rej ection of claims that may apply to services outside the system;

☐ ____ 7. members charges

☐ ____ 8. procedures for notifying those members affected by:

☐ ____ a. termination or change in any benefits,

☐ ____ b. termination of any services, or

☐ _____ c. termination of any service delivery office/site;

☐ ____ 9. notification of termination of a primary care or specialty provider and the process for selecting a new provider;

☐ ____ 10. procedures for appealing decisions adversely affecting the member's coverage, benefits, or relationship to the organization;

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☐ ____ 11. procedures for changing practitioners;

☐ ____ 12. procedures for disenrollment of nongroup subscribers;

☐ ____ 13. procedures for voicing complaints, grievances and appeals;

☐ ____ 14. procedures for recommending changes in policies and services;

☐ ____ 15. points of access to primary care, specialty care and hospital services;

☐ ____ 16. the process by which a managed care organization determines whether or not to include new and emerging technology or treatment as a covered benefit;

☐ ____ 17. information on provider names, qualifications and titles;

☐ ____ 18. a copy of written policies and procedure pertaining to confidentiality; and

☐ ____ 19. a compilation of the results of the member satisfaction survey including an assessment of:

☐ ____ a. patient complaints;

☐ ____ b. requests to change practitioners and/or facilities; and

☐ ____ c. disenrollments by members.

☐ _____ 20. Procedure by which a member can receive a standing referral to a specialist

☐ _____ e. Submit a detailed description and evidence as to how enrollees are afforded an opportunity to participate in matters of policy and operation pursuant to W. Va. Code §33- 25A-6.

☐ _____ f. Evidence of oversight of any delegated member service activities to contractors including a written description of:

☐ ____ 1. delegated activities;

☐ ____ 2. delegate's accountability for these activities;

☐ ____ 3. frequency of reporting complaints and grievances and member survey data;

☐ ____ 4. process by which the delegation will be evaluated;

☐ ____ 5. approval of the delegate's member services program; and

☐ ____ 6. evaluation of regularly specified reports.

☐ ___ 39. To establish that the HMO engages in preventive health services provide:

☐ ____ a. Copies of practice guidelines and all updates for the use of preventive health services.

☐ ____ b. A statement that the guidelines are provided in writing to all providers and members.

☐ ____ c. Evidence that the HMO monitors, evaluates and takes action to improve a minimum of two of the following:

☐ ____ Childhood immunizations recognized by the American Academy of Pediatrics or as required by state or federal law.

☐ ____ Adult immunizations:

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☐ ____ Influenza vaccine;

☐ ____ Pneumococcal vaccine;

☐ ____ Hepatitis B vaccine;

☐ ____ Diphtheria and tetanus toxoid; and

☐ ____ Rubella screening for women of childbearing age.

☐ ____ Any other required by state or federal law.

☐ ____ Coronary artery disease risk factor screening and/or counseling for smoking, cholesterol, exercise and hypertension:

☐ ____ Cancer screening:

☐ ____ Breast; and

☐ ____ Cervix.

☐ ____ Counseling for prevention of motor vehicle injury;

☐ ____ Lead toxicity screening;

☐ ____ Sexually transmitted disease screening/prevention;

☐ ____ Prenatal care;

☐ ____ Human immunodeficiency virus (HIV)/ Aids counseling, screening and education;

☐ ____ Prevention of unintended pregnancy; and/or

☐ ____ Alcohol and other drug abuse screening/prevention.

☐ ___ 40. To establish that medical records are maintained in a manner that is current, detailed, organized, and permits effective patient care and quality review provide:

☐ ____ a. A statement that records are available to health care practitioners at each patient visit and to nationally and state recognized reviewing bodies sanctioned by the Commissioner;

☐ ____ b. A copy of standards and all updates for maintaining medical records, the systematic review for conformance and the institution of corrective action when standards are not met; and

☐ ____ c. A statement that copies of all standards and goals and any updates are provided in writing to all providers.

**X. <u>MISCELLANEOUS</u>**

☐ ____ 41. Submit a description of enrollee participation in matters of policy and operation.

☐ ____ 42. Submit the attached "ACKNOWLEDGMENT AND WAIVER OF CHIEF EXECUTIVE OFFICER ON BEHALF OF HMO APPLICANT" which shall contain notarized acknowledgments that:

☐ ___ A delinquency proceeding or supervision by the Insurance Commissioner constitutes the sole and exclusive method for the liquidation, rehabilitation, reorganization or conservation.

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☐ ___ Waives any right to file or be subject to any federal bankruptcy proceeding.

☐ ___ Comes from the CEO acknowledging that he/she has read and understands his/her obligations to report any impairment of the HMO to the Insurance Commissioner.

**CERTIFICATION**

State of _____

County of _____

To-wit:

I, _____, do swear or affirm that I have carefully examined each of the questions asked in the **HEALTH MAINTENANCE ORGANIZATION APPLICATION AND CHECKLIST** and each of the responses thereto and, to the best of my knowledge and ability, all responses, information, exhibits, and documentary evidence submitted in support thereof are true and correct.

_____

(Type or Print Name)

_____

(Title)

_____

(Signature)

_____

(Date)

Sworn to and subscribed before me this _____ day of _____ 20__.

My commission expires: _____

_____

(Notary Seal) (Notary Public)

**STATE OF WEST VIRGINIA**
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## RECOMMENDED HMO HOLD HARMLESS LANGUAGE

**No Billing of Members**

1. No Charges. Participating Provider shall hold harmless and not impose any charges on HMO Members for Plan benefits and shall regard the HMO payment as payment in full for all benefits covered by this Agreement with the exception of co-payments specifically authorized in the applicable Evidence of Coverage and any non plan benefits. Participating Provider shall also be entitled to receive payment for third party claims. Participating Provider will never, under any circumstances, including non-payment by HMO, the insolvency of HMO, or breach or termination of this Agreement, seek compensation from, have any recourse against, or impose any additional charge on any HMO Member for Plan benefits. Participating Provider shall look only to HMO for payment for plan benefits. If HMO receives notice that a Participating Provider has billed or collected from a Member for any covered or non- authorized benefit, HMO may refund that amount to Member and may offset that amount from any payment to Participating Provider, with prior notice to the Participating Provider.

2. No Collection Action Against Members. Neither Participating Provider, trustees or assignees, may maintain any action at law against Member to collect sums owed by HMO.

3. Survival of Covenants. Participating Provider further agrees that these provisions shall survive the termination of this Agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of the Member, and that these provisions supersede any oral or written agreement to the contrary now existing or hereafter entered into between Participating Provider and Member or any persons acting on their behalf.

4. Collections of Co-payments. These provisions shall not preclude Participating Provider form collecting the Copayments that are specifically authorized by the Member's Evidence of Coverage.

5. Non-Covered Services. A Participating Provider may bill a Member for services if: (i) prior to receiving such services the Member is advised that such services are not Covered services; and (ii) after being so advised the Member nevertheless elects in writing to receive such non-Covered Services.

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**Suggested Minimum amounts of:**
**FIDELITY INSURANCE**

Fidelity Bonds provide coverage to the insured business or individual for money or other property lost because of dishonest acts of its bonded employees. While the need for fidelity bond coverage can vary from company to company, it is recommended that those who have access to cash and investments be bonded. This includes the people who have the ability to authorize wire transfers, write checks and those who can buy, sell, or transfer investments. The terms of each policy may vary; however, it is recommended that the policy be written to cover material acts of theft or dishonestly by bonded employees.

The following table indicates the exposure index amount with the recommended fidelity bond amount:

| Exposure Index | | Bracket No. * | | Amount of Bond | |
|---|---|---|---|---|---|
| $1,000 | $25,000 | 1 | $15,000 | - | $25,000 |
| 25,000 | 125,000 | 2 | 25,000 | - | 50,000 |
| 125,000 | 250,000 | 3 | 50,000 | - | 75,000 |
| 250,000 | 500,000 | 4 | 75,000 | - | 100,000 |
| 500,000 | 750,000 | 5 | 100,000 | - | 125,000 |
| 750,000 | 1,000,000 | 6 | 125,000 | - | 150,000 |
| 1,000,000 | 1,375,000 | 7 | 150,000 | - | 175,000 |
| 1,375,000 | 1,750,00 | 8 | 175,000 | - | 200,000 |
| 1,750,000 | 2,125,000 | 9 | 200,000 | - | 225,000 |
| 2,125,000 | 2,500,000 | 10 | 225,000 | - | 250,000 |
| 2,500,000 | 3,325,000 | 11 | 250,000 | - | 300,000 |
| 3,325,000 | 4,175,000 | 12 | 300,000 | - | 350,000 |
| 4,175,000 | 5,000,000 | 13 | 350,000 | - | 400,000 |
| 5,000,000 | 6,075,000 | 14 | 400,000 | - | 450,000 |
| 6,075,000 | 7,150,000 | 15 | 450,000 | - | 500,000 |
| 7,150,000 | 9,275,000 | 16 | 500,000 | - | 600,000 |
| 9,275,000 | 11,425,000 | 17 | 600,000 | - | 700,000 |
| 11,425,000 | 15,000,000 | 18 | 700,000 | - | 800,000 |
| 15,000,000 | 20,000,000 | 19 | 800,000 | - | 900,000 |
| 20,000,000 | 25,000,000 | 20 | 900,000 | - | 1,000,000 |
| 25,000,000 | 50,000,000 | 21 | 1,000,000 | - | 1,250,000 |
| 50,000,000 | 87,500,000 | 22 | 1,250,000 | - | 1,500,000 |
| 87,500,000 | 125,000,000 | 23 | 1,500,000 | | 1,750,000 |
| 125,000,000 | 187,500,000 | 24 | 1,750,000 | - | 2,000,000 |
| 187,500,000 | 250,000,000 | 25 | 2,000,000 | - | 2,250,000 |
| 250,000,000 | 333,325,000 | 26 | 2,250,000 | - | 2,500,000 |
| 333,325,000 | 500,000,000 | 27 | 2,500,000 | - | 3,000,000 |
| 500,000,000 | 750,000,000 | 28 | 3,300,000 | - | 3,500,000 |
| 750,000,000 | 1,000,000,000 | 29 | 3,500,000 | - | 4,000,000 |
| 1,000,000,000 | 1,250,000,000 | 30 | 4,000,000 | - | 4,500,000 |
| 1,250,000,000 | 1,500,000,000 | 31 | 4,500,000 | - | 5,000,000 |

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**Calculation of Bond Amount**

1. Total Admitted Assets

   $_____ X 5% = $_____

2. Gross Income*

   $_____ X 10% = $_____

   Exposure Index = $_____**

3. Minimum Amount of Bond

   Bracket No._____$_____

*Include gross premium written and assumed plus interest and dividend income.

** Amount is calculated by adding the results of number 1 and 2 above.

The exposure index is calculated using all insured companies named on the fidelity bond. The fidelity bond policy limits listed above are not a substitute for the risk assessment that should be made by company management in establishing a reasonable level of insurance coverage. Similarly, company management should evaluate its business needs for other insurance coverages such as general liability and property, if applicable.

The insurance examiner, therefore, in evaluating the amount of the fidelity bond coverage amount, should not rely on the schedule above as an absolute guide, but instead, should review the internal controls that serve to mitigate the exposures covered by such insurance policies. In evaluating the fidelity bond the examiner should also consider if the reporting entity has the ability to meet the deductible.

Note: Fidelity bonds are written to cover material acts of theft or dishonestly by bonded employees. Thus, if a crime is committed by an employee who is not bonded, the company may have to bear the costs of that loss. Alternatively, companies may buy a general fidelity insurance policy commonly referred to as crime coverage. Crime coverage is an acceptable alternative to fidelity bonds so that it provides coverage that is at least as broad as the coverage provided by a fidelity bond. Keep in mind that both fidelity bonds and crime coverage will vary from policy to policy, so the examiner should use professional judgment when analyzing the individual policy and the risk that the policy hedges.

HMO-FID- 1

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## ACKNOWLEDGEMENT AND WAIVER BY CHIEF EXECUTIVE OFFICER ON BEHALF OF HEALTH MAINTENANCE ORGANIZATION APPLICANT

I, _____, the _____ [Chief Executive Officer] of _____ [HMO Applicant], hereinafter referred to as the "Organization", having the authority to bind said Organization, do hereby:

(1) ACKNOWLEDGE, on behalf of the Organization, that a delinquency proceeding brought pursuant to the provisions of Article 10, Chapter 33 of the West Virginia Code of 1931, as amended [W. Va. Code §§33-10-I et seq.], or the administrative supervision provisions of article thirty-four of said chapter [W. Va. Code §§33-34-1 et seq.] constitutes the sole and exclusive method for the liquidation, rehabilitation, reorganization or conservation of a health maintenance organization licensed under the laws of this State; and

(2) WAIVE, on behalf of the Organization, any right to file or to be subject as a debtor to any bankruptcy proceedings;

(3) AFFIRM that I have read and do hereby understand the obligation imposed upon me as the chief executive officer of the Organization by the provisions of Article thirty-five of Chapter 33 of said Code [W. Va. Code §§33-35-1 et seq.] dealing with the criminal sanctions for the failure to timely report to the Insurance Commissioner an impairment of the Organization.

Dated this _____ day of _____, 20__.

_____
(HMO Applicant)

BY: _____
(Signature)

ITS: _____
(Title)

State of _____
County of _____, to wit;

I, _____, a Notary Public in and for the county and state aforesaid, hereby certify that _____ whose name is signed to the foregoing document, bearing date the _____, day of 20__, for _____ (HMO Applicant), has this day in said county, personally appeared before me in said county and acknowledged the said writing to be the act and deed of said corporation.

Given under my hand this _____, day of _____ , 20__.

My commission expires on _____.

_____
(SEAL) Notary Public