DEPARTMENT OF HEALTH/INSURANCE DEPARTMENT - HMO APPLICATION PROCESS

The application process to obtain a Certificate of Authority to operate an HMO in the Commonwealth of Pennsylvania is a joint regulatory process coordinated through the Department of Health's Bureau of Managed Care, and the Insurance Department's Bureau of Licensing and Financial Analysis, and Accident and Health Bureau.

The dual regulatory process was established by the HMO Act which gave both Departments oversight roles due to the HMOs unique nature as both a payment and health delivery system. The Department of Health (DOH) has responsibility for assuring that the HMO applicant's delivery system is adequate and accessible, in terms of quality of care and availability of services, and cost-effectiveness. The Pennsylvania Insurance Department (PID) reviews rates and policy literature, and has responsibility to assure the HMO remains financially solvent.

Approval to operate an HMO in the Commonwealth of Pennsylvania is granted pursuant to the provisions of the Health Maintenance Organization Act of December 29, 1972 as amended: 40 P.S. § 1551-1568, 28 Pa. Code Section 9.52, and 31 Pa. Code - Chapter 301, et seq. Other laws may apply in the operation of an HMO in the Commonwealth of Pennsylvania.

The Departments of Health and Insurance HMO application package is enclosed along with supporting documentation (See Table of Contents for Appendices 1-23). For additional information, please contact DOH at (717) 787-5193 or PID at (717) 787-2735 for Company Licensing or (717) 787-4192 for Forms and Rates.

Prior to application submission, applicants are encouraged to contact appropriate Department personnel concerning issues which may need clarification.

The HMO Application should be submitted **in triplicate to each of the following**; the application fee (page 13, Point # 28) should only be submitted to the Bureau of Licensing and Financial Analysis:

Bureau of Managed Care
Department of Health
Room 1030 Health and Welfare Building
P.O. Box 90
Harrisburg, Pennsylvania 17108

Bureau of Licensing and Financial Analysis
Insurance Department
1345 Strawberry Square
Harrisburg, Pennsylvania 17120

CERTIFICATE OF AUTHORITY HMO APPLICATION

The revised Department of Health/Insurance Department HMO application package is geared toward facilitating and streamlining the preparation of complete applications, and avoiding lengthy delays due to the need to provide additional materials and numerous revisions to the initial HMO application submission.

GENERAL INSTRUCTIONS FOR APPLICATION FORMAT:

Please prepare the application documentation, making sure every element of the information requested is provided.

To facilitate application preparation, please refer to the HMO Act (Appendix 1) and HMO Regulations (Appendices 2 [DOH] and 3 [PID]) and the Accident and Health Reform Filing Act (Act 159 of 1996 in Appendix 4).

1) Cover Sheet, Compliance Crosswalks and Checklist

- Use the two page form provided in Appendix 5 as the cover sheet for the HMO application.
- Complete the DOH crosswalk forms provided in Appendix 6.

  Applicants should complete only Columns 2 and 3 of the crosswalk forms, and include them with the completed HMO application.

  Column 4 of each crosswalk is for Department of Health staff reviewers' comments only. All crosswalk forms will be returned to the HMO applicant with Column 4 completed, indicating problem areas, need for additional information or requested changes.
- Complete the PID checklist form provided in Appendix 7 concerning contract forms and related material

Cover sheets and all crosswalk and checklist forms must be completed and submitted with the entire HMO application packet.

Crosswalk Forms

Crosswalk forms have been created for the quality assurance, utilization management, credentialing and provider contracts portions of the Certificate of Authority application. The crosswalk forms will serve as a clear-cut table of reference between established standards and those sections in the HMO application which documents the HMO applicant's proposed compliance. These forms are meant to ensure timely review of the submission.

The Standards for Accreditation established by the National Committee for Quality Assurance (NCQA) are the standards of choice for the Pennsylvania Certificate of Authority. The NCQA is an external quality review organization and has become an industry authority, operating its own accreditation program for managed care organizations nationwide.

The Department of Health will use NCQA standards to evaluate an applicant's proposed quality improvement, utilization management, and credentialing programs.

The crosswalk form for provider contracts is based on Department of Health standards. The guidelines for provider contracts compliance are included in Appendix 8.

<u>Checklist</u>

The checklist (Appendix 7) is based on Insurance Department law and regulations, and is provided to ensure that the application addresses specific provisions contained in those laws and regulations.

2) Page Format, Numbering, and Table of Contents

The name of the HMO applicant must be specified on the upper right-hand corner of every page of the HMO application and supporting documentation. To ensure easy reference and review, each page of the HMO application should be consecutively numbered, or at a minimum, should be consecutively numbered in each section.

The application should have a Table of Contents, and documentation provided in the appendices should be separated by tabs.

3) Application Content Requirements

Please provide the information and documentation required in the 29 points listed and explained on pages 6-13 of this application package. Use the crosswalks, checklist, guidelines and technical advisories placed in the Appendices to strengthen the overall quality of the HMO application.

The completed submission must give evidence of an HMO applicant corporation's capability to meet the minimum operating standards both initially and on an ongoing basis as defined and required in the HMO Regulations for both the Department of Health (28 Pa. Code § 9.71-9.97 in Appendix 2) and the Insurance Department (31 Pa. Code § 301.61-301.64 in Appendix 3).

It is highly recommended that appropriate staff of the HMO applicant corporation familiarize themselves with the contents of the supportive documentation in the Appendices before preparing the HMO application for submission.

4) HMO Application Review Process

Please refer to pages 14-18 for a detailed explanation and schematic of the joint HMO application review process.

DOH/PID CERTIFICATE OF AUTHORITY APPLICATION CONTENT REQUIREMENTS

1) **A copy of the basic organizational document of the applicant organization, such as the articles of incorporation, and amendments thereto.**

   The Departments of Health and Insurance will not process a Certificate of Authority application unless the applicant HMO includes evidence of having been lawfully incorporated and registered with the Pennsylvania Department of State.

2) **A copy of the bylaws, rules, and regulations or similar documents regulating the conduct of the internal affairs of the applicant corporation.**

   Please note that the Department of Health regulations require that the subscriber nominating process shall be structured so as to prevent undue influence in the selection process by nonsubscriber members of the board. This could be developed as an appendix to the bylaws or by an executed board resolution. If an applicant HMO chooses to comply with this requirement by developing an appendix to the bylaws, that should be reflected in this section of the Certificate of Authority application.

   For further information on the composition of the Board of Directors, please refer to 28 Pa. Code § 9.96 in Appendix 2.

3) **A list of the names, addresses, and official positions of the board of directors of the applicant corporation and of persons who are to be responsible for the conduct of the affairs of the applicant - including, but not limited to, the Executive Director or President, Medical Director, Director of Marketing and Director of Finance.**

   The applicant shall provide "notarized biographical affidavits" and "independent character reports" for each of these persons. The character reports shall include employment history for at least (10) years, UCC criminal litigation bankruptcy records for seven (7) years, and a business character reference from a business associate such as a partner, attorney or other contact. Please do not use coworkers or supervisors for the business reference. The reports should be obtained from an independent source such as Equifax or Proudfoot. This section will be kept confidential as a part of the Certificate of Authority application.

4) **A description of the service area of the proposed health maintenance organization including geographical boundaries, demographic data, and identification of population groups which would be sources of prepayment.**

   The Department of Health requires that an HMO applicant must have a sufficient number of providers, distributed both geographically and by specialty, within the proposed service

area to meet the HMO's commitments to provide services to a voluntarily enrolled population. Since negotiating with, contracting, and credentialing multiple providers in multiple counties is likely to take significant time and resources, the Department of Health is willing to license an applicant on the basis of a portion of the service area originally proposed in an application. For example, if nearing completion of the application review, an applicant has sufficient providers to deliver services in only two of five counties originally proposed for its service area, the Department will issue a license based on only those two counties. The HMO may then continue to develop their network in the other three counties and request subsequent approval by the Department of Health after licensure.

5) **A copy of the applicant corporation's proposed contracts with subscribers and groups of subscribers, setting forth the corporation's contractual obligations to provide basic health services.**

Both the Insurance Department and the Department of Health have interests in reviewing these documents.

For example, the Department of Health is responsible for reviewing and approving the applicant HMO's:

* basic health services (28 Pa. Code § 9.72 - Appendix 2)
* assurance of access to care (28 Pa. Code § 9.75 - Appendix 2)
* member grievance system (28 Pa. Code § 9.73 - Appendix 2)

However, the grievance system description is included in the member contracts and enrollee literature materials reviewed by the Insurance Department. In addition, the Department of Health's HMO regulations place limits on co-payments, so that they do not act as a barrier to a member's receipt of basic health care services. Yet, the actual co-payments are imposed and found in the member's contract.

The Insurance Department is interested in Evidences of Coverage and Individual Conversion Contracts, Subscriber I.D. Cards, Applications and Enrollment Forms and Health/Evidence of Insurability Forms (See Appendices 7 and 9). The Departments have worked together on a system whereby the Insurance Department, in its review of member contracts, will inform applicants of noncompliance with Department of Health issues. The Departments work together to ensure that these joint reviews do not delay the application review process.

6) **A copy of the applicant corporation's contracts with physicians, groups of physicians organized in a group-practice or individual-practice basis, hospitals, skilled nursing facilities and other providers of health care services enabling it to provide basic health services to a voluntarily enrolled population.**

Please carefully review the guidelines and technical advice and assistance regarding the content of provider contracts (Appendix 8), and Professional Staff Standards (28 Pa. Code §9.76 (a) in Appendix 2.

Publications concerning the Departments' policies on HMOs contracting with integrated delivery systems (IDS), physician-hospital organizations (PHOs), etc. are included in Appendix 10. (For HMOs planning on negotiating with IDSs for Medicaid patients, please refer to Appendix 11.)

While the Department of Health requires that the critical role of "health manager" or "gatekeeper" be undertaken by a primary care physician (PCP), exceptions to that stipulation can be made for the use of certified registered nurse practitioners (CRNPs) for justifiable reasons. One such justifiable reason may be lack of PCP availability in a medically underserved area. Please refer to Appendix 12 for technical assistance for such exemption requests.

NOTE: The crosswalk forms for NCQA standards for credentialing and DOH requirements for provider contracts are included in Appendix 6. A crosswalk form must be completed for each type of provider contract utilized.

7) **A copy of any contract with any individual, partnership, association or corporation for the performance on its behalf of necessary functions including, but not limited to, marketing, enrollments and administration and of any contract with an insurance company, hospital plan corporation or professional health service corporation for the provision of insurance or indemnity or reimbursement against the cost of health care services provided by the health maintenance organization.**

The Departments' primary concerns here are twofold: (1) that any use of indirect provider contracts contain specific amendments/riders meeting Department requirements; and (2) if the applicant intends to enter into a "management contract" with another entity, that such contract includes sufficient authority for the HMO and its board to meet its obligations, and to take corrective action if the management company's performance of critical functions, such as claims payment, operation of the quality assurance and member grievance systems, etc. are unsatisfactory.

8) **A detailed description of the applicant corporation's proposed grievance resolution system whereby the complaints of its subscribers may be acted upon promptly and satisfactorily.**

Please carefully review the information on Department expectations regarding the creation and operation of an effective member grievance system. (See Appendix 13 - in particular page 16 concerning "Filing Requirements" - for documentation which must be included in the HMO application submission). A brief description of the grievance process must appear in the group master contract, subscription agreement, evidence of coverage, etc. Applicants should note that Exhibit 3, Appendix 13 contains a sample, generic grievance system description for potential adoption by HMOs for inclusion in their member contracts.

9) **A detailed description of the applicant corporation's arrangement for an ongoing quality-of-health-care assurance program.**

Please carefully review the guidelines and technical advice and assistance regarding the content for a quality assurance program. (See also 28 Pa. Code § 9.74 in Appendix 2 and Department of Health Guidelines in Appendix 14.) Applicants operating HMOs in other states should not merely submit quality assurance plans or procedures currently utilized in other states. The quality assurance plan submitted should be Pennsylvania-specific, and should address the issues and comply with the guidelines and technical assistance advisories. Also include any Incentive Compensation for Providers that the Plan may wish to propose.

NOTE: The crosswalk forms for NCQA standards for both quality improvement and utilization management are included in Appendix 6. These forms must be completed and submitted with the HMO application.

Applicants should be aware that when meeting to discuss the quality assurance portion of the application, Department of Health staff will expect the medical director and director of quality assurance for Pennsylvania operations to be present for such discussion.

10) **A detailed description of the applicant corporation's potential ability to assure both the availability and accessibility of adequate personnel and facilities to serve enrolled subscribers in a manner enhancing availability, accessibility and continuity of services, including information regarding proposed practice site locations and hours of operation.**

Initially, the Department of Health's expectation for this requirement is a brief, general description of the applicant's proposed method of building a delivery system of participating providers. The HMO applicant need not present evidence of a satisfactory network until mid-point in the DOH review process. In fact, most applicants do not begin to enroll providers until the Department of Health has reviewed and approved the proposed provider contracts (Appendix 8) and credentialing system (Appendix 15).

As the last step in the process, the Department of Health requires submission of accessibility/availability information in the form of maps of the service area showing participating provider locations by specialty, and lists of fully credentialed providers), and then conducts an onsite, prelicensure inspection. (See Appendix 16.) At this visit, Department of Health staff will review a random sample of credentialing files to verify signed provider contracts and satisfactory credentialing. All hospital contracts will be reviewed and must be fully signed and executed by the time of the site visit.

11) **A detailed description of reasonable incentives for cost control within the structure and function of the proposed health maintenance organization.**

Applicants should describe the use of various reimbursement systems, such as capitation,

discounted fee-for-service, fee schedules, per diem payments; various utilization controls; and use of the primary care physician in contributing to its proposal to render cost-effective care to voluntarily enrolled members of the applicant HMO.

12) **A brief description of Federal grant or loan funds received by the applicant corporation for the purposes of developing a Federally qualified health maintenance organization.**

Both Departments acknowledge that such grants and loans are no longer available, but have not had the opportunity to revise the existing regulations. Therefore, HMO applicants are authorized to ignore this section.

13) **A copy of the applicant corporation's most recent financial statement.**

This information will be kept confidential.

14) **A description of the applicant corporation's capability to collect and analyze necessary data relating to the utilization of health care services by enrolled subscribers.**

Licensed HMOs are required to submit quarterly and annual reports to the Department of Health (See 28 Pa. Code § 9.91-9.92 in Appendix 2). Examples of such reporting forms are included in Appendix 17. Applicants should ensure that their data systems are capable of capturing this data.

15) **A copy of proposed general subscriber literature.**

This section should include Benefit Booklets, and Group and Subscriber Educational Material, and Group and Subscriber Marketing Material. Applicants should ensure that information in these materials does not conflict with contract forms and that information concerning the HMO is factual. The material is reviewed to ascertain how the HMO describes to enrollees such critical issues as the role of the primary care physician "health manager/gatekeeper", the requirements for obtaining specialty referral, and other health service delivery system issues.

16) **A job description for the position of medical director.**

Please carefully review the essential duties for a medical director included in the Department of Health Regulations. (See 28 Pa. Code § 9.76 (b) in Appendix 2).

17) **A procedure for referral of subscribers to nonparticipating specialists.**

Please include a brief description of this process and please include a draft referral form. For those HMOs wishing to avail themselves to the point-of-service option, please

consult Appendix 18.

18) **Written procedures for payment of emergency services provided by other than a participating provider.**

The HMO applicant should describe the procedures to be followed by a member in filing a claim for payment or reimbursement of valid emergency services provided by a non-participating provider. The reimbursement level should also be described. The Departments encourage HMOs to hold members financially harmless for such claims, that is, that the member should not have to be concerned with "balance billing" by the non-participating provider.

19) **A description of the manner in which subscribers will be selected to meet the statutory requirement that 1/3 of the board members be subscribers.**

The Departments understand that an HMO applicant has no members, and may not have a substantial enough enrollment until one year after licensure to bring members onto the board. Therefore, the Departments will expect that an HMO complies with this provision by the anniversary date of its licensure. However, the subscriber nominating process is reviewed as part of the certificate of authority review. The Department of Health regulations note that this process shall be structured so as to prevent undue influence in the selection process by nonsubscriber members of the board and this could be an appendix to the bylaws or by an executed board resolution.

20) **A description of the system established to ensure that the records of the corporation pertaining to its operation of a health maintenance organization are identifiable and distinct from other activities in which that corporation may engage.**

This item needs to be addressed only by existing corporations which desire to develop and operate an HMO as a "line of business." Most applicant HMOs incorporate a new corporation to seek and receive a Certificate of Authority, and such applicants need not address this issue.

21) **A copy of the written procedures regarding frequently utilized services required by 28 P.S. § 9.75 (c) relating to assurance of access to care.**

28 P.S. Section 9.75 (c) is found in Appendix 2.

22) **A detailed description of reinsurance contracts and a description of insolvency reinsurance obtained by the applicant.**

23) **A sworn statement that no funds may be transferred out of this Commonwealth by the applicant without the prior approval and written consent of the Insurance Department.**

24) **A plan of insolvency in compliance with standards set forth in Title 31 Pa. Code Chapter 301.123.**

Guidelines for these standards are located in Appendix 19.

25) **A Business Plan setting forth the organization and management structure, products, and services, intended market and financial projections in conformance with the format described in DOI-132.**

Guidelines for developing this section can be found in Appendix 20 ("Business Plan for Newly Formed HMOs"). This section will be kept confidential as a part of the Certificate of Authority application.

26) **A description of any existing or contemplated financial risk-sharing arrangements, including any existing or contemplated relationships with integrated delivery systems (IDSs) (e.g. PHOs, HPOs or IPAs) including a description of how the applicant HMO will retain financial and legal accountability.**

See the IDS Statement of Policy in Appendix 10 for additional information.

27) **In accordance with Section 301.42 (9), rates filing shall be submitted separately from the HMO application. Additional information on the filing and review of base rates under Act 159 of 1996 is found in Appendix 4. The filing must however contain the following:**

* Proposed premium rates (on a separate rate page for each base benefit plan and for each rider).
* Detailed description of underlying assumptions utilized in deriving the rates. All assumptions must be supported.
* Projected utilization of inpatient hospital days, subdivided by age and sex.
* Projected utilization of skilled nursing facility days, subdivided by age and sex.
* Projected cost of hospitals to be specifically utilized by the HMO through contract or otherwise
* Projected outpatient utilization, subdivided by age and sex.
* Projected same day surgery utilization, subdivided by age and sex.
* Projected outpatient costs.
* Projected same day surgery costs.
* Projected utilization of various physician services, subdivided by category according to standardized format in Appendix 21, subdivided by age and sex.
* Projected cost of various physician services.

* Identification of services that are capitated, capitation amounts, inclusion of capitation contracts showing capitation payment schedules.
* Projected cost and utilization of emergency services.
* Projected cost and utilization of out-of-area services.

* Projected cost of other services, subdivided by category according to the standardized format in Appendix 21.
* Identification of copays and their effect on rates.
* Identification of incentive arrangements and risk policy arrangements and their effect on rates.
* Identification, justification, and derivation of a separate trend factor. For each separate trend factor, the specific benefits to which the trend factor applies shall be identified.
* Identification of profit factor. Profit factor shall be no more than 5%.
* Projected cost of reinsurance, both gross and net of recoveries.
* A detailed breakdown of administrative expenses into component parts including management fees. Administration is limited to a maximum 15% of total required revenue. Additionally, the dollar amount of administrative expenses on a PMPM basis are currently limited to a maximum increase of 4% per year.
* Identification of demographic information used to convert the total cost per member per month to the proposed premium rates.
* Identification and derivation of large group rate adjustment formulas. Guidelines are located in Appendix 21.
* A rate table listing proposed premium rates by effective period, class of membership and applicable contract form number which is separate from the rate justification materials.
* Projected financial statements, including schedules of cash flow, for a number of years that go at least past the breakeven point. Assumptions underlying the financial statements, including the projected number of members, shall be included.
* Projected amount of investment income.

<u>This section will be kept confidential as a part of the Certificate of Authority application.</u>

$2,500

28) **A check for [illegible] made payable to the "Commonwealth of Pennsylvania."**

This application fee should be submitted <u>only</u> to the Insurance Department (Bureau of Licensing and Financial Analysis) whose address is listed on page 1 of this application packet.

29) **Other information that the applicant corporation may wish to submit which reasonably relates to its capability of operating and maintaining a health maintenance organization.**

CERTIFICATE OF AUTHORITY
APPLICATION REVIEW PROCESS

A detailed schematic of the interdepartmental review process of the jointly issued Certificate of Authority is contained on page 18. A step-wise narrative explanation follows:

- DEPARTMENT OF HEALTH:

It is the goal of the Department of Health to complete its review process within 90 days of receipt of a complete HMO Certificate of Authority application. By definition, a complete Certificate of Authority application must include an adequate provider network for which all providers have been fully contracted and credentialed (See point number 4 of the Review Process). This particular element of the HMO application can only be established following Department of Health approval of the provider contract and credentialing sections of the HMO application.

The option to use an Integrated Delivery System (IDS) is one way to minimize this intrinsic delay of HMO network development in the HMO application review process.

The turn-around time for an HMO applicant to provide the Department of Health with any additional required information to have a complete application is not part of the 90-day calculation.

1) Receipt of Application

Upon receipt of an application, notice of receipt will be published in the Pennsylvania Bulletin for comment. The application itself is handled by the professional staff of the Bureau of Managed Care (BMC) of the Department of Health.

Internally, the HMO application will be assigned to a member of the BMC professional staff. This person serves as the applicant's principal liaison with the Department of Health for all communications (e.g., arrangement of meetings, prelicensure site visits, etc.). The Bureau will coordinate a concurrent review of the key elements of the application, such as quality assurance plan, provider contracts, credentialing system, and member grievance provisions.

A comprehensive review meeting of the application with the applicant will occur approximately 30-45 business days after receipt of the application.

2) Comprehensive Review Meeting

This is an extremely important meeting which is held in the Bureau's office (Room 1030) in the Health & Welfare Building in Harrisburg. It is the Department of Health's expectation that at a minimum, the applicant's CEO, Medical Director, and Director of Quality Assurance will attend. During the course of this meeting, member grievances, provider contracts, credentialing, quality assurance, etc., or any areas requiring clarification will be discussed.

3) Comprehensive Review Letter and Follow-Up

Shortly after the comprehensive review meeting, the HMO applicant corporation will receive a letter from the Department of Health. This **comprehensive review letter** will suggest a pre-licensure onsite visit date, contingent upon the applicant's submission of a complete response addressing every item identified by the Department of Health in the comprehensive review letter.

The applicant's response letter should be submitted to the Department of Health at least two (2) weeks prior to the scheduled onsite visit. This response letter must include any additional information, revisions, etc. that the Department of Health has requested, as well as preliminary evidence of network adequacy and capacity.

The Department of Health defines "adequate network" as a network having fully credentialed and contracted providers with appropriate facilities and specialists accessible throughout the requested service area. Furthermore, documentation should be submitted which demonstrates that the PCP network has the additional "capacity" to accept at least the estimated number of new members for the first year of HMO operation.

Please note that as of the date of this DOH review letter, the 90-day timetable will be suspended until date of receipt of the HMO's review letter response.

4) Network Development

Many HMO applicants find that development of an adequate network is the most time-consuming portion of the HMO application process, and frequently must defer the pre-licensure onsite visit until they have built an adequate provider network with sufficient capacity.

For those corporations choosing the IDS option for network development, please refer to Appendix 10 (Appendix 11 in case of IDS for MA recipients).

The Department of Health recognizes two important tools that an applicant needs to have approval of before beginning network development:

- provider contracts
- physician credentialing system

Thus, these are usually the first two items to be reviewed. Furthermore, these two elements may be discussed with the applicant, and a DOH review letter may be written even before the comprehensive review meeting.

5) Pre-licensure Site Visit

The final step in the Department of Health approval process for the HMO Certificate of Authority application is an on-site, pre-licensure visit to the applicant's Pennsylvania office. At this site visit, the Department of Health will judge the applicant's capacity to become operational (including sufficient staff and other resources, such as a data processing/claims processing system). Furthermore, the Department of Health will

specifically review a random sample of credentialing files to ensure that each file contains a DOH-approved provider contract signed by the participating provider and that all credentialing has been successfully completed, including the HMO's on-site visit to primary care physician offices and other related documentation.

6) Post Onsite Visit

Prior to final approval, the applicant must submit two completely revised and updated copies of the HMO application, reflecting all changes made during the course of the Department of Health HMO application review process.

7) DOH Interface with PID

After a successful site visit and upon receipt of the revised application submitted in duplicate, the Department of Health will notify the Insurance Department in writing that it has completed its review.

- THE INSURANCE DEPARTMENT

The Certificate of Authority application is processed in two separate bureaus within the Department.

1) The Policy Review Division in the Accident and Health Bureau will
   * review rate information and forms, including the Evidence of Coverage and Group Contracts,
   * suggest revisions and continue the review of Member Handbook material, Group and Subscriber Educational material, Group and Subscriber Marketing material, Subscriber I.D. cards, Applications, Enrollment Forms, and Health/Evidence of Insurability Forms.

   The review of this information shall be subject to the requirements of Act 159 of 1996 (See Appendix 4).

2) Bureau of Licensing and Financial Analysis

   At the time that rates and forms are found to be acceptable, and the Department of Health has notified the Insurance Department of its completed review, the Insurance Department's Bureau of Licensing and Financial Analysis will then complete its review. (See Appendix 22- Organizational Examination)

Issuance of the Certificate of Authority

When the Insurance Department completes its review, the Department of Health will process the Certificate of Authority for signature by the Secretary of Health and the Insurance Commissioner. An applicant is not authorized to begin marketing or to become operational until such time as it has received the actual appropriately signed Certificate of Authority.

Post-Issuance of the Certificate of Authority

Quarterly and Annual Reports

The Department of Health requires submission of quarterly and annual reports (Appendix 17), and the Insurance Department requires submission of quarterly and annual financial statements.

External Quality Review

In keeping with 28 Pa. Code § 9.93 (Appendix 2) and as part of DOH's ongoing quality review, an HMO must undergo an external quality assurance assessment one year after receipt of the Certificate of Authority, and then every three years thereafter. The list of DOH-approved external quality review organizations is detailed in Appendix 23.

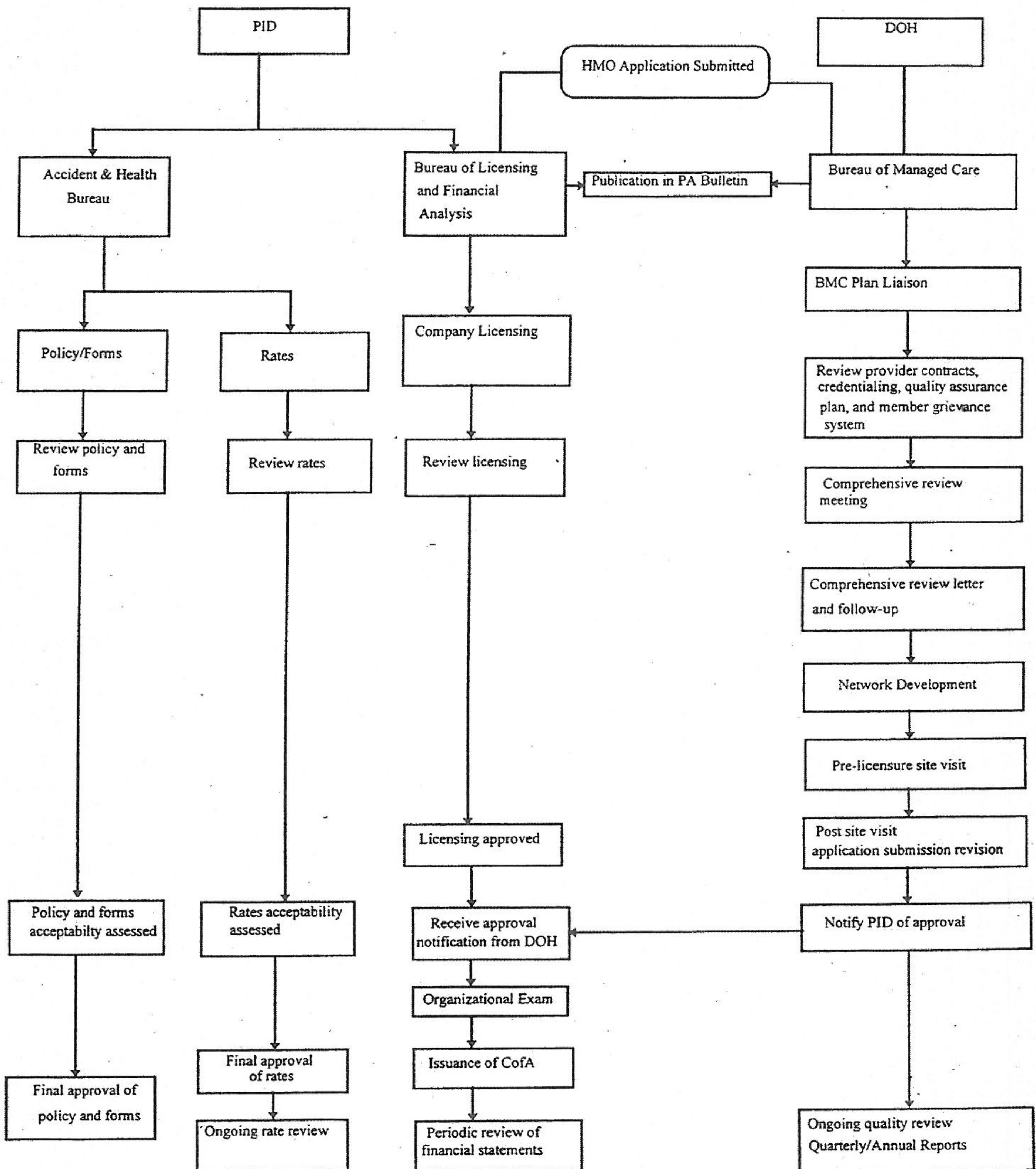
Rate Review

The Insurance Department also performs ongoing rate reviews and financial examinations at least every five years.

Service Area Expansion

Any HMO planning to expand and market services beyond the service area initially approved at the time of the Certificate of Authority application must obtain prior approval from the Department of Health and the Insurance Department. Guidelines are provided in Appendix 24. Please contact the Bureau of Managed Care for further information.

Schematic of Review Process



FOR FURTHER INFORMATION AND ASSISTANCE:

If you have any questions about the issues or sections described in this packet concerning the content or review of your application, please feel free to contact the appropriate offices, as follows:

Department of Health
Bureau of Managed Care (717) 787-5193

The Bureau of Managed Care reviews all areas concerned with quality assurance, utilization management, provider contracts, credentialing, network capacity, and member grievances.

Insurance Department
Bureau of Licensing and Financial Analysis
Office of Regulation Companies
Company Licensing Division (717) 787-2735

Company Licensing reviews the portions of the application regarding organizational structure, financial requirements, transfer of risk to other parties, and the HMO applicant corporation's Business Plan.

Insurance Department
Accident and Health Bureau
Office of Rate and Policy Regulation
Policy Review Division (717) 787-4192

The Policy Review Division reviews contract forms and other forms for subscribers, and the rates the HMO charges employers.

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APPENDIX 17: Department of Health HMO Quarterly and Annual Reporting Instructions and Forms

APPENDIX 18: Department of Health and Insurance Department Joint Policy Statement regarding HMO Point-of-Service Products and Gatekeeper PPOs

APPENDIX 19: Insurance Department Memo regarding Minimum Capital and Surplus Requirements for Licensure of HMOs

APPENDIX 20: Insurance Department Guidelines/Technical Advice Regarding the Development of a Business Plan for Newly Formed HMOs

APPENDIX 21: Insurance Department Guidelines/Technical Advice Regarding Rates

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