
BULLETIN

Number 97-B-1

TO: All Licensed HMOs

FROM: Managed Care And Health Benefits Division

RE: Intermediaries And Other Contractors Providing Services To HMOs;
Requirements For Preferred Provider Organization Networks;
Utilization Review Organizations; And Third Party Administrators

DATE: March 24, 1997

ATTENTION: Chief Executive Officer

As a result of the Managed Care Rules that became effective October 1, 1996, HMOs contracting with "intermediaries" for provider (PPO) networks and provider credentialing now have explicit regulatory requirements relating to their use of such arrangements. One purpose of this Bulletin is to alert you to these regulatory provisions. In addition, HMOs are reminded of their obligations under regulations governing Utilization Review and statutes governing Third Party Administrators.

Responsibilities Of HMOs Contracting With Preferred Provider Organizations (PPOs)

Companies offering PPO networks that contract with insurance companies and HMOs fall under the definition of "intermediary organization" as used in our Managed Care Rules, and are no longer required to register with the Department. Rather, the HMOs and insurance companies contracting with these intermediaries are required to file information related to these entities with the Department to demonstrate compliance. Requirements applicable to HMOs are as follow:

- Pursuant to 11 NCAC 20.0204, each form contract with an intermediary must be filed with and approved by the Managed Care and Health Benefits Division before an HMO executes such a contract. This filing is to be accompanied by a certification that the intermediary provider network with which the HMO is contracting is contractually bound to comply with statutes and regulations applicable to the services the intermediary will perform on behalf of the HMO and with the HMO's own policies and procedures. The certification must also include assurance that the HMO will monitor such compliance on an on-going basis. In addition, the intermediary contract must comply with all other requirements of 11 NCAC 20.0204.
- Once an HMO has contracted with a specific intermediary network, it must, in accordance with 11 NCAC 20.0601(c), notify the Managed Care and Health Benefits Division (MCHB Division) of such contract within 30 days of its execution. The MCHB Division must also be notified of the deletion of a network within 30 days of termination of its contract, as provided in 11 NCAC 20.0601(d).

- To facilitate compliance with 11 NCAC 20.0204 and 20.0601(c), the HMO will be permitted to submit both the required notification and the certification within 30 days following the execution of an intermediary contract. An HMO may use the Intermediary Contract Notification and Certification form accompanying this Bulletin or a substantially similar form of the HMO's own design.
- All requirements of Title 11, Chapter 20 of the North Carolina Administrative Code that apply to the use of intermediaries and delegation of activities, including those relating to health care provider contracts, verification of health care provider credentials, quality management, and network availability and accessibility, apply to an HMO's use of an intermediary PPO network.
- HMOs are responsible for their own compliance, the compliance of their intermediary, and for on-going monitoring of the intermediary's performance. The fact of an intermediary's compliance does not excuse an HMO for not having met its obligations to monitor performance. The mere act of monitoring an intermediary's performance does not relieve an HMO from its responsibility to demand corrective action, terminate a contract or rescind delegation if necessary.

Responsibilities Of HMOs Contracting With Utilization Review Organizations (UROs)

Independent UROs providing services to insurers and HMOs are no longer required to register with the Department. Rather, insurers and HMOs who make use of utilization review in their benefit plans, whether such functions are conducted in-house or delegated, are required to file information annually with the Department to demonstrate compliance. HMOs have always been subject to regulations that apply to utilization review activities. Requirements applicable to HMOs are as follow:

- HMOs must meet all requirements of 11 NCAC 12.0900 when they perform utilization review functions themselves.
- As provided in 11 NCAC 12.0903(a), no HMO may contract with an entity to perform utilization review unless that entity complies with 11 NCAC 12.0900.
- Pursuant to 11 NCAC 12.0903, on or before April 1 of each year, HMOs must file with the MCHB Division a certification that it (the HMO and/or the entity with which it contracts to perform utilization review) are in compliance with 11 NCAC 12.0900.
- Summary reporting of utilization review activities, as specified in 11 NCAC 12.0917, is due to the MCHB Division on or before April 1 of each year. Reporting should include activities performed by contracted entities as well as the HMO's own activities.
- HMOs are responsible for their own compliance, the compliance of any contracting entity, and for monitoring a contracted entity's performance. The fact of a contracted entity's compliance does not excuse an HMO for not having met its obligations to monitor performance. The mere act of monitoring a contracted entity's performance does not relieve an HMO from its responsibility to demand corrective action, terminate a contract, or rescind delegation if necessary.

Responsibilities Of HMOs Contracting With Third Party Administrators (TPAs)

- In cases where an HMO contracts with an entity that acts in the capacity of a TPA, such entity must be licensed with this Department.

- Pursuant to NCGS 58-56-26(b), it is the sole responsibility of the HMO to provide for competent administration of its programs, whether the administration is done in-house or delegated to a licensed TPA.
- Pursuant to NCGS 58-56-26(c), in cases where a TPA administers benefits for more than 100 certificate holders on behalf of an HMO, the HMO shall, at least semiannually, conduct a review of the operations of the TPA. At least one semiannual review shall be an on-site audit of the operations of the TPA.

Responsibility Of HMOs To Notify All Intermediaries Of This Bulletin

All HMOs receiving this bulletin are required to distribute a photocopy to all intermediary PPOs, UROs, and TPAs with whom they contract and notify the Department that such distribution has been accomplished. Notification to the Department must include: a list of the name of each entity to whom a copy of this bulletin was sent; the entity's address, telephone number, chief executive officer; and a description of the type of administrative and/or medical services provided. (e.g., mental health network and utilization management, physician network that credentials its own providers, utilization review for all services, claims processing for prescription drug claims.) Notification to the Department shall be made within 30 days of the HMO's receipt of this bulletin and shall be directed to the attention of:

Managed Care And Health Benefits Division
North Carolina Department Of Insurance
PO Box 26387
Raleigh, NC 27611

Notice to newly contracted intermediaries and the Department shall continue on an ongoing basis.

To assist you in your compliance efforts, definitions of PPOs, UROs and TPAs, along with examples of each, are attached. Should you have any questions regarding your responsibilities, you may contact DeAnne J. Nelson, Assistant Director, Managed Care & Health Benefits Division, at (919) 715-0526.

DEFINITIONS

Definition Of Preferred Provider Organization (PPO)

Any entity that contracts with health care providers, that also contracts with an HMO, insurer, or other entity offering a health benefit plan, or another PPO network used by an HMO or insurer, will be considered to be a PPO. The term "intermediary" as used in Title 11, Chapter 20 of the North Carolina administrative code, includes a PPO. An affiliate of your company or another HMO or insurer that provides network services is considered a PPO or intermediary.

Examples of PPOs include provider-based organizations, such as PHOs and IPAs, as well as freestanding networks that are not provider-based.

Contracts with chains that operate from multiple locations, such as nursing home or pharmacy chains, will not normally be considered to be a PPO. Contracts with these entities would be viewed as provider contracts. However, if unusual circumstances exist, an HMO should check with the Department to verify their status.

Definition Of Utilization Review Organization (URO)

Any entity that performs utilization review functions on behalf of an HMO, insurer, or any entity offering a health benefit plan will be considered to be a URO. An affiliate of your HMO or another HMO or insurer is considered a URO.

UROs may provide their services as part of a benefit carveout (e.g., a company administering all aspects of your vision benefit), as part of a PPO network (e.g., a PPO network delivers care and performs utilization review for services delivered by its contracted providers to determine whether services are medically necessary), or under an agreement to provide only utilization review services for some or all services sought under an HMO's plan.

Definition Of Third Party Administrator

Because of the broad definition of the term "third party administrator" as defined in NCGS 58-56-2(5), questions have arisen as to whether IPAs, provider networks, and other intermediary contractors are acting as a TPA when they receive payment directly from an HMO (either on a capitated or fee-for-service basis) and distribute funds to their own contracted providers (either on a capitated or fee-for-service basis).

HMO intermediaries that meet each of the following criteria will not be deemed to be adjusting or settling claims, and therefore will not be required to be licensed as TPA:

- The contracts between the intermediary and its providers and between the intermediary and the HMO stipulate that the HMO's payment to the intermediary constitutes payment in full for covered services and prohibit the billing of members for covered services, except for copayments and deductibles stipulated in the members' benefit policy issued by the HMO.
- The intermediary does not directly or indirectly receive claims from the HMO's members, adjudicate claims from the HMO's members, or disburse funds to the HMO's members.
- The intermediary distributes funds only to its own contracting providers, in accordance with written agreements. Such payment is made in return for medical services rendered by the intermediary's contracted providers directly to enrollees of an HMO contracting with the intermediary, in which arrangement the provider has agreed to participate.
- HMO member eligibility determinations are made by the HMO, not the intermediary.

- *Neither the provider nor the intermediary determines whether or not a service is covered under the benefit plan; all such determinations are made only by the HMO. (HMOs may provide intermediaries with a list of covered and non-covered services or have them perform utilization review, but only the HMO is responsible for determining coverage.)*
- *Providers who participate in an intermediary's network but also contract directly with an HMO submit their claims and encounter information directly to the HMO. (i.e., the intermediary does not submit claims to the HMO on behalf of a provider in cases where services are rendered pursuant to a separate direct contract between the HMO and the provider.)*

Intermediaries may not make payment to providers for services rendered to HMO members unless such provider has a written contract with the intermediary. If payment is made by an intermediary to a provider without such a contract, the intermediary will be deemed to have made claims payment. If the intermediary pays such a claim to a non-contracting provider out of a capitation pool, it will be deemed to be engaged in the business of insurance. Both of these activities require licensure from the Department of Insurance.

HMOs should review the definition of TPA provided in NCGS 58-56-2(5). An intermediary that engages in any activities that could in any way be included in the definition of a TPA should contact the Department of Insurance to determine whether licensing is required.

Intermediary Contract Notification and Certification

Pursuant to 11 NCAC 20.0601(c) and 20.0204, _____, a/an _____ duly licensed and authorized to do business in the State of North Carolina, ("Carrier") hereby provides notification that Carrier has entered into an intermediary relationship with the entity named below and certifies the following to the Commissioner of the North Carolina Department of Insurance:

- 1) Carrier contracts with _____, an intermediary under the provisions of 11 NCAC 20.0101(b)(4), ("Intermediary") to perform or provide the following services: _____ (the "Services").

- 2) Carrier's contract with Intermediary obligates Intermediary to comply with all statutes and regulations which apply to Carrier and the Services, including 11 NCAC 20.0200, et seq., and includes provisions addressing the following:
 - (a) Intermediary's obligation not to subcontract for its services without Carrier's written permission;
 - (b) Carrier's retention of the right to approve or disapprove the participation of individual providers in the network made available to Carrier's plan members;
 - (c) Intermediary's obligation to make available to Carrier and the Department of Insurance all provider contracts and subcontracts; and
 - (d) compliance, to the extent applicable, with the provisions of 11 NCAC 20.0204(b)(6).

- 4) Carrier has examined all Intermediary's provider contracts related to the Services and has found that all such contracts comply with applicable provisions of 11 NCAC 20.0202, including provisions addressing the following:
 - (a) whether contract and related appendices constitute the entire agreement between the parties;
 - (b) definitions of technical insurance or managed care terms;
 - (c) term of the contract;
 - (d) requirements, if any, for written notice of termination and grounds for termination;
 - (e) providers' continuing obligations in the event of termination of the contract or the insolvency of Carrier or Intermediary;
 - (f) requirement that each provider (i) maintain credentials sufficient to meet Carrier's credentialing requirements and (ii) provide notification of changes in the status of such professional credentials;
 - (g) obligation that the provider (or Intermediary on behalf of the provider) maintain acceptable levels of professional liability insurance and provide Carrier timely notification of changes in its coverage;
 - (h) for prepaid plans, prohibition against billing network plan members for covered services, except for specified coinsurance, copayments and applicable deductibles;
 - (i) responsibility, if any, for collecting applicable deductibles, copayments, coinsurance and fees for noncovered services;

- (j) responsibility for arranging call or backup coverage in accordance with Carrier's provider accessibility standards;
 - (k) Carrier's or Intermediary's obligation to provide a member eligibility verification mechanism;
 - (l) requirements regarding patient records, including maintenance standards, confidentiality, and accessibility;
 - (m) obligation to cooperate in member grievance procedures;
 - (n) obligation not to discriminate against members on the basis of race, color, national origin, gender, age, religion, marital status, health status, or insurance coverage; and
 - (o) obligation to comply with Carrier's utilization management, quality assessment, credential verification, and provider sanctions programs, with the proviso that such programs shall not override the professional or ethical responsibilities of a provider or interfere with a provider's ability to provide information or assistance to patients.
- 5) Carrier has developed policies and procedures related to Intermediary's performance of the Services and shall monitor such performance, as well as Intermediary's statutory and regulatory compliance, on an on-going basis.
 - 6) Carrier has examined Intermediary's policies and procedures related to the Services and has found them to be in compliance with applicable statutes and regulations, as well as Carrier's own policies and procedures.
 - 7) Carrier has developed policies and procedures, and has obtained all contractual provisions necessary and appropriate to enable it to take those actions necessary to maintain compliance with applicable statutes and regulations, including the ability to (i) demand that Intermediary take corrective action, (ii) terminate the intermediary relationship, and (iii) rescind delegation.
 - 8) Carrier retains ultimate responsibility for services provided to its members.
 - 9) Carrier retains financial responsibility to its members.
 - 10) Carrier retains ultimate responsibility for compliance with all applicable statutes and regulations related its activities as a network plan carrier, whether or not those activities are delegated.

By: _____

Name: _____

Title: _____

Date: _____