PREFERRED PROVIDER ARRANGEMENT
CARRIER
Initial Registration Application

Section I. General Information

1. Name:

2. Principal address: (City, State, Zip)

3. Mailing address: (if different) (City, State, Zip)

4. Contact person/Title, telephone number, fax, email address:

5. Federal I.D. #:

6. NAIC company code: (if applicable)

7. Does the company/organization hold any other licenses or registrations in Maine (If yes, specify what type. Please list all used. Use separate sheet if necessary.)

Section II. Separate Organizations/Third Party Administrators

1. If any separate organization(s) will be administering the preferred provider arrangement (PPA), including claims processing, utilization review, or other functions related to the PPA, on behalf of the administrator or carrier in Maine, please provide the following:

    A. The name, address, phone number, and license number of the organization(s);
    B. An explanation of the functions to be performed by the organization(s); and
    C. Attach copies of all signed contracts or agreements with the organization(s).

2. Provide a complete list of carriers and their health plans that intend to use the PPA network in Maine. Please identify which plans are self-funded and which plans are fully-funded.

Section III. Financial Statements

Attach complete audited financial statements for the most recently completed year. Such financial statements may be reviewed by an independent certified public accountant in lieu of an audit if the administrator does not handle money.

Section IV. Operations

Describe the general business activities and operations of the proposed PPA:

1. Provide a general statement of the health care services proposed to be offered (e.g., medical/surgical, behavioral health, vision, dental).

2. Provide the geographic area proposed to be served (e.g., statewide, specific counties), including an estimate of the projected number of enrollees in each county to be served for two (2) calendar years.

3. Describe the PPA's relationship to existing health plans, specifying whether the PPA will be offered as an alternative to coverage currently offered or as a replacement or modification of coverage currently offered, and explaining the reasons if certain classes of potential enrollees will be affected differently than others.

4. Describe the proposed provider network:

    A. Provide a directory with the names and addresses of primary care providers and specialty providers, and a description of the mechanism for identifying providers accepting new patients.
    B. Project the ratio of primary care providers to enrollees by county.
    C. Provide the names of participating hospitals.
    D. Provide the names and addresses of participating ancillary providers.
    E. If health care services are provided by salaried health care professionals employed by the PPA, describe the number and types of salaried professionals and the services provided.
    F. Calculate a 12-month average percentage of physicians in the network with open practices.
    G. Demonstrate that physicians have admitting privileges at participating hospitals.
    H. Describe the credentialing criteria and recruitment plan for preferred providers and demonstrate compliance with 24-A M.R.S. § 4303(2), which requires carriers to make credentialing decisions within 60 days after receiving a completed application from a provider.
    I. If contracting with a physician-hospital organization (PHO), provide a copy of the signed contract.
    J. Provide written standards for access to basic health care services and a description of the basis for determining that the network is sufficient to meet those standards.
    K. Provide written appointment scheduling guidelines and timeliness standards.
    L. Describe policies and procedures for enrollees who wish to change primary care providers.
    M. Please explain the plan for compliance with 24-A MRSA §4320K. Effective 1/1/19 carriers offering a health plan in Maine shall provide coverage for services performed by a licensed naturopathic doctor. A carrier shall demonstrate that the carrier's provider network includes reasonable access to all covered services, within the scope of practice of a naturopathic doctor.

5. Describe the compensation arrangement between the plan and the providers.

6. Describe the financial or other incentives for enrollees to use preferred providers:

    A. Describe procedures, if any, for referral of an enrollee to a nonpreferred provider by a preferred provider or by the carrier, or administrator, including the conditions under which such referral will occur.
    B. Demonstrate that the benefit level differential between services rendered by preferred providers and non-preferred providers does not exceed 20% of the allowable charge for

the service rendered unless the Superintendent waives this requirement for a given benefit plan pursuant to 24-A M.S.R. § 2677-A(2).

C. Describe how the services of a nonpreferred provider will be covered without the application of any benefit level differential if a preferred provider is not reasonably accessible, unless the Superintendent waives the prohibition of this differential for a given benefit plan pursuant to 24-A M.S.R. § 2673-A(3).

D. Describe how enrollees who live in areas with inadequate access to certain providers of covered benefits are made aware that they are able to obtain the covered benefit at no greater cost than if the benefit were obtained from participating providers.

E. Describe standards and procedures for access to emergency services.

7. Describe procedures to allow an enrollee with a special condition requiring ongoing care from a specialist to receive a standing referral to a specialist participating in the carrier's network for treatment of that condition or, if a specialist able to treat the enrollee's special condition does not participate in the carrier's network, to allow the enrollee to receive a standing referral to a nonparticipating specialist. The description must describe how enrollees with special needs will be identified, and what criteria will be used for this determination.

8. Describe procedures for providing coordination and continuity of care for new enrollees who notify the plan that, as of the effective date of enrollment, they are undergoing care or treatment for covered services by providers not in the plan's network.

9. Describe the policies and procedures providing for continuity of care in the event of contract termination between the plan and any of its contracted providers. Include a description of how enrollees with special needs or who are at special risk will be identified and how continuity of care will be provided.

10. Describe the plan for providing services for rural and underserved populations and for developing relationships with essential community providers.

11. Attach sample copies of provider contracts. Demonstrate that provider contracts include provisions holding enrollees financially harmless for payment denials for improper utilization of covered health services in situations where the enrollee has used the services of a preferred provider in accordance with the terms of the plan.

12. Attach a map subdivided by town indicating the geographic distribution by service location of primary care and specialty producers and contracted facilities in the carrier's service area, each category of provider and facility to be separately identified. Provide correlative data to support all requisite maps.

13. Attach sample copies of contracts used with employers or other purchasers.

14. Attach copies of certificates, schedules of benefits, and other such materials provided to enrollees or to prospective enrollees. Attach a copy of the health plan member identification card, if issued. State whether the applicable forms have been approved by the Maine Bureau of Insurance.

15. Describe the following:

A. Utilization review (UR) process, including:

a. Title 24-A M.R.S. § 4301-A(10-A) requires managed care plans to comply with a specific definition of "medically necessary health care". Attach copies of documents demonstrating that the plan complies with this definition.
b. Describe the qualifications of the UR staff.
c. Describe the notification procedures for adverse determinations.
d. Describe the procedures for requests for reconsideration and appeals.
e. Describe the circumstances under which an enrollee is entitled to independent external review and how this is communicated to enrollees.

B. Procedures for maintaining and monitoring quality of health care.

a. Describe the quality assurance program including staff (scope and size).
b. Describe the process for removing a provider found to be giving poor quality care.

C. Procedures for timely resolution of enrollee grievances.

D. Procedures for ensuring confidentiality of medical records.

E. Procedures related to the development and use of a formulary if the preferred provider arrangement provides coverage for prescription drugs but limits that coverage to drugs included in a formulary.

a. Provide a description of the formulary.
b. Describe procedures an enrollee must follow to obtain medicines that are subject to a formulary.
c. Provide a description of the extent to which an enrollee will be reimbursed for the cost of a drug that is not on the formulary.

F. Requirements for enrollees to obtain coverage of routine costs of clinical trials and how information is provided on the manner in which enrollees not eligible to participate in clinical trials may qualify for the compassionate use program of the federal Food and Drug Administration for use of investigational drugs pursuant to 21 Code of Federal Regulations, §312.34.

16. Attach copies of all contracts or agreements used in the operation of the PPA that have not already been provided elsewhere.

17. Attach any other information that the administrator or carrier may wish to submit that reasonably relates to its ability to establish, operate, maintain, or underwrite a PPA.

Section V. Signature

As the authorized representative of the administrator or carrier, I hereby certify that all of the information submitted in this form and attachments is true and complete.

_____ _____

Signature of Authorized Person Date

_____

Type or Print Name

_____

Title