

CHAPTER 20 - MANAGED CARE HEALTH BENEFIT PLANS

SECTION .0100 - MANAGED CARE DEFINITIONS

11 NCAC 20 .0101 SCOPE AND DEFINITIONS

(a) Scope.

- (1) Sections .0200, .0300, and .0400 of this Chapter shall apply to HMOs, licensed insurers offering PPO benefit plans, and any other entity that is a network plan carrier as defined in this Rule.
- (2) Sections .0500 and .0600 of this Chapter shall apply only to HMOs.
- (3) Nothing in this Chapter shall apply to service corporations offering benefit plans pursuant to G.S. 58-65-25 or G.S. 58-65-30 that do not have any differences in copayments, coinsurance, or deductibles based on the use of network versus non-network providers.

(b) Definitions. As used in this Chapter:

- (1) "Carrier" means a network plan carrier.
- (2) "Health care provider" means any person who is licensed, registered, or certified pursuant to Chapter 90 of the General Statutes; a health care facility as defined in G.S. 131E-176(9b); or a pharmacy.
- (3) "Health maintenance organization" or "HMO" has the same meaning as in G.S. 58-67-5(f).
- (4) "Intermediary" or "intermediary organization" means any entity that employs or contracts with health care providers for the provision of health care services and that also contracts with a network plan carrier or its intermediary.
- (5) "Member" means an individual who is insured by a network plan carrier.
- (6) "Network plan carrier" means an insurer, health maintenance organization, or any other entity acting as an insurer as defined in G.S. 58-1-5(3) that provides reimbursement or provides or arranges to provide health care services and uses increased copayments, deductibles, or other benefit reductions for services rendered by non-network providers to encourage members to use network providers.
- (7) "Network provider" means any health care provider participating in a network utilized by a network plan carrier.
- (8) "PPO benefit plan" means a benefit plan that is offered by a hospital or medical service corporation or network plan carrier, pursuant to G.S. 58-50-56, in which plan:
 - (A) either or both of the following features are present:
 - (i) utilization review or quality management programs are used to manage the provision of covered services; or
 - (ii) enrollees are given incentives via benefit differentials to limit the receipt of covered services to those furnished by participating providers; and
 - (B) health care services are provided by participating providers who are paid on negotiated or discounted fee-for-service bases or have agreed to accept special reimbursement or other terms for health care services under a contract with the hospital or medical service corporation or network plan carrier.
- (9) "Provider" means a health care provider.
- (10) "Quality management" means a program of reviews, studies, evaluations, and other activities used to monitor and enhance the quality of health care and services provided to members.
- (11) "Service area" means the geographic area in North Carolina as described by the HMO pursuant to G.S. 58-67-10(c)(11) where an HMO enrolls persons who either work in the service area, reside in the service area, or work and reside in the service area, as approved by the Commissioner pursuant to G.S. 58-67-20.
- (12) "Service corporation" means a medical or hospital service corporation operating pursuant to Article 65 of Chapter 58 of the General Statutes.
- (13) "Single service HMO" means an HMO that undertakes to provide or arrange for the delivery of a single type or single group of health care services to a defined population on a prepaid or capitated basis, except for a member's responsibility for non-covered services, coinsurance, copayments, or deductibles.
- (14) "Utilization review" has the same meaning as in G.S. 58-50-61(17).

History Note: Authority G.S. 58-2-40(1); 58-50-61; 58-65-1; 58-67-150;

Eff. October 1, 1996;
Amended Eff. July 1, 2006;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. December 16, 2014;
Temporary Amendment Eff. September 24, 2018;
Amended Eff. February 1, 2019.

SECTION .0200 - CONTRACTS BETWEEN NETWORK PLAN CARRIERS AND HEALTHCARE PROVIDERS

11 NCAC 20 .0201 WRITTEN CONTRACTS

- (a) All contracts between network plan carriers and health care providers and between network plan carriers and intermediary organizations offering networks of health care providers to be used by network plan carriers for the provision of care on a preferred or in-network basis shall be in writing and shall comply with 11 NCAC 20 .0202 as a condition of such health care providers' and networks' being listed in the carrier's provider directory.
- (b) The form of every contract under Paragraph (a) of this Rule shall be filed with the Division for approval according to these Rules before it is used.
- (c) As used in this Section and in Section .0600 of this Chapter, "Division" means the Life and Health Division of the Department of Insurance.

History Note: Authority G.S. 58-2-40(1); 58-50-50; 58-50-55; 58-65-25; 58-65-140; 58-67-10; 58-67-20; 58-67-35; 58-67-65; 58-67-140; 58-67-150;
Eff. October 1, 1996;
Amended Eff. July 1, 2006;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. December 16, 2014.

11 NCAC 20 .0202 CONTRACT PROVISIONS

All contract forms shall contain provisions addressing the following:

- (1) Whether the contract and any attached or incorporated amendments, exhibits, or appendices constitute the entire contract between the parties.
- (2) Definitions of technical insurance or managed care terms used in the contract, and whether those definitions reference other documents distributed to providers and are consistent with definitions included in the evidence of coverage issued in conjunction with the network plan.
- (3) Term of the contract.
- (4) Any requirements for written notice of termination and each party's grounds for termination.
- (5) The provider's continuing obligations after termination of the provider contract or in the case of the carrier or intermediary's insolvency. The obligations shall address:
 - (a) Transition of administrative duties and records.
 - (b) Continuation of care, when inpatient care is on-going. If the carrier provides or arranges for the delivery of health care services on a prepaid basis, inpatient care shall be continued until the patient is ready for discharge.
- (6) The provider's obligation to maintain licensure, accreditation, and credentials that meet the carrier's credential verification program requirements and to notify the carrier of subsequent changes in status of any information relating to the provider's professional credentials.
- (7) The provider's obligation to maintain professional liability insurance coverage in an amount acceptable to the carrier and notify the carrier of subsequent changes in status of professional liability insurance.
- (8) With respect to member billing:
 - (a) If the carrier provides or arranges for the delivery of health care services on a prepaid basis under G.S. 58, the provider shall not bill any network plan member for covered services, except for specified coinsurance, copayments, and applicable deductibles. This provision shall not prohibit a provider and member from agreeing to continue non-covered services at the member's own expense, as long as the provider has notified the member in advance that the carrier may not cover or continue to cover specific services and the member chooses to receive the service.

- (b) Any provider's responsibility to collect applicable member deductibles, copayments, coinsurance, and fees for noncovered services shall be specified.
- (9) Any provider's obligation to arrange for call coverage or other back-up to provide service in accordance with the carrier's standards for provider accessibility.
- (10) The carrier's obligation to provide a mechanism that allows providers to verify member eligibility, based on current information held by the carrier, before rendering health care services. Mutually agreeable provision may be made for cases where incorrect or retroactive information was submitted by employer groups.
- (11) Provider requirements regarding patients' records. The provider shall:
 - (a) Maintain confidentiality of enrollee medical records and personal information as required by G.S. 58, Article 39 and other health records as required by law.
 - (b) Maintain medical and other health records according to standards established by the carrier and as required by law.
 - (c) Make copies of such records available to the carrier and Department in conjunction with its regulation of the carrier.
- (12) The provider's obligation to cooperate with members in member grievance procedures.
- (13) A provision that the provider shall not discriminate against members on the basis of race, color, national origin, gender, age, religion, marital status, health status, or health insurance coverage.
- (14) Provider payment that describes the methodology to be used as a basis for payment to the provider. For example, Medicare DRG reimbursement, discounted fee for service, withhold arrangement, HMO provider capitation, or capitation with bonus.
- (15) The carrier's obligations to provide data and information to the provider, such as:
 - (a) Performance feedback reports or information to the provider, if compensation is related to efficiency criteria.
 - (b) Information on:
 - (i) benefit exclusions;
 - (ii) administrative and utilization management requirements;
 - (iii) credential verification programs;
 - (iv) quality assessment programs; and
 - (v) provider sanction policies.

Notification of changes in these requirements shall also be provided by the carrier, allowing providers time to comply with such changes.
- (16) The provider's obligations to comply with the carrier's utilization management programs, credential verification programs, quality management programs, and provider sanctions programs with the stipulation that none of these shall override the professional or ethical responsibility of the provider or interfere with the provider's ability to provide information or assistance to their patients.
- (17) The provider's authorization and the carrier's obligation to include the name of the provider or the provider group in the provider directory distributed to its members.
- (18) Any process to be followed to resolve contractual differences between the carrier and the provider.
- (19) Provisions on assignment of the contract shall contain:
 - (a) The provider's duties and obligations under the contract shall not be assigned, delegated, or transferred without the prior written consent of the carrier.
 - (b) The carrier shall notify the provider, in writing, of any duties or obligations that are to be delegated or transferred, before the delegation or transfer.

History Note: Authority G.S. 58-2-40(1); 58-2-131; 58-39-45; 58-39-75; 58-65-25; 58-65-105; 58-67-10; 58-67-20; 58-67-35; 58-67-65; 58-67-100; 58-67-115; 58-67-140; 58-67-150;
 Eff. October 1, 1996;
 Readopted Eff. August 1, 2018.

11 NCAC 20 .0203 CHANGES REQUIRING APPROVAL

All material changes to an approved contract form shall be filed with the Division for approval before use. For the purpose of this Rule, a "material change" includes a change in:

- (1) the means of calculating payment to the provider; for example, change from fee for service to capitation;

- (2) the distribution of risk between parties; or
- (3) the delegation of clinical and administrative responsibilities.

History Note: Authority G.S. 58-2-40(1); 58-65-25; 58-67-10; 58-67-20; 58-67-35; 58-67-115; 58-67-120; 58-67-150;
Eff. October 1, 1996;
Readopted Eff. December 1, 2017.

11 NCAC 20 .0204 CARRIER AND INTERMEDIARY CONTRACTS

(a) If a carrier contracts with an intermediary for the provision of a network to deliver health care services, the carrier shall file with the Division for prior approval its form contract with the intermediary. The filing shall be accompanied by a certification from the carrier that the intermediary will, by the terms of the contract, be required to comply with all statutory and regulatory requirements that apply to the functions delegated. The certification shall also state that the carrier shall monitor such compliance.

(b) A carrier's contract form with the intermediary shall state that:

- (1) All provider contracts used by the intermediary shall comply with the provisions of Rule .0202 of this Section.
- (2) The network carrier retains its legal responsibility to monitor and oversee the offering of services to its members and financial responsibility to its members.
- (3) The intermediary may not subcontract for its services without the carrier's written permission.
- (4) The carrier may approve or disapprove participation of individual providers contracting with the intermediary for inclusion in or removal from the carrier's own network plan.
- (5) The carrier shall retain copies or the intermediary shall make available for review by the Department all provider contracts and subcontracts held by the intermediary.
- (6) If the intermediary organization assumes risk from the carrier or pays its providers on a risk basis or is responsible for claims payment to its providers:
 - (A) The carrier shall receive documentation of utilization and claims payment and maintain accounting systems and records.
 - (B) The carrier shall arrange for financial protection of itself and its members through such approaches as member hold harmless language, retention of signatory control of the funds to be disbursed, or financial reporting requirements.
 - (C) To the extent provided by law, the Department shall have access to the books, records, and financial information to examine activities performed by the intermediary on behalf of the carrier. Such books and records shall be maintained in North Carolina.
- (7) The intermediary shall comply with all statutory and regulatory requirements that apply to the functions delegated by the carrier and assumed by the intermediary.

(c) If a carrier contracts with an intermediary to provide health care services and pays that intermediary directly for the services provided, the carrier shall either monitor the financial condition of the intermediary to ensure that providers are paid for services, or maintain member hold harmless agreements with providers.

History Note: Authority G.S. 58-2-40(1); 58-2-131; 58-34-10; 58-34-15; 58-65-1; 58-65-25; 58-65-105; 58-65-140; 58-67-10; 58-67-20; 58-67-30; 58-67-35; 58-67-65; 58-67-100; 58-67-115; 58-67-150;
Eff. October 1, 1996;
Readopted Eff. August 1, 2018.

11 NCAC 20 .0205 FILING REQUIREMENTS

All contract form filings shall be submitted to the Department in the following manner:

- (1) New managed care contract forms shall be submitted in either paper or an electronic format in accordance with 11 NCAC 12 .0329.
- (2) Amendments to contract forms shall include both a red-line formatted copy and a clean copy of the contract.
- (3) Each contract form shall be designated by a unique form number assigned by the carrier for identification purposes that shall not exceed the length of 70 character spaces.
- (4) Contract form filings shall be held open for a 60-day period beginning on the date that the Division receives the submission. If the submission is not brought into compliance within that period, the file shall be formally disapproved and closed.

History Note: Authority G.S. 58-2-40(1); 58-50-50; 58-50-55; 58-65-25; 58-65-140; 58-67-10; 58-67-20; 58-67-35; 58-67-150;
Eff. October 1, 1996;
Amended Eff. July 1, 2006;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. December 16, 2014.

SECTION .0300 - PROVIDER ACCESSIBILITY AND AVAILABILITY

11 NCAC 20 .0301 PROVIDER AVAILABILITY STANDARDS

Each network plan carrier shall develop a methodology to determine the size and adequacy of the provider network necessary to serve the members. The methodology shall provide for the development of performance targets that shall address the following:

- (1) The number and type of primary care physicians, specialty care providers, hospitals, and other provider facilities, as defined by the carrier.
- (2) A method to determine when the addition of providers to the network will be necessary based on increases in the membership of the network plan carrier.
- (3) A method for arranging or providing health care services outside of the service area when providers are not available in the area.

History Note: Authority G.S. 58-2-40(1); 58-65-1; 58-65-25; 58-67-10; 58-67-20; 58-67-35; 58-67-65; 58-67-140; 58-67-150;
Eff. October 1, 1996;
Readopted Eff. June 1, 2018.

11 NCAC 20 .0302 PROVIDER ACCESSIBILITY STANDARDS

Each carrier shall establish performance targets for member accessibility to primary and specialty care physician services and hospital-based services. Carriers shall also establish similar performance targets for health care services provided by providers who are not physicians. Carriers shall establish written policies and performance targets that address the following:

- (1) The proximity of network providers, as measured by such means as driving distance or time a member must travel to obtain primary care, specialty care, and hospital services, taking into account local variations in the supply of providers, and geographic considerations.
- (2) The availability to provide emergency services on a 24-hour, 7 day per week basis.
- (3) Emergency provisions within and outside of the service area.
- (4) The average or expected waiting time for urgent, routine, and specialist appointments.

History Note: Authority G.S. 58-2-40(1); 58-65-1; 58-65-25; 58-67-10; 58-67-20; 58-67-35; 58-67-65; 58-67-140; 58-67-150;
Eff. October 1, 1996;
Readopted Eff. June 1, 2018.

11 NCAC 20 .0303 PROVIDER NETWORK SAFEGUARDS

History Note: Authority G.S. 58-2-40(1); 58-50-55(b); 58-65-1; 58-65-25; 58-65-140; 58-67-10; 58-67-20; 58-67-35; 58-67-65; 58-67-140; 58-67-150;
Eff. October 1, 1996;
Pursuant to G.S. 150B-21.3A, rule Expired January 1, 2015.

11 NCAC 20 .0304 MONITORING ACTIVITIES

Each carrier shall, by means of site visits or review of information gathered by the carrier, monitor compliance with this Section and evaluate provider availability and accessibility at least annually to ensure that the needs of its members are met. The documentation of these activities shall be maintained by domestic carriers for a period of five years or until the completion of the next quintennial examination conducted by the Department, whichever is later. Foreign carriers shall maintain the documentation of these activities for a period of at least five years.

History Note: Authority G.S. 58-2-40(1); 58-2-131; 58-50-55(b); 58-65-1; 58-65-25; 58-65-105; 58-65-140; 58-67-10; 58-67-20; 58-67-35; 58-67-65; 58-67-100; 58-67-140; 58-67-150;
Eff. October 1, 1996;
Amended Eff. January 1, 2009;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. December 16, 2014.

SECTION .0400 - NETWORK PROVIDER CREDENTIALS

11 NCAC 20 .0401 CREDENTIAL VERIFICATION PROGRAM

In order to assure accessibility and availability of services, each carrier shall establish a program in accordance with this Section that verifies that its network providers are credentialed before the carrier lists those providers in the carrier's provider directory, handbooks, or other marketing or member materials.

History Note: Authority G.S. 58-2-40(1); 58-50-55(b); 58-65-1; 58-65-25; 58-65-140; 58-67-5; 58-67-10; 58-67-20; 58-67-35; 58-67-65; 58-67-140; 58-67-150;
Eff. October 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. December 16, 2014.

11 NCAC 20 .0402 ORGANIZATION STRUCTURE

The program established under Rule .0401 of this Section shall provide for an identifiable person or persons to be responsible for all credential verification activities, which person or persons shall be capable of carrying out that responsibility.

History Note: Authority G.S. 58-2-40(1); 58-50-55(b); 58-65-1; 58-65-25; 58-65-140; 58-67-5; 58-67-10; 58-67-20; 58-67-35; 58-67-65; 58-67-140; 58-67-150;
Eff. October 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. December 16, 2014.

11 NCAC 20 .0403 WRITTEN CREDENTIAL VERIFICATION PLAN

Each carrier shall develop and adopt a written credentialing plan that contains policies and procedures to support the credential verification program. The plan shall include:

- (1) The purpose, goals, and objectives of the credential verification program.
- (2) The roles of those persons responsible for the credential verification program.

History Note: Authority G.S. 58-2-40(1); 58-50-55(b); 58-65-1; 58-65-25; 58-65-105; 58-65-140; 58-67-5; 58-67-10; 58-67-20; 58-67-35; 58-67-65; 58-67-140; 58-67-150;
Eff. October 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. December 16, 2014.

11 NCAC 20 .0404 APPLICATION

For all providers who submit applications to be added to a carrier's network:

- (1) The definitions in G.S. 58-3-167 are incorporated into this Rule by reference. Each carrier that is an insurer that issues a health benefit plan shall obtain and retain on file each provider's signed and dated application on the form approved by the Commissioner under G.S. 58-3-230. All required information shall be current upon final approval of the provider by the carrier. The application shall include, when applicable:
 - (a) The provider's name, address, and telephone number.
 - (b) Practice information, including call coverage.
 - (c) Education, training, and work history.
 - (d) The current provider license, registration, or certification, and the names of other states where the applicant is or has been licensed, registered, or certified.

- (e) Drug Enforcement Agency (DEA) registration number and prescribing restrictions.
 - (f) Specialty board or other certification.
 - (g) Professional and hospital affiliation.
 - (h) The amount of professional liability coverage and any malpractice history.
 - (i) Any disciplinary actions by medical organizations and regulatory agencies.
 - (j) Any felony or misdemeanor convictions.
 - (k) The type of affiliation requested, for example, primary care, consulting specialists, ambulatory care.
 - (l) A signed and dated statement by the provider attesting that the information provided is true, accurate, and complete, and authorizing the release of information and materials related to the provider's qualifications and competence.
 - (m) Letters of reference or recommendation or letters of oversight from supervisors, or both, that attest to the qualifications or competence of the provider or otherwise recommend approval of the provider's application.
- (2) The carrier shall obtain and retain on file the following information regarding facility provider credentials, when applicable:
- (a) The Joint Commission's certification or certification from other accrediting agencies.
 - (b) State licensure.
 - (c) Medicare and Medicaid certification.
 - (d) Evidence of active malpractice insurance.
- (3) No credential item listed in Items (1) or (2) of this Rule shall be construed as a substantive threshold or criterion or as a standard for credentials that must be held by any provider in order to be a network provider.

History Note: Authority G.S. 58-2-40(1); 58-2-131; 58-3-167; 58-3-230; 58-65-1; 58-65-25; 58-65-105; 58-67-10; 58-67-20; 58-67-35; 58-67-65; 58-67-100; 58-67-140; 58-67-150; Eff. October 1, 1996; Temporary Amendment Eff. October 1, 2001; Amended Eff. May 1, 2008; August 1, 2002; Readopted Eff. December 1, 2017.

11 NCAC 20 .0405 VERIFICATION OF CREDENTIALS

- (a) Each carrier's process for verifying credentials shall take into account and make allowance for the time required to request and obtain primary source verifications and other information that must be obtained from third parties in order to authenticate the applicant's credentials, and shall make allowance for the scheduling of a final decision by a credentialing committee, if the carrier's credentialing program requires such review.
- (b) Within 60 days after receipt of a completed application and all supporting documents, the carrier shall assess and verify the applicant's qualifications and notify the applicant of its decision. If, by the 60th day after receipt of the application, the carrier has not received all of the information or verifications it requires from third parties, or date-sensitive information has expired, the carrier shall issue a written notification to the applicant either closing the application and detailing the carrier's attempts to obtain the information or verification, or pending the application and detailing the carrier's attempts to obtain the information or verifications. If the application is held, the carrier shall inform the applicant of the length of time the application will be pending. The notification shall include the name, address and phone number of a credentialing staff person who will serve as a contact person for the applicant.
- (c) Within 15 days after receipt of an incomplete application, the carrier shall notify the applicant in writing of all missing or incomplete information or supporting documents, in accordance with the following procedures:
- (1) The notice to the applicant shall include a complete and detailed description of all of the missing or incomplete information or documents that must be submitted in order for review of the application to continue. The notification shall include the name, address, and telephone number of a credentialing staff person who will serve as a contact person for the applicant.
 - (2) Within 60 days after receipt of all of the missing or incomplete information or documents, the carrier shall assess and verify the applicant's qualifications and notify the applicant of its decision, in accordance with paragraph (b) of this rule.
 - (3) If the missing information or documents have not been received within 60 days after initial receipt of the application or if date-sensitive information has expired, the carrier shall close the application or delay final review, pending receipt of the necessary information. The carrier shall

provide written notification to the applicant of the closed or pending status of the application and where applicable, the length of time the application will be pending. The notification shall include the name, address, and telephone number of a credentialing staff person who will serve as a contact person to the applicant.

(d) If a carrier elects not to include an applicant in its network, for reasons that do not require review of the application, the carrier shall provide written notice to the applicant of that determination within 30 days after receipt of the application.

(e) Nothing in this rule shall require a carrier to include a health care provider in its network or prevent a carrier from conducting a complete review and verification of an applicant's credentials, including an assessment of the applicant's office, before agreeing to include the applicant in its network.

History Note: Authority G.S. 58-2-40(1); 58-3-230; 58-65-1; 58-65-25; 58-65-105; 58-67-5; 58-67-10; 58-67-20; 58-67-35; 58-67-65; 58-67-140; 58-67-150;
Eff. October 1, 1996;
Temporary Amendment Eff. October 1, 2001;
Eff. July 1, 2002;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. December 16, 2014.

11 NCAC 20 .0406 PROVIDER FILES

Each carrier shall maintain centralized files, either paper or electronic, on each individual provider making application to affiliate with the carrier. Each file shall include documentation of compliance with Rules .0404 and .0405 of this Section.

History Note: Authority G.S. 58-2-40(1); 58-2-131; 58-50-55(b); 58-65-1; 58-65-25; 58-65-105; 58-65-140; 58-67-5; 58-67-10; 58-67-20; 58-67-35; 58-67-65; 58-67-100; 58-67-140; 58-67-150;
Eff. October 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. December 16, 2014.

11 NCAC 20 .0407 REVERIFICATION OF PROVIDER CREDENTIALS

Each carrier shall reverify the credentials of all network providers at least every three years. On or after October 1, 2001, carriers shall use the form approved by the Commissioner under G.S. 58-3-230. Carriers may require completion of all or only selected sections of the form for reverification of credentials.

History Note: Authority G.S. 58-2-40(1); 58-3-230; 58-65-1; 58-65-25; 58-65-105; 58-67-5; 58-67-10; 58-67-20; 58-67-35; 58-67-65; 58-67-140; 58-67-150;
Eff. October 1, 1996;
Temporary Amendment Eff. October 1, 2001;
Amended Eff. August 1, 2002;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. December 16, 2014.

11 NCAC 20 .0408 CONFIDENTIALITY

Each carrier shall develop written policies and procedures to protect the confidentiality of patient health or medical record information and personal information, as provided by law.

History Note: Authority G.S. 58-2-40(1); 58-2-131; 58-39-45; 58-39-75; 58-50-55(b); 58-65-1; 58-65-25; 58-65-105; 58-67-5; 58-67-10; 58-67-20; 58-67-35; 58-67-65; 58-67-100; 58-67-140; 58-67-180;
Eff. October 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. December 16, 2014.

11 NCAC 20 .0409 RECORDS AND EXAMINATIONS

History Note: Authority G.S. 58-2-40(1); 58-2-131; 58-50-55(b); 58-65-1; 58-65-25; 58-65-105; 58-65-140;

58-67-5; 58-67-10; 58-67-20; 58-67-35; 58-67-65; 58-67-100; 58-67-140; 58-67-150;
Eff. October 1, 1996;
Amended Eff. January 1, 2009;
Pursuant to G.S. 150B-21.3A, rule Expired January 1, 2015.

11 NCAC 20 .0410 DELEGATION OF CREDENTIAL VERIFICATION ACTIVITIES

Whenever any carrier delegates credential verification activities to a contracting entity, whether an intermediary or subcontractor, the carrier shall review the contracting entity's credential verification program before contracting to ensure that the entity complies with all applicable requirements in this Section. The carrier shall monitor the contracting entity's credential verification activities. The carrier shall implement oversight mechanisms, including:

- (1) Reviewing the contracting entity's credential verification plans, policies, procedures, forms, and adherence to verification procedures.
- (2) Requiring the contract entity to submit an updated list of providers quarterly.
- (3) Conducting an evaluation of the contracting entity's credential verification program every three years.

History Note: Authority G.S. 58-2-40(1); 58-65-1; 58-65-25; 58-67-10; 58-67-20; 58-67-35; 58-67-65; 58-67-140; 58-67-150;
Eff. October 1, 1996;
Readopted Eff. December 1, 2017.

11 NCAC 20 .0411 SUSPENSION OR TERMINATION OF NETWORK PROVIDERS

Each carrier shall have a mechanism in place to reduce, suspend, or terminate the participation of any network provider.

History Note: Authority G.S. 58-2-40(1); 58-50-55(b); 58-65-1; 58-65-25; 58-65-105; 58-65-140; 58-67-5; 58-67-10; 58-67-20; 58-67-35; 58-67-65; 58-67-140; 58-67-150;
Eff. October 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. December 16, 2014.

SECTION .0500 - HMO QUALITY MANAGEMENT PROGRAMS

11 NCAC 20 .0501 PROGRAM

(a) Each HMO shall have a program designed to monitor, evaluate, improve, and promote:

- (1) The quality of health care and quality of services provided through its network of providers; and
- (2) Its policies, procedures, and performance.

(b) The program shall identify those areas and aspects of health care covered by the HMO's benefit plan or plans that are included in its quality management program.

History Note: Authority G.S. 58-2-40(1); 58-67-5; 58-67-10; 58-67-20; 58-67-35; 58-67-65; 58-67-140; 58-67-150;
Eff. October 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. December 16, 2014.

11 NCAC 20 .0502 STRUCTURE

Each HMO shall develop and maintain an organizational structure to conduct quality management. The structure shall provide for an identifiable person or persons to be responsible for all quality management, which person or persons shall be capable of carrying out that responsibility.

History Note: Authority G.S. 58-2-40(1); 58-67-5; 58-67-10; 58-67-20; 58-67-35; 58-67-65; 58-67-100; 58-67-140; 58-67-150;
Eff. October 1, 1996;

Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. December 16, 2014.

11 NCAC 20 .0503 PLAN

Each HMO shall develop and adopt a written quality management plan that contains policies and procedures to support the quality management program. This plan shall include the following:

- (1) The purpose, goals, and objectives of the quality management program.
- (2) The role of those responsible for all quality management programs.
- (3) The specific services to be monitored in accordance with 11 NCAC 20 .0501.

History Note: Authority G.S. 58-2-40(1); 58-67-5; 58-67-10; 58-67-20; 58-67-35; 58-67-65; 58-67-100; 58-67-140; 58-67-150; Eff. October 1, 1996; Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. December 16, 2014.

11 NCAC 20 .0504 ACTIVITIES

(a) Each HMO shall develop quality of care and quality of service standards and establish a mechanism to determine if the standards are being met.

(b) Each HMO shall employ a variety of quality management tools that assess and monitor:

- (1) The quality of health care and quality of service and that takes into account treatment settings for all types of medical care that have been provided through its network of providers; and
- (2) Administrative and utilization management decisions of the carrier.

History Note: Authority G.S. 58-2-40(1); 58-67-5; 58-67-10; 58-67-20; 58-67-35; 58-67-65; 58-67-140; 58-67-150; Eff. October 1, 1996; Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. December 16, 2014.

11 NCAC 20 .0505 QUALITY OF CARE COMPLAINTS

Each HMO shall maintain policies and procedures to record, investigate, and take corrective action in response to patient complaints about the quality of care delivered by network providers and decisions made by the HMO. The policies and procedures shall provide for the following:

- (1) Complaints about quality of care issues shall be forwarded to and investigated by individuals who are capable of performing that function.
- (2) A method of aggregating, categorizing, and analyzing quality of care complaints relating to provider performance or HMO policies or procedures.

History Note: Authority G.S. 58-2-40(1); 58-67-5; 58-67-10; 58-67-20; 58-67-35; 58-67-65; 58-67-100; 58-67-140; 58-67-150; Eff. October 1, 1996; Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. December 16, 2014.

11 NCAC 20 .0506 DELEGATION OF ACTIVITIES

Whenever any HMO delegates quality management activities to another entity, the HMO shall review and approve the entity's quality management program before contracting with the entity and shall monitor the entity's quality management activities. The HMO shall implement oversight mechanisms, including:

- (1) Reviewing the contracting entity's quality management plans, policies, procedures, activities, and provider contracting forms; and verifying that they meet the HMO's standards.
- (2) Requiring the contracting entity to submit, at least annually, reports of its quality management activities and operations.
- (3) Conducting audits of the contracting entity's quality assurance activities and operations.

History Note: Authority G.S. 58-2-40(1); 58-67-5; 58-67-10; 58-67-20; 58-67-35; 58-67-65; 58-67-140; 58-67-150;
Eff. October 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. December 16, 2014.

11 NCAC 20 .0507 CORRECTIVE ACTION

Each HMO shall have procedures for identifying and taking corrective action on quality of care and quality of service problems related to network providers or the carrier, whether a specific individual or system-wide.

History Note: Authority G.S. 58-2-40(1); 58-67-5; 58-67-10; 58-67-20; 58-67-35; 58-67-65; 58-67-140; 58-67-150;
Eff. October 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. December 16, 2014.

11 NCAC 20 .0508 CONFLICTS OF INTEREST

Each HMO shall develop written policies and procedures about conflicts of interest. No person shall conduct utilization review of health care provided by any facility or entity in which that person or any member of his or her family has, directly or indirectly, a financial interest. That person shall recuse himself or herself from such review.

History Note: Authority G.S. 58-2-40(1); 58-67-5; 58-67-10; 58-67-20; 58-67-35; 58-67-65; 58-67-140; 58-67-150;
Eff. October 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. December 16, 2014.

11 NCAC 20 .0509 CONFIDENTIALITY

Each HMO shall develop written policies and procedures to protect the confidentiality of medical record information and personal information relating to covered individuals, as those terms are defined in G.S. 58-39-15.

History Note: Authority G.S. 58-2-40(1); 58-39-45; 58-39-75; 58-67-5; 58-67-10; 58-67-20; 58-67-35; 58-67-65;
58-67-140; 58-67-150; 58-67-180;
Eff. October 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. December 16, 2014.

11 NCAC 20 .0510 RECORDS AND EXAMINATIONS

History Note: Authority G.S. 58-2-40(1); 58-67-5; 58-67-10; 58-67-20; 58-67-35; 58-67-65; 58-67-100; 58-67-140; 58-67-150;
Eff. October 1, 1996;
Amended Eff. January 1, 2009;
Pursuant to G.S. 150B-21.3A, rule Expired January 1, 2015.

11 NCAC 20 .0511 INTERNAL AUDIT

Each HMO shall at least annually evaluate its quality management program to assure that it complies with this Section and the HMO's internal standards, policies, and procedures. The effectiveness and efficiency of the program shall also be evaluated. The results of the evaluation shall be used in continuous improvement efforts.

History Note: Authority G.S. 58-2-40(1); 58-67-5; 58-67-10; 58-67-20; 58-67-35; 58-67-65; 58-67-140; 58-67-150;
Eff. October 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. December 16, 2014.

SECTION .0600 - SIGNIFICANT MODIFICATIONS TO HMO OPERATIONS

11 NCAC 20 .0601 APPLICATIONS FOR MODIFICATIONS TO SERVICE AREAS OR PRODUCT LINES

(a) All requests to expand an HMO's service area shall be submitted in electronic format as an application to the Division for review and approval. The application shall include the following information:

- (1) a description of operational changes that will result from the expansion;
- (2) financial and actuarial information as required by 11 NCAC 11C .0311 and 11 NCAC 16 .0605;
- (3) a description of provider interest and network development in the service area requested and information as to the HMO's existing provider network; and
- (4) copies of any form contracts to be made as a result of the expansion, including providers and subcontractors.

(b) Material changes in the product lines offered by an HMO shall be submitted in electronic format as an application to the Division for review and approval. For the purposes of this Section, "material changes" include the addition of a point of service product, or the addition of or changes to the HMO's existing health care delivery model, such as the addition of an IPA product or group model product or the addition of a gatekeeper product. The application shall include the following information:

- (1) a description of operational changes that will result from the expansion;
- (2) financial and actuarial information as required by 11 NCAC 11C .0311 and 11 NCAC 16 .0605;
- (3) a description of provider interest and network development in the service area requested and information as to the HMO's existing provider network; and
- (4) copies of form contracts to be made as a result of the expansion, including providers and subcontractors.

(c) Notice of the addition of an intermediary shall be submitted by an HMO in writing to the Division within 30 days after the execution of the contract for the intermediary's services.

(d) Notice of the deletion of an intermediary shall be submitted by the HMO in writing within 30 days after termination of the contract, unless termination is immediate, along with a plan to select another intermediary or for the HMO to perform the formerly delegated functions in-house.

(e) All changes to provider and intermediary contract forms shall be submitted to the Division for review and approval in accordance with Rule .0203 of this Chapter prior to the use of the amended form.

(f) Each HMO shall submit written notice to the Division of its intent to engage in any arrangement through which the HMO owns, controls, or manages any operations of another HMO in any other state, before entering into the arrangement.

History Note: Authority G.S. 58-2-40; 58-67-10; 58-67-150;
Eff. October 1, 1996;
Readopted Eff. December 1, 2017.

11 NCAC 20 .0602 WRITTEN NOTICE

In addition to those modifications set out in G.S. 58-67-10(d)(1), an HMO shall submit written notice to the Division of the following:

- (1) Changes to the members of the HMO's Board of Directors, Trustees, Officers, or any entity maintaining at least 10 percent ownership in the HMO, within 15 days after the change.
- (2) Reductions in the number of providers that exceed 10 percent of the total number of providers in a particular service area within 15 days after the change.
- (3) Any application made in any other state for licensure as an HMO, insurance company or any other type of managed care organization, within 15 days after making the application.
- (4) Any application made in North Carolina or any other state to engage in business arrangements involving Medicare, Medicaid, CHAMPUS or Workers Compensation, within 15 days after making the application.

History Note: Authority G.S. 58-2-40; 58-67-10; 58-67-150;
Eff. October 1, 1996;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. December 16, 2014.

