

**WEST VIRGINIA
SECRETARY OF STATE
NATALIE E. TENNANT
ADMINISTRATIVE LAW DIVISION**

Form #3

Do Not Mark In this Box

2012 AUG 31 PM 1:44

OFFICE WEST VIRGINIA
SECRETARY OF STATE

**NOTICE OF AGENCY APPROVAL OF A PROPOSED RULE
AND
FILING WITH THE LEGISLATIVE RULE-MAKING REVIEW COMMITTEE**

AGENCY: WV Offices of the Insurance Commissioner TITLE NUMBER: 114

CITE AUTHORITY WV Code §§33-25G-5

AMENDMENT TO AN EXISTING RULE: YES _____ NO X

IF YES, SERIES NUMBER OF RULE BEING AMENDED: _____

TITLE OF RULE BEING AMENDED: _____

IF NO, SERIES NUMBER OF RULE BEING PROPOSED: 43A

TITLE OF RULE BEING PROPOSED: Provider Sponsored Network

THE ABOVE PROPOSED LEGISLATIVE RULE HAVING GONE TO A PUBLIC HEARING OR A PUBLIC COMMENT PERIOD IS HEREBY APPROVED BY THE PROMULGATING AGENCY FOR FILING WITH THE SECRETARY OF STATE AND THE LEGISLATIVE RULE MAKING REVIEW COMMITTEE FOR THEIR REVIEW.



8/24/12

Charles O. Lorensen
Cabinet Secretary
West Virginia Department of Revenue

Insurance Commissioner
Legislative Rule
Title 114, Series 43A

PROVIDER SPONSORED NETWORKS

TITLE 114, SERIES 43A

BRIEF SUMMARY OF RULE

This is a new rule to implement a bill enacted in 2012, HB 4438 ("Provider sponsored networks"), that among other things requires a new form of licensure for Provider Sponsored Networks. The licensing scheme set forth in the rule will be the same as that applicable to HMOs except for the following differences: (1) A PSN must be "controlled by" one or more federally qualified health centers; (2) upon an adequate showing, solvency requirements may be lowered by the Commissioner; (3) a PSN must allow any willing provider to participate in its networks; and (4) PSNs will be restricted to serving Medicaid enrollees.

QUESTIONNAIRE

(Please include a copy of this form with each filing of your rule: Notice of Public Hearing or Comment Period, Proposed Rule, and if needed, Emergency and Modified Rule.)

DATE: August 30, 2012

TO: LEGISLATIVE RULE-MAKING REVIEW COMMITTEE

FROM: WV OFFICE OF THE INSURANCE COMMISSIONER
ATTN: Legal Division
1124 Smith Street
Post Office Box 50540
Charleston, West Virginia 25305-0540

LEGISLATIVE RULE TITLE: Provider Sponsored Networks
Title 114, Series 43A

1. Authorizing statute(s) citation:

West Virginia Code §33-25G-5.

2. a. Date filed in State Register with Notice of Hearing or Public Comment Period:

July 5, 2012 (notice of public comment period).

b. What other notice, including advertising, did you give of the hearing?

N/A

c. Date of Public Hearing(s) or Public Comment Period ended:

Public comment period ended on August 6, 2012.

d. Attach list of persons who appeared at hearing, comments received, amendments, reasons for amendments.

Attached X No comments received

**e. Date you filed in State Register the agency approved proposed Legislative Rule following public hearing:
(be exact)**

August 30, 2012.

Insurance Commissioner
Title 114, Series 35

- f. Name, title, address and phone/fax/e-mail numbers of agency person(s) to receive all written correspondence regarding this rule: (Please type)

Timothy R. Murphy, Associate Counsel
WV Offices of the Insurance Commissioner
P.O. Box 50540
Charleston, WV 25305
304-558-6279 Ext. 1210
304-558-1362 FAX
Timothy.Murphy@wvinsurance.gov

- g. IF DIFFERENT FROM ITEM 'f', please give Name, title, address and phone number(s) of agency person(s) who wrote and/or has responsibility for the contents of this rule: (Please type)

N/A

3. If the statute under which you promulgated the submitted rules requires certain findings and determinations to be made as a condition precedent to their promulgation:

N/A

- a. Give the date upon which you filed in the State Register a notice of the time and place of a hearing for the taking of evidence and a general description of the issues to be decided.
- b. Date of hearing or comment period:
- c. On what date did you file in the State Register the findings and determinations required together with the reasons therefor?
- d. Attach findings and determinations and reasons:



SPILMAN THOMAS & BATTLE, PLLC

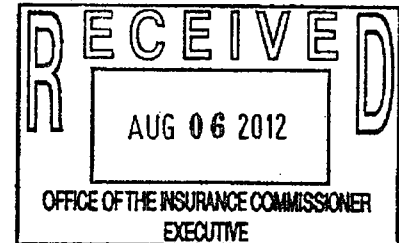
ATTORNEYS AT LAW

(304) 720-4072
jcline@spilmanlaw.com

August 6, 2012

VIA HAND DELIVERY

Michael D. Riley
WV Offices of the Insurance Commissioner
1124 Smith Street
Charleston, WV 25301



RE: Comments on Proposed Legislative Rule Relating to Licensure of Provider
Sponsored Networks – Title 114 CSR Series 43A

Dear Commissioner Riley:

The West Virginia HMO Association appreciates the opportunity to offer comments on your proposed Legislative Rule relating to the licensure of Provider Sponsored Networks (“PSNs”). Because the enabling legislation authorized this new type of licensed entity to provide services specifically to the state’s Medicaid population, the standards under which PSNs are licensed and regulated are very important to the Managed Care Organizations (“MCOs”) that currently provide services to that population. In addition, the approach that will be taken by the Offices of the Insurance Commissioner (“OIC”) to licensing, regulatory standards and financial oversight for PSNs is vitally important to the Medicaid program, its beneficiaries, and our state. There are sound and well-tested public policy reasons why the Legislature has enacted statutes and rules to prevent the insolvency of MCOs and to ensure that they are able to fulfill their contractual obligations toward enrollees and providers, and in the case of Medicaid, the State of West Virginia. In addition, all MCOs are held to very specific quality and other technical operating standards that exist to protect the population as well as properly manage and coordinate care. Regulatory oversight of MCO’s is both time-tested and proven effective. If a PSN wishes to operate in our state, it is incumbent upon the Offices of the Insurance Commissioner to apply the exacting standards required of an MCO, to the extent that those standards are not altered by applicable law. To the extent that the Insurance Commissioner has discretion to apply any different standards, the HMO Association nonetheless encourages a cautious and deliberate approach to the licensing and regulation of an organization whose structure, operation and management is untested in our state.

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West Virginia

North Carolina

Pennsylvania

Virginia

Michael D. Riley, WV Offices of the Insurance Commissioner
August 6, 2012
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Before offering comments relating to specific provisions of the rule, the HMO Association believes it is important to highlight certain provisions in the enabling legislation (H.B. 4438), and comment on amendments made to the introduced bill during the 2012 regular session. The changes to H.B. 4438 during the 2012 regular session affirm that the Legislature intended a PSN to bear risk in the same manner as an HMO on a Medicaid contract. In addition, it is clear that the Legislature intended that a contract under which a PSN provides services to Medicaid beneficiaries must be subject to the same criteria and standards applied to other MCOs, and that identical service, administrative and performance criteria must be met by both PSNs and other MCOs providing services to Medicaid beneficiaries.

The OIC's understanding of the legislative intent relating to licensing is apparent from the inclusion in the proposed rule of subsection 4.1, which states that a PSN's application for a certificate of authority is subject to the provisions of the HMO Act and all rules, bulletins or other guidance issued by the Commissioner regarding the licensing of HMOs unless the rule provides otherwise. In addition, the OIC has included subsection 5.1, which states that PSNs are subject to all statutes, rules and other legal bases for the ongoing regulation of HMOs by the Commissioner, except to the extent that they are specifically made inapplicable or are superseded by applicable federal law or regulation. The HMO Association supports the Insurance Commissioner's clear direction on the applicability of HMO standards for licensure and regulation of PSNs outside of the very specific exemptions set out in the proposed rule. The HMO Association further supports the Insurance Commissioner's reliance on Article 25A provisions and applicable rules in determining whether a PSN applicant is financially responsible, and strongly urges continued adherence to those standards.

The HMO Association does have serious concerns relating to subdivision 4.3.b. of the proposed rule. That subdivision allows a petition from a PSN to operate at lower standards of financial responsibility than would otherwise be required for an HMO, and essentially repeats the statutory factors that the Commissioner may consider in acting upon such a petition. The HMO Association suggests that the rule also include a requirement that a PSN have a proven record of financial stability before it may petition for a deviation from otherwise applicable solvency standards. That proven record should be based on a period of time, such as 3 years of operations, during which it would be possible for the OIC to more accurately assess the management policies and practices of the PSN. Currently the rule contains no applicable time period, and the addition would provide an opportunity for greater certainty. It is noteworthy that there is no guaranty association or other such "safety net" for beneficiaries or providers, or the state, should a PSN become insolvent and unable to fulfill its contractual obligations. There has been no PSN Legislative interim study or pilot program upon which to gauge the likelihood of success of this new type of entity and its management in West Virginia. Therefore, it is critical that the Commissioner have the ability to oversee the solvency of a PSN over time before authorizing

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any deviations from financial standards. In addition, it is important to the overall success and financial strength of the Medicaid program that a PSN not create exposure to the state which could be avoided by holding the PSN to the same standards as other MCO's.

The HMO Association further encourages the OIC to clearly require in subdivision 4.4.b. that a PSN shall, rather than "may", require that providers agree to observe the PSN's care management protocols, be credentialed, and comply with the PSN's utilization management programs and referral systems. While it is true that the enabling legislation uses the word "may" in this context, the statute also quite clearly demands that the same standards apply to PSN's as to HMO's generally as well as in connection with Medicaid contracts. This ambiguity should be resolved in this proposed rule by use of the word "shall". Utilization management and quality assurance programs are required by Article 25A and by rules that are applicable to PSN's. Utilization management is not only the "lynch pin" for cost effectiveness of a program, it also helps to ensure the patient gets the medically appropriate hospital and physician services. Quality assurance, as the name states, helps to ensure the provision of quality hospital and physician services to the patient and the program. Given the inherent risk associated with regulating an entity that is new to the market, the OIC should have heightened sensitivity and concern toward any plan that does not include programs designed to objectively and systematically monitor, evaluate and improve the quality and appropriateness of medical care. In addition, any lack of diligence toward provider credentialing would create legal exposure that will be harmful to the Medicaid program and the state. These programs are essential to fulfilling the mission of a managed care organization and provide direct protection of Medicaid beneficiaries and the state.

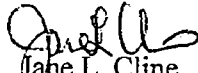
The HMO Association further encourages the OIC to resist any effort to include provisions in the proposed rule that would give a PSN any authority in the law to require providers to enter into exclusive contracts or otherwise address any requirements or allowances associated with provider contracting issues such as this. The enabling legislation already speaks to participation by providers with a PSN and with other MCO's. There is no lack of clarity on this point in statute and it would be inappropriate to place into law any such unnecessary provisions that would apply to PSNs.

Thank you again for this opportunity to provide comments on this very important matter. As you know, bearing the risk on a healthcare product, and certainly a Medicaid product, can be very challenging for even the most seasoned entities. The possibility of an entity which is not experienced, without existing infrastructure, and not well financed could fail financially. If a PSN or HMO with a West Virginia Medicaid contract fails financially, the state and its taxpayers would then be liable for possibly millions of dollars.

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In closing, the HMO Association commends the OIC on its thoughtful stewardship over the solvency, market conduct and business affairs of the insurance industry and managed care organizations. These comments are offered with this proven success in mind, and with the understanding that a cautious and deliberate approach toward licensing and regulation of an entity that is new to a market will ensure protection of the state and its citizens.

Sincerely,


Jane L. Cline
Director of Public Policy

JLC/sec

cc: Timothy R. Murphy

ATTACHMENT TO QUESTION 2(d):

The West Virginia HMO Association raises 2 issues in its comments on the proposed rule:

- 1) The HMO Association raises concerns with the proposed rule's subdivision 4.3.b that essentially mirrors the statutory provision [WV Code §33-25G-3(b)] authorizing the Commissioner to allow a PSN to operate at lower standards of financial responsibility than would otherwise be required for an HMO:

4.3.b. A PSN that has been issued a certificate of authority may petition the Commissioner to be permitted to operate with lower standards of financial responsibility than would otherwise be required for a HMO, including lower surplus and capital.

4.3.b.1. In ruling upon a petition submitted pursuant to subdivision b of this subsection, the Commissioner, in consultation with the Secretary, may consider actuarial evaluations and other qualified technical standards as well as the possible lower risks of insolvency arising from the control of the PSN or applicant by one or more FQHCs, any transfer of risk to a third party, and the restriction of the PSN to the provision of Medicaid-related services. The Commissioner may also require that the PSN submit such other information as may be deemed necessary for a decision on the petition.

4.3.b.2. The decision whether and how to change the solvency requirements is committed to the sole discretion of the Commissioner.

The HMO Association suggests that the rule also include a requirement that a PSN have a “proven record of financial stability” before it may petition for a deviation from otherwise applicable solvency standards and that such “track record” be of a given length, such as 3 years of operations, so that the OIC can more accurately assess the management policies and practices of the PSN.¹ The Commissioner agrees that a “track record” can be a

¹ The Association also correctly notes that there is no guaranty association to act as a “safety net” for beneficiaries, providers or the State should a PSN become insolvent and be unable to fulfill its contractual obligations. *See* W. Va.

valuable predictor of a PSN's ability to operate under standards that differ from the well-established ones that have been established for HMOs and notes that HMOs are required to file monthly pro forma financial statements for at least the first 3 years of operation after receiving their certificates of authority.² Accordingly, the Commissioner amends the proposed rule as follows:

4.3.b.1. In ruling upon a petition submitted pursuant to subdivision b of this subsection, the Commissioner, in consultation with the Secretary, may consider actuarial evaluations and other qualified technical standards as well as the possible lower risks of insolvency arising from the control of the PSN or applicant by one or more FQHCs, any transfer of risk to a third party, and the restriction of the PSN to the provision of Medicaid-related services. The Commissioner may also require that the PSN submit such other information as may be deemed necessary for a decision on the petition. A PSN will be presumed to be unable to operate with lower standards of financial responsibility until it submits at least 3 years of audited financial statements that reflect positive net worth.³

2) The West Virginia HMO Association asks that the OIC clearly require in subdivision 4.4.b. that a PSN *shall*, rather than *may* (as it is provided for in W. Va. Code 33-25G-4(b)), require that providers agree to observe the PSN's care management protocols, be credentialed and comply with the PSN's utilization management programs and referral systems.

4.4.b. A PSN may require that providers:

4.4.b.1. Agree to observe the PSN's care management protocols, including provisions for designations of certain services that may be provided only by designated providers or classes of providers;

Code §33-26B-5(a)(8) (excluding from the coverage of the HMO guaranty association any HMO with 100% of its enrollees in the state Medicaid program).

² In a somewhat analogous situation, OIC requires that an employer wishing to become self-insured for workers' compensation purposes is required to demonstrate a "track record" of at least 3 years of audited financial statements to be reviewed for financial solvency. See W. Va. Code St. R. §85-18-5.2.

³A similar requirement is already in place for COA applicants at W. Va. Code St. R. §114-46.2.3 ("Each application [for an HMO certificate of authority] shall set forth or be accompanied by: ... h. The applicant's financial statements, including:...B. Monthly pro forma financial statements including a balance sheet, income statement and cash flow analysis, with annual totals, for the greater of three (3) years or until the applicant is projected to be profitable for twelve (12) consecutive months, on a statutory accounting principal basis with documentation of all assumptions used and income, expense and capital items projected ...")

4.4.b.2. Be credentialed before they may provide certain services; and

4.4.b.3. Comply with the PSN's utilization management programs and referral systems.

The HMO code provisions (to which PSNs are bound generally⁴) mandates that every HMO have in place a quality assurance program that includes a utilization management program, written policies for credentialing, and “any other criteria deemed necessary by the commissioner”). Moreover, similar requirements of adherence to the PSN’s utilization review and quality assurance standards are also requirements for any managed care organization seeking accreditation.⁵ The Commissioner agrees that the public policy underpinning these general statutory mandates for HMOs dictates that the same requirements should be imposed on PSNs through incorporation into the corresponding provisions in the PSN rule. Accordingly, the Commissioner amends the proposed rule as follows:

4.4.b. A PSN ~~may~~ shall require that providers:

⁴ A PSN is subject to the provisions of the HMO statute except as specifically provided otherwise in the PSN statute. *See* W. Va. Code §33-25G-3(a); *see also* §114-43A.5.1 of the proposed rule (“PSNs are subject to all statutes, rules and other legal bases for the regulation of HMOs by the Commissioner, except to the extent any such statutes, rules or other legal bases for regulation are expressly made inapplicable to PSNs or are superseded by an applicable federal law or regulation”).

⁵ After operating for 3 years in West Virginia, an HMO is required to submit to an accreditation examination by a nationally recognized accreditation and review organization. *See* W. Va. Code §33-25A-17(c).

Insurance Commissioner
Legislative Rule
Title 114, Series 43A

PROVIDER SPONSORED NETWORKS

TITLE 114, SERIES 43A

STATEMENT OF CIRCUMSTANCES

This is a new rule mandated by a 2012 bill 4438 (codified at W. Va. Code §33-25G-1 et. seq.) creating Provider Sponsored Networks, a new form of health insurer that will be limited to serving Medicaid beneficiaries. This rule sets out the licensing scheme (which will be similar to that of a HMO) and provides that, unless expressly expressed otherwise, all other aspects of OIC regulation will be the same as that for HMOs. DHHR will have to provide for implementation of other aspects of PSN regulation in the context of the state Medicaid program.

FISCAL NOTE FOR PROPOSED RULES

Rule Title: Provider Sponsored Networks (Title 114, Series 43A)

Type of Rule: X Legislative Interpretive Procedural

Agency: WV Offices of the Insurance Commissioner

Address: Post Office Box 50540
1124 Smith Street, Summers Building
Charleston, West Virginia 25305-0540

Phone Number: (304) 558-0401 Email: Timothy.Murphy@wvinsurance.gov

Fiscal Note Summary

Summarize in a clear and concise manner what impact this measure will have on costs and revenues of state government.

Licensing and ongoing financial regulation of the single PSN, which is essentially an HMO, will have minimal impact on costs and revenues.

Fiscal Note Detail

Show over-all effect in Item 1 and 2 and, in Item 3, give an explanation of Breakdown by fiscal year, including long-range effect.

FISCAL YEAR			
Effect of Proposal	Current Increase/Decrease (use "-") FY2013	Next Increase/Decrease (use "-") FY2014	Fiscal Year (Upon Full Implementation) FY 2015+
1. Estimated Total Cost	N/A	N/A	N/A
Personal Services	\$3792	\$3792	\$3792
Current Expenses	N/A	N/A	\$41,000*
Repairs & Alterations	N/A	N/A	N/A
Assets	N/A	N/A	N/A
Equipment	N/A	N/A	N/A
Other	N/A	N/A	N/A
2. Estimated Total Revenues	\$1350	\$1350	\$1350

* Annual exam fees are levied on all insurance entities licensed in West Virginia. Exams are required to be performed on domestic entities at least every five years. Examination costs are paid from the OIC's exam revolving fund (7150) the estimated costs of performing this exam is within the current level of the OIC budget. No increase in exam fees charged will be necessary because of this rule.

- .3. Explanation of above estimates (including long-range effect):**
Please include any increase or decrease in fees in your estimated total revenues.

It is projected that one (1) PSN will apply for licensure.

First year expenses consist of the PS and EB costs for the review of the application, financial projections and network adequacy.

Revenues

Initial licensing fee \$200

Annual renewal \$200

Annual Statement filing fee \$100

Annual exam assessment fee \$1050 (WVC 33-2-9)

Costs

In order to regulate the PSN, an Insurance Financial Specialist (\$35,000 Salary + Benefits = \$45,500 will need to allocate approximately 1 month of their annual workload to PSNs or \$3,792.

*Financial exam (every 5 yrs) -- approximately \$41,000 (based on similar exam performed by contractor)

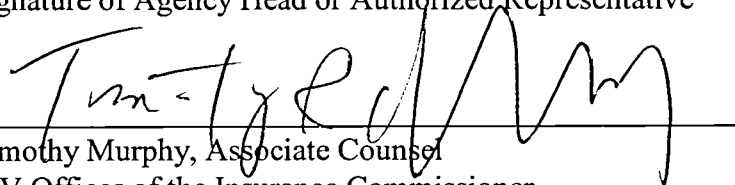
MEMORANDUM

Please identify any areas of vagueness, technical defects, reasons the proposed rule **would not** have a fiscal impact, and/or any special issues **not** captured elsewhere on this form.

As a Medicaid only entity, OIC will have no rate and form obligations with regard to policies used and will not perform market conduct exams. Many of the duties involved in HMO regulation, e.g. determination of network adequacy, will be the sole or shared responsibility of the state Medicaid office. OIC has experience with one other Medicaid-only managed care organization, Unicare, and the information presented herein is based in part on such experience.

Date: 8-31-12

Signature of Agency Head or Authorized Representative



Timothy Murphy, Associate Counsel
WV Offices of the Insurance Commissioner
P. O. Box 50540
Charleston WV 25305-0540
Timothy.Murphy@wvinsurance.gov

**TITLE 114
LEGISLATIVE RULE
INSURANCE COMMISSIONER**

**SERIES 43A
PROVIDER SPONSORED NETWORKS**

Sections.

- 114-46A-1. General.
- 114-46A-2. Applicability.
- 114-46A-3. Definitions.
- 114-46A-4. Application for certificate of authority.
- 114-46A-5. Regulation as an HMO.

**TITLE 114
LEGISLATIVE RULE
INSURANCE COMMISSIONER**

**SERIES 43A
PROVIDER SPONSORED NETWORKS**

FILED
2012 AUG 31 PM 1:45
OFFICE OF THE VIRGINIA
SECRETARY OF STATE

§114-43A-1. General.

1.1. Scope. -- This rule provides for the licensing and regulation of provider sponsored networks.

1.2. Authority. -- W. Va. Code §33-25G-5 (2012).

1.3. Filing Date. --

1.4. Effective Date. --

§114-43A-2. Applicability.

2.1. This rule applies to any applicant for a certificate of authority from the Commissioner to operate in this state as a provider sponsored network and to any entity to which such a certificate has been granted.

§114-43A-3. Definitions.

3.1. "Commissioner" means the West Virginia Insurance Commissioner.

3.2. "Federally Qualified Health Center" or "FQHC" means an entity as defined in 42 U.S.C. §1396d(1)(2)(B).

3.3. "Medicaid beneficiary" means any person participating, through either a state plan amendment or waiver authority, in any Medicaid program administered by the West Virginia Department of Health and Human Resources or its Bureau for Medical Services.

3.4. "Participating provider" means a licensed health care provider who has entered into a contract with a provider sponsored network to provide services to Medicaid enrollees.

3.5. "Provider sponsored network" or "PSN" means an entity that satisfies the definition of a "Medicaid managed care organization" set forth in 42 U.S.C. §1396b(m)(1)(A), is controlled by one or more FQHCs, and provides or otherwise makes available health care services solely to Medicaid beneficiaries pursuant to contract with the Secretary executed in accordance with W. Va. Code §16-2L-1 *et seq.*

3.6. "Secretary" means the Secretary of the West Virginia Department of Health and Human Resources.

§114-43A-4. Licensing Requirements.

4.1. Except to the extent provided differently by this rule, a PSN may apply for a certificate of authority to operate in West Virginia as a Medicaid managed care organization in accordance with the provisions of W. Va. Code §33-25A-1 *et seq.*, W. Va. Code St. R. §114-43 and §114-46, and any other rule, bulletin or guidance issued by the Commissioner regarding the licensing of health maintenance organizations ("HMOs").

4.2. An applicant must demonstrate that it is controlled by one or more FQHCs. For purposes of this subsection, the term "controlled by" means the direct or indirect possession by one or more FQHCs of the power to direct or cause the direction of the management and policies of the organization through membership, board representation or an ownership interest greater than 50 percent.

4.3.a. In determining whether an applicant has demonstrated that it is financially responsible, the Commissioner shall take into consideration the factors set forth in W. Va. Code §33-25A-4(c) as well as, but not limited to, W. Va. Code St. R. §114-43 and §114-46, in the same manner as if the applicant were applying for a certificate of authority to operate as a HMO.

4.3.b. A PSN that has been issued a certificate of authority may petition the Commissioner to be permitted to operate with lower standards of financial responsibility than would otherwise be required for a HMO, including lower surplus and capital.

4.3.b.1. In ruling upon a petition submitted pursuant to subdivision b of this subsection, the Commissioner, in consultation with the Secretary, may consider actuarial evaluations and other qualified technical standards as well as the possible lower risks of insolvency arising from the control of the PSN or applicant by one or more FQHCs, any transfer of risk to a third party, and the restriction of the PSN to the provision of Medicaid-related services. The Commissioner may also require that the PSN submit such other information as may be deemed necessary for a decision on the petition. A PSN will be presumed to be unable to operate with lower standards of financial responsibility until it submits at least 3 years of audited financial statements that reflect positive net worth.

4.3.b.2. The decision whether and how to change the solvency requirements is committed to the sole discretion of the Commissioner.

4.4.a. Every application for a certificate of authority to operate as a PSN shall include a certification that any physician or behavioral health provider licensed by the appropriate West Virginia state agency or board shall be permitted to contract with the PSN to become a participating provider as long as he or she agrees to participate in the health care delivery approach designed by the PSN and such other applicable requirements of the Department of Health and Human Resources.

4.4.b. A PSN may require that providers:

4.4.b.1. Agree to observe the PSN's care management protocols, including provisions for designations of certain services that may be provided only by designated providers or classes of providers;

4.4.b.2. Be credentialed before they may provide certain services; and

4.4.b.3. Comply with the PSN's utilization management programs and referral systems.

4.4.c. A PSN shall not:

4.4.c.1. Require a participating physician provider to sell or transfer ownership of his, her or its assets or practice operations to the PSN or any of the PSN's participating providers as a condition of participation or of being permitted access or use of the PSN's medical home resources and care management systems; or

4.4.c.2. Prohibit a participating provider from participating in or contracting with other networks or other managed care organizations to provide services to Medicaid beneficiaries.

§114-43A-5. Regulation as an HMO.

5.1. PSNs are subject to all statutes, rules and other legal bases for the regulation of HMOs by the Commissioner, except to the extent any such statutes, rules or other legal bases for regulation are expressly made inapplicable to PSNs or are superseded by an applicable federal law or regulation.