40-3203. Certificate of authority required; application; contents; rules and regulations governing modifications and amendments; approval of commissioner. (a) Except as otherwise provided by this act, it shall be unlawful for any person to provide health care services in the manner prescribed in subsection (n) or subsection (r) of K.S.A. 40-3202 and amendments thereto without first obtaining a certificate of authority from the commissioner.

(b) Applications for a certificate of authority shall be made in the form required by the commissioner and shall be verified by an officer or authorized representative of the applicant and shall set forth or be accompanied by:

(1) A copy of the basic organizational documents of the applicant such as articles of incorporation, partnership agreements, trust agreements or other applicable documents;

(2) a copy of the bylaws, regulations or similar document, if any, regulating the conduct of the internal affairs of the applicant;

(3) a list of the names, addresses, official capacity with the organization and biographical information for all of the persons who are to be responsible for the conduct of its affairs, including all members of the governing body, the officers and directors in the case of a corporation and the partners or members in the case of a partnership or corporation;

(4) a sample or representative copy of any contract or agreement made or to be made between the health maintenance organization or medicare provider organization and any class of providers and a copy of any contract made or agreement made or to be made, excluding individual employment contracts or agreements, between third party administrators, marketing consultants or persons listed in subsection (3) and the health maintenance organization or medicare provider organization;

(5) a statement generally describing the organization, its enrollment process, its operation, its quality assurance mechanism, its internal grievance procedures, in the case of a health maintenance organization the methods it proposes to use to offer its enrollees an opportunity to participate in matters of policy and operation, the geographic area or areas to be served, the location and hours of operation of the facilities at which health care services will be regularly available to enrollees in the case of staff and group practices, the type and specialty of health care personnel and the number of personnel in each specialty category engaged to provide health care services in the case of staff and group practices, and a records system providing documentation of utilization rates for enrollees. In cases other than staff and group practices, the organization shall provide a list of names, addresses and telephone numbers of providers by specialty;

(6) copies of all contract forms the organization proposes to offer enrollees together with a table of rates to be charged;

(7) the following statements of the fiscal soundness of the organization:

(A) Descriptions of financing arrangements for operational deficits and for developmental costs if operational one year or less;

(B) a copy of the most recent unaudited financial statements of the health maintenance organization or medicare provider organization;

(C) financial projections in conformity with statutory accounting practices prescribed or otherwise permitted by the department of insurance of the state of domicile for a minimum of three years from the anticipated date of certification and on a monthly basis from the date of certification through one year. If the health maintenance organization or medicare provider organization is expected to incur a deficit, projections shall be made for each deficit year and for one year thereafter. Financial projections shall include:

(i) Monthly statements of revenue and expense for the first year on a gross dollar as well as per-member-per-month basis, with quarters consistent with standard calendar year quarters;

(ii) quarterly statements of revenue and expense for each subsequent year;

(iii) a quarterly balance sheet; and

(iv) statement and justification of assumptions;

(8) a description of the procedure to be utilized by a health maintenance organization or medicare provider organization to provide for:

(A) Offering enrollees an opportunity to participate in matters of policy and operation of a health maintenance organization;

(B) monitoring of the quality of care provided by such organization including, as a minimum, peer review; and

(C) resolving complaints and grievances initiated by enrollees;

(9) a written irrevocable consent duly executed by such applicant, if the applicant is a nonresident, appointing the commissioner as the person upon whom lawful process in any legal action against such organization on any cause of action arising in this state may be served and that such service of process shall be valid and binding in the same extent as if personal service had been had and obtained upon said nonresident in this state;

(10) a plan, in the case of group or staff practices, that will provide for maintaining a medical records system which is adequate to provide an accurate documentation of utilization by every enrollee, such system to identify clearly, at a minimum, each patient by name, age and sex and to indicate clearly the services provided, when, where, and by whom, the diagnosis, treatment and drug therapy, and in all other cases, evidence that contracts with providers require that similar medical records systems be in place;

(11) evidence of adequate insurance coverage or an adequate plan for self-insurance to respond to claims for injuries arising out of the furnishing of health care;

(12) such other information as may be required by the commissioner to make the determinations required by K.S.A. 40-3204 and amendments thereto; and

(13) in lieu of any of the application requirements imposed by this section on a medicare provider organization, the commissioner may accept any report or application filed by the medicare provider organization with the appropriate examining agency or official of another state or agency of the federal government.

(c) The commissioner may promulgate rules and regulations the commissioner deems necessary to the proper administration of this act to require a health maintenance organization or medicare provider organization, subsequent to receiving its certificate of authority to submit the information, modifications or amendments to the items described in subsection (b) to the commissioner prior to the effectuation of the modification or amendment or to require the health maintenance organization to indicate the modifications to the commissioner. Any modification or amendment for which the approval of the commissioner is required shall be deemed approved unless disapproved within 30 days,

except the commissioner may postpone the action for such further time, not exceeding an additional 30 days, as necessary for proper consideration.

History: L. 1974, ch. 181, § 3; L. 1976, ch. 280, § 22; L. 1985, ch. 208, § 3; L. 1988, ch. 162, § 1; L. 1996, ch. 169, § 7; L. 1997, ch. 13, § 1; L. 1998, ch. 174, § 14; July 1.