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1. INTRODUCTION. The Texas Department of Insurance proposes amendments to §§11.1 - 11.2, 11.203 - 11.204, 11.301 - 11.302, 11.501, 11.503, 11.504 - 11.506, 11.508 -11.511, 11.602 ,11.706, 11.801, 11.804, 11.810, 11.901 – 11.902, 11.904, 11.1201, 11.1206, 11.1301 – 11.1302, 11.1401, 11.1403, 11.1600, 11.1605, 11.1607, 11.1702 – 11.1703, 11.1801, 11.1901 – 11.1902, 11.2103, 11.2201, 11.2207, 11.2303, 11.2315, 11.2402, 11.2405 - 11.2406, 11.2501 – 11.2503, 11.2601 - 11.2604, 11.2608, and 11.2609, concerning the regulation of health maintenance organizations (HMOs). These amendments update statutory references, correct typographical errors and incorrect cross references within Chapter 11, replace references to the "Texas Health Maintenance Organization Act" with references to Insurance Code chapters and other applicable insurance laws and regulations of this state that apply to HMOs, amend the

definitions of *adverse determination* and *institutional provider*, provide for the use of *matrix filings*, clarify fee amounts for evidence of coverage filings, remove restrictions on variable language allowed in evidence of coverage documentation, delete certain minimum worth requirements, amend copayment requirements, clarify the requirements of enrollee participation in quality improvement programs, adopt nationally recognized standards for physician and provider credentialing, amend the term *specialty care* to include specialty hospitals and single healthcare service plan physicians and providers, and waive access requirements for HMOs providing covered services to participants in the CHIP Perinatal Program as requested by the Health and Human Services Commission.

The proposed amendments to several sections delete references to the terms "Texas Health Maintenance Organization Act" and "Act" as a result of the enactment of the non-substantive Insurance Code revisions, Acts 2001, 77th Legislature, Regular Session, Chapter 1419 §1, effective April 1, 2003, and Acts 2003, 78th Legislature, Regular Session, Chapter 1274 §3, effective April 1, 2005, which reorganized the regulatory statutes that apply to HMOs into multiple statutes that are no longer organized as a single “Act.” To address this, the proposed amendments to these sections replace the terms "Texas Health Maintenance Organization Act" and “Act” with references to the applicable chapters of the Insurance Code, including Chapters 843 (Health Maintenance Organizations), 1271 (Benefits Provided by Health Maintenance Organizations; Evidence of Coverage; Charges), 1272 (Delegation of Certain Functions by Health Maintenance Organizations), 1367 (Coverage of Children), 1452 (Physician

and Provider Credentials), and other applicable insurance laws and regulations of this state that apply to HMOs. Therefore, since all statutory references to the Act no longer accurately identify all of the statutory regulations that apply to HMOs, this deletion and replacement is being made throughout Chapter 11, including those references in §§11.1, 11.2(a) and (b)(1), 11.203(d), 11.204, 11.301, 11.302, 11.504, 11.506, 11.508 - 11.511, 11.602, 11.706, 11.804, 11.810(b)(5), 11.901, 11.902, 11.904, 11.1201, 11.1301, 1302(a)(3) and (d)(4), 11.1401, 11.1600, 11.1605(c), (d), and (e), 11.1607, 11.1702 – 11.1703, 11.1801, 11.2103, 11.2303, 11.2315, 11.2405 - 11.2406, 11.2501 – 11.2503, 11.2601(a) and (b), 11.2602(1) and (2), (4)(A), and (B), 11.2603(a), (e), and (g), 11.2604, 11.2608(b) and 11.2609.

The proposed amendment to §11.2(b)(3) changes the definition of *adverse determination* to be consistent with the definition contained in the Insurance Code §843.002(1) by replacing the term *furnished* with the term *provided*, by replacing the term *adopted* with the term *proposed*, by substituting the term *enrollee* for the term *patient*, and by adding the phrase *by a health maintenance organization*. The Legislature changed the definition of *adverse determination* during the 77th Legislative Session. The proposed amendment to §11.2(b)(24) deletes the terms *infusion services centers* and *urgent care centers* from the definition of *institutional providers*. This change is necessary for consistency with the credentialing requirements in proposed §11.1902(4) and (7), which require an institutional provider to be a licensed entity. Because infusion services centers and urgent care centers are not licensed entities, they are deleted in the definition of *institutional providers*. New regulations regarding

the use of *matrix filings* have been included in the proposed amendments to §§11.501 and 11.505. Accordingly, the proposed amendment to §11.2 includes a new definition of *matrix filing*. Lastly, the proposed amendment to §11.2 re-numbers the remaining definitions accordingly.

In addition to updating statutory references, the proposed amendment to §11.301(4)(A) revises the term *evidence of coverage* to *evidence of coverage filings*. Section 11.301(4)(A) cross references §11.501 of Chapter 11 (relating to Forms Which Must Be Approved Prior to Use). The proposed changes to §11.501 of Chapter 11 relate to the term *evidence of coverage*. The proposed changes to §11.301(4)(A) are necessary for consistency with the terms included in §11.501 of Chapter 11 that are also being proposed for amendment in this proposal.

The proposed amendments to §11.501 include new provisions relating to the use of *matrix filings*. The proposed amendments designate the current text as subsection (a) and add new subsections (b) and (c). The proposed amendment to newly designated §11.501(a) adds *matrix filings* to the list of forms that are considered part of an evidence of coverage. The existing rule does not address matrix filings, and this proposal is the first formal recognition of their acceptability for HMO evidence of coverage filings. The proposed new §11.501(b) clarifies that each of the listed forms in subsection (a) must be identified with a unique form number and must be individually approved by the commissioner before being issued, delivered, or used in Texas. Additionally, the proposed new §11.501(b) clarifies that each of the forms listed in subsection (a), except for *matrix filings*, are considered individual evidence of coverage

filings and are subject to the filing fees prescribed in 28 Texas Administrative Code §7.1301(g)(4) (relating to Regulatory fees). Section 7.1301(g)(4) prescribes that a fee of $100 be assessed for evidence of coverage filings that require approval. The proposed amendment is necessary to provide clarification, fairness, and consistency regarding the amount of the filing fees that will be charged for the filing of these types of forms. The proposed new §11.501 makes clear that a fee of $100, as prescribed in §7.1301(g)(4), will be assessed for each form listed in subsection (a), except for a *matrix filing*, that is filed with the Department, and that a fee of $50 will be assessed for each form that is resubmitted to the Department after withdrawal or disapproval. A review of all evidence of coverage form filings received by the Department from five major HMOs during the past year reveals that all of the evidence of coverage filings were received as individual filings, rather than one filing containing multiple evidence of coverage form filings linked together under one form number. While some HMOs may have filed a small number of their evidence of coverage filings as one document linked together under a single form number in order to pay $100 for the entire filing, that does not appear to be the standard practice. Therefore, the proposed clarification does not substantially alter the current practice of the Department or the industry. The proposed new §11.501(c) prescribes the fees for *matrix filings* as $50 per individual evidence of coverage provision, with a maximum fee of $500, whether the filing be an initial filing or a resubmission. Unlike the current structure for single evidence of coverage filings that require an HMO to refile the entire document whenever any provision within the document must be changed to accommodate new business needs, *matrix filings* allow

HMOs to file various individual provisions at one time that may be combined in a variety of ways to create new evidences of coverage. Once the various provisions are approved by the Department, an HMO has much more flexibility to create new evidences of coverage by combining the approved provisions into new documents, and this flexibility will contribute to increased speed to market for new products. An additional benefit of *matrix filings* is a cost savings to HMOs. Currently, the Department only accepts single evidence of coverage filings and assesses a fee of $100 per filing. Therefore, an HMO filing 12 single evidence of coverage filings will be assessed filing fees totaling $1200 for those filings. However, under the proposed matrix filing approach, an HMO will be able to file multiple provisions that are adequate for many more than 12 evidences of coverage in a single filing. If the HMO files more than 10 evidence of coverage provisions in its *matrix filing*, it will only be assessed $500, since the maximum fee allowed for a matrix filing is $500. This will save the HMO $700 compared to the filing of 12 single evidence of coverage filings and will allow more flexibility for creating many more evidences of coverage. In addition, the Department anticipates the use of *matrix filings* will streamline and expedite the Department's overall review process.

The proposed amendments to §11.503 amend the term *evidence of coverage* to *evidence of coverage filing*. These proposed changes are necessary for consistency with the terms in §§11.301 and 11.501 of Chapter 11 (relating to Filing Requirements and Forms Which Must Be Approved Prior to Use) that are also proposed to be amended in this proposal.

The specifications for filing a *matrix filing* are set out in the proposed new §11.505(h)(1) and (2). Each *matrix filing* must comply with the filing requirements of §11.301 (relating to Filing Requirements) and must include a unique form number that is sufficient to distinguish the filing as a *matrix filing*. The proposed new §11.505(h)(2) describes the requirements relating to provision language. While variable language must still be enclosed in brackets and must include the range of variable information or amounts, the proposed amendment to §11.505(f) eliminates the remaining restrictions on variable language allowed in evidence of coverage filings.

The proposed amendment to §11.506(2)(A) eliminates the current copayment charge requirement that a basic service HMO may not impose copayment charges that exceed 50 percent of the total cost of providing any single service to its enrollees, nor in the aggregate more than 20 percent of the total cost to the HMO of providing all basic health care services. The proposed amendment to §11.506(2)(A) also eliminates the current copayment charge requirement that a basic service HMO may not impose copayment charges on any enrollee in any calendar year, when the copayments made by the enrollee in that calendar year total 200 percent of the total annual premium cost which is required to be paid by or on behalf of that enrollee. Instead, the proposed amendment to §11.506(2)(A) prescribes a copayment charge requirement modeled after the Insurance Code §1301.0046 (regulating preferred provider benefit plans). The proposal provides that each HMO may establish one or more reasonable copayment options and specifies that a reasonable copayment option may not exceed 50 percent of the total covered amount applicable to the medical or health care services. Although

§1301.0046 of the Insurance Code relates specifically to preferred provider benefit plans, the Department is proposing this standard as a fair and reasonable standard that will adequately protect the interest of HMO enrollees.

The proposed amendment to §11.801(a) eliminates the requirement that an HMO licensed before September 1, 1999, must comply with the minimum net worth requirements specified in the Insurance Code §843.4031. This change is necessary to reflect the fact that §843.4031 is no longer law. Insurance Code §843.4031 was enacted by the 76th Texas Legislature as a temporary provision and expired on January 1, 2003. Also, an amendment to §11.810(b)(20) to delete the reference to the Insurance Code §843.4031 is proposed for the same reason.

The proposed amendment to §11.1206(b) deletes the reference to the "Act" and replaces it with a specific reference to the Insurance Code §843.105. For clarity and accuracy, the proposed amendment to §11.1206(b) replaces the phrase *defined* with the phrase *provided for*. This change is necessary because the Insurance Code §843.105 provides for the use of management and exclusive agency contracts, but does not define these terms.

The proposed amendment to §11.1403 corrects a typographical error in the toll-free complaint number in the Spanish language notice and corrects the misspelling of the term *complaint*.

The proposed amendment to §11.1605(c) clarifies that small employer plans, as defined by Insurance Code §1501.002, are exempt from the requirement that HMOs that provide coverage for prescription drugs under an individual or group health benefit

plan must comply with Insurance Code Chapter 1369 Subchapter A and Department rules.

The proposed amendment to §11.1607(h)(2) clarifies that the term *specialty care* includes specialty hospitals and single healthcare service plan physicians and providers, such as vision and dental care. There has been some industry confusion and Department inconsistency regarding the treatment of vision and dental care providers with regards to access of care requirements. The proposed amendment is necessary to make clear that vision and dental care providers are subject to the access of care requirements prescribed in §11.1607(h)(2) and not those prescribed in (h)(1). The proposed new §11.1607(i) originates from a request from the Commissioner of the Health and Human Services Commission. The Health and Human Services Commission recently implemented a new program, the CHIP Perinatal Program. Eligible participants in this program will receive care from HMOs for certain covered services. Pursuant to the Health and Safety Code §62.051(c) and (d), the Commissioner of the Health and Human Services Commission requested that the access of care requirements for HMOs participating in this program be waived. The Health and Safety Code §62.051(c) provides that the Health and Human Services Commission oversee the implementation of a child health plan program and coordinate the activities of each agency necessary to the implementation of the program, including the Texas Department of Insurance. Additionally, the Health and Safety Code §62.051(d) provides that the Health and Human Services Commission may, with the consent the Texas Department of Insurance, delegate to the Texas Department of

Insurance the authority to adopt, with the approval of the Health And Human Services Commission, any rules necessary to implement the program. The proposed new §11.1607(i) waives the access of care requirements for an HMO that has a contract with the Health and Human Services Commission and provides covered services to participants in the CHIP Perinatal Program. The proposed amendments to §11.1607 also re-designate remaining subsections.

The proposed amendment to §§11.1901(a) and (b)(1) specifies that an enrollee, unless the HMO has no enrollees, must be actively involved in an HMO's quality improvement program, but eliminates the requirement that an enrollee must be appointed to the HMO's quality improvement committee. This amendment is needed to provide flexibility in enrollee participation in an HMO's quality improvement program. An enrollee may participate in the HMO's program in a variety of ways, and therefore, the rule still requires an enrollee's active participation in the HMO's program to ensure better service for all enrollees in the plan.

Pursuant to the Insurance Code §1452.006, the proposed amendments to §11.1902(4) and (7) eliminate the current requirements relating to the credentialing process for contracted physicians and providers. In lieu of these requirements, the Department is proposing to adopt by reference the credentialing standards of the National Committee on Quality Assurance (NCQA). Section 1452.006 of the Insurance Code requires that rules adopted by the Commissioner under the Insurance Code §843.102, which regulates HMO quality assurance, that relate to implementation and maintenance by an HMO of a process for selecting and retaining affiliated physicians

and providers must comply with the Insurance Code Chapter 1452 Subchapter A and standards adopted by the NCQA, to the extent those standards do not conflict with other laws of this state. The Department has determined that the standards do not conflict with the laws of this state. These proposed amendments will also streamline the Department's health plan oversight while maintaining the HMO's plan accountability. Also, as a result of the Department's adoption of the NCQA's standards by reference, the Department will not need to update its regulations each time the NCQA amends its standards, which is approximately once a year. This will ensure that the Department's credentialing regulations for contracted physicians and providers are current and accurate, resulting in more efficient industry regulation and better service to plan enrollees.

The proposed amendments to §§11.2201(b) and 11.2402(b) correct cross references to other rule provisions within Chapter 11.

The proposed amendment to §§11.2207(a) and (b)(1) are necessary for consistency with the proposed amendments to §§11.1901(a) and (b)(1) and clarify that an enrollee must be actively involved in an HMO's quality improvement program but does not have to be appointed to the HMO's quality improvement committee. The proposed amendments to §11.2207(d)(4) and (d)(7) are necessary for consistency with the proposed amendments to §11.1902(4) and (7) and eliminate the current credentialing requirements relating to the retention of contracted physicians and providers, and in lieu of those requirements, adopt by reference the credentialing standards of the NCQA.

The proposed amendment to §11.2602 re-numbers the paragraphs setting out definitions.

2. FISCAL NOTE. Jennifer Ahrens, Associate Commissioner for the Life, Health & Licensing Division, has determined that for each year of the first five years the proposed amendments will be in effect, there will be no fiscal implications for state or local government as a result of enforcing and administering the amendments. The proposal will have no anticipated effect on local employment or local economy.

3. PUBLIC BENEFIT/COST NOTE. Ms. Ahrens has determined that for each year of the first five years the proposed amendments are in effect, the public benefits anticipated as a result of the proposed amendments will be better quality of service for HMO enrollees, increased regulatory efficiency, and reduced industry confusion resulting from prior inconsistent interpretations. Any economic costs to HMOs will result from compliance with proposed §§11.501, 11.1902(4) and (7) and 11.2207(d)(4) and (d)(7).

Proposed §11.501(c) requires a filing fee of $50 for each evidence of coverage provision included in a matrix filing with a maximum fee of $500, whether the filing is an initial filing or a resubmission. However, the proposal does not require HMOs to use matrix filings. Those opting not to do so will not be affected by the filing fee, as they may continue to pay the existing rate for each single evidence of coverage filing submitted for review. A matrix filing is one which contains a number of various

provisions which an HMO may use to create multiple evidences of coverage. The existing rule does not address matrix filings, and this proposal is the first formal recognition of their acceptability for HMO evidence of coverage filings. Accordingly, when the Department currently accepts evidence of coverage filings, it assesses the standard single filing fee of $100 for each reviewed filing. The proposed fee reflects the fact that an HMO can create more than one evidence of coverage through the combination of various matrix provisions. The provision for matrix filings actually allows an HMO to better manage its filing costs by taking advantage of filing multiple evidence of coverage provisions for a single maximum fee of $500, resulting in potential savings.

Under proposed §11.501(c), HMOs that re-submit an evidence of coverage filing after withdrawal or disapproval will be required to pay a fee of $50.

Proposed §§1902(4) and (7) and 11.2207(d)(4) and (d)(7) adopt the credentialing standards of the National Committee for Quality Assurance (NCQA) by reference and require all HMOs to follow these credentialing standards. At a minimum, an HMO will have to obtain these credentialing standards in order to comply with proposed §§1902(4) and (7) and 11.2207(d)(4) and (d)(7). For the year 2007, these credentialing standards will be published by the NCQA at a cost of $180. It is anticipated that the NCQA will publish these standards each year at a similar cost.

There will be no difference in the cost of compliance between a large and small business as a result of the proposed amendments. A matrix filing fee will only be charged to an HMO that opts to make a matrix filing, regardless of the HMO's size. The cost of purchasing the NCQA publication containing the applicable credentialing

standards will be the same for each HMO required to comply with these standards, regardless of its size. The agency has considered the purpose of the Insurance Code §§843.102 and 1452.006, which is to maintain effective regulation of HMOs by ensuring that health care services are provided to enrollees under reasonable standards of quality of care that are consistent with prevailing professionally recognized standards of medical practice. The agency has considered the purpose of the Insurance Code §843.154, which is to collect fees sufficient to administer the proper review of evidence of coverage filings. Accordingly, the Department has determined that it is neither legal nor feasible to waive the provisions of the proposed amendments for small or micro businesses. Additionally, it is the Department's position that the applicable statutes require equal application to all HMOs, regardless of their size, and that the applicable statutes do not contemplate any disparate effect on enrollees of HMOs based on the size of the HMO.

4. REQUEST FOR PUBLIC COMMENT. To be considered, written comments on the proposal must be submitted no later than 5:00 p.m. on September 18, 2006, to Gene C. Jarmon, General Counsel and Chief Clerk, Mail Code 113-2A, Texas Department of Insurance, P. O. Box 149104, Austin, Texas 78714-9104. An additional copy of the comment must be simultaneously submitted to Jennifer Ahrens, Associate Commissioner for the Life, Health & Licensing Program, Mail Code 107-2A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104. Any request for a public hearing should be submitted separately to the Office of the Chief Clerk

before 5:00 p.m. on September 18, 2006. If a hearing is held, oral and written comments presented at the hearing will be considered.

5. STATUTORY AUTHORITY. The amendments are proposed pursuant to the Insurance Code §§843.002(1), 843.008, 843.102, 843.151, 843.154, 1271.101, 1271.104, 1301.0046, 1369.003, 1452.006, 36.001, and the Health and Safety Code §§62.051(c) and (d). The Insurance Code §843.002(1) specifies the definition of *adverse determination*. The Insurance Code §843.008 provides that the money collected under the Insurance Code Chapter 843 must be sufficient to administer the Insurance Code Chapters 843 and Chapter 20A, re-adopted as a result of the enactment of the non-substantive Insurance Code revisions, Acts 2001, 77th Legislature, Regular Session, Chapter 1419 §1, effective April 1, 2003, and Acts 2003, 78th Legislature, Regular Session, Chapter 1274 §3, effective April 1, 2005, as Insurance Code Chapters 1271 (Benefits Provided by Health Maintenance Organizations; Evidence of Coverage; Charges), 1272 (Delegation of Certain Functions by Health Maintenance Organizations), 1367 (Coverage of Children), and 1452 (Physician and Provider Credentials) and other applicable insurance laws of this state that apply to HMO regulation. The Insurance Code §843.102 authorizes the Commissioner to establish by rule minimum standards and requirements for the quality assurance programs of health maintenance organizations, including standards for ensuring availability, accessibility, quality, and continuity of care. The Insurance Code §843.154 requires the Commissioner to prescribe a filing fee for an evidence of

coverage that requires approval in an amount not to exceed $200. The Insurance Code §1271.101 provides that an evidence of coverage or an amendment of an evidence of coverage may not be issued or delivered to a person in this state until the form of the evidence of coverage or amendment has been filed with and approved by the commissioner. The Insurance Code §1271.104 provides that the commissioner may require the submission of any relevant information the commissioner considers necessary in determining whether to approve or disapprove the form of the evidence of coverage. The Insurance Code §1301.0046 provides that an insured's coinsurance applicable to payment to nonpreferred providers may not exceed 50 percent of the total covered amount applicable to the medical or health care services. The Insurance Code §1369.003 excepts small employer health benefit plans from providing coverage of prescription drugs pursuant to the provisions of the Insurance Code Chapter 1369 Subchapter A. The Insurance Code §1452.006 provides that a rule adopted by the commissioner under the Insurance Code §843.102, which regulates HMO quality assurance, relating to implementation and maintenance by a health maintenance organization of a process for selecting and retaining affiliated physicians and providers must comply with standards adopted by the National Committee for Quality Assurance, to the extent those standards do not conflict with other laws of this state. The Insurance Code §843.151 provides that the Commissioner may adopt rules necessary to implement the Insurance Code Chapter 843 and Chapter 20A, including rules to ensure that enrollees have adequate access to health care services and rules to establish minimum physician-to-patient rations, mileage requirements for primary and specialty

care, maximum travel time, and maximum waiting time for obtaining an appointment; Chapter 20A was re-adopted as part of the enactment of the non-substantive Insurance Code revisions by the 77th Legislature, Regular Session, effective April 1, 2003, and by the 78th Legislature, Regular Session, effective April 1, 2005, as Insurance Code Chapters 1271, 1272, 1367, 1452, and other applicable insurance laws of this state that apply to HMO regulation. The Health and Safety Code §62.051(c) provides that the Health and Human Services Commission shall oversee the implementation of the child health plan program and coordinate the activities of each agency necessary to the implementation of the program, including the Texas Department of Health, Texas Department of Human Services, and Texas Department of Insurance. The Health and Safety Code §62.051(d) provides that the Health and Human Services Commission may, with the consent of another agency, including the Texas Department of Insurance, delegate to that agency the authority to adopt, with the approval of the commission, any rules that may be necessary to implement the child health plan program. The Insurance Code §36.001 authorizes the Commissioner of Insurance to adopt rules to implement the powers and duties of the Department under the Insurance Code and other laws of this state.

6. CROSS REFERENCE TO STATUTE. The proposed amendments affect regulation pursuant to the following statutes:

Rule	Statute
§§11.1 - 11.2, 11.203 - 11.204, 11.301 - 11.302, 11.501, 11.503,	Insurance Code §§843.002(1), 843.008, 843.102, 843.151,

11.504 - 11.506, 11.508 -11.511, 11.602 ,11.706, 11.801, 11.804, 11.810, 11.901 – 11.902, 11.904, 11.1201, 11.1206, 11.1301 – 11.1302, 11.1401, 11.1403, 11.1600, 11.1605, 11.1607, 11.1702 – 11.1703, 11.1801, 11.1901 – 11.1902, 11.2103, 11.2201, 11.2207, 11.2303, 11.2315, 11.2402, 11.2405 - 11.2406, 11.2501 – 11.2503, 11.2601 - 11.2604, 11.2608, and 11.2609

843.154, 1271.101, 1271.104, 1301.0046, 1369.003, 1452.006, and the Health and Safety Code §§62.051(c) and (d)

7. TEXT.

SUBCHAPTER A. General Provisions

§11.1. Purpose. This chapter implements the Insurance Code Chapters 843, 1271, 1272, 1367, and 1452, and other applicable insurance laws of this state that apply to HMOs [~~Texas Health Maintenance Organization Act, Texas Insurance Code, Chapters 20A and 843~~].

(1) Severability. Where any terms or sections of this chapter are determined by a court of competent jurisdiction to be inconsistent with the Insurance Code Chapters 843, 1271, 1272, 1367, or 1452, or other applicable insurance laws of this state that apply to HMOs, the applicable chapters of the Insurance Code [~~Texas Health Maintenance Organization Act, as identified by this section, the Act~~] will apply, but the remaining terms and provisions of this chapter will continue in effect.

(2) (No change.)

(3) Violation of rules. A violation of the lawful rules or orders of the commissioner made pursuant to this chapter constitutes a violation of the Insurance

Code Chapters 843, 1271, 1272, 1367, and 1452 and other applicable insurance laws of this state that apply to HMOs [Texas Health Maintenance Organization Act].

§11.2. Definitions.

(a) The definitions found in the [Texas Health Maintenance Organization Act, Texas] Insurance Code §843.002[,] are incorporated into this chapter.

(b) The following words and terms, when used in this chapter, shall have the following meanings unless the context clearly indicates otherwise.

(1) [Act--The Texas Health Maintenance Organization Act, codified as the Texas Insurance Code Chapters 20A and 843].

[(2)] Admitted assets--All assets as defined by statutory accounting principles, as permitted and valued in accordance with §11.803 of this title (relating to Investments, Loans, and Other Assets).

(2)[(3)] Adverse determination--A determination by a health maintenance organization or a [upon] utilization review agent that [the] health care services provided [furnished] or proposed [adopted] to be provided [furnished] to an enrollee [a patient] are not medically necessary or are not appropriate.

(3)[(4)] Affiliate--A person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified.

(4)[(5)] Agent--A person who may act as an agent for the sale of a health benefit plan under a license issued under the Insurance Code [Chapter 21].

(5)[~~(6)~~] ANHC or approved nonprofit health corporation--A nonprofit health corporation certified under the Occupations Code §162.001 [~~of the Occupations Code~~], as amended.

(6)[~~(7)~~] Annual financial statement--The annual statement to be used by HMOs, as promulgated by the NAIC and as adopted by the commissioner under the Insurance Code Chapter 802 [~~Article 1.11~~] and §843.155 [~~§§802.001, 802.003 and 843.155~~].

(7)[~~(8)~~] Authorized control level--The number determined under the RBC formula in accordance with the RBC instructions.

(8)[~~(9)~~] Basic health care service--Health care services which an enrolled population might reasonably require to maintain good health, as prescribed in §§11.508 and 11.509 of this title (relating to Mandatory Benefit Standards: Group, Individual and Conversion Agreements, and Additional Mandatory Benefit Standards: Group Agreement Only).

(9)[~~(10)~~] Clinical director--Health professional who meets the following criteria:

(A) is appropriately licensed;

(B) is an employee of, or party to a contract with, a health maintenance organization; and

(C) is responsible for clinical oversight of the utilization review program, the credentialing of professional staff, and quality improvement functions.

(10)[~~(11)~~] Code--The Texas Insurance Code.

(11)[~~(12)~~] Consumer choice health benefit plan--A health benefit plan authorized by the Insurance Code Chapter 1507 [~~Article 3.80 or Article 20A.09N~~], and as described in Subchapter AA of Chapter 21 of this title (relating to Consumer Choice Health Benefit Plans).

(12)[~~(13)~~] Contract holder--An individual, association, employer, trust or organization to which an individual or group contract for health care services has been issued.

(13)[~~(14)~~] Control--As defined in the Insurance Code §§823.005 and 823.151.

(14)[~~(15)~~] Controlled HMO--An HMO controlled directly or indirectly by a holding company.

(15)[~~(16)~~] Controlled person--Any person, other than an HMO, who is controlled directly or indirectly by a holding company.

(16)[~~(17)~~] Copayment--A charge, which may be expressed in terms of a dollar amount or a percentage of the contracted rate, in addition to premium to an enrollee for a service which is not fully prepaid.

(17)[~~(18)~~] Credentialing--The process of collecting, assessing, and validating qualifications and other relevant information pertaining to a physician or provider to determine eligibility to deliver health care services.

(18)[~~(19)~~] Dentist--An individual provider licensed to practice dentistry by the Texas State Board of Dental Examiners.

(19)[~~(20)~~] General hospital--A licensed establishment that:

(A) offers services, facilities, and beds for use for more than 24 hours for two or more unrelated individuals requiring diagnosis, treatment, or care for illness, injury, deformity, abnormality, or pregnancy; and

(B) regularly maintains, at a minimum, clinical laboratory services, diagnostic X-ray services, treatment facilities including surgery or obstetrical care or both, and other definitive medical or surgical treatment of similar extent.

(20)[~~(21)~~] HMO--A health maintenance organization as defined in the Insurance Code §843.002(14).

(21)[~~(22)~~] Health status related factor--Any of the following in relation to an individual:

(A) health status;

(B) medical condition (including both physical and mental illnesses);

(C) claims experience;

(D) receipt of health care;

(E) medical history;

(F) genetic information;

(G) evidence of insurability (including conditions arising out of acts of domestic violence, including family violence as defined by the Insurance Code Chapter 544 Subchapter D [~~Article 21.21-5)~~]; or

(H) disability.

(22)[~~(23)~~] Individual provider--Any person, other than a physician or institutional provider, who is licensed or otherwise authorized to provide a health care service. Includes, but is not limited to, licensed doctor of chiropractic, dentist, registered nurse, advanced practice nurse, physician assistant, pharmacist, optometrist, registered optician, and acupuncturist.

(23)[~~(24)~~] Institutional provider--A provider that is not an individual. Includes any medical or health related service facility caring for the sick or injured or providing care or supplies for other coverage which may be provided by the HMO. Includes but is not limited to:

(A) - (L) (No change.)

(M) [~~Infusion services centers,~~]

[~~(N)~~] Residential treatment centers,

(N)[~~(O)~~] Community mental health centers,

[~~(P) Urgent care centers,~~] and

(O)[~~(Q)~~]) Pharmacies.

(24)[~~(25)~~] Limited provider network--A subnetwork within an HMO delivery network in which contractual relationships exist between physicians, certain providers, independent physician associations and/or physician groups which limit the enrollees' access to only the physicians and providers in the subnetwork.

(25)[~~(26)~~] Limited service HMO--An HMO which has been issued a certificate of authority to issue a limited health care service plan as defined in the Insurance Code §843.002.

(26) Matrix filing--A filing consisting of individual provisions, each with its own unique identifiable form number, that allows an HMO the flexibility to create multiple evidences of coverage by using combinations of approved individual provisions.

(27) - (29) (No change.)

(30) Pharmaceutical services--Services, including dispensing prescription drugs, under the Texas Pharmacy Act, Occupations Code, Subtitle J, as amended, that are ordinarily and customarily rendered by a pharmacy or pharmacist.

(31) Pharmacist--An individual provider licensed to practice pharmacy under the Texas Pharmacy Act, Occupations Code, Subtitle J, as amended.

(32) Pharmacy--A facility licensed under the Texas Pharmacy Act, Occupations Code, Subtitle J, as amended.

(33) - (59) (No change.)

(60) Voting security--As defined in the Insurance Code §823.007, including any security convertible into or evidencing a right to acquire such security.

SUBCHAPTER C. Application for Certificate of Authority

§11.203. Revisions during Review Process.

(a) – (c) (No change.)

(d) Staff shall conduct qualifying examinations and notify the applicant of the need for revisions necessary to meet the requirements of the Insurance Code Chapter 843, [~~Act or~~] this chapter, and applicable insurance laws and regulations of this state that apply to HMOs. If the applicant does not make the necessary revisions, the

department shall deny the application. If the time required for the revisions will exceed the time limits set out in §1.809 of this title (relating to HMO Certificate of Authority), the applicant must request additional time within which to make the revisions. The applicant must specifically set out the length of time requested, which may not exceed 90 days. The commissioner may grant or deny the request for an extension of time at his or her discretion under §1.809 of this title. Additional extensions may be requested. The request for any additional extension must set out the need for the additional time, in writing, in sufficient detail for the commissioner to determine if good cause for the extension exists. The commissioner may grant or deny any additional request for an extension of time at his or her discretion.

§11.204. Contents. Contents of the application must include the items in the order listed in this section. The applicant must submit two additional copies of the application along with the original application.

(1) – (12) (No change.)

(13) the form of any contract or monitoring plan between the applicant and:

(A) (No change.)

(B) any physician, medical group, association of physicians, delegated entity, as described in the Insurance Code Chapter 1272 [~~Article 20A.18C~~], delegated network, as described in the Insurance Code Chapter 1272 [~~Article 20A.18D~~], or any other provider, plus the form of any subcontract between such entities and any

physician, medical group, association of physicians, or any other provider to provide health care services. All contracts shall include a hold-harmless provision, as specified in §11.901(a)(1) of this title (relating to Required Provisions). Such clause shall be no less favorable to enrollees than that outlined in §11.901(a)(1) of this title.

(C) – (F) (No change.)

(14) – (24) (No change.)

SUBCHAPTER D. Regulatory Requirements for an HMO Subsequent to Issuance of Certificate of Authority

§11.301. Filing Requirements. Subsequent to the issuance of a certificate of authority, each HMO is required to file certain information with the commissioner, either for approval prior to effectuation or for information only, as outlined in paragraphs (4) and (5) of this section and in §11.302 of this title (relating to Service Area Expansion or Reduction Applications). These requirements include filing changes necessitated by federal or state law or regulations.

(1) Completeness and format of filings.

(A) The department shall not accept a filing for review until the filing is complete. An application to modify the approved application for a certificate of authority which requires the commissioner's approval in accordance with the Insurance Code §843.080 and Chapter 1271 Subchapter C [~~Article 20A.09(l)~~] is considered complete when all information required by this section, §11.302 of this title, and §§11.1901 - 11.1902 of this title (relating to Quality of Care) that is applicable and

reasonably necessary for a final determination to be made by the department, has been filed.

(B) (No change.)

(2) – (3) (No change.)

(4) Filings requiring approval. Subsequent to the issuance of a certificate of authority, each HMO shall file for approval with the commissioner information required by any amendment to items specified in §11.204 of this title (relating to Contents) if such information has not previously been filed and approved by the commissioner. In addition, an HMO shall file with the commissioner a written request to implement or modify the following operations or documents and receive the commissioner's approval prior to effectuating such modifications:

(A) the evidence of coverage filings, [~~and related forms,~~] as described in §11.501 of this title (relating to Forms Which Must Be Approved Prior to Use);

(B) – (M) (No change.)

(5) – (7) (No change.)

§11.302. Service Area Expansion or Reduction Applications

(a) (No change.)

(b) If any of the following items are changed by a service area expansion or reduction application, the new item or any amendments to an existing item must be

submitted for approval or filed for information, as specified in §11.301 of this title (relating to Filing Requirements):

(1) – (11) (No change.)

(12) a description of the method by which the complaint procedure, as specified in the Insurance Code §843.251, et seq. and related regulations, will be made reasonably available in the new service area or division, including a toll free call, and the information and complaint telephone number required by the Insurance Code §521.102 [Article 21.71], where applicable. For HMOs subject to the Insurance Code §521.102 [Article 21.71], the toll free call required by this rule and the toll free information and complaint number required by the Insurance Code §521.102 [Article 21.71] may be the same number.

(c) The department shall not accept an application for review until the application is complete. An application to modify the certificate of authority that requires the commissioner's approval in accordance with the Insurance Code §843.080 and Chapter 1271 Subchapter C [Article 20A.09(l)] is considered complete when all information required by §11.301 of this title, this section, and §§11.1901 - 11.1902 of this title (relating to Quality of Care) that is reasonably necessary for a final determination by the department, has been filed with the department.

(d) (No change.)

SUBCHAPTER F. Evidence of Coverage

§11.501. Forms Which Must Be Approved Prior to Use.

(a) No evidence of coverage or amendment thereto may be issued, delivered, or used in Texas unless it has been filed for review and has received the approval of the commissioner. The following forms are always considered to be part of the evidence of coverage [~~which must be approved by the commissioner prior to use~~]:

(1) - (6) (No change.)

(7) matrix filings; and

(8) [~~(7)~~] any other form attached to or made a part of the evidence of coverage.

(b) Each of the forms described in subsection (a)(1) – (8) of this section shall be identified with a unique form number and shall be individually approved by the commissioner before being issued, delivered, or used in Texas. Each of the forms described in subsection (a)(1) – (8) of this section shall be considered a separate evidence of coverage filing and, except as provided in subsection (c) of this section, shall be subject to the filing fee prescribed in §7.1301(g)(4) of this title (relating to Regulatory Fees) for initial submissions. Each form that is resubmitted after withdrawal or disapproval will be assessed a fee of $50.

(c) Notwithstanding the fee requirements prescribed in subsection (b) of this section, a fee of $50 per individual evidence of coverage provision, with a maximum fee of $500, is required for matrix filings, as listed in subsection (a)(7) of this section, whether the filing be an initial filing or a resubmission.

§11.503. Filing Requirements for Evidence of Coverage Subsequent to Receipt of Certificate of Authority. Subsequent to receipt of a certificate of authority, no evidence of coverage filing may be amended or altered in any manner, and no new evidence of coverage filing may be used, unless the proposed new or revised evidence of coverage filing has been filed for review and has received the approval of the commissioner. Filing requirements for the evidence of coverage filing when filed subsequent to receipt of a certificate of authority are as follows:

(1) The HMO must submit the original of the revised or new evidence of coverage filing, transmittal letter and the HMO transmittal and certification form, addressed to the Texas Department of Insurance, Life, Health & HMO Intake Unit, Mail Code 106-1E, P.O. Box 149104, Austin, Texas 78714-9104.

(2) The department will notify the HMO of the department's action in accordance with §1.704 of this title (relating to Summary Procedure; Notice).

(3) The department will base its approval or disapproval on the content of drafts submitted to the department. Printing must comply with the specifications described in §11.505 of this title (relating to Specifications for the Evidence of Coverage). Any discrepancy in content between the final print to be issued and the approved draft is grounds for revocation of certificate of authority.

(4) The review period for an evidence of coverage filing filed begins on the date on which an acceptable, typed draft of the form is received.

(5) The review period may be extended upon 30 days written notice of such extension to the HMO before the expiration of the initial review period.

(6) At the end of the review period, the evidence of coverage filing is considered approved unless it has already been either affirmatively approved or disapproved by the commissioner.

§11.504. Disapproval of an Evidence of Coverage.

(a) If the department disapproves any portion of any evidence of coverage, the department will specify the reason for the disapproval. The department is authorized to disapprove any form or withdraw any previous approval for any of the following reasons:

(1) it fails to meet the requirements of the Insurance Code Chapter 1271 [~~Act~~], these sections, or other applicable statutes and regulations;

(2) (No change.)

(3) it contains any statements that are unclear, untrue, unjust, unfair, inequitable, misleading, or deceptive or that violate the Insurance Code Chapters 541, 542, 543, 544, and 547, [~~Articles 21.21, 21.21A, 21.21-1, 21.21-2, 21.21-5, 21.21-6, or 21.55~~] in accordance with the Insurance Code §1271.005 [~~Article 20A.09Z~~] or any regulations thereunder or any other applicable law;

(4) – (7) (No change.)

(b) (No change.)

§11.505. Specifications for the Evidence of Coverage and Matrix Filings.

(a) – (e) (No change.)

(f) Certain language shall not be varied or changed without resubmitting a form for the commissioner's approval. Changeable language must be enclosed in brackets and shall include the range of variable information or amounts[~~ and is limited to rates, dates, addresses, phone numbers, optional provisions as set forth in §11.511 of this title (relating to Optional Provisions) and optional benefits as set forth in §11.512 of this title (relating to Optional Benefits), and other such information, as approved by the commissioner~~].

(g) (No change).

(h) Matrix Filings. A matrix filing must comply with the filing requirements in this section and §11.301 of this chapter (relating to Filing Requirements). In addition, an HMO submitting a matrix filing:

(1) shall identify each provision with a unique form number that is sufficient to distinguish it as a matrix filing; and

(2) may use the same provision filed under one form number for all HMO products, provided the language is applicable to each HMO product; however, any changes in the language to comply with the requirements for each HMO product will require a unique form number.

§11.506. Mandatory Contractual Provisions: Group, Individual and Conversion Agreement and Group Certificate. Each enrollee residing in this state is entitled to an evidence of coverage under a health care plan. By agreement between the issuer of the evidence of coverage and the enrollee, the evidence of coverage approved under

this subchapter and required by this section may be delivered electronically. Each group, individual and conversion contract and group certificate must contain the following provisions.

(1) Name, address, and phone number of the HMO--The toll-free number referred to in the Insurance Code §521.102 [~~Article 21.71~~], where applicable, must appear on the face page.

(A) – (B) (No change.)

(C) The HMO must provide the information regarding the toll-free number referred to in the Insurance Code Chapter 521 Subchapter C, [~~Article 21.71~~] in accordance with §1.601 of this title (relating to Notice of Toll-Free Telephone Numbers and Information and Complaint Procedures).

(2) Benefits--A schedule of all health care services that are available to enrollees under the basic, limited, or single health care service plan, including any copayments or deductibles and a description of where and how to obtain services. An HMO may use a variable copayment or deductible schedule. The copayment schedule must clearly indicate the benefit to which it applies.

(A) Copayments. An HMO may require copayments to supplement payment for health care services. Each HMO may establish one or more reasonable copayment options. A reasonable copayment option may not exceed 50 percent of the total covered amount applicable to the medical or health care services. [~~A basic service HMO may not impose copayment charges that exceed fifty percent of the total cost of providing any single service to its enrollees, nor in the aggregate more than twenty~~

~~percent of the total cost to the HMO of providing all basic health care services. A basic service HMO may not impose copayment charges on any enrollee in any calendar year, when the copayments made by the enrollee in that calendar year total two hundred percent of the total annual premium cost which is required to be paid by or on behalf of that enrollee. This limitation applies only if the enrollee demonstrates that copayments in that amount have been paid in that year.~~] The HMO shall state the copayment in the group, individual or conversion agreement and group certificate.

(B) (No change.)

(C) Immunizations. An HMO shall not charge a copayment or deductible for immunizations as described in the Insurance Code Chapter 1367 Subchapter B [~~Article 21.53F~~] for a child from birth through the date the child is six years of age, except that a small employer health benefit plan, as defined by the Insurance Code §1501.002 [~~Chapter 26~~], that covers such immunizations may charge a copayment or deductible.

(3) (No change.)

(4) Claim payment procedure--A provision that sets forth the procedure for paying claims, including any time frame for payment of claims which must be in accordance with the Insurance Code Chapter 542 Subchapter B and §1271.005 [~~Articles 21.55 and 20A.09Z~~] and the applicable rules.

(5) (No change.)

(6) Continuation of coverage--Group agreements must contain a provision providing for mandatory continuation of coverage for enrollees who were continuously

covered under a group certificate for three months prior to termination of the group coverage, or newborn or newly adopted children of enrollees with three months prior continuous coverage, that is no less favorable than provided by the Insurance Code Chapter 1271 Subchapter G [~~Article 20A.09(k)~~].

(A) An enrollee shall have the option to continue coverage as provided for by the Insurance Code Chapter 1271 Subchapter G [~~Article 20A.09(k),~~] upon completion of any continuation of coverage provided under The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) (Public Law Number 99-272, 100 stat. 222) and any amendments thereto.

(B) A dependent, upon completion of any continuation of coverage provided under the Insurance Code Chapter 1251 Subchapter G [~~Article 3.51-6 §3B~~], shall have the privilege to continue coverage for the six [~~6~~] months prescribed by the Insurance Code Chapter 1271 Subchapter G [~~Article 20A.09(k)~~].

(C) If an HMO offers conversion coverage, it must be offered to the enrollee not less than 30 days prior to the expiration of the COBRA or the Insurance Code Chapter 1251 Subchapter G [~~Article 3.51-6 §3B~~] continuation coverage period.

(D) A basic service HMO shall notify the enrollee not less than 30 days before the end of the six months from the date continuation under the Insurance Code Chapter 1271 Subchapter G [~~Article 20A.09(k)~~] was elected that the enrollee may be eligible for coverage under the Texas Health Insurance Risk Pool, as provided under the Insurance Code Chapter 1506 [~~Article 3.77~~], and shall provide the address and toll-free number of the pool.

(7) – (8) (No change.)

(9) Eligibility--A statement of the eligibility requirements for membership, including:

(A) – (D) (No change.)

(E) a clear statement regarding the coverage of the enrollee's grandchildren up to the age of 25 under the conditions under which such coverage is required by the Insurance Code §§1201.062 and 1271.006 [~~Article 3.70-2, subsection (L) and Article 20A.09H (Children and Grandchildren)~~].

(10) – (15) (No change.)

(16) Schedule of charges--A statement that discloses the HMO's right to change the rate charged with 60 days written notice pursuant to the Insurance Code Chapter 1254 [~~Article 3.51-10~~].

(17) – (18) (No change.)

(19) Termination due to student dependent's change in status--Each group agreement and certificate that conditions dependent coverage for a child twenty-five years of age or older on the child's being a full-time student at an educational institution shall contain a provision in accordance with the Insurance Code Chapter 1503 [~~Article 21.24-2~~].

(20) Conformity with state law--A provision that if the agreement or certificate contains any provision not in conformity with the Insurance Code Chapter 1271 [~~Act~~] or other applicable laws it shall not be rendered invalid but shall be construed

and applied as if it were in full compliance with the Insurance Code Chapter 1271 [~~Act~~] and other applicable laws.

(21) (No change.)

(22) Nonprimary care physician specialist as primary care physician--A provision that allows enrollees with chronic, disabling, or life threatening illnesses to apply to the HMO's medical director to utilize a nonprimary care physician specialist as a primary care physician as set forth in the Insurance Code §1271.201 [~~Article 20A.09(g)~~].

(23) Selected obstetrician or gynecologist--Individual, conversion and group agreements and certificates, except small employer plans as defined by the Insurance Code §1501.002 [~~Chapter 26~~], must contain a provision that permits an enrollee to select, in addition to a primary care physician, an obstetrician or gynecologist to provide health care services within the scope of the professional specialty practice of a properly credentialed obstetrician or gynecologist, and subject to the provisions of the Insurance Code Chapter 1451 Subchapter F [~~Article 21.53D~~]. An HMO shall not preclude an enrollee from selecting a family physician, internal medicine physician, or other qualified physician to provide obstetrical or gynecological care.

(A) – (E) (No change.)

(F) An HMO shall include in its enrollment form a space in which an enrollee may select an obstetrician or gynecologist as set forth in the Insurance Code Chapter 1451 Subchapter F [~~Article 21.53D~~]. The enrollment form must specify that the enrollee is not required to select an obstetrician or gynecologist, but may

instead receive obstetrical or gynecological services from her primary care physician or primary care provider. Such enrollee shall have the right at all times to select or change a selected obstetrician or gynecologist. An HMO may limit an enrollee's request to change an obstetrician or gynecologist to no more than four changes in any 12-month period.

(G) (No change.)

(24) Diagnosis of Alzheimer's disease--An HMO that provides for the treatment of Alzheimer's disease must provide that a clinical diagnosis of Alzheimer's disease by a physician licensed in this state pursuant to the Insurance Code Chapter 1354 [~~Article 3.78~~] shall satisfy any requirement for demonstrable proof of organic disease.

(25) Drug Formulary--A group agreement and certificate, except small employer plans as defined by the Insurance Code §1501.002 [~~Chapter 26~~], that covers prescription drugs and uses one or more formularies must comply with the Insurance Code Chapter 1369 Subchapter B [~~Article 21.52J~~] and Chapter 21, Subchapter V of this title (relating to Pharmacy Benefits).

(26) (No change.)

§11.508. Mandatory Benefit Standards: Group, Individual and Conversion Agreements.

(a) Each evidence of coverage providing basic health care services shall provide the following basic health care services when they are provided by network physicians

or providers, or by non-network physicians and providers as set forth in §11.506(10) or (15) of this title (relating to Mandatory Contractual Provisions: Group, Individual and Conversion Agreement and Group Certificate):

(1) Outpatient services, including the following:

(A) – (G) (No change.)

(H) preventive services, including:

(i) periodic health examinations for adults as required in the Insurance Code §1271.153 [~~Article 20A.09B~~];

(ii) immunizations for children as required in the Insurance Code §1367.053 [~~Article 21.53F §3~~];

(iii) well-child care from birth as required in the Insurance Code §1271.154 [~~Article 20A.09E~~];

(iv) cancer screenings as required in the Insurance Code Chapter 1356 [~~Article 3.70-2(H)~~] relating to mammography;

(v) cancer screenings as required in the Insurance Code Chapter 1362 [~~Article 21.53F~~] relating to screening for prostate cancer;

(vi) cancer screenings as required in the Insurance Code Chapter 1363 [~~Article 21.53S~~] relating to screening for colorectal cancer;

(vii) – viii) (No change.)

(I) (No change.)

(J) emergency services as required by the Insurance Code §1271.155 [~~Article 20A.09Y~~].

(2) – (4) (No change.)

(b) In addition to the basic health care services in subsection (a) of this section, each evidence of coverage shall include coverage for services as follows:

(1) – (2) (No change.)

(3) diabetes self-management training, equipment and supplies as required in the Insurance Code Chapter 1358 Subchapter B [~~Article 21.53G~~].

(c) – (e) (No change.)

§11.509. Additional Mandatory Benefit Standards: Group Agreement Only. Group agreements must contain the following additional mandatory provisions.

(1) – (2) (No change.)

(3) Chemical dependency. A provision to provide benefits for the necessary care and treatment of chemical dependency that are not less favorable than for physical illness generally, subject to the same durational limits, dollar limits, deductibles and coinsurance factors is required for state-mandated health benefit plans defined in §11.2(b) of this title (relating to Definitions). Dollar or durational limits which are less favorable than for physical illness generally may be set only if such limits are sufficient to provide appropriate care and treatment under the guidelines and standards adopted under the Insurance Code Chapter 1368 [~~Article 3.51-9, §2A(d)~~], including §§3.8001 - 3.8022 of this title (relating to Standards for Reasonable Cost Control and Utilization Review for Chemical Dependency Treatment Centers).

(A) Coverage for chemical dependency may be limited to a lifetime maximum of three separate series of treatment for each covered individual as described by the Insurance Code §1368.006 [~~Article 3.51-9, §2A(b)~~].

(B) (No change.)

(4) Osteoporosis. A provision that provides coverage to a qualified individual as defined in the Insurance Code Chapter 1361 [~~Article 21.53C~~] for medically accepted bone mass measurement for the detection of low bone mass and to determine the person's risk of osteoporosis and fractures associated with osteoporosis is required for state-mandated health benefit plans defined in §11.2(b) of this title.

(5) Serious mental illness. Group agreements, except for contracts issued to small employer plans, must include a provision for the treatment of serious mental illness, as required in the Insurance Code Chapter 1355 Subchapter A [~~Article 3.51-14~~]. Small employer plans must be offered coverage for serious mental illness as required in the Insurance Code Chapter 1355 Subchapter A [~~Article 3.51-14~~]. Serious mental illness benefits are also subject to the provisions of the Insurance Code Chapter 1355 Subchapters B and C [~~Articles 3.70-2(F) and 3.72~~].

(6) Conditions affecting the temporomandibular joint. Group agreements, except for contracts issued to small employer plans and consumer choice health benefit plans defined in §11.2(b) of this title must include a provision that provides coverage for a condition affecting the temporomandibular joint as required by the Insurance Code Chapter 1360 [~~Article 21.53A~~].

(7) (No change.)

§11.510. Mandatory Offers. Group agreements must offer the following provisions:

(1) Coverage for services and benefits on an expense incurred, service, or prepaid basis for out-patient expenses that may arise from in-vitro fertilization procedures. Benefits for in-vitro fertilization procedures must be provided to the same extent as the benefits provided for other pregnancy-related procedures under the plan. The offer to make such coverage available is required only under the conditions set out in the Insurance Code §1366.005 [~~Article 3.51-6, §3A(e)~~].

(2) Hospital and medical coverage benefits for the necessary care and treatment of loss or impairment of speech or hearing that are not less favorable than for physical illness generally, subject to the same durational limits, dollar limits, deductibles, and copayment factors, pursuant to the Insurance Code Chapter 1365 [~~Article 3.70-2(G)~~].

(3) Benefits for mental and emotional illness and disorders when confined in a hospital, with corresponding alternative treatment facility benefits pursuant to the Insurance Code Chapter 1355 Subchapter C [~~Article 3.70-2(F)~~], to the extent that such benefits are not mandated as serious mental illness under §11.509(5) of this title (relating to Additional Mandatory Benefit Standards: Group Agreement Only).

(4) For small employer groups, serious mental health benefits pursuant to the Insurance Code Chapter 1355 Subchapter C [~~Article 3.51-14~~].

§11.511. Optional Provisions. Group, individual and conversion certificates may contain optional provisions, including, but not limited to, the following:

(1) Coordination of benefits. Group plans may contain a provision that the value of any benefits or services provided by the HMO may be coordinated with any other type of group insurance plan or coverage under governmental programs so no more than 100% of eligible expenses incurred is paid. The coordination of benefits provision applies to the plan when an enrollee has health care coverage under more than one plan. This provision will only apply for the duration of the enrollee's coverage in a group plan.

(A) – (B) (No change.)

(C) Requirements of the Insurance Code Chapter 1203 [~~Article 3.51-6B~~] and §§3.3501 - 3.3511 of this title (relating to Group Coordination of Benefits) relating to coordination of benefits by insurers should be followed by HMOs that include a coordination of benefits provision in their plan.

(2) – (5) (No change.)

SUBCHAPTER G. Advertising and Sales Material

§11.602. Health Maintenance Organizations Subject to the [~~Texas~~] Insurance Code Chapters 541, 542, and 547 [~~Articles 21.21, 21.21-1, and 21.21-2,~~] and Related Rules. Health maintenance organizations must comply with the [~~Texas~~] Insurance Code Chapters 541, 542, and 547 [~~Articles 21.21, 21.21-1, and 21.21-2,~~] and rules promulgated by the Texas Department of Insurance, pursuant to the [~~Texas~~]

Insurance Code Chapters 541, 542, and 547 [~~Articles 21.21, 21.21-1, and 21.21-2~~], to the extent these rules may be applied in the same manner as insurance companies.

SUBCHAPTER H. Schedule of Charges

§11.706. Determination of Reasonability of Rates.

(a) (No change.)

(b) The following factors shall be considered in any review of rates under the Insurance Code Chapter 1271 Subchapter F [~~Article 20A.09~~]:

(1) – (6) (No change.)

(c) (No change.)

SUBCHAPTER I. Financial Requirements

§11.801. Minimum Net Worth.

(a) On or after September 1, 1999, at the time of the initial qualifying examination, an applicant for a certificate of authority to operate an HMO must have unencumbered assets of the type described in subsection (b) of this section in excess of all of its liabilities equal to or greater than the required net worth established in Insurance Code §843.403. [~~An HMO licensed before September 1, 1999, must comply with the minimum net worth requirement in Insurance Code §843.4031.~~]

(b) – (d) (No change.)

§11.804. Investment Management by Affiliate Companies. Subject to compliance with the provisions of the Insurance Code Chapter 843, this chapter, and applicable insurance laws and regulations of this state that apply to HMOs [~~HMO Act, as amended~~], nothing in this section shall prevent a domestic HMO, which is a member of an HMO holding company system with assets in an aggregate amount in excess of $1 billion and a tangible net worth of at least $100 million and having affiliates licensed in this state, from authorizing an affiliated corporation which, if other than the ultimate parent holding company, is solvent with at least $10 million tangible net worth and its performance and obligations under a written agreement with the HMO are guaranteed by the ultimate holding company, to invest, hold and administer as agent or nominee on behalf of such domestic HMO those bonds, notes, or other evidences of indebtedness and repurchase agreements that are authorized and permissible investments under the Insurance Code Chapter 843 and applicable insurance laws and regulations of this state that apply to HMOs [~~HMO Act and rules promulgated thereunder~~], and which mature within one year of the date of acquisition thereof; provided that such securities are invested, held, and administered pursuant to a written agreement authorized by the board of directors of the HMO or an authorized committee thereof, and which is submitted to the commissioner for prior approval, such approval to be based upon satisfactory evidence that such agreement will facilitate the operations of the domestic HMO and will not unreasonably diminish the service to or protection of the domestic HMO's enrollees within this state. The agreement must comply with the provisions of paragraphs (1) - (8) of this section.

(1) – (4) (No change.)

(5) All of such investments and transactions between or among affiliates and the HMO must otherwise comply with all other applicable provisions of the Insurance Code Chapter 843 and applicable insurance laws and regulations of this state that apply to HMOs [~~HMO Act, as amended, or applicable rules adopted thereunder by the department~~].

(6) If the HMO or the affiliate does not comply with the Insurance Code Chapter 843 and applicable insurance laws and regulations of this state that apply to HMOs [~~HMO Act as amended, and this chapter promulgated thereunder,~~] or does not comply with the written agreement governing such investing, holding, and administering of securities, then the commissioner's approval will be withdrawn after reasonable notice and ample opportunity to cure the noncompliance, and any further desire to continue such arrangement must be submitted for approval.

(7) – (8) (No change.)

§11.810. Hazardous Conditions for HMOs.

(a) (No change.)

(b) An HMO may be found to be in hazardous condition, after notice and opportunity for hearing, when the commissioner finds one or more of the following conditions to exist:

(1) – (4) (No change.)

(5) an HMO fails to comply with the Insurance Code Chapter 843 and applicable insurance laws and regulations of this state that apply to HMOs [~~Texas Health Maintenance Organization Act (Insurance Code Chapters 20A and 843)~~] or Title 28, Texas Administrative Code, Chapter 11;

(6) – (19) (No change.)

(20) an HMO does not have the minimum net worth required by the Insurance Code §843.403 [~~or §843.4031~~];

(21) – (22) (No change.)

SUBCHAPTER J. Physician and Provider Contracts and Arrangements

§11.901. Required Provisions.

(a) Physician and provider contracts and arrangements shall include provisions:

(1) – (7) (No change.)

(8) regarding prompt payment of claims as described in the Insurance Code Chapter 542 Subchapter B and §1271.005 [~~Article 20A.09Z~~] and all applicable statutes and rules pertaining to prompt payment of clean claims, including Insurance Code Chapter 843, Subchapter J (Payment of Claims to Physicians and Providers) and Chapter 21, Subchapter T of this title (relating to Submission of Clean Claims) with respect to the payment to the physician or provider for covered services that are rendered to enrollees;

(9) – (10) (No change.)

(11) entitling the physician or provider upon request to all information necessary to determine that the physician or provider is being compensated in accordance with the contract. A physician or provider may make the request for information by any reasonable and verifiable means. The information must include a level of detail sufficient to enable a reasonable person with sufficient training, experience and competence in claims processing to determine the payment to be made according to the terms of the contract for covered services that are rendered to enrollees. The HMO may provide the required information by any reasonable method through which the physician or provider can access the information, including e-mail, computer disks, paper or access to an electronic database. Amendments, revisions or substitutions of any information provided pursuant to this paragraph must be made in accordance with subparagraph (D) of this paragraph. The HMO shall provide the fee schedules and other required information by the 30th day after the date the HMO receives the physician's or provider's request.

(A) – (D) (No change.)

(E) Failure to comply with this paragraph constitutes a violation of the Insurance Code Chapter [~~Chapters~~] 843, this chapter, and applicable insurance laws and regulations of this state that apply to HMOs [~~and 20A (Texas Health Maintenance Organization Act)~~].

(F) - (I) (No change.)

(12) – (13) (No change.)

(b) - (c) (No change.)

§11.902. Prohibited Actions.

(a) (No change.)

(b) Pursuant to the Insurance Code §843.3045, an HMO may not refuse to contract with a nurse first assistant as defined by the Occupations Code §301.353, as added by Acts 2005, 79th Leg. R.S., ch. 966, sec. 1, as amended [~~§301.1525, Occupations Code~~], to be included in the HMO's provider network or refuse to reimburse the nurse first assistant for a covered service that a physician has requested the nurse first assistant to perform.

(c) An HMO may not by contract or any other method require a physician to use the services of a nurse first assistant as defined by the Occupations Code §301.353, as added by Acts 2005, 79th Leg. R.S., ch. 966, sec. 1, as amended [~~§301.1525, Occupations Code~~].

(d) – (e) (No change.)

§11.904. Provision of Services Related to Immunizations and Vaccinations.

(a) Pursuant to the Insurance Code Chapter 1353 [~~Article 21.53K~~], an HMO shall not require a physician to issue an immunization or vaccination protocol for an immunization or vaccination to be administered to an enrollee by a pharmacist.

(b) (No change.)

SUBCHAPTER M. Acquisition of Control of, or Merger of, A Domestic HMO

§11.1201. Definitions. The following words and terms, when used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise.

(1) Control (including the terms "controlling," "controlled by," and "under common control with")--The possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position with or corporation office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote or holds irrevocable proxies representing, 10% or more of the voting securities or authority of any other person. This presumption may be rebutted by a showing made in the manner provided by the Insurance Code §823.010 [~~, Article 21.49-1, §3(i),~~] that control does not exist in fact. The commissioner may determine, after furnishing all persons in interest notice and opportunity to be heard and making specific findings of fact to support such determination, that control exists in fact, notwithstanding the absence of a presumption to that effect, where a person exercises directly or indirectly, either alone or pursuant to an agreement with one or more other persons, such a controlling influence over the management or policies of an authorized health maintenance organization as to make it necessary or appropriate in the public interest or for the protection of the enrollees or shareholders of the health maintenance organization that the person be deemed to control the health maintenance organization.

(2) – (7) (No change.)

§11.1206. Exemptions.

(a) (No change.)

(b) A change consisting only of the substitution of management contractors under a contract with the health maintenance organization as provided for [~~defined~~] in the Insurance Code §843.105 [~~Act, §18,~~] shall be subject to the approval of the commissioner according to the provisions of [~~that section of~~] the Insurance Code §843.105 [~~Act~~] and shall be exempt from the provisions of this subchapter. No order of exemption is necessary for this purpose.

SUBCHAPTER N. HMO Solvency Surveillance Committee Plan of Operation

§11.1301. Plan of Operation. This plan of operation, hereinafter referred to as the plan, shall become effective upon written approval of the Texas Department of Insurance, hereinafter referred to as the department, as provided by the Insurance Code Chapter 843 and applicable insurance laws and regulations of this state that apply to HMOs [~~Texas Health Maintenance Organization Act, Insurance Code Chapters 20A and 843, hereinafter referred to as the Act~~]. As used in this subchapter, the committee shall be the solvency surveillance committee as provided for and defined in the Insurance Code Chapter 843 and applicable insurance laws and regulations of this state that apply to HMOs [~~Act~~], and the members shall be the members of the committee as provided for and defined in the Insurance Code Chapter 843 and applicable insurance laws and regulations of this state that apply to HMOs [~~Act~~].

§11.1302. Solvency Surveillance Committee.

(a) Members. The composition of the committee shall be in accordance with the Insurance Code §843.436.

(1) – (2) (No change.)

(3) A member shall serve until a successor is appointed unless such member's term is in conflict with the Insurance Chapter 843 and applicable insurance laws and regulations of this state that apply to HMOs [~~Act~~], or unless a member misses two or more consecutive meetings or engages in willful misconduct, in which case the commissioner may remove the member. The committee shall make recommendations to the commissioner and the department to fill vacancies. Members shall not receive any remuneration or emolument of office

(4) (No change.)

(b) – (c) (No change.)

(d) Special or emergency meetings. The committee shall hold a special or emergency meeting promptly after receiving notice from the commissioner of the need for such meeting. In addition, a special meeting of the committee may be held at the request of a majority of the membership, which shall be polled by the chairman at the request of any two members seeking a special meeting. At such meetings, the committee, if appropriate, shall perform the following functions.

(1) – (3) (No change.)

(4) In addition to the powers described in paragraphs (1) - (3) of this subsection, the committee shall have and exercise such other powers as may be reasonably necessary to implement its powers and responsibilities under the Insurance Code Chapter 843 and applicable insurance laws and regulations of this state that apply to HMOs [Act].

(e) – (f) (No change.)

SUBCHAPTER O. Administrative Procedures

§11.1401. Commissioner's Authority to Require Additional Information. The commissioner may require additional information as needed to make any determination required by the Insurance Code[,] Chapters 1271 [20A] and 843, [or] this chapter, and applicable insurance laws and regulations of this state that apply to HMOs.

§11.1403. Requirement for Notifying Enrollees of Toll-free Telephone Number for Complaints about Psychiatric or Chemical Dependency Services of Private Psychiatric Hospitals, General Hospitals, and Chemical Dependency Treatment Centers. Health Maintenance Organizations shall include in their next available newsletter or other general mailing to all enrollees following the effective date of this section, and shall include in information provided to new subscribers, the following notice:

FIGURE: 28 TAC §11.1403:

NOTICE OF SPECIAL TOLL-FREE COMPLAINT [COMPAINT] NUMBER

TO MAKE A COMPLAINT ABOUT A PRIVATE PSYCHIATRIC HOSPITAL, CHEMICAL DEPENDENCY TREATMENT CENTER, OR PSYCHIATRIC OR CHEMICAL DEPENDENCY SERVICES AT A GENERAL HOSPITAL, CALL:

1-800-832-9623

Your complaint will be referred to the state agency that regulates the hospital or chemical dependency treatment center.

AVISO DE NUMERO TELEFONICO GRATIS ESPECIAL PARA QUEJAS PARA SOMETER UNA QUEJA ACERCA DE UN HOSPITAL PSIQUIATRICO PRIVADO, DE CENTRO TRATAMIENTO PARA LA DEPENDENCIA QUIMICA, DE SERVICIOS PSIQUIATRICOS O DE DEPENDENCIA QUIMICA EN UN HOSPITAL GENERAL, LLAME A:

1-800-832-9623 [~~1-800-832-0623~~]

Su queja sera referida a la agencia estatal que regula la hospital o centro de tratamiento para la dependencia quimica.

The entire notice shall be in at least 10-point type. If the newsletter or other mailing is in larger than 10-point type, the notice shall be in the same type as the rest of the newsletter or mailing. Paragraphs 1 - 3 of the English notice and paragraphs 1 - 3 of the Spanish notice must be in boldface type. Paragraphs 1 and 2 of the English and Spanish notices must be in capital letters. A final print of the mailing shall be submitted to the HMO Division of the Texas Department of Insurance for filing within 30 days following distribution to enrollees.

SUBCHAPTER Q. Other Requirements

§11.1600. Information to Prospective and Current Contract Holders and Enrollees.

(a) (No change.)

(b) The written or electronic plan description must be in a readable and understandable format that meets the requirements of §3.602 of this title (relating to Plain Language Requirements), by category, and must include a clear, complete and accurate description of these items in the following order:

(1) – (10) (No change.)

(11) a current list of physicians and providers, including behavioral health providers and substance abuse treatment providers, if applicable, updated on at least a quarterly basis. The list shall include the information necessary to fully inform prospective or current enrollees about the network, including names and locations of physicians and providers, a statement of limitations of accessibility and referrals to specialists, including any limitations imposed by a limited provider network, and a disclosure of which physicians and providers will not accept new enrollees or participate in closed provider networks serving only certain enrollees.

(A) (No change.)

(B) If an HMO does not limit an enrollee's selection of an obstetrician or gynecologist to the limited provider network to which that enrollee's primary care physician or provider belongs, it shall provide to current or prospective enrollees a notice in compliance with the Insurance Code Chapter 1451 Subchapter F

[~~Article 21.53D~~] in substantially the following form: "ATTENTION FEMALE ENROLLEES: You have the right to select an OB-GYN to whom you have access without first obtaining a referral from your PCP. (Name of HMO) has opted not to limit your selection of an OB-GYN to your PCP's network. You are not required to select an OB-GYN. You may elect to receive your OB-GYN services from your PCP."

(C) – (E) (No change.)

(12) (No change.)

(c) – (f) (No change.)

§11.1605. Pharmaceutical Services.

(a) – (b) (No change.)

(c) An HMO that provides coverage for prescription drugs under an individual or group health benefit plan, except small employer health benefit plans as defined by the Insurance Code §1501.002, shall comply with the requirements of the Insurance Code Chapter 1369 Subchapter A [~~Article 21.53M,~~] and §21.3010 and §21.3011 of this title (relating to Definitions; Coverage of Off-Label Drugs and Minimum Standards of Coverage for Off-Label Drug Use).

(d) An HMO that provides coverage for prescription drugs or devices under an individual or group state-mandated health benefit plan shall comply with the requirements of the Insurance Code Chapter 1369 Subchapter C (Coverage of Prescription Contraceptive Drugs and Devices and Related Services) [~~Article 21.52L~~

~~(Health Benefit Plan Coverage for Prescription Contraceptive Drugs and Devices and Related Services)~~].

(e) An HMO that provides coverage for prescription drugs under a group state-mandated health benefit plan and that utilizes one or more drug formularies to specify which prescription drugs the plan will cover shall comply with the requirements of <u>the</u> Insurance Code <u>Chapter 1369 Subchapter B</u> [~~Article 21.52J~~] and §§21.3020 - 21.3023 of this title (relating to Definitions; Prescription Drug Formulary, Required Disclosure of Drug Formulary, Continuation of Benefits, and Nonformulary Prescription Drugs; Adverse Determination).

§11.1607. Accessibility and Availability Requirements.

(a) – (g) (No change.)

(h) An HMO is required to provide an adequate network for its entire service area. All covered services must be accessible and available so that travel distances from any point in its service area to a point of service are no greater than:

(1) (No change.)

(2) 75 miles for specialty care<u>, specialty hospitals, and single healthcare service plan physicians or providers</u>.

<u>(i) Notwithstanding subsection (h) of this section, an HMO that has a contract with the Health and Human Services Commission is not required to meet the access requirements prescribed in this section for covered services provided to participants in the CHIP Perinatal Program.</u>

(j)[~~(i)~~] If any covered health care service or a participating physician and provider is not available to an enrollee within the mileage radii specified in subsection (h)(1) and (2) of this section because physicians and providers are not located within such mileage radii, or if the HMO is unable to obtain contracts after good faith attempts, or physicians and providers meeting the minimum quality of care and credentialing requirements of the HMO are not located within the mileage radii, the HMO shall submit an access plan to the department for approval, at least 30 days before implementation in accordance with the filing requirements in §11.301 of this title (relating to Filing Requirements). The access plan shall include the following:

(1) the geographic area identified by county, city, ZIP code, mileage, or other identifying data in which services and/or physicians and providers are not available;

(2) for each geographic area identified as not having covered health care services and/or physicians or providers available, the reason or reasons that covered health care services and/or physicians and providers cannot be made available;

(3) a map, with key and scale, which identifies the areas in which such covered health care services and/or physicians and providers are not available;

(4) the HMO's plan for making covered health care services and/or physicians and providers available to enrollees in each geographic area identified;

(5) the names and addresses of the participating physicians and providers and a listing of the covered health care services to be provided through the

HMO delivery network to meet the medical needs of the enrollees covered under the HMO's plan required under paragraph (4) of this subsection;

(6) the names and address of other physicians and providers and a listing of the specialties for any other health care services or physicians and providers to be made available in the geographic area in addition to those physicians and providers participating in the HMO delivery network listed under paragraph (5) of this subsection;

(7) the procedures to be followed by the HMO to assure that primary care physicians, general hospitals, specialists, special hospitals, psychiatric hospitals, diagnostic and therapeutic services, or single or limited health care service providers and all other mandated health care services are made available and accessible to enrollees in the geographic areas identified as being areas in which such covered health care services and/or physicians and providers are not available and accessible, and any plans of the HMO for attempting to develop an HMO delivery network through which covered health care services are available and accessible to enrollees in these geographic areas in the future; and

(8) any other information which is necessary to assess the HMO's plan.

(k)[(j)] The HMO may make arrangements with physicians or providers outside the service area for enrollees to receive a higher level of skill or specialty than the level which is available within the HMO service area such as, but not limited to, transplants, treatment of cancer, burns, and cardiac diseases. An HMO may not require an enrollee to travel out of the service area to receive such services, unless the HMO provides the

enrollee with a written explanation of the benefits and detriments of in-area and out-of-area options.

(l)[(k)] The HMO shall not be required to expand services outside its service area to accommodate enrollees who live outside the service area, but work within the service area.

(m)[(l)] In accordance with the Insurance Code Chapter 1455 (Telemedicine and Telehealth) [Article 21.53F (Telemedicine)], each evidence of coverage or certificate delivered or issued for delivery by an HMO may provide enrollees the option to access covered health care services through a telehealth service or a telemedicine medical service.

SUBCHAPTER R. Approved Nonprofit Health Corporations

§11.1702. Requirements for Issuance of Certificate of Authority to ANHC.

(a) Prior to obtaining a certificate of authority under the Insurance Code[,] Chapter 844 (concerning Certification of Certain Nonprofit Health Corporations), an applicant ANHC must:

(1) comply with each requirement for the issuance of a certificate of authority imposed on an HMO under the Insurance Code[,] Chapters 1271 [20A] and 843; this chapter; and applicable insurance laws and regulations of this state; and

(2) (No change.)

(b) The commissioner shall grant a provisional certificate of authority to an applicant ANHC under the Insurance Code[,] Chapter 844, if:

(1) the applicant ANHC complies with each requirement for the issuance of a certificate of authority imposed on an HMO under the Insurance Code[~~,~~] Chapters 1271 [~~20A~~] and 843; this chapter; and applicable insurance laws and regulations of this state.

(2) – (4) (No change.)

(c) An ANHC with a certificate of authority or a provisional certificate of authority must comply with all the appropriate requirements that an HMO must comply with under the Insurance Code[~~,~~] Chapters 1271 [~~20A~~] and 843; this chapter; and applicable insurance laws and regulations of this state in order to maintain a certificate of authority.

(d) (No change.)

§11.1703. Requirements for Agents of an ANHC Certificate of Authority Holder. Any agent for an ANHC with a certificate of authority or a provisional certificate of authority shall be considered an HMO agent and shall comply with the requirements of the Insurance Code Chapter 4054 [~~Article 21.07-1~~] and Chapter 19 of this title (relating to Agent's Licensing), as applicable.

SUBCHAPTER S. Solvency Standards for Managed Care Organizations Participating in Medicaid

§11.1801. Entities Covered.

(a) As used in this subchapter, a managed care organization is an entity holding a certificate of authority to operate as an HMO under the Insurance Code Chapters

1271 [~~20A~~] and 843 [~~of the Texas Insurance Code~~] or as an approved nonprofit health corporation under [~~Chapter 844 of~~] the [~~Texas~~] Insurance Code Chapter 844.

(b) (No change.)

SUBCHAPTER T. Quality of Care

§11.1901. Quality Improvement Structure for Basic and Limited Services HMOs.

(a) A basic or limited services HMO shall develop and maintain an ongoing quality improvement (QI) program designed to objectively and systematically monitor and evaluate the quality and appropriateness of care and services and to pursue opportunities for improvement. Unless the HMO has no enrollees, the QI program shall include the active involvement of one or more enrollee(s) who are not employees of the HMO.

(b) The governing body is ultimately responsible for the QI program. The governing body shall:

(1) appoint a quality improvement committee (QIC) that shall include practicing physicians[~~,~~] and individual providers; and may include [~~at least~~] one or more enrollee(s) [~~enrollee~~] from throughout the HMO's service area. For purposes of this section, if an enrollee(s) is [~~the enrollee~~] appointed to the committee, the enrollee(s) may not be an employee of the HMO;

(2) – (5) (No change.)

(c) (No change.)

§11.1902. Quality Improvement Program for Basic and Limited Services HMOs. The QI program for basic and limited services HMOs shall be continuous and comprehensive, addressing both the quality of clinical care and the quality of services. The HMO shall dedicate adequate resources, such as personnel and information systems, to the QI program.

(1) – (3) (No change.)

(4) Credentialing. An HMO shall implement a documented process for selection and retention of contracted physicians and providers. The credentialing process required by this section must comply with the standards promulgated by the National Committee for Quality Assurance (NCQA), to the extent that those standards do not conflict with other laws of this state.[~~, which includes the following elements, as applicable:~~]

[~~(A) The HMO's policies and procedures shall clearly indicate the physician or individual provider directly responsible for the credentialing program and shall include a description of his or her participation.~~]

[~~(B) HMOs shall develop written criteria for credentialing of physicians and providers and written procedures for verifications.~~]

[~~(i) The HMO shall credential all physicians and providers, including advanced practice nurses, and physician assistants, if they are listed in the provider directory. An HMO shall credential each physician or individual provider who is a member of a contracting group, such as an independent physician association or medical group.~~]

[~~(ii) Policies and procedures must include the following physicians' and providers' rights:~~]

[~~(I) the right to review information submitted to support the credentialing application;~~]

[~~(II) the right to correct erroneous information;~~]

[~~(III) the right, upon request, to be informed of the status of the credentialing or recredentialing application; and~~]

[~~(IV) the right to be notified of these rights.~~]

[~~(iii) An HMO is not required to credential:~~]

[~~(I) hospital-based physicians or individual providers, including advanced practice nurses and physician assistants unless listed in the provider directory;~~]

[~~(II) individual providers who furnish services only under the direct supervision of a physician or another individual provider except as specified in clause (i) of this subparagraph;~~]

[~~(III) students, residents, or fellows;~~]

[~~(IV) pharmacists; or~~]

[~~(V) opticians.~~]

[~~(iv) An HMO must complete the initial credentialing process, including application, verification of information, and a site visit (if applicable), before the effective date of the initial contract with the physician or provider.~~]

[(v) Policies and procedures shall include a provision that applicants be notified of the credentialing or recredentialing decision no later than 60 calendar days after the credentialing committee's decision.]

[(vi) An HMO shall have written policies and procedures for suspending or terminating affiliation with a contracting physician or provider, including an appeals process, pursuant to Insurance Code §§843.306 - 843.309.]

[(vii) The HMO shall have a procedure for the ongoing monitoring of physician and provider performance between periods of recredentialing and shall take appropriate action when it identifies occurrences of poor quality. Monitoring shall include:]

[(I) Medicare and Medicaid sanctions: the HMO must determine the publication schedule or release dates applicable to its physician and provider community; the HMO is responsible for reviewing the information within 30 calendar days of its release;]

[(II) Information from state licensing boards regarding sanctions or licensure limitations; and]

[(III) Complaints.]

[(viii) The HMO's procedures shall ensure that selection and retention criteria do not discriminate against physicians or providers who serve high-risk populations or who specialize in the treatment of costly conditions. Procedures shall also include a provision that credentialing and recredentialing decisions are not based

solely on an applicant's race, ethnic/national identity, gender, age, sexual orientation or the types of procedures or types of patients.]

[(ix) The HMO shall have a procedure for notifying licensing or other appropriate authorities when a physician's or provider's affiliation is suspended or terminated due to quality of care concerns.]

[(C) Initial credentialing process for physicians and individual providers shall include the following:]

[(i) Physicians, advanced practice nurses and physician assistants shall complete the standardized credentialing application adopted in §21.3201 of this title (relating to the Texas Standardized Credentialing Application for Physicians, Advanced Practice Nurses and Physician Assistants) and individual providers shall complete an application which includes a work history covering at least five years, a statement by the applicant regarding any limitations in ability to perform the functions of the position, history of loss of license and/or felony convictions; and history of loss or limitation of privileges, sanctions or other disciplinary activity, lack of current illegal drug use, current professional liability insurance coverage information, and information on whether the individual provider will accept new patients from the HMO. This does not preclude an HMO from using the standardized credentialing application form specified in §21.3201 of this title for credentialing of individual providers. The completion date on the application shall be within 180 calendar days prior to the date the credentialing committee deems a physician or individual provider eligible for initial credentialing.]

[~~(ii) The HMO shall verify the following from primary sources and shall include evidence of verification in the credentialing files:~~]

[~~(I) A current license to practice in the State of Texas and information on sanctions or limitations on licensure. The primary source for verification shall be the state licensing agency or board for Texas, and the license and sanctions must be verified within 180 calendar days prior to the date the credentialing committee deems a physician or individual provider eligible for initial credentialing. The license must be in effect at the time of the credentialing decision.~~]

[~~(II) Education and training, including evidence of graduation from an appropriate professional school and completion of a residency or specialty training, if applicable. Primary source verification shall be sought from the appropriate schools and training facilities or the American Medical Association MasterFile. If the state licensing board, agency, or specialty board verifies education and training with the physician's or individual provider's schools and facilities, evidence of current state licensure or board certification shall also serve as primary source verification of education and training.~~]

[~~(III) Board certification, if the physician or individual provider indicates that he/she is board certified on the application. The HMO may obtain primary source verification from the American Board of Medical Specialties Compendium, the American Osteopathic Association, the American Medical Association MasterFile, or from the specialty boards, and the HMO must use the most recent available source.~~]

[(IV) Valid Drug Enforcement Agency (DEA) or Department of Public Safety (DPS) Controlled Substances Registration Certificate, if applicable. These must be in effect at the time of the credentialing decision, and the HMO may verify them by any one of the following means:]

[(-a-) copy of the DEA or DPS certificate;]

[(-b-) visual inspection of the original certificate;]

[(-c-) confirmation with DEA or DPS;]

[(-d-) entry in the National Technical Information Service database; or

[(-e-) entry in the American Medical Association Physician MasterFile.]

[(iii) The HMO shall verify within 180 calendar days prior to the date of the credentialing decision and shall include in the physician's or individual provider's credentialing file the following:]

[(I) Past five-year history of professional liability claims that resulted in settlements or judgments paid by or on behalf of the physician or individual provider, which the HMO may obtain from the professional liability carrier or the National Practitioner Data Bank;]

[(II) Information on previous sanction activity by Medicare and Medicaid which the HMO may obtain from one of the following:]

[(-a-) National Practitioner Data Bank;]

[(-b-) Cumulative Sanctions Report available over the internet;]

[(-c-) Medicare and Medicaid Sanctions and Reinstatement Report distributed to federally contracting HMOs;]

[(-d-) state Medicaid agency or intermediary and the Medicare intermediary;]

[(-e-) Federation of State Medical Boards;]

[(-f-) Federal Employees Health Benefits Program department record published by the Office of Personnel Management, Office of the Inspector General; or]

(-g-) entry in the American Medical Association Physician MasterFile.]

[(iv) The HMO shall perform a site visit to the offices of each primary care physician or individual primary care provider, obstetrician-gynecologist, primary care dentist, and high-volume behavioral health physician or individual behavioral health provider as part of the initial credentialing process. In addition, the HMO shall have written procedures for determining high-volume behavioral health physicians or individual behavioral health providers. If physicians or individual providers are part of a group practice that shares the same office, the HMO may perform one visit to the site for all physicians or individual providers in the group practice, as well as for new physicians or individual providers who subsequently join the group practice. The HMO shall make the site visit assessment available to the department for review. The

~~HMO shall have a process to track the relocation of and the opening of additional office sites for primary care physicians and individual primary care providers, obstetrician-gynecologists, primary care dentists, and high-volume behavioral health physicians or individual behavioral health providers as they open.~~]

[~~(v) Site visits shall consist of an evaluation of the site's accessibility, appearance, appointment availability, and space, using standards approved by the HMO. If a physician or individual provider offers services that require certification or licensure, such as laboratory or radiology services, the physician or individual provider shall have the current certification or licensure available for review at the site visit. In addition, as a result of the site visits, the HMO shall determine whether the site conforms to the HMO's standards for record organization, documentation, and confidentiality practices. Should the site not conform to the HMO's standards, the HMO shall require a corrective action plan and perform a follow-up site visit every six months until the site complies with the standards.~~]

[~~(D) The HMO shall have written procedures for recredentialing physicians and individual providers at least every three years through a process that updates information obtained in initial credentialing.~~]

[~~(i) Recredentialing will include a current and signed attestation that must be completed within 180 days prior to the date the credentialing committee deems a physician or individual provider eligible for recredentialing with the following factors:~~]

[(I) reasons for any inability to perform the essential functions of the position, with or without accommodation;]

[(II) lack of current illegal drug use;]

[(III) history of loss or limitation of privileges or disciplinary activity;]

[(IV) current professional liability insurance coverage; and]

[(V) correctness and completeness of the application.]

[(ii) Recredentialing procedures must be completed within 180 days prior to the date the credentialing committee deems a physician or individual provider eligible for recredentialing and shall include the following processes:]

[(I) Reverification of the following from the primary sources:]

[(-a-) Licensure and information on sanctions or limitations on licensure;]

[(-b-) Board certification:]

[(-1-) if the physician or individual provider was due to be recertified; or]

[(-2-) if the physician or individual provider indicates that he or she has become board certified since the last time he or she was credentialed or recredentialed; and]

[~~(-c-) Drug Enforcement Agency (DEA) or Department of Public Safety (DPS) Controlled Substances Registration Certificate, if applicable. These may be reverified by any one of the following means:~~]

[~~(-1-) copy of the DEA or DPS certificate;~~]

[~~(-2-) visual inspection of the original certificate;~~]

[~~(-3-) confirmation with DEA or DPS;~~]

[~~(-4-) entry in the National Technical Information Service database; or~~]

[~~(-5-) entry in the American Medical Association Physician MasterFile.~~]

[~~(II) Review of updated history of professional liability claims in accordance with the verification sources and time limits specified in subparagraph (C)(iii) of this paragraph.~~]

[~~(E) The credentialing process for institutional providers shall include the following:~~]

[~~(i) Evidence of state licensure;~~]

[~~(ii) Evidence of Medicare certification;~~]

[~~(iii) Evidence of other applicable state or federal requirements, e.g., Bureau of Radiation Control certification for diagnostic imaging centers, certification for community mental health centers from the Texas Department of~~

~~Mental Health and Mental Retardation or its successor agency, CLIA (Clinical Laboratory Improvement Amendments of 1988) certification for laboratories;~~]

[~~(iv) Evidence of accreditation by a national accrediting body, as applicable; the HMO shall determine which national accrediting bodies are appropriate for different types of institutional providers. The HMO's written policies and procedures must state which national accrediting bodies it accepts; and~~]

[~~(v) Evidence of on-site evaluation of the institutional provider against the HMO's written standards for participation if the provider is not accredited by the national accrediting body required by the HMO.~~]

[~~(F) The HMO procedures shall provide for recredentialing of institutional providers at least every three years through a process that updates information obtained for initial credentialing as set forth in subparagraph (E)(i) - (iv) of this paragraph.~~]

[~~(G) Under Insurance Code Article 20A.39, the standards adopted in this paragraph must comply with the standards promulgated by the National Committee for Quality Assurance (NCQA) to the extent that those standards do not conflict with other laws of the state. Therefore, if the NCQA standards change and there is a difference between the standards specified in this paragraph and the NCQA standards, the NCQA standards shall prevail to the extent that those standards do not conflict with the other laws of this state.~~]

(5) – (6) (No change.)

(7) Delegation of Credentialing. If the HMO delegates credentialing functions to other entities, its credentialing process must comply with the standards promulgated by the National Committee for Quality Assurance (NCQA), to the extent that those standards do not conflict with other laws of this state.[~~it shall have:~~]

[~~(i) a process for developing delegation criteria and for performing pre-delegation and annual audits;~~]

[~~(ii) a delegation agreement;~~]

[~~(iii) a monitoring plan; and~~]

[~~(iv) a procedure for termination of the delegation agreement for non-performance.~~]

[~~(B) If the HMO delegates credentialing functions to an entity accredited by the NCQA, the annual audit of that entity is not required for the function(s) listed in the NCQA accreditation; however, evidence of this accreditation shall be made available to the department for review.~~]

[~~(C) The HMO shall maintain:~~]

[~~(i) documentation of pre-delegation and annual audits;~~]

[~~(ii) executed delegation agreements;~~]

[~~(iii) semi-annual reports received from the delegated entities;~~]

[~~(iv) evidence of evaluation of the reports;~~]

[~~(v) current rosters or copies of signed contracts with physicians and individual providers who are affected by the delegation agreement; and~~]

[~~(vi) documentation of ongoing monitoring and shall make it available to the department for review.~~]

[~~(D) Credentialing files maintained by the other entities to which the HMO has delegated credentialing functions shall be made available to the department for examination upon request.~~]

[~~(E) In all cases, the HMO shall maintain the right to approve credentialing, suspension, and termination of physicians and providers.~~]

SUBCHAPTER V. Standards for Community Mental Health Centers

§11.2103. Requirements for Issuance of Certificate of Authority to a CHMO.

(a) Prior to obtaining a certificate of authority under Section 534.101[~~,~~] of the Health and Safety Code (concerning Health Maintenance Organizations Certificate of Authority), an applicant CHMO must comply with each requirement for the issuance of a certificate of authority imposed on a limited health care service plan under the Insurance Code Chapters 1271 [~~20A~~] and 843; this chapter; and applicable insurance laws and regulations of this state.

(b) A CHMO with a certificate of authority must comply with all the appropriate requirements that a limited health care service plan must comply with under the Insurance Code Chapters 1271 [~~20A~~] and 843; this chapter; and applicable insurance laws and regulations of this state to maintain a certificate of authority. A CHMO shall be subject to the same statutes and rules as a limited service HMO and considered a limited service HMO for purposes of regulation and regulatory enforcement.

(c) – (d) (No change.)

SUBCHAPTER W. Single Service HMOs

§11.2201. General Provisions.

(a) (No change.)

(b) Each single service HMO schedule of enrollee copayments shall specify an appropriate description of covered services and benefits, as required under §11.506 of this title (relating to Mandatory Contractual Provisions: Group, Individual and Conversion Agreement and Group Certificate), and may specify recognized procedures or other information which is used for the purpose of maintaining a statistical reporting system[, as required under §11.1601 of this title (relating to Organization of an HMO].

(c) - (d) (No change.)

§11.2207. Quality Improvement Structure and Program for Single Service HMOs.

(a) A single service HMO shall develop and maintain an ongoing quality improvement (QI) program designed to objectively and systematically monitor and evaluate the quality and appropriateness of care and services and to pursue opportunities for improvement. Unless the HMO has no enrollees, the QI program shall include the active involvement of one or more enrollee(s) who are not employees of the HMO.

(b) The governing body is ultimately responsible for the QI program. The governing body shall:

(1) appoint a QI committee (QIC) that shall include practicing physicians[,] and individual providers, and may include [at least] one or more enrollee(s) [enrollee] from throughout the HMO's service area. For purposes of this section, if an enrollee(s) is [the enrollee] appointed to the committee, the enrollee(s) may not be an employee of the HMO;

(2) – (5) (No change.)

(c) (No change.)

(d) The QI program for single service HMOs shall be continuous and comprehensive, addressing both the quality of clinical care and the quality of services. The HMO shall dedicate adequate resources, such as personnel and information systems, to the QI program.

(1) – (3) (No change.)

(4) Credentialing. An HMO shall implement a documented process for selection and retention of contracted physicians and providers. The credentialing process required by this section must comply with the standards promulgated by the National Committee for Quality Assurance (NCQA), to the extent that those standards do not conflict with other laws of this state.[, which includes the following elements, as applicable:]

[(A) The HMO's policies and procedures shall clearly indicate the physician or individual provider directly responsible for the credentialing program and shall include a description of his or her participation.]

[~~(B) HMOs shall develop written criteria for credentialing of physicians and providers and written procedures for verifications.~~]

[~~(i) The HMO shall credential all physicians and providers including advanced practice nurses and physician assistants, if they are listed in the provider directory. An HMO shall credential each physician and individual provider who is a member of a contracting group, such as an independent practice association or medical group.~~]

[~~(ii) Policies and procedures must include the following physicians' and providers' rights:~~]

[~~(I) the right to review information submitted to support the credentialing application;~~]

[~~(II) the right to correct erroneous information;~~]

[~~(III) the right, upon request, to be informed of the status of the credentialing or recredentialing application; and~~]

[~~(IV) the right to be notified of these rights.~~]

[~~(iii) An HMO is not required to credential:~~]

[~~(I) hospital-based physicians or individual providers, including advanced practice nurses and physician assistants unless listed in the provider directory;~~]

[~~(II) individual providers who furnish services only under the direct supervision of a physician or another individual provider except as specified in clause (i) of this subparagraph;~~]

[~~(III) students, residents, or fellows;~~]

[~~(IV) pharmacists; or~~]

[~~(V) opticians.~~]

[~~(iv) An HMO must complete the initial credentialing process, including application, verification of information, and a site visit (if applicable), before the effective date of the initial contract with the physician or provider.~~]

[~~(v) Policies and procedures shall include a provision that applicants be notified of the credentialing or recredentialing decision no later than 60 calendar days after the credentialing committee's decision.~~]

[~~(vi) An HMO shall have written policies and procedures for suspending or terminating affiliation with a contracting physician or provider, including an appeals process, pursuant to Insurance Code §§843.306 - 843.309.~~]

[~~(vii) The HMO shall have a procedure for the ongoing monitoring of physician and provider performance between periods of recredentialing and shall take appropriate action when it identifies occurrences of poor quality. Monitoring shall include:~~]

[~~(I) Medicare and Medicaid sanctions: the HMO must determine the publication schedule or release dates applicable to its physician and provider community; the HMO is responsible for reviewing the information within 30 calendar days of its release;~~]

[~~(II) Information from state licensing boards regarding sanctions or licensure limitations; and~~]

[(III) Complaints.]

[(viii) The HMO's procedures shall ensure that selection and retention criteria do not discriminate against physicians or providers who serve high-risk populations or who specialize in the treatment of costly conditions. Procedures shall also include a provision that credentialing and recredentialing decisions are not based solely on an applicant's race, ethnic/national identity, gender, age, sexual orientation, or the types of procedures or types of patients.]

[(ix) The HMO shall have a procedure for notifying licensing or other appropriate authorities when a physician's or provider's affiliation is suspended or terminated due to quality of care concerns.]

[(C) Initial credentialing process for physicians and individual providers shall include the following:]

[(i) Physicians, advanced practice nurses and physician assistants shall complete the standardized credentialing application adopted in §21.3201 of this title (relating to the Texas Standardized Credentialing Application for Physicians, Advanced Practice Nurses and Physician Assistants) and individual providers shall complete an application which includes a work history covering at least five years, a statement by the applicant regarding any limitations in ability to perform the functions of the position, history of loss of license and/or felony convictions; and history of loss or limitation of privileges, sanctions or other disciplinary activity, lack of current illegal drug use, current professional liability insurance coverage information, and information on whether the individual provider will accept new patients from the HMO.

This does not preclude an HMO from using the standardized credentialing application form specified in §21.3201 of this title for credentialing of individual providers. The completion date on the application shall be within 180 calendar days prior to the date the credentialing committee deems a physician or individual provider eligible for initial credentialing.]

[(ii) The HMO shall verify the following from primary sources and shall include evidence of verification in the credentialing files:]

[(I) A current license to practice in the State of Texas and information on sanctions or limitations on licensure. The primary source for verification shall be the state licensing agency or board for Texas, and the license and sanctions must be verified within 180 calendar days prior to the date the credentialing committee deems a physician or individual provider eligible for initial credentialing. The license must be in effect at the time of the credentialing decision.]

[(II) Education and training, including evidence of graduation from an appropriate professional school and completion of a residency or specialty training, if applicable. Primary source verification shall be sought from the appropriate schools and training facilities or the American Medical Association MasterFile. If the state licensing board, agency, or specialty board verifies education and training with the physician's or individual provider's schools and facilities, evidence of current state licensure or board certification shall also serve as primary source verification of education and training.]

[(III) Board certification, if the physician or individual provider indicates that he/she is board certified on the application. The HMO may obtain primary source verification from the American Board of Medical Specialties Compendium, the American Osteopathic Association, the American Medical Association MasterFile, or from the specialty boards, and the HMO must use the most recent available source.]

[(IV) Valid Drug Enforcement Agency (DEA) or Department of Public Safety (DPS) Controlled Substances Registration Certificate, if applicable. These must be in effect at the time of the credentialing decision, and the HMO may verify them by any one of the following means:]

[(-a-) copy of the DEA or DPS certificate;]

[(-b-) visual inspection of the original certificate;]

[(-c-) confirmation with DEA or DPS;]

[(-d-) entry in the National Technical Information Service database; or]

[(-e-) entry in the American Medical Association Physician MasterFile.]

[(iii) The HMO shall verify within 180 calendar days prior to the date of the credentialing decision and shall include in the physician's or individual provider's credentialing file the following:]

[~~(I) Past five-year history of professional liability claims that resulted in settlements or judgments paid by or on behalf of the physician or individual provider, which the HMO may obtain from the professional liability carrier or the National Practitioner Data Bank;~~]

[~~(II) Information on previous sanction activity by Medicare and Medicaid which the HMO may obtain from one of the following:~~]

[~~(-a-) National Practitioner Data Bank;~~]

[~~(-b-) Cumulative Sanctions Report available over the internet;~~]

[~~(-c-) Medicare and Medicaid Sanctions and Reinstatement Report distributed to federally contracting HMOs;~~]

[~~(-d-) state Medicaid agency or intermediary and the Medicare intermediary;~~]

[~~(-e-) Federation of State Medical Boards;~~]

[~~(-f-) Federal Employees Health Benefits Program department record published by the Office of Personnel Management, Office of the Inspector General;~~]

[~~(-g-) entry in the American Medical Association Physician MasterFile.~~]

[~~(iv) The HMO shall perform a site visit to the offices of each primary care physician or individual provider, obstetrician-gynecologist, primary care dentist, and high-volume behavioral health physician or individual provider as part of the~~

~~initial credentialing process. In addition, the HMO shall have written procedures for determining high-volume behavioral health physicians and individual providers. If physicians or individual providers are part of a group practice that shares the same office, the HMO may perform one visit to the site for all physicians or individual providers in the group practice, as well as for new physicians or individual providers who subsequently join the group practice. The HMO shall make the site visit assessment available to the department for review. The HMO shall have a process to track the opening of new physician or individual provider offices. The HMO shall perform a site visit of each new office site of primary care physicians and individual providers, obstetrician-gynecologists, primary care dentists, and high-volume behavioral health physicians or individual providers as they open.~~]

[~~(v) Site visits shall consist of an evaluation of the site's accessibility, appearance, appointment availability, and space, using standards approved by the HMO. If a physician or individual provider offers services that require certification or licensure, such as laboratory or radiology services, the physician or individual provider shall have the current certification or licensure available for review at the site visit. In addition, as a result of the site visits, the HMO shall determine whether the site conforms to the HMO's standards for record organization, documentation, and confidentiality practices. Should the site not conform to the HMO's standards, the HMO shall require a corrective action plan and perform a follow-up site visit every six months until the site complies with the standards.~~]

[~~(D) The HMO shall have written procedures for recredentialing physicians and individual providers at least every three years through a process that updates information obtained in initial credentialing.~~]

[~~(i) Recredentialing will include a current and signed attestation that must be completed within 180 days prior to the date the credentialing committee deems a physician or individual provider eligible for recredentialing with the following factors:~~]

[~~(I) reasons for any inability to perform the essential functions of the position, with or without accommodation;~~]

[~~(II) lack of current illegal drug use;~~]

[~~(III) history of loss or limitation of privileges or disciplinary activity;~~]

[~~(IV) current professional liability insurance coverage; and~~]

[~~(V) correctness and completeness of the application.~~]

[~~(ii) Recredentialing procedures must be completed within 180 days prior to the date the credentialing committee deems a physician or individual provider eligible for recredentialing and shall include the following processes:~~]

[~~(I) Reverification of the following from the primary sources:~~]

[~~(-a-) Licensure and information on sanctions or limitations on licensure;~~]

[~~(-b-) Board certification:~~]

[~~(-1-) if the physician or individual provider was due to be recertified; or~~]

[~~(-2-) if the physician or individual provider indicates that he or she has become board certified since the last time he or she was credentialed or recredentialed; and~~]

[~~(-c-) Drug Enforcement Agency (DEA) or Department of Public Safety (DPS) Controlled Substances Registration Certificate, if applicable. These may be reverified by any one of the following means:~~]

[~~(-1-) copy of the DEA or DPS certificate;~~]

[~~(-2-) visual inspection of the original certificate;~~]

[~~(-3-) confirmation with DEA or DPS;~~]

[~~(-4-) entry in the National Technical Information Service database; or~~]

[~~(-5-) entry in the American Medical Association Physician MasterFile.~~]

[~~(II) Review of updated history of professional liability claims, and sanction and restriction information from Medicare and Medicaid in~~

~~accordance with the verification sources and time limits specified in subparagraph (C)(iii) of this paragraph.~~]

[~~(E) The credentialing process for institutional providers shall include the following:~~]

[~~(i) Evidence of state licensure;~~]

[~~(ii) Evidence of Medicare certification;~~]

[~~(iii) Evidence of other applicable state or federal requirements, e.g., Bureau of Radiation Control certification for diagnostic imaging centers, certification for community mental health centers from Texas Mental Health and Mental Retardation or its successor agency, CLIA (Clinical Laboratory Improvement Amendments of 1988) certification for laboratories;~~]

[~~(iv) Evidence of accreditation by a national accrediting body, as applicable; the HMO shall determine which national accrediting bodies are appropriate for different types of institutional providers. The HMO's written policies and procedures must state which national accrediting bodies it accepts;~~]

[~~(v) Evidence of on-site evaluation of the institutional provider against the HMO's written standards for participation if the provider is not accredited by the national accrediting body required by the HMO.~~]

[~~(F) The HMO's procedures shall provide for recredentialing of institutional providers at least every three years through a process that updates information obtained for initial credentialing as set forth in subparagraph (E)(i) - (iv) of this paragraph.~~]

[~~(G) Under Insurance Code Article 20A.39, the standards adopted in this paragraph must comply with the standards promulgated by the National Committee for Quality Assurance (NCQA) to the extent that those standards do not conflict with other laws of the state. Therefore, if the NCQA standards change and there is a difference between the standards specified in this paragraph and the NCQA standards, the NCQA standards shall prevail to the extent that those standards do not conflict with the other laws of this state.~~]

(5) – (6) (No change.)

(7) Delegation of Credentialing. If the HMO delegates credentialing functions to other entities, its credentialing process must comply with the standards promulgated by the National Committee for Quality Assurance (NCQA), to the extent that those standards do not conflict with other laws of this state.[~~it shall have:~~]

[~~(i) a process for developing delegation criteria and for performing pre-delegation and annual audits;~~]

[~~(ii) a delegation agreement;~~]

[~~(iii) a monitoring plan; and~~]

[~~(iv) a procedure for termination of the delegation agreement for non-performance.~~]

[~~(B) If the HMO delegates credentialing functions to an entity accredited by the NCQA, the annual audit of that entity is not required for the function(s) listed in the NCQA accreditation; however, evidence of this accreditation shall be made available to the department for review.~~]

[~~(C) The HMO shall maintain:~~]

[~~(i) documentation of pre-delegation and annual audits;~~]

[~~(ii) executed delegation agreements;~~]

[~~(iii) semi-annual reports received from the delegated entities;~~]

[~~(iv) evidence of evaluation of the reports;~~]

[~~(v) current rosters or copies of signed contracts with physicians and individual providers who are affected by the delegation agreement; and~~]

[~~(vi) documentation of ongoing monitoring and shall make it available to the department for review.~~]

[~~(D) Credentialing files maintained by the other entities to which the HMO has delegated credentialing functions shall be made available to the department for examination upon request.~~]

[~~(E) In all cases, the HMO shall maintain the right to approve credentialing, suspension, and termination of physicians and providers.~~]

SUBCHAPTER X. Provider Sponsored Organizations

§11.2303. Application for Certificate of Authority.

(a) (No change.)

(b) Prior to obtaining a certificate of authority under the Insurance Code[~~,~~] Chapter 843 [~~20A~~], an applicant PSO must comply with each requirement for the issuance of a certificate of authority imposed on an HMO under the Insurance Code[~~,~~]

Chapters 1271 [20A] and 843, 28 Texas Administrative Code Chapter 11 and other applicable insurance laws and regulations of this state except where preempted by federal law.

(c) (No change.)

§11.2315. Application of Other Insurance Laws. Subject to the provisions of this subchapter, the holder of a certificate of authority issued under this subchapter has all the powers granted to and duties imposed on a health maintenance organization under the Insurance Code Chapter 843 and applicable [Texas Health Maintenance Organization Act (Insurance Code, Chapter 843) and the] insurance laws and regulations of this state that apply to HMOs, and is subject to regulation and regulatory enforcement under these laws in the same manner as a health maintenance organization.

SUBCHAPTER Y. Limited Service HMOs

§11.2402. General Provisions.

(a) (No change.)

(b) Each limited service HMO schedule of enrollee copayments shall specify an appropriate description of covered services and benefits, as required under §11.506 of this title (relating to Mandatory Contractual Provisions: Group, Individual and Conversion Agreement and Group Certificate), and may specify recognized procedure codes or other information used for maintaining a statistical reporting system[, as

required under §11.1902 of this title (relating to Quality Improvement Program for Basic and Limited Services HMOs)].

(c) - (d) (No change.)

§11.2405. Minimum Standards, Mental Health and Chemical Dependency Services and Benefits.

(a) (No change.)

(b) Each limited service HMO evidence of coverage providing coverage for mental health/chemical dependency services and benefits shall provide primary mental health/chemical dependency services and benefits, including:

(1) For treatment of serious mental illness (as defined in the [Texas] Insurance Code Chapter 1355 Subchapter A [Article 3.51-14]), up to 45 inpatient days per year, up to 60 outpatient visits per year, which include assessment/screening, treatment planning, and crisis services.

(2) – (4) (No change.)

(c) (No change.)

§11.2406. Minimum Standards, Long Term Care Services and Benefits. Each limited service HMO evidence of coverage providing long-term care services and benefits shall comply with the Insurance Code Chapter 1651 [Article 3.70-12] and §§3.3801, et seq. of this title (relating to Standards for Long-Term Care Insurance Coverage Under Individual and Group Policies).

SUBCHAPTER Z. Point-of-Service Riders

§11.2501. Definitions. The following words and terms, when used in this subchapter, shall have the following meaning, unless the context indicates otherwise.

(1) (No change.)

(2) Corresponding benefits--Benefits provided under a point-of-service (POS) rider or the indemnity portion of a point-of-service (POS) plan, as defined in [~~Article 3.64(a)(4) and §843.108 of~~] the <u>Insurance</u> Code <u>§§1273.001 and 843.108</u>, that conform to the nature and kind of coverage provided to an enrollee under the HMO portion of a <u>POS</u> [~~point-of-service~~] plan.

(3) – (13) (No change.)

§11.2502. Issuance of Point-of-Service Riders. An HMO may issue a POS rider plan only if the HMO meets all of the applicable requirements set forth in this section.

(1) - (2) (No change.)

(3) Renewability and discontinuance of POS rider plans.

(A) POS rider plans issued under this subchapter are guaranteed renewable if the plan is:

(i) a small employer plan, pursuant to [~~Article 26.23 of~~] the <u>Insurance</u> Code <u>§1501.108</u>;

(ii) a large employer plan, pursuant to [~~Article 26.86 of~~] the <u>Insurance</u> Code <u>§1501.108</u>;

(iii) – (iv) (No change.)

(B) (No change.)

(C) An HMO that discontinues existing POS rider plans in order to bring the HMO into compliance with the 10% cap:

(i) shall offer, if the discontinued plan is issued to:

(I) a small employer group, to each employer, the option to purchase other small employer coverage offered by the small employer carrier at the time of the discontinuation, pursuant to [~~Article 26.24(d) of~~] the Insurance Code §1501.109(d);

(II) a large employer group, to each employer, the option to purchase any other large employer coverage offered by the large employer carrier at the time of the discontinuation, pursuant to [~~Article 26.87(d) of~~] the Insurance Code §1501.109(d);

(III) – (IV) (No change.)

(ii) (No change.)

(4) – (5) (No change.)

§11.2503. Coverage Relating to POS Rider Plans.

(a) – (c) (No change.)

(d) An HMO that issues or offers to issue a POS rider plan is subject, to the same extent as the HMO is subject in issuing any other health plan product, to all applicable provisions of the Insurance Code Chapters [~~20A and~~] 843, 541, 542, 543,

544, and 547 [and Articles 21.21, 21.21A, 21.21-1, 21.21-2, 21.21-5 and 21.21-6 of the Code].

(e) A POS rider plan offered under this subchapter must contain:

(1) a POS rider that:

(A) – (L) (No change.)

(M) if it is issued to a group, shall contain provisions that comply with [Article 3.51-6 Sec. 1(d)(2)(vii) - (xiii) of] the Insurance Code Chapter 1251 Subchapter C; and

(N) if it is issued to an individual, shall contain provisions that comply with [Article 3.70-3(A)(5) - (11) of] the Insurance Code §§1201.211 – 1201.217.[;]

(2) – (3) (No change.)

SUBCHAPTER AA. Delegated Entities

§11.2601. General Provisions.

(a) Purpose. The purpose of this subchapter is to set forth the requirements that must be met by any HMO that delegates any function as described in the [Texas] Insurance Code Chapters 843 and 1272, this chapter, and applicable insurance laws and regulations of this state that apply to HMOs [Art. 20A.18C]. These requirements are designed to ensure that a delegating HMO:

(1) – (3) (No change.)

(b) Severability. Where any terms or sections of this subchapter are determined by a court of competent jurisdiction to be inconsistent with the Insurance Code Chapters 843 and 1272 and applicable insurance laws of this state related to health maintenance organization regulation [~~Act~~], as identified by this subchapter, the Insurance Code Chapters 843 and 1272 and applicable insurance laws of this state that apply to HMOs [~~Act~~] will apply and the remaining terms and provisions of this subchapter shall continue in effect

(c) (No change.)

§11.2602. Definitions. The following words and terms, when used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise.

(1) [~~Act--The HMO Act, Insurance Code, Chapters 20A and 843.~~]

[~~(2)~~] Delegated entity--An entity, other than an HMO authorized to do business under the Insurance Code Chapters 843 and 1272 and applicable insurance laws and regulations of this state that apply to HMOs [~~Act~~], that by itself, or through subcontracts with one or more entities, undertakes to arrange for or to provide medical care or health care to an enrollee in exchange for a predetermined payment on a prospective basis and that accepts responsibility to perform on behalf of the HMO any function regulated by the Insurance Code Chapters 843 and 1272 and applicable insurance laws and regulations of this state that apply to HMOs [~~Act~~]. The term does not include an individual physician or a group of employed physicians practicing medicine under one federal tax identification number and whose total claims paid to

providers not employed by the group is less than 20 percent of the total collected revenue of the group calculated on a calendar year basis.

(2)[~~(3)~~] Delegated network--Any delegated entity that assumes total financial risk for more than one of the following categories of health care services: medical care, hospital or other institutional services, or prescription drugs, as defined by Section 551.003, Occupations Code. The term does not include a delegated entity that shares risk for a category of services with an HMO.

(3)[~~(4)~~] Delegated third party--A third party other than a delegated entity that contracts with a delegated entity, either directly or through another third party, to:

(A) accept responsibility to perform any function regulated by the Insurance Code Chapters 843 and 1272 and applicable insurance laws and regulations of this state that apply to HMOs [~~Act~~]; or

(B) receive, handle, or administer funds, if the receipt, handling, or administration of the funds is directly or indirectly related to a function regulated by the Insurance Code Chapters 843 and 1272 and applicable insurance laws and regulations of this state that apply to HMOs [~~Act~~].

(4)[~~(5)~~] Health care--Any services, including the furnishing to any individual of pharmaceutical services, medical, chiropractic, or dental care, or hospitalization, or incident to the furnishing of such services, care, or hospitalization, as well as the furnishing to any person of any and all other services for the purpose of preventing, alleviating, curing or healing human illness or injury.

§11.2603. Requirements for Delegation by HMOs.

(a) Any delegation of any function pursuant to the [~~Texas~~] Insurance Code Chapters 843 and 1272 and applicable insurance laws and regulations of this state that apply to HMOs [~~Art. 20A.18C~~] by an HMO shall comply with this subchapter.

(b) – (d) (No change.)

(e) The department may require an HMO to immediately terminate any delegation agreement to ensure that the HMO is in compliance with the Insurance Code Chapters 843 and 1272 and applicable insurance laws and regulations of this state that apply to HMOs [~~Act~~].

(f) (No change.)

(g) A delegated entity's failure to comply with applicable statutes or rules constitutes a violation of the Insurance Code Chapter 843 and 1272 and applicable insurance laws and regulations of this state that apply to HMOs [~~Act~~] by the delegating HMO.

(h) – (l) (No change.)

§11.2604. Delegation Agreements – General Requirements and Information to be Provided to HMO.

(a) An HMO that delegates to a delegated entity any function required by the Insurance Code Chapters 843 and 1272 and applicable insurance laws and regulations of this state that apply to HMOs [~~Act~~] shall execute a written agreement with that delegated entity.

(b) Written agreements shall include the following:

(1) – (11) (No change.)

(12) a provision that the delegated entity shall provide the license number of any delegated third party performing any function that requires a license as a third party administrator under the [~~Texas~~] Insurance Code Chapter 4151 [~~Art. 21.07-6~~], or a license as a utilization review agent under the [~~Texas~~] Insurance Code Article [~~Art.~~] 21.58A, or that requires any other license under the [~~Texas~~] Insurance Code or another insurance law of this state;

(13) (No change.)

(14) a provision that any agreement in which the delegated entity directly or indirectly delegates to a delegated third party any function delegated to the delegated entity by the HMO pursuant to the [~~Texas~~] Insurance Code Chapters 843 and 1272 and applicable insurance laws and regulations of this state that apply to HMOs [~~Art. 20A.18C~~], including any handling of funds, shall be in writing;

(15) a provision that upon any subsequent delegation of a function by a delegated entity to a delegated third party, the executed updated agreements shall be filed with the department and enrollees shall be notified of the change of any party performing a function for which notification of an enrollee is required by this chapter or the Insurance Code Chapters 843 and 1272 and applicable insurance laws and regulations of this state that apply to HMOs [~~Act~~];

(16) – (20) (No change.)

(21) a provision relating to enrollee complaints that requires the delegated entity to ensure that upon receipt of a complaint, as defined in the Insurance Code Chapter 843 and applicable insurance laws and regulations of this state that apply to HMOs [~~Act~~], a copy of the complaint shall be sent to the HMO within two business days, except that in a case in which a complaint involves emergency care, as defined in the Insurance Code Chapter 843 and applicable insurance laws and regulations of this state that apply to HMOs [~~Act~~], the delegated entity shall forward the complaint immediately to the HMO, and provided that nothing in this paragraph prohibits the delegated entity from attempting to resolve a complaint

(22) – (24) (No change.)

§11.2608. Department May Order Corrective Action.

(a) (No change.)

(b) The commissioner shall order the HMO to take any action the commissioner determines is necessary to ensure that the HMO maintains compliance with the Insurance Code Chapter 1272, this chapter, and applicable insurance laws and regulations of this state that apply to HMOs [~~Act~~], including but not limited to:

(1) – (4) (No change.)

§11.2609. Reserve Requirements for Delegated Networks. In addition to any other requirements set forth in this subchapter, HMOs that contract with delegated networks shall ensure that the delegated network complies with the [~~Texas~~] Insurance Code

Chapter 1272 Subchapter D [~~Art. 20A.18D~~]. The HMO's agreement with the delegated network shall include a provision:

(1) that records related to the requirements of the [~~Texas~~] Insurance Code Chapter 1272 Subchapter D [~~Art. 20A.18D~~] shall be accessible at all times to the HMO;

(2) requiring all financial records and related information necessary to show the delegated network's compliance with the requirements of the [~~Texas~~] Insurance Code Chapter 1272 Subchapter D [~~Art. 20A.18D~~];

(3) (No change.)

(4) that records be kept providing evidence that the HMO has adequately monitored the delegated network for compliance with the requirements of the [~~Texas~~] Insurance Code Chapter 1272 Subchapter D [~~Art. 20A.18D~~].

8. CERTIFICATION. This agency hereby certifies that the proposal has been reviewed by legal counsel and found to be within the agency's authority to adopt.

Issued at Austin, Texas, on ________________, 2006.

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Gene C. Jarmon
General Counsel and Chief Clerk
Texas Department of Insurance