Checklist HMO Certificate of Authority Application

Reference Texas Insurance Code (TIC), Chapter 843, and 28 Texas Administrative Code (TAC), Chapter 11, Section 11.204 for compliance with state regulations relevant to an HMO Certificate of Authority Application. All documents should have an identifying form number per TIC 11.301(2).

- ☐ 1. Name Reservation Application (FIN300); with any certificate of reservation of corporate name issued by the secretary of state
- ☐ 2. HMO Application for Certificate of Authority (FIN302)
- ☐ 3. Basic organizational documents and all amendments, complete with the original incorporation certificate with charter number and seal indicating certification by the Secretary of State, if applicable:
    a. Articles of Incorporation
    b. Articles of Association
    c. Partnership Agreement
    d. Trust Agreement
- ☐ 4. Bylaws, rules, or any similar document regulating the conduct of the internal affairs of the applicant.
- ☐ 5. Information about officers, directors, and staff, including
    a. Officer and Directors Page (FIN306)
    b. Biographical affidavits (NAIC UCAA Form 11)
    c. Fingerprint receipt from IdentoGo (Fingerprint requirements and instructions)
- ☐ 6. Organizational information, as follows:
    a. a chart or list clearly identifying the relationships between the applicant and any affiliates, and a list of any currently outstanding loans or contracts to provide services between the applicant and affiliates;
    b. a chart showing the internal organizational structure of the applicant's management and administrative staff; and
    c. a chart showing contractual arrangements of the HMO's delivery network
- ☐ 7. Fidelity bond or deposit for officers and employees
- ☐ 8. Service of legal process and out-of-state licensure statement
- ☐ 9. Evidence of coverage to be issued to enrollees and any group agreement that is to be issued to employers, unions, trustees, or other organizations.
- ☐ 10. Financial information, consisting of the following:
    a. a financial statement that includes a balance sheet reflecting the required net worth, assets, and any liabilities
    b. if the applicant is newly formed, a balance sheet reflecting the HMO's proposed initial funding
    c. 3 year projected financial statements using the NAIC UCAA ProForma Financial Statements for Health Companies (UCAA Form 13-Health Companies)
    d. the most recent audited financial statements of the HMO's immediate parent company, the ultimate holding company parent, and any sponsoring organization.

☐ 11. Schedule of charges, excluding any charges for Medicaid products, with an actuarial certification and supporting documentation meeting the qualifications specified in Section 11.702 of this title (relating to Actuarial Certification).

☐ 12. If the applicant proposes to write Medicaid products, an actuarial certification and supporting documentation meeting the qualifications specified in Section 11.702 of this title and noting whether the proposed rates are the maximum rates allowed by the contracting state agency if rates less than the maximum rates allowed are being proposed or if the contracting state agency rates are not available.

☐ 13. Service area map with key and scale, which must identify the county or counties, or portions of counties, to be served; provided that all copies of the map must be in color, if the HMO submits a map on paper and in color.

☐ 14. Contract or monitoring plan between the applicant and:

a. any person listed on the Officer and Directors Page (FIN306);
b. any physician, medical group, association of physicians, or any other provider, and the form of any subcontract between those entities and any physician, medical group, association of physicians, or any other provider to provide health care services;
c. any affiliated exclusive agent or agency;
d. any affiliated person who will perform marketing, administrative, data processing services, or claims processing services;
e. any affiliated person who will perform management services, together with a deposit or the original or a copy of a bond with no deductible;
f. an ANHC that agrees to arrange for or provide health care services, other than medical care or services ancillary to the practice of medicine, or a provider HMO that agrees to arrange for or provide health care services on a risk-sharing or capitated risk arrangement on behalf of a primary HMO as part of the primary HMO delivery network; together with a monitoring plan;
g. any insurer or group hospital service corporation to offer indemnity benefits under a point-of-service contract; and
h. any delegated entity or delegated network.

Management contracts require a fidelity bond or deposit on officer/employee.

☐ 15. A description of the quality improvement program and work plan (TIC 843.082 and 843.102).

☐ 16. Insurance, guarantees, and other protection against insolvency:

a. any affiliated reinsurance agreement and any other affiliated agreement described in TIC 843.082(4)(C);
b. any conversion policy or policies; and
c. any other arrangements offering protection against insolvency, including guarantees.

☐ 17. A written description of health care plan terms and conditions.

☐ 18. Network configuration information for each of the HMO's physician or provider networks, including limited provider networks.

☐ 19. A written description of the types of compensation arrangements.

☐ 20. Documentation demonstrating that the applicant will pay for emergency care services performed by non-network physicians or providers.

☐ 21. A description of the procedures by which:
   a. a member handbook and materials relating to the complaint and appeal process and the independent review process will be provided to enrollees in languages other than English;
   b. access to a member handbook and materials relating to the complaint and appeal process and the independent review process will be provided to an enrollee who has a disability affecting communication or reading.

☐ 22. Notification of the physical address in Texas of all books and records.

☐ 23. A description of the HMO's information systems, management structure, and personnel that demonstrates the applicant's capacity to meet the needs of enrollees and contracted physicians and providers, and to meet the requirements of regulatory and contracting entities.

☐ 24. A written description of the utilization management and utilization review program.

☐ 25. The URA name and certificate or registration number if the applicant performs utilization review.

☐ 26. Complaint and appeal procedures, templates of letters, and logs, including the complaint log, which must categorize each complaint.

☐ 27. Documentation of claim systems and procedures that demonstrates the HMO's ability to pay claims timely and comply with applicable claim payment statutes and rules.

📎 Email filing to CLRFilings@tdi.texas.gov

► Questions?

Email us at CompanyLicense@tdi.texas.gov or call 512-676-6365.