

Health Maintenance Organization (HMO) FAQs

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Health Maintenance Organizations

Does Texas have any health maintenance organization (HMO) "Prompt Pay"-related requirements?

Yes. Texas statutes require an HMO to pay the claims of physicians/providers promptly. You may access and review TDI's Prompt Payment "Virtual" Workshops and related information using the following link:
<http://www.tdi.texas.gov/hprovider/ppresource.html>.

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What is an HMO Certificate of Authority and how do I become an HMO?

A "Certificate of Authority" (COA) is the term used to refer to the Department's authorization of a person to operate an HMO in Texas. A person who desires to operate an HMO in Texas must submit an application to the Department that complies with the requirements under [§843.078, Texas Insurance Code \(TIC\)](#), and which includes the documentation requested by the Commissioner of Insurance under [28 Texas Administrative Code \(TAC\) §11.204](#).

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What laws apply to an HMO in Texas?

HMOs are authorized and regulated under [Chapter 843, Texas Insurance Code \(TIC\)](#). The HMO rules are designated under [Chapter 11](#) in the Texas Administrative Code (TAC). However, there are other laws and rules that also apply to a Texas-licensed HMO, including, but not limited to [Ch. 544, TIC](#), [Ch. 1271, TIC](#), [Ch. 1272, TIC](#), [Ch. 1367, TIC](#), and [Ch. 1452, TIC](#).

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Are there any required provisions for an HMO-provider contract in Texas?

Yes. A complete listing of Texas' required HMO-physician/provider contractual provisions may be found at [28 TAC §§ 11.901](#).

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Does the State of Texas regulate the fees that a Texas-licensed HMO pays to the physicians and providers in the HMO's delivery network?

No. TDI does not set or limit the fees that an HMO pays to its contracted physicians and providers.

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Is a Texas-licensed HMO allowed to delegate functions to other entities?

Yes. A Texas-licensed HMO is allowed to delegate certain functions to other entities. [Chapter 1272, TIC](#), and the rules under [28 TAC §§11.2601-11.2612](#) regulate the delegation of certain functions from an HMO to a delegated entity. In addition, other laws, such as [Chapter 4151, TIC](#), and any rules adopted thereunder, may apply.

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Complaints

What information do you need to submit with a complaint?

When submitting a complaint, you may either complete the TDI complaint form that may be found on our website at <http://www.tdi.texas.gov/consumer/complfrm.html> or write the complaint out in a letter format. The complaint should include the name and contact information for the enrollee, the enrollee identification number, the name of the HMO, the reason for the complaint, and all supporting documentation. Supporting documentation may include a copy of the enrollee's ID card, a copy of the claim form, documentation of collection attempts, explanations of benefits (EOBs), and any correspondence between the HMO and the enrollee.

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What is the difference between a fully insured plan and a self-funded plan?

The most common type of fully insured plan is a health benefit plan in which an employer contracts with a HMO/carrier to pay health care claims based on the benefits purchased for a monthly premium. Covered employees may be responsible for deductibles and/or copayments, as applicable. Fully insured plans could also be offered by an association.

A self-funded plan is a health benefit plan offered and funded by an employer or employee organization to pay for claims incurred by enrollees or employees.

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Who handles Medicaid, Medicare, TRICARE (formerly known as CHAMPUS), and CHIP complaints?

Medicaid complaints are handled by the Texas Health and Human Services Commission.

Traditional Medicaid complaints can be sent to:
HHSC Claims Administration and Contract Management
Texas Health and Human Services Commission
Operations Oversight-Mail Code 91-X
P.O. Box 204077
Austin, TX 78720-4077
Phone: (512) 249-3744

Medicaid Star or Star-Plus Plans complaints can be sent to:
Complaint Coordinator
Health Plan Management
Texas Health and Human Services Commission
Managed Care Operations-Mail Code H-320
PO Box 85200
Austin, TX 78708
Phone: 1-877-787-8999 (Toll-Free)
TDD: 1-888-425-6889 (Toll-Free) For the deaf or hearing impaired

Medicare complaints are handled by the Centers for Medicaid and Medicare Services. Medicare complaints can be sent to:
Centers for Medicare and Medicaid Services
Dallas Regional Office
1301 Young Street, Room 833
Dallas, TX 75202
Phone: (214) 767-4463

TRICARE complaints for the South Region, which includes Texas, are handled by Humana. TRICARE complaints can be sent to:
Regional Grievance Coordinator
Humana Military Healthcare Services
8123 Datapoint Drive Suite 400
San Antonio, TX 78229

For mental health concerns, send your grievance to:
Grievance Specialist
ValueOptions
PO Box 551188
Jacksonville, FL 32255-1188

CHIP complaints concerning enrollment or eligibility issues are handled by the Health and Human Services Commission. These types of CHIP complaints can be sent to:

Health and Human Services Commission
Attention: Complaint Department
PO Box 14200
Midland, TX 79711-4200
Phone: 1-800-647-6558

CHIP complaints concerning claims issues are handled by the Texas Department of Insurance. These types of CHIP complaints can be sent to:

Texas Department of Insurance
MCQA Office, Mail Code 103-6A
PO Box 149104
Austin, TX 78714-9104
Phone: 1-866-554-4926 or (512) 322-4266
Fax: (512) 490-1012

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Does TDI accept anonymous complaints?

Yes. When a complaint is received from someone who does not wish to provide his or her contact information, the complaints are still accepted and investigated.

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Does the law prohibit an HMO from retaliating against an enrollee or provider for filing a complaint?

Yes. Under the Texas Insurance Code (TIC) [§843.281](#) and the Texas Administrative Code, [28 TAC §11.901\(2\)](#), an HMO is prohibited from engaging in retaliatory action against a group contract holder, an enrollee, a person acting on behalf of a group contract holder or enrollee, or a physician/provider for filing a complaint against the HMO or for appealing a decision of the HMO.

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Credentialing Application

Where do I send the credentialing application?

Send the credentialing application to the appropriate entity/carrier through which you wish to be credentialed.

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Are all providers required to complete the credentialing form?

Texas Insurance Code [§1452.052](#) requires the Commissioner to prescribe a standardized form for the verification of the credentials of a physician, advance practice nurse, or physician assistant. The Texas Standardized Credentialing Application is located on the internet, on the TDI website, located at: <http://www.tdi.texas.gov/forms/form9credential.html>.

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Network Availability

How does an HMO deliver care?

An HMO delivers care by providing or arranging for health care services directly or indirectly through contracts and subcontracts with physicians, providers, and/or other HMOs.

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What determines whether an HMO has an adequate health care delivery system?

All covered health care services that are offered by the HMO shall be sufficient in number and location to be readily available and accessible within the geographical service area to all enrollees. The HMO must have a sufficient number of primary care physicians and specialists with hospital admitting privileges at participating facilities who are available and accessible 24 hours per day, seven days per week within the HMO's geographical service area. Additionally, an HMO shall make emergency care available and accessible 24 hours per day, seven days per week without restrictions as to where the services are rendered.

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What are the accessibility and availability requirements for an HMO?

An HMO is required to provide an adequate network which would consist of contracted physicians and providers for its entire geographical service area.* All covered health care services must be accessible and available to enrollees within certain travel distances. The distance from any point in the HMOs service area to a point of service can be no greater than:

- 30 miles for primary care and general hospital care; and
- 75 miles for specialty care, specialty hospitals, and single healthcare service plan physicians or providers.

An HMO must arrange and make available urgent care within:

- 24 hours for medical and dental conditions; and
- 24 hours for behavioral health conditions.

An HMO must arrange and make available routine care within:

- 3 weeks for medical conditions;
- 8 weeks for non-emergent dental conditions; and
- 2 weeks for behavioral health conditions

An HMO must arrange and make available preventive care within:

- 2 months for a child;
- 3 months for an adult; and
- 4 months for dental services.

*Geographic Service Area is defined as a geographic area within which direct service benefits are available and accessible to HMO enrollees who live, reside, or work within that geographic area.

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What is an Access plan?

An Access Plan is an action plan filed with the Department for approval by the Commissioner as received from an HMO. The plan establishes arrangements for healthcare in previously approved or proposed service areas in which the HMO does not have an adequate number of contracted physicians, providers, or facilities. For access plan requirements see [28 TAC §11.1607](#).

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Referrals

What are referrals? What is the difference between referrals for in-network and out-of network-care?

Referrals - In-Network - A directive or request from a primary care physician and/or treating doctor that allows the patient to receive care from a specialist or other contracted provider within the geographical service area.

Referrals - Out-of-Network - A directive or request from a physician or provider for health care services to be provided outside the geographical service area when care is not available within the network.

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If medically necessary covered services are not available through network physicians and providers, who pays for Out-of-Network services?

If medically necessary covered services are not available through contracted HMO network providers, the HMO, upon request from a network provider, must allow a referral to a non-network physician or provider. The HMO must reimburse the non-network physician or provider at an agreed rate or usual and customary rate.

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Can an HMO deny a referral request for Out-of-Network services?

Yes, if the HMO has documented that an in-network provider is available to provide the requested services.

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Utilization Review Agents

Where can I find the most current URA application form?

Please refer to the Department's website for the latest application and exhibit checklist at: <http://www.tdi.texas.gov/forms/form9ura.html>.

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Does the notary have to be in Texas?

No. The applicant may use any commissioned notary.

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If I delegate utilization review, do I have to be a certified URA?

No, however, the delegatee must be certified as a URA.

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I am a URA in another state. What do I need to do to become certified in Texas?

Please see <http://www.tdi.texas.gov/hmo/indexura.html> which includes information on how to become a certified URA in Texas.

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What is the fee for an original and renewal URA certification?

The fees for an original URA application and renewal are set by rule ([28 TAC §19.802\(A\) and \(B\)](#)). The current fees are \$2,150 for an original application and \$545 for a renewal.

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Can the application be emailed or faxed?

No, the application and required fee must be mailed to the following address:

Texas Department of Insurance
MCQA Office, Mail Code 103-6A
P O Box 149104
Austin, Texas 78714-9104

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As a certified/registered URA, if my address, contact person, or ownership changes do I need to submit anything to the Department?

Yes. The URA must fill out and submit the URA Application to notify the Department of any material change. The URA application may be obtained at: <http://www.tdi.texas.gov/forms/form9ura.html>

The regulation designated at [28 TAC §19.1704\(d\)](#) requires a URA to report any material changes in its application or renewal form to the Department no later than the 30th day after the date on which the change takes effect. Material changes include, but are not limited to, new officers or directors who are hired to perform utilization review, changes in the URA's organizational structure, changes in the URA's contractual relationships, and changes in the utilization review plan. Pursuant to Texas Insurance Code [§4201.106](#), a certification of registration is not transferrable.

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