

CHAPTER 13. MISCELLANEOUS INSURERS AND OTHER REGULATED ENTITIES

SUBCHAPTER E. HEALTH CARE COLLABORATIVES

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INTRODUCTION. The Texas Department of Insurance proposes new 28 Texas Administrative Code (28 TAC) Chapter 13, Subchapter E, §§13.401 – 13.404, 13.411 – 13.417, 13.421 – 13.426, 13.429, 13.431 – 13.432, 13.441, 13.451 – 13.455, 13.461,

13.471 – 13.474, 13.481 – 13.483, and 13.491 – 13.494. The department proposes this new subchapter to implement ARTICLE 4 of Senate Bill (SB) 7, enacted by the 82nd Legislature, First Called Session, effective September 28, 2011. SB 7 adds Insurance Code Chapter 848 relating to health care collaboratives (HCCs).

SB 7 provisions include legislative findings directed to health care collaboratives.

The legislature found that it would benefit the State of Texas to:

- (1) explore innovative health care delivery and payment models to improve the quality and efficiency of health care in this state;
- (2) improve health care transparency;
- (3) give health care providers the flexibility to collaborate and innovate to improve the quality and efficiency of health care; and
- (4) create incentives to improve the quality and efficiency of health care.

Id. at Art. 2, §2.01(a).

The legislature further found that, “[U]se of certified health care collaboratives will increase pro-competitive effects as the ability to compete on the basis of quality of care . . . will overcome any anticompetitive effects . . .” and that it is “. . . appropriate and necessary to authorize health care collaboratives to promote the efficiency and quality of health care.”

Id. at Art. 2, §2.01(b).

In conjunction with the creation of HCCs to provide or arrange to provide health care services under contract with a governmental or private entity, the legislature included in SB 7 a specific finding relating to state action immunity:

The legislature intends to exempt from antitrust laws and provide immunity from federal antitrust laws through the state action doctrine a health care collaborative that holds a certificate of authority . . . and that collaborative’s negotiations of contracts with payors. The legislature does

not intend or authorize any person or entity to engage in activities or to conspire to engage in activities that would constitute per se violations of federal antitrust laws.

Id. at Art. 2, §2.01(c).

Every initial or renewal application for an HCC certificate of authority requires independent department and attorney general antitrust review. This competition-related review must occur at least annually to ensure that: (1) no reduction of competition due to HCC size or composition occurs; (2) pro-competitive benefits outweigh anticompetitive effects of increases in market power; and (3) HCCs do not violate the enumerated rights of physicians. Review associated with the pro-competitive benefit analysis will be in accordance with established antitrust principles of market power analysis.

Other essential aspects of the department's application review focus on solvency, organization, quality, and efficiency in service delivery.

Solvency and organization review standards are necessary to ensure that the HCC maintains financial solvency through sufficient capitalization and reserves and that it complies with statutory formation and governance requirements.

Quality and efficiency review standards are necessary to ensure that the HCC provides adequate networks; increases collaboration; promotes improved outcomes, safety, and coordination of services; reduces preventable events; and contains costs without compromising the quality of patient care.

If the commissioner determines that an application for certificate of authority complies with all Chapter 848 certification requirements, the commissioner must forward the application and all items considered by the commissioner in making the determination

to the attorney general. The attorney general must then conduct an independent antitrust review of the application to determine if the applicant meets the requirements of Insurance Code §848.057(a)(5) and (6). After making the determination, the attorney general must notify the commissioner of concurrence or nonconcurrence with the commissioner's determination.

Insurance Code §848.151 authorizes the commissioner and attorney general to adopt reasonable rules necessary and proper to implement the requirements of Insurance Code Chapter 848.

This proposed subchapter is also necessary to implement the requirements of Insurance Code §848.054 and §848.152, which require the commissioner to adopt rules governing the application for certificate of authority to organize and operate an HCC and to prescribe the fees to be charged and the assessments to be imposed to pay the reasonable expenses of the department and the attorney general in administering Chapter 848.

In drafting the rules that create this new type of health delivery system, the department includes a number of requirements similar to those that apply to issuers of other network-based health plans, such as health maintenance organization (HMO) and preferred provider benefit plans. The proposal also includes more expansive requirements consistent with the consideration of antitrust issues and regulations.

The following provides an overview of the proposed new rules.

Division 1. General Provisions.

Section 13.401 states the purpose of Subchapter E, which is to implement Insurance Code Chapter 848 and other Texas insurance laws that apply to HCCs. Section 13.401 also provides that the subchapter's provisions are severable and do not limit the commissioner's exercise of statutory authority. Section 13.402 contains definitions for words and terms used in the proposed new subchapter, providing for uniform application of the subchapter. Section 13.403 describes the location and method to file original or renewal HCC applications. It also identifies and adopts by reference the forms that must be used with the proposed new subchapter to facilitate review and requires completion of the forms in accordance with each form's instructions and data content requirements. Section 13.404 provides restrictions on the use of the term "HCC" by an applicant both before and after issuance of a certificate of authority to ensure that members of the public interacting with the developing or established HCC are informed of its status.

Division 2. Application for Certificate of Authority.

Section 13.411 provides that the application fees for original and renewal applications are \$10,000 and \$5,000, respectively, and are also nonrefundable. The section provides that each HCC must pay an annual assessment to the department as described in §13.421(c). The annual assessment will make up any shortfall between the expenses incurred by the department and the attorney general and the funds collected through application fees, renewal fees, and examination expenses. The section also provides notice that the application is public information except as provided by Insurance Code §848.005(b).

Section 13.412 addresses procedures governing revisions during the review of an HCC application. This section also provides that a certification of the corporate secretary or president that the revision is true, accurate, and complete must accompany each revision to the basic organizational documents, bylaws, or officers' and employees' bond.

Section 13.412 also provides notice that the department will conduct examinations and notify the applicant of any necessary revisions to the application and that the department may withdraw the application on behalf of the applicant if the applicant does not make the necessary changes. The section provides that if the time required to make the corrections exceeds the time limit provided in Insurance Code §848.056(c), the applicant must: (1) request a specific amount of additional time, which may not exceed 90 days; and (2) include sufficient detail for the commissioner to determine if cause exists to grant the extension. The applicant may request additional time as needed. The commissioner may grant or deny a request under Insurance Code §848.056.

Section 13.413 addresses the contents of an application for an HCC certificate of authority.

To facilitate the department's review, §13.413(a) requires that the application include items in the order listed in §13.413, and §13.413(b) requires that nonelectronic filings include two additional copies of the application.

Section 13.413(c) requires the filing of a complete application for certificate of authority that includes an HCC representative's affirmed declaration that the HCC's collection methodology for confidential information satisfies the requirement of the rule for

any confidential information included in the filing. The filing must also include the following general contents:

- (1) basic organizational documents and any amendments, including an original incorporation certificate with charter number and seal;
- (2) certified copies of bylaws, rules, and other documents regulating the internal affairs of the applicant;
- (3) the applicant's proposed plan of operation, including specified information designed to convey the intended scope of operations and pro-competitive strategies;
- (4) biographical information about officers, directors, and staff;
- (5) separate organizational charts or lists identifying contractual relationships with the applicant's health care delivery system and affiliates; lists of contracts between the applicant and affiliates addressing provision of services; and a chart showing the internal organizational structure of the applicant's staff;
- (6) notice of the physical address in Texas of all of the applicant's books and records; and
- (7) a description of specified information items demonstrating the applicant's capacity to meet the needs of patients and participants and to comply with regulatory and contractual requirements.

Section 13.413(d) addresses financial information filing requirements, including:

- (1) specified projected financial statements;
- (2) a balance sheet reflecting actual assets and liabilities and net assets complying with §13.431;

(3) the form of any applicant-payor contract that addresses the applicant arranging for medical and health care services for the payor in exchange for payments in cash or kind as provided in Insurance Code Chapter 848;

(4) if applicable, insurance or other protection against insolvency;

(5) proof of maintenance of a fidelity bond or similar officer and employee antifraud protection as provided in §13.473; and

(6) authorization for disclosure to the commissioner of financial records to confirm the assets of the applicant and affiliates.

Section 13.413(e) addresses provider and service area information filing requirements. It requires:

(1) a description and map of the service area as specified;

(2) specified network configuration information and lists of participants with information detail as specified;

(3) a listing of and specific information about any integrated practice group or independent practice association to which each participant belongs;

(4) for each participating facility, the facility's name and business address, a description of services provided, and a statement about whether the facility's agreement with the HCC permits it to affiliate or contract with other HCCs;

(5) the form of specified HCC contracts or monitoring plans and applicable subcontracts; and

(6) a written description of the types of compensation arrangements made or to be made with physicians and health care providers in exchange for providing or arranging to

provide health care services, including any financial incentives for physicians and health care providers.

Section 13.413(f) addresses quality assurance (QA) and quality improvement (QI) information. It requires the application to include a detailed description of policies and processes contained in the QA and QI program required by §13.482.

Section 13.413(g) requires disclosure information as specified about any accreditation the HCC has attained from a nationally recognized accrediting body.

Section 13.413(h) sets forth antitrust analysis information filing requirements. It requires the filing of the following information:

(1) disclosure, for each participant, of any known past or pending investigation, or administrative or judicial proceeding, in which it is alleged that the participant has engaged in price-fixing or other antitrust violation, or health care fraud or abuse, including any related judgments, fines, or penalties;

(2) identification of each common service provided by participants, grouped as specified;

(3) identification of the primary service area (PSA) for each common service of each participant;

(4) the HCC's calculated market share for each common service in each PSA in which two or more participants provide the common service, using the calculation steps set forth in §13.414;

(5) identification of all physicians, physician groups, or other entities the HCC applicant considers to be or have been its competitors, including its participants' competitors, in its proposed service area;

(6) a description of each pro-competitive benefit that the applicant anticipates will result from establishment of the HCC, as well as an explanation of how achievement of the benefit will be assessed; why the establishment of the HCC will help achieve the benefit; and for a benefit resulting from financial integration, a description of any alternative payment methods that will be used to create and achieve the benefit;

(7) a description of the policies and procedures the HCC will use to ensure that none of its financial incentives will result in any limitation on medically necessary services; and

(8) a description of confidentiality policies and procedures used by the HCC applicant as required by §13.426 to protect the confidential information of an HCC participant from disclosure to other HCC participants.

Section 13.413(i) provides for additional information required of an HCC applicant that does not fall within the limited filing exemption set forth in §13.414. It requires the filing of the following information:

(1) for each participant, the name of each private payor that individually accounts for five percent or more of the participant's business in the past year and completion of the Health Care Collaborative Payor Information Form to provide information related to revenue;

(2) specified business planning documents created within 24 months prior to application and relating to the applicant's or its participants' plans regarding any health care service in each service area;

(3) the name of each individual responsible for negotiating contracts on behalf of participants with payors over the last five years, the name of the participant on whose behalf that individual negotiated, the time periods for which the individual was responsible for those negotiations, and, if known, the individual's current address and phone number;

(4) documents reflecting the applicant's price lists and pricing plans, policies, forecasts, strategies, analyses, and decisions relating to any medical health care service in the service area;

(5) specified information for each individual or entity that has provided or stopped providing any competing health care service in the service area within the previous 36 months;

(6) documents reflecting participants' contribution margins or identifying or quantifying fixed or variable costs for the provision of any health care service in the service area;

(7) if the applicant believes that approval of the application is necessary for the future financial viability of one or more participants, for that participant, documents referencing its future viability, gross or net margins, ability to obtain financing for capital improvements, or other documents the applicant deems necessary for the evaluation of that participant's financial condition;

(8) all memoranda created within 24 months prior to application relating to cost savings, economies, or other efficiencies that have been or could be achieved by any participant regardless of whether the applicant establishes and operates the proposed HCC;

(9) identification of every physician or health care provider in its proposed PSA that the applicant has communicated with about contracting with the HCC within the past 12 months; and

(10) for each participant, for the previous 12 months, all agendas, minutes, summaries, handouts, and presentations made to its board of directors, executive committee, and any other specified committees.

Section 13.414 establishes a limited exemption from certain information filing requirements and provides for certain exceptions.

Section 13.414(a) provides a general purpose statement.

Section 13.414(b) states that an applicant is not required to provide information specified in §13.413(i) if, for each PSA in which two or more participants provide common services, the applicant's market share is 35 percent or less and no contract between the HCC and any participating hospital restricts either party from contracting with other HCCs, networks, hospitals, physicians, physician groups, health care providers, or private payors.

Section 13.414(c) provides that an HCC that contracts with a physician or health care provider in a rural county and does not restrict that physician or health care provider from contracting or dealing with other HCCs, networks, physicians, or health care providers does not have to provide the information specified in §13.413(i) if inclusion of the

physician or health care provider is the sole reason that the HCC's share of any common service exceeds 35 percent.

Section 13.414(d) provides that an HCC that includes a rural hospital and does not restrict the hospital from contracting with other HCCs, networks, physicians, or health care providers does not have to provide the information specified in §13.413(i) if inclusion of the rural hospital is the sole reason that the HCC's share of any common service exceeds 35 percent.

Section 13.414(e) provides by categories the formula for calculating market share.

Section 13.414(f) permits an alternative method of calculating market share on a satisfactory demonstration that calculation based on the HCC's PSA for a health care specialty provides a more accurate measure of competition relating to the participant in the context of the HCC than calculation based on the participant's PSA.

Section 13.414(g) provides notice that the commissioner has discretion to require an applicant to provide any or all of the information specified in §13.413(i), §13.461, or both, when the commissioner deems the information necessary to conduct the review required by Insurance Code Chapter 848.

Section 13.415 addresses documents that must be available for examinations.

Section 13.415 specifies 18 types of documents that an HCC must provide to the department on request, make available for review at the HCC's office located in Texas, and maintain for at least five years.

Section 13.416 addresses the review of an original or renewal application.

Section 13.416(a) provides that Insurance Code §§848.056 – 848.060 and 848.153 govern the processing of the application.

Section 13.416(b) explains when examinations will be performed.

Section 13.416(c) provides that application review will include evaluation of pro-competitive benefits and anticompetitive effects of market power increase in accordance with established antitrust principles.

Section 13.416(d) sets forth by example six categories of restrictions that the commissioner has discretion to impose on an HCC applicant's certificate of authority if determined necessary to preserve competition.

Section 13.417 provides for withdrawal of an application by an applicant, or by the department on behalf of an applicant, if the department determines that the applicant has failed to timely respond to department requests for additional information on an incomplete application.

Division 3. Examinations; Regulatory Requirements for an HCC After Issuance of Certificate of Authority; and Advertising and Sales Material.

Section 13.421 addresses examinations and fees for examination expenses.

Section 13.421(a) provides that the department may conduct financial examinations, quality of care examinations, market conduct examinations, or antitrust examinations individually or in consolidation.

Section 13.421(b) states the authority of the commissioner under Insurance Code §848.152(d) to set and collect fees in an amount sufficient to pay reasonable expenses of the department, the attorney general, and their contractors in administering Insurance

Code Chapter 848. It also sets forth the specific fee components associated with examination of an HCC.

Section 13.421(c) outlines specific details for imposition of an annual assessment by the department and sets forth a timetable to phase in full implementation of HCC revenue reporting requirements, as well as the assessment basis and timeframe for assessment of and assessment payment by all certified HCCs.

Section 13.421(d) provides that an HCC, on department notification of a pending examination, may request conversion to a renewal review if the request is submitted prior to issuance of any draft examination report. The subsequent renewal date for the HCC will be 12 months following the approval date of the application to renew.

Section 13.422 addresses HCC filing requirements that apply after certification.

Section 13.422(a) provides that an authorized HCC must file certain information with the commissioner, either for approval prior to effectuation or for information.

Section 13.422(b) requires the HCC to report to the department a material change in the size, composition, or control of the HCC.

Section 13.422(c) addresses the specific filings that an HCC must make.

Section 13.422(c)(1) provides that the department will not accept a filing for review until it is complete.

Section 13.422(c)(2) provides that filings requiring approval include:

- (1) changes to service area;
- (2) material changes to size, composition, or control of the HCC;

(3) proposed dividend payments with a distribution value that meets or exceeds 10 percent of the HCC's net asset value or net income for the prior year;

(4) new or revised loan agreements with affiliates or participants, or amendments to those loan agreements;

(5) any proposed material amendment to basic organizational documents;

(6) any material amendments to the HCC's bylaws;

(7) a change to any name or assumed name on a form specified in §13.404; and

(8) an original or renewal service contract or management agreement.

Section 13.422(c)(3) provides that an HCC must make certain filings for information on or before 30 days after an anticipated change is effective. The filings for information include deletions of and modifications to previously approved or filed operations and documents as specified, including:

(1) officers and directors data;

(2) any change in the physical address of books and records;

(3) any new trademark or service mark or changes to an existing mark;

(4) copies of forms of all new or substantively amended contracts, with revisions marked, as described in §13.413(d)(3) and (e)(5), not including management agreements filed for approval;

(5) notice of cancellation of management contracts;

(6) any insurance contracts or amendments to those contracts, or other protection against insolvency;

(7) any change in the HCC's affiliate chart;

(8) modification to any type of compensation arrangement, including any financial incentives for physicians and providers;

(9) any material change in network configuration; and

(10) the QA and QI program description.

Section 13.422(c)(4) generally addresses the approval time period and process for approving, withdrawing approval for, and rejecting forms.

Section 13.422(c)(5) specifies the filing review procedures that apply to filings under the section.

Section 13.423 addresses service area change applications.

Section 13.423(a) requires the HCC to file an application for approval before expanding or reducing an existing service area or adding a new service area.

Section 13.423(b) sets forth eight categories of items that, if changed by a service area expansion or reduction, must be submitted for approval or information, as appropriate.

Section 13.423(c) and (d) require that the application be complete before review takes place and state that an application is complete when all information reasonably necessary for a final determination by the department, including information demonstrating the HCC's compliance with the subchapter's QA, QI, and credentialing requirements, has been filed with the department.

Section 13.423(e) sets forth circumstances under which the department may require the HCC to file an application for renewal before the date required by Insurance Code §848.060(a).

Section 13.424 addresses certificate of authority renewal requirements.

Section 13.424(a) provides that the HCC must file with the commissioner an application to renew its certificate not later than 180 days before its certificate anniversary date.

Section 13.424(b) sets forth items to be included in the filing.

Section 13.424(c) operates to prevent duplicative filings by specifying that the HCC need not resubmit previously filed documents that are not amended, modified, revised, canceled, terminated, replaced, or otherwise changed since issuance of the HCC's most recent certificate of authority. Instead, the HCC must file a transmittal form identifying those documents along with an authorized HCC representative's attestation that the identified documents are unchanged.

Section 13.424(d) extends the scope of §13.424(c) to documents filed and either approved or accepted after issuance of the certificate of authority pursuant to §13.422.

Section 13.424(e) states that review of the filing will begin only when the filing is complete and sets forth content specification for notices the department will issue to advise an HCC about necessary additional submissions to complete the filing.

Section 13.424(f) provides that the review of, and official action related to, a completed renewal application will accord with Insurance Code §848.060, with the review conducted as if the application for renewal were a new application.

Section 13.425 addresses compensation arrangements.

Section 13.425(a) restates the requirement that an HCC comply with Insurance Code §848.053, concerning a compensation advisory committee and the sharing of data.

Section 13.425(b) requires that the HCC establish and enforce procedures to maintain the confidentiality of charge, fee, and payment data and information between its participants and any individual or entity outside the HCC, including information for transmittal to the department.

Section 13.425(c) prohibits a participant from using confidential charge, fee, and payment data collected by the HCC in any negotiation to which the HCC is not a party.

Section 13.426 addresses confidentiality and requires an HCC to establish and administer procedures and internal controls to safeguard and ensure against the sharing of confidential information with or among participants. The requirements include establishing and enforcing collection, custodial, retrieval, and transmittal procedures to ensure information is protected as confidential both as to entities and individuals outside the HCC, including through submission to the department or the attorney general, and between or among participants.

Section 13.429 provides that HCCs must comply with Insurance Code Chapters 541 and 542 and department rules adopted pursuant to those chapters, as applicable, in the same manner as insurance companies or HMOs.

Division 4. Financial Requirements.

Section 13.431 addresses reserves and working capital requirements.

Section 13.431(a) requires an HCC to maintain working capital that is composed of current assets and that meets the requirements of the subsection concerning unencumbered net equity and asset-liability ratio as applicable.

Section 13.431(b) requires an HCC to have reserves sufficient to operate and maintain the HCC and to arrange for services and expenses it incurs, and to compute financial reserves in accordance with Generally Accepted Accounting Principles in an amount not less than 100 percent of incurred but not paid claims of nonparticipating physicians and providers.

Section 13.431(c) specifies reserve requirements that apply to any certified HMO or insurer that contracts with an HCC under Insurance Code §848.103. The reserve must be: (1) equivalent in value to three months of prepaid funding or capitation payments; (2) phased in over a no-more-than 36-month period; (3) maintained separately from and in addition to all other reserves and liabilities of the HMO or insurer; (4) unencumbered and dedicated to assure its availability for its intended purpose; and (5) reported separately from all other reserves and liabilities of the HMO or insurer.

Section 13.431(d) provides that current assets are limited to U.S. currency, certificates of deposit with fixed terms of one year or less, money market accounts, accounts receivable from government payors, and other accounts receivable net of all allowances and 90 days or less old for purposes of meeting the section's minimum working capital requirements.

Section 13.431(e) provides that investments in capital assets, mortgages, notes, and loan-backed securities are excluded from the calculation of reserves and net equity in determining satisfaction of the section's minimum requirements.

Section 13.432 prohibits a director, member of a committee, officer, or representative of an HCC who is charged with the duty of handling or investing its funds

from intentionally depositing or investing those funds other than in the corporate name of the HCC or in the name of a nominee of the HCC, or taking or receiving to his or her own use any fee, brokerage, or commission for, or on account of a loan made by or on behalf of the HCC, except for reasonable interest on amounts that the individual has loaned to the HCC.

Division 5. HCC Contract Arrangements.

Section 13.441 addresses general provisions concerning HCC contracts.

Section 13.441(a) provides that an HCC's contracts with physicians and health care providers must not impede application of provisions in the Insurance Code and Title 28 TAC that regulate HMOs and preferred provider benefit plans and that impose requirements concerning relations with physicians or health care providers.

Section 13.441(b) prohibits an HCC from using a financial incentive or making a payment to a physician or health care provider if the incentive or payment acts directly or indirectly as an inducement to limit medically necessary services.

Section 13.441(c) prohibits a dominant provider as defined in the subsection from requiring a private payor to contract exclusively with the HCC or otherwise restricting a private payor's ability to contract or deal with other HCCs, networks, physicians, or health care providers.

Division 6. Change of Control by Acquisition of or Merger with HCC.

Section 13.451 contains definitions for "control" and "voting security."

Section 13.452 addresses determination of control for this division of the subchapter, with provisions for rebutting the presumption of control, as well as commissioner determination of control.

Section 13.453 addresses filing requirements that apply in connection with a change of control of the HCC.

Section 13.453(a) specifies prohibitions that apply concerning the acquisition of ownership interest in or control of a certified HCC unless the individual or entity acquiring the interest or control has filed specified documents with the department.

Section 13.453(b) specifies the documents that the individual or entity acquiring the ownership interest or control must file under oath or affirmation.

Section 13.453(c) and (d) clarify the application of the section's requirements concerning each partner of a partnership, member of a syndicate or group, and individual or entity who controls the partner or member subject to the filing requirements of the section.

Section 13.454 provides the grounds for commissioner disapproval of a proposed acquisition of control and the timetable within which either the commissioner action is to take place or approval of the change of control is deemed.

Section 13.455 provides that for any change of control of an HCC resulting in an increase to market share for any PSA as provided in §13.414, the department may require that the HCC file an application for renewal before the date required by Insurance Code §848.060. Further, an HCC may submit an application for renewal of certificate of authority in connection with a filing under this division.

Division 7. Administrative Procedures.

Section 13.461 provides that the commissioner may require additional information from an HCC or any participant as reasonably necessary to make any determination required by Insurance Code Chapter 848, this subchapter, and applicable insurance laws and regulations, including any or all of the 24 additional information item types set forth in the section. The section does not require the creation of items listed unless required to be provided; once created, however, the HCC or participant must maintain the documents for at least five years.

Division 8. Other Requirements.

Section 13.471 requires an HCC to notify all affected payors in writing of a material change in the payment arrangement for physicians, health care providers, or both within 30 days of any change in payment arrangement type. The notification must include descriptions of the payment arrangement that has been changed and the new payment arrangement. This notice is distinct from notice requirements in Insurance Code §843.321 and §1301.136 requiring notice not later than the 90th day before an insurer or HMO effects changes to coding guidelines or fee schedules that will result in a change of payments to a physician or provider.

Section 13.472 identifies contracts with other specified providers and requires for those contracts that the HCC must submit to the department a monitoring plan to ensure the implementation of all delegated functions in compliance with all department regulatory requirements. The section also requires the HCC to conduct an on-site or desk audit of the delegated entity, delegated network, or delegated third party at least annually to verify

continuing compliance with department regulatory requirements. It also requires prompt action to correct any failure by the delegated entity, delegated network, or delegated third party to comply with the department's regulatory requirements applicable to delegated functions.

Section 13.473 addresses the general organization of an HCC.

Section 13.473(a) provides that the governing body of an HCC must be ultimately responsible for the development, approval, implementation, and enforcement of essential policies and procedures related to the HCC's operations.

Section 13.473(b) specifies requirements that apply to the HCC's clinical director.

Section 13.473(c) permits the HCC to establish one or more service areas within Texas, specified by counties and ZIP codes or portions of counties, with cost center accounting for each service area to facilitate the reporting of divisional operations in financial reporting. Section 13.473 also states the requirements for network adequacy for any of the service areas that the HCC establishes in Texas.

Section 13.473(d) requires that the HCC protect against acts of fraud or dishonesty by its officers and employees in one of three ways: (1) maintaining in force in its own name a fidelity bond on its officers and employees in an amount of at least \$100,000 or another amount prescribed by the commissioner; (2) maintaining in force in its own name insurance coverage in a form and amount acceptable to the commissioner; or (3) depositing with the office of the comptroller in Texas readily marketable liquid securities acceptable to the commissioner.

Section 13.474 sets forth essential requirements for an HMO's or insurer's delegation of functions to HCCs. It states that delegation of HMO or insurer functions to an HCC is governed by Insurance Code Chapter 1272 and 28 TAC Chapter 11, Subchapter AA. It further provides that if provisions of this subchapter conflict with Chapter 1272 or 28 TAC Chapter 11, Subchapter AA, this subchapter will govern. The section also requires specified disclosures in provider listings, insurance policies, and certificates distributed to insureds or enrollees if there is a delegation agreement between the HCC and an HMO or an insurer.

Division 9. Quality and Cost of Health Care Services.

Section 13.481 provides essential details for the QI structure for HCCs. It requires the HCC to develop and maintain an ongoing QI program to objectively and systematically monitor and evaluate the quality and appropriateness of health care services it arranges for or offers. It provides that the governing body ultimately is responsible for the QI program and sets forth QI duties of the governing board. It provides that board must appoint a QI committee (QIC) that must evaluate the overall effectiveness of the QI program and use multidisciplinary teams when indicated to accomplish the HCC's QI program goals. It permits the QIC to delegate QI activities to other appointed committees, which are then to submit a written report of any recommendations as a result of committee findings regarding QI.

Section 13.482 requires an HCC to establish, implement, and administer a continuous QA and QI program that includes defined policies and processes to achieve the basic legislative objectives for HCCs. The proposed new section sets forth specific

program components and specifically addresses the promotion of evidence-based medicine and best practices; patient engagement; coordination of care across a continuum of care; and measurement and reporting about quality of health care services and impact on cost.

Section 13.483 addresses credentialing and requires an HCC to implement a documented process for selection and retention of contracted participants. It provides that the process must comply with standards promulgated by the National Committee for Quality Assurance, URAC, or the Joint Commission on Accreditation of Hospital Organizations, as appropriate and applicable.

Division 10. Complaint Systems; Rights of Physicians; Limitations on Participation.

Section 13.491 addresses complaint systems. It requires each HCC to implement and maintain a complaint system that complies with Insurance Code §848.107 to provide reasonable procedures for resolving an oral or written complaint initiated by a complainant concerning the HCC or health care services arranged by or offered through the HCC. The section defines “complaint,” requires a process for notice and appeal of a complaint initiated by or on behalf of a patient who sought or received health care services by a participant, and affirms the commissioner’s authority to examine a complaint system for compliance with §848.107 and the subchapter.

Section 13.492 sets forth requirements for acknowledgement, response, investigation, and issuance of a resolution letter. It also provides for issuance of a decision letter in situations where a patient complaint has been appealed. The letter must include

specific reasons for the decision and disclose that the complainant may file a complaint with the department if dissatisfied with the resolution, the appeal, or the complaint process. The section also requires maintenance of a complaint log capturing and categorizing each complaint. The HCC must maintain the log for each complaint and documentation on each complaint, complaint proceeding, and action taken until the third anniversary after the date the complaint was received.

Section 13.493 addresses rights of physicians and provides that before a complaint against a physician is resolved or a physician's association with an HCC is involuntarily terminated, the HCC must provide the physician with the opportunity to dispute the complaint or termination. The section requires that the process include written notice of the complaint or basis of termination, an opportunity for hearing and presentation of information at the hearing, and a written decision that specifies reasons for the decision.

Section 13.494 permits an HCC to limit a physician or physician group from participating in the HCC only if the limitation is based on an established development plan approved by the HCC's board of directors, a copy of which must be provided to the physician or physician group. The section also prohibits the HCC from taking a retaliatory or adverse action against a physician or health care provider that files a complaint with a regulatory authority regarding an HCC's action.

Department Outreach.

On January 30, 2012, the department held an initial stakeholder meeting to provide interested persons the opportunity to discuss anticipated rulemaking topics for development and inclusion in HCC rules. Representatives from the office of the attorney

general attended the meeting. General discussion areas included: (1) the application process, including organizational and financial documents, networks, and antitrust issues; (2) the regulatory fees and assessments associated with the organization and operational processes of an HCC; and (3) the renewal process.

On April 16, 2012, the department posted a call for comments from the public on the substance and possible implementation costs of an informal working draft of the rule. In addition to receiving written comments on the draft, the department held a second stakeholder meeting on April 24, 2012, to discuss the draft and potential compliance costs. Representatives of the office of the attorney general also attended this meeting.

The department appreciates all comments received and discussions held during the drafting process.

2. FISCAL NOTE. Jeff Hunt, admissions officer, Company Licensing & Registration, has determined that for each year of the first five years the proposal will be in effect, there will be no measurable fiscal impact to state or local governments as a result of the enforcement or administration of the proposal. No measurable effect on local employment or the local economy will result from the proposal.

3. PUBLIC BENEFIT/COST NOTE. Mr. Hunt also has determined that for each year of the first five years the proposed subchapter is in effect, public benefits anticipated as a result of the enforcement and administration of this proposal include: (1) the implementation of rules necessary to comply with SB 7; (2) the establishment of

regulatory standards for the new HCCs, including standards for certification, acquisition, financial requirements, contracting, market power, advertising and sales, complaint systems, rights of physicians, and limitations on participation; (3) transparency of information for consumers using HCCs through the establishment and maintenance of advertising requirements, quality improvement program requirements, and complaint resolution requirements; and (4) the efficient regulation and operation of HCCs in Texas.

The department has drafted the proposed rules to maximize public benefits consistent with the authorizing statutes while mitigating costs.

Mr. Hunt also has determined potential compliance costs for physicians and other entities that complete an application to organize and operate an HCC, as set forth in this part.

On April 16, 2012, the department posted a call for comments on its website that included a request for comments regarding the costs of implementing the rule. As a result, the department received general input on the cost of compliance, as well as a specific single-case cost estimate. The department has modified the rule text in an effort to lessen potential costs and has developed estimated costs for compliance with the proposed rule based on the single estimate received, as well as cost components previously used by the department for similar compliance requirements. HCCs and participants that identify differing costs for those components based on their own operations will be able to calculate their particular costs using the department's cost analysis approach.

The department has identified six categories of labor reasonably necessary to implement the proposed subchapter. HCCs may calculate the total cost of labor for each

category by multiplying the number of estimated hours for each cost component by the median hourly wage for each category of labor. The hourly cost of labor for each HCC might vary from the median due to factors such as additional compensation benefits paid by the HCC or variations in wages in different parts of the state. The median hourly wage for each category of labor is published online by the Texas Workforce Commission as follows:

(i) a general operations manager or functional director: \$58.64

(www.texasindustryprofiles.com/apps/win/eds.php?geocode=4801000048&indclass=8&indcode=5241&occcode=11-1021&compare=2);

(ii) a computer programmer: \$38.60

(<http://www.texasindustryprofiles.com/apps/win/eds.php?geocode=4801000048&indclass=8&indcode=5241&occcode=15-1131&compare=2>);

(iii) an administrative assistant: \$21.69

(www.texasindustryprofiles.com/apps/win/eds.php?geocode=4801000048&indclass=8&indcode=5241&occcode=43-6011&compare=2);

(iv) a staff attorney: \$51.56

(www.texasindustryprofiles.com/apps/win/eds.php?geocode=4801000048&indclass=8&indcode=5241&occcode=23-1011&compare=2);

(v) a medical director: \$105.65

(www.texasindustryprofiles.com/apps/win/eds.php?geocode=4801000048&indclass=8&indcode=6221&occcode=11-1011&compare=2); and

(vi) a financial analyst: \$28.76

(<http://www.texasindustryprofiles.com/apps/win/eds.php?geocode=4801000048&indclass=1&indcode=000000&occcode=13-2011&compare=2>).

The department anticipates that an applicant organizing an HCC under Insurance Code Chapter 848 and this new subchapter will incur costs related to printing, copying, mailing, and transmitting documents.

According to the United States Postal Service business price calculator, available at dbcalc.usps.gov, the cost to mail machinable letters in a standard business mail envelope with a weight limit of 3.3 ounces to a standard five-digit ZIP code in the United States is approximately 27 cents. With the weight limit of 3.3 ounces, approximately 18 pages could be sent per envelope for the 27 cent cost. This estimate is based on six pages of standard printing paper, which weighs one ounce. The department estimates that the cost of a standard business envelope is 1.6 cents. The department further estimates that the cost of printing or copying is between 6 and 8 cents per page.

The department is not able to estimate the total printing, copying, mailing, and transmitting costs attributable to compliance with the proposed subchapter. Several variable factors drive these costs so that reliable calculation by the department is impracticable. These variable factors include the size of the HCC's service area, the number of patients utilizing the HCC, the number of participants in the HCC, the market share of the HCC and its participants, the range of services offered by the HCC, and the number of complaints generated annually.

Each HCC formed under the new subchapter will have the information necessary to determine its individual printing, copying, mailing, and transmitting costs necessary to meet

the requirements of the subchapter, and the department has identified factors for the sections that may contribute to the costs of printing, copying, mailing, and transmitting where applicable.

Section 13.411. Filing Fee; Annual Assessments; Open Records.

Section 13.411(b) imposes an original application nonrefundable filing fee of \$10,000.

Section 13.411(c) imposes an annual renewal nonrefundable filing fee of \$5,000.

Section 13.411(d) imposes an annual assessment as set forth in §13.421, which is discussed in further detail in a subsequent paragraph. The filing fees and assessments imposed under §13.411 will result in compliance costs for physicians and entities who choose to form an HCC.

Sections 13.413, 13.415, and 13.416. Contents of the Application, Documents to be Available for Quality of Care and Financial Examinations, and Review of Original or Renewal Application; Commissioner Discretion.

Section 13.413 provides the content requirements for the initial application. Section 13.415 specifies the documents required to be available and provided on request during an examination. Section 13.416 requires the department to process an application pursuant to Insurance Code §§848.056 – 848.060 and 848.153, review the documents required by proposed §13.413, and perform quality of care and financial examinations.

In accordance with Insurance Code §848.059, once the commissioner has determined that an application complies with all requirements, the department will forward the application and all data, documents, and analysis considered in making the

determination to the attorney general for review. The attorney general will notify the department if the attorney general does not concur with the department's determination. The attorney general will request additional information if needed to make a determination.

Section 13.421 addresses the commissioner's authority to collect fees sufficient to pay the reasonable expenses of both the department and attorney general in reviewing HCC applications. This will result in a cost of compliance as described in detail in the subsequent discussion related to the §13.421 fee for expenses.

The department estimates that an HCC's administrative staff, financial analysts, computer programmers, and general operations manager will provide most of the labor necessary to assemble and file an application for approval. A general operations manager will supervise the work of the administrative staff in creating the application. For an average HCC providing a full range of medical services in one major metropolitan area, the department estimates that supervision of the application preparation will require 10 to 20 hours.

In the following figure, the department has estimated the number of other staff hours that may be necessary to create or compile the required documents for an average HCC. In some cases, staff time may be necessary to determine that the required documents do not exist and thus do not have to be produced. The creation of documents that are required pursuant to another section of the rule is analyzed in the discussion of those sections.

Figure: 28 TAC Chapter 13 – - Preamble

Rule Section	Document Type	Employee Type	Estimated
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			Time
§13.413(c)(1)	declaration or affirmation	officer/director	1 hour
§13.413(c)(2)	application form	administrative staff	1 – 2 hours
§13.413(c)(3)	organizational documents	administrative staff	1 hour
§13.413(c)(4)	bylaws	administrative staff	1 hour
§13.413(c)(5)	plan of operation	administrative staff	2 – 6 hours
§13.413(c)(6)(A)	officers and directors page	administrative staff	1 – 2 hours
§13.413(c)(6)(B)	biographical data	administrative staff	1 – 2 hours
		officers/directors	1 – 3 hours each
§13.413(c)(7)	organizational charts	administrative staff	2 – 3 hours
§13.413(c)(8)	physical address notice	administrative staff	1 hour
§13.413(c)(9)	description of the information systems	administrative staff	2 – 3 hours
§13.413(d)(1)	financial projections	administrative staff	4 – 6 hours
		financial analyst	4 – 8 hours
§13.413(d)(2)	balance sheet	financial analyst	1 hour
§13.413(d)(3)	contract forms	administrative staff	1 – 3 hours
§13.413(d)(4)	If applicable, insurance, agreements, or arrangements protecting against insolvency	administrative staff	1 hour
§13.413(d)(6)	financial authorization	administrative staff	1 hour
§13.413(e)(1) – (2)	service area, network information	administrative staff	5 – 20 hours
		programmer	5 – 10 hours

§13.413(e)(3)	practice groups, associations	administrative staff	1 – 2 hours
§13.413(e)(4)	participating facilities	administrative staff	1 – 2 hours
§13.413(e)(5)	contract copies	administrative staff	1 – 2 hours
§13.413(e)(6)	compensation arrangements	administrative staff	2 – 4 hours
§13.413(g)	accreditation disclosures	administrative staff	1 hour
§13.413(h)(1)	antitrust, fraud proceedings	administrative staff	1 – 5 hours
§13.413(h)(2)	identification of common services	administrative staff	20 – 80 hours
§13.413(h)(3)	identification of primary service area	administrative staff	1 hour/service
§13.413(h)(4)	market share calculation	administrative staff	1 hour/service
§13.413(h)(5)	competitor identification	administrative staff	1 – 8 hours
§13.413(h)(6)	benefit analysis	administrative staff	3 – 20 hours
§13.413(h)(7)	financial incentive analysis	administrative staff	1 – 5 hours
§13.413(h)(8)	confidentiality policies description	administrative staff	1 – 5 hours
§13.413(i)(1)	identification of payors	administrative staff	1 – 5 hours
§13.413(i)(2)	payor information form	administrative staff	2 – 4 hours
§13.413(i)(3)	business planning documents	administrative staff	2 – 6 hours
§13.413(i)(4)	identification of negotiators	administrative staff	1 – 3 hours
§13.413(i)(5)	pricing documentation	administrative staff	2 – 6 hours
§13.413(i)(6)	competitor information	administrative staff	1 – 5 hours
§13.413(i)(7)	margins/costs documents	administrative staff	1 – 5 hours

§13.413(i)(8)	documents for evaluation of participant's financial condition	administrative staff	1 – 3 hours
§13.413(i)(9)	alternative efficiencies memos	administrative staff	1 – 3 hours
§13.413(i)(10)	potential participants' identification	administrative staff	1 – 3 hours
§13.413(i)(11)	internal meeting documents	administrative staff	1 – 3 hours

The department is unable to quantify additional time that administrative staff may require to perform miscellaneous tasks in completing the application. Additionally, an HCC may use legal assistance in applying for a certificate. For instance, an HCC might choose to employ a lawyer to assist with the compilation of application contents required in §13.413(h), relating to the broad range of antitrust analysis information required of all applicants. The use of legal counsel is discretionary, and the department is unable to quantify the time or other resource cost of legal counsel assistance with the HCC application. The department has, however, received from stakeholders a range of possible legal fee expenses associated with preparation of an HCC's application -- from \$5,000 to \$25,000.

To provide the network information required under §13.413(e)(2), it may be reasonably necessary for an HCC to procure auto-mapping software, such as Geo-Access or ArcGIS, to make the required maps available for review and to employ information technology staff to use the auto-mapping software. The initial cost of procuring ArcGIS software is \$3,000 to \$5,000. The department bases this range on cost estimates received from web-based searches conducted by department staff for software availability and price quotes. It will be reasonably necessary for an HCC's computer programmer or

administrative assistant to spend an average of five to 10 hours operating the auto-mapping software, determining service areas, and printing the required maps.

Though the department has identified factors attributable to the cost of compliance with §13.413, it cannot estimate the total compliance cost that an HCC applicant could incur because several cost factors are HCC specific, including the size, composition, and complexity of the HCC and whether the HCC or a participant already holds a certificate issued by the department.

Section §13.415 requires HCCs to make available 18 categories of documents for review during an examination, as set forth in §13.415(a)(1) – (18). It will be reasonably necessary for the HCC's general operations manager to spend an average of seven to nine hours identifying and collecting the applicable documents for an examination. Additionally, it will be reasonably necessary for an administrative assistant to spend an average of four hours copying or printing and combining the required documents. The average print and copy costs necessary for compliance could vary for each HCC depending on the number of pages necessary to print or copy.

In addition, it will be reasonably necessary for an HCC to employ a general operations manager and a functional division director from each of the HCC's functional divisions to facilitate an examination in compliance with §13.415, and it will be reasonably necessary for a general operations manager and each functional division director to spend an average of six hours each per examination facilitating the examination by attending meetings with staff from the department.

The total amount of time necessary to facilitate an examination will vary, depending

on the number of functional divisions in the HCC's organizational structure and the complexity of the issues that arise during the examination. Though the department has identified factors attributable to the cost of compliance with proposed §13.415, it cannot estimate the total compliance cost that an HCC applicant could incur because several cost factors are HCC specific, including the size, composition, and complexity of the HCC, and the number of additional relevant documents requested by the department during an examination. If deficiencies are noted in the documents produced, additional nonquantifiable staff time may be required to correct deficiencies. The estimated cost to comply with §13.415 represents an average size collaborative, with documents stored in electronic format, and an examination that requires the department to request few additional documents.

Section 13.421. Examination; Fee for Expenses.

Section 13.421(a) provides that in addition to the review and examinations described in §13.416, the department may conduct examinations of HCCs under Insurance Code §848.153 to determine financial condition, quality of health care services, compliance with laws affecting the conduct of business, or effect on market competition.

An exam conducted under §13.421(a)(1) to determine the financial condition of an HCC will cost an average of \$10,000, based on the cost to examine entities of similar complexity. An exam conducted under §13.421(a)(2) to determine the quality of health care services provided by an HCC will cost an average of \$2,450. The department is unable to estimate the cost of an average exam conducted under §13.421(a)(3) to determine an HCC's compliance with laws affecting the conduct of business because the

scope of these exams varies based on the individual events precipitating the exam. The cost of an exam under §13.421(a)(4) to determine the effect on market competition will vary depending on factors that are HCC specific but generally will have costs similar to the initial review of the application under §13.416, potentially including costs on the part of both the department and attorney general staff.

These estimated processing costs represent an examination of an average size collaborative, with documents stored in electronic format, that requires the department or attorney general to request few additional documents. Though the department has identified factors attributable to the cost, it cannot estimate the total compliance cost that an HCC applicant could incur because several cost factors are HCC specific, including the size, composition, and complexity of the HCC, and the number of additional relevant documents requested by the department or the attorney general during an examination.

Section 13.421(b) addresses the commissioner's authority to collect fees in an amount sufficient to pay the reasonable expenses of both the department and attorney general, including direct and indirect expenses incurred by the department and attorney general in examining and reviewing HCCs. The following estimates relate to the costs eligible for recoupment under §13.421(b) that the department will incur as a result of the implementation of Insurance Code Chapter 848 and this proposed subchapter, thus resulting in fees that the department will need to collect pursuant to §13.421(b).

As previously noted, an original or renewal HCC application will be processed pursuant to Insurance Code §848.056 – 848.060 and §848.153 under §13.416. After completion of the department's review of documents corresponding to an original

application, the department will perform the qualifying quality of care and financial examinations. The department may also perform examinations after completion of the department's review of documents corresponding to a renewal application. These examinations will produce costs eligible for recoupment under §13.421(b).

It will be reasonably necessary for department staff to spend approximately 300 to 350 total hours reviewing and conducting an examination under §13.416 for a single application, either original or renewal, with a total cost of \$9,150. These estimates are based on costs previously incurred by the department for similar compliance activities. In addition, an original or renewal application will be subject to antitrust review of information required by §13.413(h) and §13.413(i). It will be reasonably necessary for the department to contract with an independent third party to perform the required antitrust review at a cost of up to \$25,000 per application for an HCC that presents material antitrust issues.

As the department has been unable to ascertain a publicly available market price for a review in light of the unique nature of the HCC statute, the department based its estimate on consultation with an independent third party attorney with extensive antitrust experience.

Insurance Code §848.059 requires the attorney general to perform an independent review of an original or renewal HCC application that the commissioner has determined to be compliant with Chapter 848 to determine whether the attorney general concurs with the commissioner's decision. Attorney general staff estimate that the cost to review an application will vary depending largely on the complexity of the antitrust issues presented by the HCC. HCCs with no participants having over 35 percent of the market share for any

common services and presenting no complex issues will usually be reviewed for a total attorney general cost of under \$10,000. On the other hand, HCCs that have over 35 percent market share or present complex antitrust issues could cost \$50,000 or more to review, and increased complexity of antitrust issues could result in higher costs.

These estimated processing costs represent the review and examination of an average size collaborative, with documents stored in electronic format, and an examination that requires the department to request few additional documents. Though the department has identified factors attributable to the cost, it cannot estimate the total compliance cost that an HCC applicant could incur because several cost factors are HCC specific, including the size, composition, and complexity of the HCC, the number of revisions needed during the review of an application, and the number of additional relevant documents requested by the department during the review and qualifying examination.

Section 13.421(c) provides that annually each HCC must pay an assessment to the department as set forth in §13.421(c)(1) – (6), related to the cost by fiscal year to administer Insurance Code Chapter 848 and this proposed subchapter, including direct and indirect expenses incurred by the department and the attorney general attributable to carrying out their responsibilities under Chapter 848, but excluding examination expenses billed directly to the HCC.

The assessment required of each HCC under §13.421(c) will vary depending on their adjusted revenues, since the total regulatory costs are distributed among the HCCs on a pro rata basis.

Though the department has identified factors attributable to the fiscal year cost and

estimated costs based on that identification, it cannot estimate the total fiscal year cost because several nonquantifiable cost factors are HCC specific and market defined, including the size, composition, and complexity of an HCC, and the actual number of HCCs for which the department must administer Insurance Code Chapter 848 and this proposed subchapter.

Section 13.422 and §13.423. Filing Requirements that Apply After Issuance of Certificate of Authority and Service Area Change Applications.

Section 13.422(a) provides that after the issuance of a certificate of authority, each HCC must file certain information with the commissioner, either for approval prior to effectuation or for information only.

Section 13.422(b) requires an HCC to report to the department any material change in size, composition, or control of the HCC.

Section 13.422(c)(2) sets forth information filings requiring department approval before implementation. It includes by example information about any material change in size or composition of the HCC, proposed dividends, and any new or revised loan agreements evidencing loans made by the HCC to any physician or health care provider or to any affiliated individual or entity, and any guarantees of any physician's, health care provider's, or affiliated individual's or entity's obligations to any third party.

Section 13.422(c)(3) sets forth information that must be filed with the department for informational purposes within 30 days of implementation. It includes by example information about changes to: biographical data sheets; affiliate charts; compensation arrangements; and network configuration.

Section 13.423(a) requires an HCC to file an application for approval with the department before expanding or reducing an existing service area or adding a new service area. Section 13.423(b) provides that if any information required to be filed under §13.422 is changed as a result of the service area change, the new information or amendments to existing information must be filed with the department for approval or for information as specified in §13.422.

Section 13.423(e) provides that if the proposed service area change might materially affect the HCC's ability to arrange for or provide health care services, or might materially change the antitrust analysis of the HCC, the department may require the HCC to file an application for renewal before the date required by Insurance Code §848.060(a).

The department cannot accurately estimate the compliance cost amount that an HCC could incur as a result of §13.422 and §13.423, because that amount will vary by HCC depending on the frequency of creation or modification of documents or changes in service area that would trigger the filing requirements in §13.422 and §13.423, as well as the number of additional relevant documents requested by the department. However, the department estimates that any incurred costs associated with §13.422 will be similar to the costs incurred by §13.413 relating to the contents of an application based on the HCC staff assigned to prepare and file the information.

Sections 13.424, 13.425, and 13.426. Certificate of Authority Renewal Requirements, Compensation Arrangements, and Confidentiality.

Section 13.424(a) provides that not less than 180 days before its certificate anniversary date, an HCC must file an application to renew its certificate.

Section 13.424(b) provides that the application for renewal must include the Original/Renewal Application for Certificate of Authority to do the Business of a Health Care Collaborative (HCC) in the State of Texas form and the financial statements for the HCC as of the close of the preceding calendar year.

Section 13.424(c) and (d) provide that an HCC does not need to make duplicate filings of documents already on file with the department, if the documents have not changed since the department approved or accepted their filing.

Section 13.424(f) provides that an application for renewal will be reviewed under Insurance Code §848.057 as if the application for renewal were a new application.

The documents and review process required for the renewal application are generally the same as the documents and review process required for the original application and examination, which may reduce the cost of making the documents available for renewal applications under §13.424. The department's time estimates for producing documents for the original application and examination apply equally to this section for the same or similar documents. In addition, the estimated department costs attributable to the review of the original application and examination that may be recouped under §13.421(c) apply equally to this section.

Section 13.425(a) provides that an HCC must comply with the requirements of Insurance Code §848.053, relating to charges, fees, distributions, or other compensation assessed for services provided by HCC participants and to the sharing of that data among nonparticipating physicians and health care providers.

Section 13.425(b) provides that an HCC must establish and enforce procedures to

maintain the confidentiality of charge, fee, and payment data information between HCC participants and any individual or entity outside of the HCC, including information to be transmitted to the department.

Section 13.426(a) provides that an HCC must establish and administer procedures and internal controls to safeguard and ensure against the sharing of any confidential information with or among participants.

Section 13.426(b) provides that the requirements of §13.426 include establishing and enforcing collection, custodial, retrieval, and transmittal procedures to ensure that information that the HCC or its participants must maintain as confidential is protected as confidential both as to entities and individuals outside the HCC and between or among participants.

These requirements apply to confidential information that the HCC maintains as custodian and that the HCC or any of its participants submit to the department under Insurance Code §848.057 or to the attorney general under Insurance Code §848.059.

The department estimates that it will be reasonably necessary for an HCC's general operations manager to spend an average of five to 10 hours creating the policies and procedures required by §13.425 and §13.426. The department also estimates that it may be reasonably necessary for the HCC's general operations manager to consult with legal counsel during the development of these policies and procedures due to the confidentiality requirements and possible antitrust implications. The use of legal counsel is discretionary, however, and the department is unable to accurately quantify the time or other resource cost of legal counsel assistance to develop these policies and procedures.

Though the department has identified factors attributable to the cost of compliance with §13.425 and §13.426, it cannot estimate the total compliance cost that an HCC applicant could incur because several cost factors are HCC specific, including the size, composition, and complexity of the HCC. The estimated costs to comply with the new sections represent an estimate for an average size HCC. The department estimates that each HCC will have the information necessary to determine its individual costs necessary to meet the requirements of the sections.

Section 13.431. Reserves and Working Capital Requirements.

Section 13.431(a)(1) provides that HCCs consisting of physicians and one or more facilities must maintain working capital that is composed of unencumbered net equity of not less than \$200,000, with a ratio of current assets to current liabilities of 1.25:1, based on the greater of the prior operating year's actual liabilities or the projected liabilities for the subsequent year. An HCC that has not been certified for more than one year must base its ratio on the projected liabilities for the subsequent year.

Section 13.431(a)(2) provides that all other HCCs must have a ratio of current assets to current liabilities of 1.25:1, based on the greater of the prior operating year's actual liabilities in the instance of an HCC that has been certified for more than one year, or the projected liabilities for the subsequent year.

Section 13.431(b) provides that an HCC must have reserves sufficient to operate and maintain the HCC and to arrange for services and expenses it incurs, computed in accordance with Generally Accepted Accounting Principles in an amount not less than 100 percent of incurred but not paid claims of nonparticipating physicians and providers.

Section 13.431(c) provides that any HMO or insurer holding a certificate of authority from the department that enters into a contract with an HCC pursuant to Insurance Code §848.103 must maintain a reserve equivalent in value to three months of prepaid funding or capitation payments, phased in over not more than a 36-month period.

Section 13.431(d) provides that for the purpose of meeting minimum working capital requirements, current assets of an HCC are limited to U.S. currency, certificates of deposit with fixed terms of one year or less, money market accounts, accounts receivable from government payors, and other accounts receivable that have remained due 90 days or less. Under §13.431(d), accounts receivable must be reported net of all allowances, and assets with a maturity period or fixed term that is greater than one year are not considered current assets.

Section 13.431(e) provides that, to meet the minimum reserve and minimum net equity requirements of the section, investments in capital assets, mortgages, notes, and loan-backed securities must be excluded from the calculation of reserves and net equity.

The department cannot accurately estimate the total compliance cost that an HCC applicant could incur in complying with §13.431 because several cost factors are HCC specific, including the size, composition, complexity, and liabilities of the HCC. The total cost for §13.431 compliance will vary among HCCs. However, the department estimates that each HCC will have the information necessary to determine its individual costs necessary to meet the requirements of the section.

Moreover, the enabling statute requires that TDI adopt rules that establish the working capital and reserve requirements applicable to HCCs.

Sections 13.453, 13.454, and 13.455. Filing Requirements, Commissioner Action, and Change of Control with Increased Market Share.

Section 13.453(a) provides that an individual or entity is prohibited from acquiring an ownership interest in an entity that holds a certificate of authority as an HCC if the individual or entity is, or after the acquisition would be, directly or indirectly in control of the certificate holder or would otherwise acquire control of or exercise any control over the certificate holder unless, in accordance with §13.453(b), the individual or entity, under oath or affirmation, files a Biographical Affidavit form for each individual by whom or on whose behalf the acquisition of control is to be effected and a Health Care Collaborative (HCC) Acquisition Form.

Section 13.454(b)(2) provides that the department may require an HCC to file an application for renewal as a result of a proposed acquisition of control. Section 13.455 provides that the department may require an HCC to file a renewal application before the date required by Insurance Code §848.060(a) as a result of any change in control of an HCC that results in an increase to its market share in any primary service area.

The time cost of completing and providing the Biographical Affidavit form required by proposed §13.453(b)(1) to the HCC's administrative staff will be one to two hours for each individual required to file the form under the proposed subsection. The time cost of preparing and filing the Health Care Collaborative (HCC) Acquisition Form required by §13.453(b)(2) will be one to two hours of administrative staff time. The estimated costs of complying with §13.424 in relation to certificate of authority renewal requirements apply equally to §13.454(b)(2) and §13.455 regarding the department requiring an HCC to file an

application for renewal.

Section 13.461. Commissioner's Authority to Require Additional Information.

Section 13.461(a) addresses the commissioner's authority to require additional information from the HCC or any participant in the HCC as reasonably necessary to make any determination required by Insurance Code Chapter 848, this subchapter, and applicable insurance laws and regulations of this state.

Section 13.461(b) provides that an HCC or participant is not required to create the information listed under §13.461(c) unless the commissioner requires the items to be provided; however, the documents must be maintained by the HCC or participant for at least five years once created.

Section 13.461(c) provides examples of the additional information the commissioner may require.

The department is unable to reliably estimate the cost of compliance with §13.461 because the information required to be submitted by the HCC will vary and is subject to the commissioner's discretion, which makes quantification by the department impracticable. However, this cost note has previously identified the potential administrative, managerial, and legal expertise needed to prepare, gather, and file the types of possible information required by §13.461.

Sections 13.471, 13.472, and 13.473. Notification of Change in Payment Arrangements, Requirements for Certain Delegation Contracts, and Organization of an HCC.

Section 13.471 requires an HCC to notify all affected payors in writing of a material

change in the payment arrangement for physicians, health care providers, or both, within 30 days of any change in the type of payment arrangement for any type of service.

The notification of the change must include a description of the payment arrangement that has been changed and a description of the new payment arrangement. The HCC's general operations manager will likely supervise the work of the administrative staff in creating the notices, and that supervision will require one to two hours. It will be reasonably necessary for the HCC's administrative staff to spend two to four hours creating, printing, and mailing the notifications. Though the department has identified factors attributable to the cost of compliance with §13.471, it cannot estimate the total compliance cost that an HCC applicant could incur because several cost factors are HCC specific, including the size, composition, and complexity of the HCC and the number of payors affected by the material change in the payment arrangement.

Section 13.472 provides that an HCC that delegates responsibility by contract with a delegated entity, delegated network, or delegated third party, as those terms are defined in Insurance Code §1272.001 through reference to contracts with HMOs, must submit to the department a monitoring plan setting out how the HCC will ensure that all delegated HCC functions are implemented in a manner consistent with full compliance by the HCC with all regulatory requirements of the department. The section also requires the HCC to conduct an on-site or desk audit of the delegated entity, delegated network, or delegated third party no less frequently than annually, or more frequently on indication of material noncompliance, to obtain information necessary to verify compliance with all regulatory requirements of the department. Written documentation of each audit required by this

paragraph must be made available to the department on request; and the HCC must take prompt action to correct any failure by the delegated entity, delegated network, or delegated third party to comply with regulatory requirements of the department relating to any matters delegated by the HCC and necessary to ensure the HCC's compliance with the regulatory requirements.

It will be reasonably necessary for the HCC's general operations manager to spend five to 10 hours creating the monitoring plan required by §13.472. It will also be reasonably necessary for the HCC's administrative staff to spend one to two hours printing and submitting the monitoring plan. Though the department has identified factors attributable to the cost of compliance with §13.472, it cannot accurately estimate the total compliance cost that an HCC applicant could incur because several cost factors are HCC specific, including the size, composition, and complexity of the HCC and the substance of the contracts between HCCs and health care providers.

Section 13.473(b) provides that the HCC must have a clinical director who is currently licensed in Texas or otherwise authorized to practice in this state in the field of services offered by the HCC; resides in Texas; is available at all times to address complaints, clinical issues, utilization review, and any quality of care issues on behalf of the HCC; demonstrates active involvement in all quality management activities; and is subject to the HCC's credentialing requirements, as appropriate. The estimated cost to comply with §13.473(b) is included in the subsequent discussion of the costs of compliance with the required quality improvement program provisions in §13.481 and §13.482.

For each defined service area, §13.473(c)(1) requires the HCC to provide a delivery network that is adequate and complies with Insurance Code Chapter 848 and to demonstrate to the department its ability to provide continuity, accessibility, availability, and quality of services within the HCC's service area.

The requirements under §13.473(c)(1) include that a defined service area have:

- (1) participants that are sufficient in number, size, and geographic distribution to be capable of furnishing the contracted health care services;
- (2) an adequate number of participants available and accessible to patients 24 hours a day, seven days a week;
- (3) sufficient numbers and classes of participants to ensure choice, access, and quality of care;
- (4) an adequate number of participating physicians who have admitting privileges at one or more participating hospitals to make any necessary hospital admissions; and
- (5) emergency care that is available and accessible 24 hours a day, seven days a week;
- (6) services sufficiently available and accessible as necessary to ensure that the distance from any point in the HCC's designated service area to a point of service is not greater than 30 miles in nonrural areas and 60 miles in rural areas for primary care and general hospital care and 75 miles for specialty care and specialty hospitals;
- (7) urgent care available and accessible within 24 hours for health and behavioral health conditions;

(8) routine care available and accessible within three weeks for health conditions and within two weeks for behavioral health conditions; and

(9) preventive health services available and accessible within two months for a child, or earlier if necessary for compliance with recommendations for specific preventive care services, and within three months for an adult.

The general operations manager or functional division director will need to be responsible for developing an adequate provider network that complies with §13.473(c)(1). The department cannot accurately estimate the amount of time required to develop the network, since it will vary depending on factors such as the size and complexity of the HCC, the size and location of the HCC's service area, and the length of time a credentialing decision takes. The timeframe for the credentialing decision will depend in part on the type of credentialing system used, as described in §13.483.

The department has determined that the compliance cost would be lessened if an HCC were to contract with independent provider networks to meet network adequacy requirements. While the HCC will be ultimately responsible to ensure compliance with §13.473(c)(1), the factors and components affecting the cost of compliance with the requirements may vary for each requirement. This variation would be based on the size of the network used by an HCC, the scope of the underlying contract between the HCC and the network, and the fees charged by the network for performance of the contract.

Section 13.473(d)(1) provides that an HCC must maintain in force in its own name a fidelity bond on its officers and employees of at least \$100,000, or another amount prescribed by the commissioner, issued by an insurer that holds a certificate of authority in

Texas.

Section 13.473(d)(3)(A) provides that instead of obtaining a fidelity bond, an HCC may obtain and maintain in force in its own name insurance coverage subject to the same coverage amount and conditions required for a fidelity bond under §13.473(d)(1). The costs of a fidelity bond under §13.473(d)(1) or an insurance policy under §13.473(d)(3)(A) generally will range from \$200 – \$700 annually.

Section 13.473(d)(3)(B) provides that instead of obtaining a fidelity bond or an insurance policy, an HCC may deposit readily marketable liquid securities acceptable to the commissioner with the office of the comptroller in Texas, subject to the same coverage amount and conditions required for a fidelity bond under proposed §13.473(d)(1).

Sections 13.481, 13.482, and 13.483. Quality Improvement Structure for HCCs, Quality Assurance and Quality Improvement, and Credentialing.

Section 13.481(a) provides that an HCC must develop and maintain an ongoing QI program designed to objectively and systematically monitor and evaluate the quality and appropriateness of health care services that it arranges for or offers and to pursue opportunities for improvement.

Section 13.481(b) provides that the governing body must: (1) appoint a quality improvement committee that includes the clinical director, practicing physicians, and, if applicable, other individual health care providers, and may include one or more patients from throughout the HCC's service area; (2) approve the QI program; (3) approve an annual QI plan; (4) meet no less than semiannually to receive and review reports of the QIC or group of committees and take action when appropriate; and (5) review the annual

written report on the QI program. Section 13.481(c) provides that the QIC must evaluate the overall effectiveness of the QI program and may delegate activities to other committees. All committees must collaborate and coordinate efforts to improve the quality, availability, and accessibility of health care services and meet regularly and report the findings of each meeting, including any recommendations, in writing to the QIC. If the QIC delegates any QI activity to any subcommittee, then the QIC must establish a method to oversee each subcommittee.

Section 13.482(a) requires an HCC to establish, implement, and administer a continuous QA and QI program that includes defined policies and processes to: (1) promote evidence-based medicine and best practices; (2) secure patient engagement; (3) promote coordination of care across a continuum of care; and (4) measure and report the quality of health care services and impact on cost.

Section 13.482(b) requires the QA and QI program to include appropriate practice evaluation tools, periodic review, and policies for coordinating with the HCC's QI committee to make necessary updates and adjustments.

Section 13.482(c) provides that the patient engagement process must include: (1) evaluating the health needs of its enrolled population; (2) communicating clinical knowledge to patients and patient representatives clearly and understandably; (3) promoting patient engagement, including engagement in treatment decisions; and (4) establishing written standards for patient communications.

Section 13.482(d) provides that the processes to promote coordination of care across a continuum of care must include a method or system to identify high-risk

individuals and processes to manage care throughout an episode of care and during transitions.

Section 13.482(e) provides that the processes for measuring and reporting quality of health care services and impact on cost must include measurement and evaluation of health care services and processes, a process for medical peer review, and arrangements for sharing pertinent medical records between participants and ensuring confidentiality.

Section 13.483 provides that an HCC must implement a documented process for selection and retention of contracted participants.

The department has determined that the total estimated cost for an HCC to comply with the new sections could vary based on the following: (1) hiring personnel necessary to develop and maintain an ongoing QA and QI program in compliance with §13.481 and §13.482; (2) compensating members of the required quality improvement committee to comply with §13.481(b)(1) and §13.481(c) related to the committee's ongoing evaluation of the overall effectiveness of the QI program; (3) conducting semiannual meetings in compliance with §13.481(b)(4); (4) hiring a qualified credentialing organization or an in-house credentialing body to comply with the credentialing function requirements in §13.483; and (5) drafting, copying, printing, combining, and mailing.

It will be reasonably necessary for an HCC to employ a medical director to serve as clinical director for the required QA and QI program, to employ administrative staff to assist the clinical director, and to employ information technology personnel to assist with the compilation of data necessary for drafting the required work plan and written report. An HCC's clinical director might provide most of the labor necessary to develop and maintain

an ongoing QA and QI program, including providing the required written description, drafting an annual work plan, drafting an annual written report, implementing the required credentialing process, overseeing the peer review process, promoting evidence-based medicine and best practices, securing patient engagement, promoting coordination of care, and measuring and reporting the quality of health care services and impact on cost. It will be reasonably necessary for a clinical director to spend between 10 and 40 hours per week developing and maintaining the QA and QI program.

An HCC's administrative staff will provide some of the labor necessary to develop and maintain an ongoing QA and QI program, including drafting, copying, printing, combining, and mailing. It will be reasonably necessary for an administrative assistant to spend an average of six hours per week assisting the clinical director with the work plan, written report, and other required administrative tasks.

It will be reasonably necessary for an HCC to employ a computer programmer to assist with the compilation of data necessary to create the annual work plan and written report. The number of hours necessary to compile data for the required annual work plan and written report will vary from five to 15 hours of computer programmer labor per year to assist the clinical director with the necessary data.

It may be reasonably necessary for an HCC to provide compensation to members of the appointed quality improvement committee for time necessary to meet regularly and to provide an ongoing evaluation of the overall effectiveness of the quality improvement program. However, it is not feasible for the department to estimate the total cost attributable to compliance with §13.481(b)(1) because several cost factors are HCC

specific and variable, based on features such as the size of the HCC's service area, the variation in the negotiated fees of physicians and providers agreeing to participate in the committee, the number of physicians and providers appointed to the committee by the HCC's governing body, and whether the governing body chooses to include one or more patients from throughout the HCC's service area. Each HCC has the information necessary to determine its individual labor costs necessary to meet the requirements of §13.481(b)(1).

It also may be reasonably necessary for an HCC to provide additional compensation to members of the governing body for time necessary to plan and conduct the required semiannual meetings of the governing body. However, it is not feasible for the department to estimate the total amount of cost attributable to compliance with §13.481(b)(4) because of varying cost factors that are HCC specific, like the size of the HCC's service area(s) and the current salaries of the HCC's governing body members. Each HCC has the information necessary to determine its individual labor costs necessary to meet the requirements of §13.481(b)(4).

Additionally, HCCs may incur additional costs to print or copy the required written description, annual work plan, annual written report, required committee reports, procedures, and additional paperwork necessary to comply with §13.481 and §13.482. The average print, copy, and postage costs necessary for compliance could vary for each HCC depending on the number of pages necessary to print and copy per year.

Finally, it may be reasonably necessary for an HCC to delegate credentialing functions to a qualified credentialing organization for a per-provider fee or employ an in-

house credentialing body, including a peer review committee to review and approve credentialed providers. An HCC may incur compliance costs for staff time spent researching credentials, including fees for accessing credentialing databases. An HCC may spend up to one hour per physician or provider researching their credentials with an additional estimated cost of \$10 per physician or provider to access the various credentialing databases. An HCC might assign an administrative assistant to perform these tasks. This monthly cost component will vary for each HCC depending on how many providers are researched for credentialing. Each HCC has the information necessary to determine its approximate cost.

Section 13.491 and §13.492. Complaint Systems and Complaints; Deadline for Response and Resolution.

Section 13.491(a) requires each HCC to implement and maintain a complaint system compliant with Insurance Code §848.107. The system must provide reasonable procedures for resolving an oral or written complaint initiated by a complainant concerning the HCC or health care services arranged by, or offered through, the HCC. Section 13.492(a) provides that not later than seven calendar days after receipt of an oral or written complaint, the HCC must acknowledge receipt of the complaint in writing; acknowledge the date of receipt; and provide a description of the HCC's complaint procedures, its appeal process for complaints filed by patients, and deadlines associated with each.

Section 13.492(b) provides that an HCC must investigate each complaint received in accordance with the HCC's policies and in compliance with Insurance Code §848.107.

Section 13.492(c) provides that after an HCC has investigated a complaint, the HCC must issue a resolution letter to the complainant not later than the 30th calendar day after the HCC receives the written complaint or the close of any hearing held under §13.493(2). The resolution letter must include: (1) an explanation of the HCC's resolution of the complaint; (2) the specific reasons for the resolution; (3) the specialization of any health care provider consulted; and (4) if the complainant is a patient who is dissatisfied with the resolution of the complaint, notice that the complainant may file an appeal of the complaint resolution or may file a complaint with the department.

Section 13.492(d) provides that in situations in which a patient complaint has been appealed, the HCC must issue a post-appeal decision letter that includes specific reasons for the decision and states that if the complainant is dissatisfied with the resolution of the complaint, the appeal, or the complaint process, the complainant may file a complaint with the department.

It will be reasonably necessary for the HCC's general operations manager or functional director to spend an average of five to 10 hours creating the policies and procedures necessary to implement the complaint system required by proposed §13.491. The HCC's administrative staff will investigate complaints under the supervision of the general operations manager or functional director. The administrative staff time needed to comply with §13.492 will vary depending on the number and complexity of complaints received. Additionally, the department estimates that HCCs may incur additional costs to print and mail the required complaint acknowledgment and resolution letters necessary to comply with §13.492. The average print and postage costs necessary for compliance

could vary for each HCC depending on the number of complaints received per year.

It may be reasonably necessary for an HCC to employ a computer programmer to assist with the creation of a complaint resolution database or to procure complaint resolution software. The number of computer programmer hours necessary to create a complaint resolution database will vary from 10 to 40 hours. The department is unable to accurately estimate the cost of procuring complaint resolution software, since an HCC may choose from several product options.

Though the department has identified factors attributable to the cost of compliance with §13.491 and §13.492, it cannot estimate the total compliance cost that an HCC applicant could incur because several cost factors are HCC specific, including the size, composition, and complexity of the HCC, and the volume of complaints received. The estimated costs to comply with the new sections represent an estimate for an average size HCC. Each HCC will have the information necessary to determine its individual costs necessary to meet the requirements of the sections.

4. ECONOMIC IMPACT STATEMENT AND REGULATORY FLEXIBILITY ANALYSIS

FOR SMALL AND MICRO BUSINESSES. As required by the Government Code §2006.002(c), the department has determined that Subchapter E might have an adverse economic effect on businesses that would qualify either as small businesses under §2006.001(2) or micro businesses under §2006.001(1) if those businesses were to pursue a certificate of authority to establish and operate an HCC.

However, the new nature of the HCC as a regulated entity makes it impracticable to

quantify the number of businesses that might experience an adverse economic effect from the rules as proposed. The costs identified in the public benefit/cost note portion of this proposal are incorporated into this economic impact statement and, unless otherwise noted, apply equally to all HCCs, including all HCCs that are small or micro businesses. Additionally, the cost for small or micro businesses will vary based on multiple factors as described in the public benefit/cost note portion of this proposal.

In accordance with the Government Code §2006.002(c-1), the department has considered other regulatory methods to accomplish the objectives of the proposal that will also minimize any adverse impact on small and micro businesses to the extent possible within the provisions of Insurance Code Chapter 848, and based on this consideration, the department has taken steps to mitigate adverse economic impact on any HCC, including any that might qualify as a small or micro business. Three primary areas reflect this effort.

The first area concerns the requirement that an HCC submit to the department all information necessary to facilitate the independent department and attorney general antitrust review that must be performed for every initial or renewal application. On this item, §13.414 provides a limited exemption from certain filing requirements based on the market share of the HCC applicant. If the HCC applicant meets the criteria specified in proposed subsection (b) of that section, it will not incur costs associated with having to provide the information.

The second area is associated with the provisions addressing examinations of HCCs, including financial, quality of care, market conduct, and antitrust examinations. These provisions permit the department to perform any or all of these exams on a

consolidated basis where possible. Consolidated administration of the examination function to the extent possible will mitigate costs associated with the ongoing review of any HCC.

The third area regards the SB 7 requirement that HCCs pay the expenses of the department and the attorney general in administering Insurance Code Chapter 848. The subchapter scales the assessment associated with payment of expenses to the size of the HCC by:

1. assessing each HCC for its own examination expenses;
2. assessing all HCCs for all other expenses on a pro rata basis of revenues, excluding revenues attributable to drugs or medical devices; and
3. applying the annual fee amount to the assessment amount.

The department rejects further alternative regulatory methods to accomplish the objectives of the proposal in a way that would minimize adverse impact on small and micro businesses for the following reasons.

First, the portions of SB 7 applicable to the proposed subchapter do not support different rule requirements or exclusion from rule requirements for small or micro businesses. SB 7 adds Insurance Code Chapter 848 relating to health care collaboratives. In conjunction with the creation of HCCs to provide or arrange to provide health care services under contract with a governmental or private entity, the legislature included in SB 7 a specific finding relating to state action immunity:

The legislature intends to exempt from antitrust laws and provide immunity from federal antitrust laws through the state action doctrine a health care collaborative (HCC) that holds a certificate of authority ... and that collaborative's negotiations of contracts with payors. The legislature does

not intend or authorize any person or entity to engage in activities or to conspire to engage in activities that would constitute per se violations of federal antitrust laws.

SB 7, §2.01(c).

Independent department and attorney general antitrust review must be performed for every initial or renewal application for an HCC certificate of authority. The complexity of an antitrust review is a function of not only the size of the HCC, but its composition. Therefore, allowing different standards based on the size of an HCC would foil the legislative intent behind SB 7.

Second, the ongoing dual oversight and antitrust review functions by both the department and the attorney general established in Insurance Code Chapter 848 must be achieved without cost to the state, through the imposition of fees and assessments sufficient to pay expenses. Reducing or waiving fees for some HCCs would limit the department and attorney general's ability to conduct their dual oversight and antitrust review functions or would result in cost to the state.

Third, based on provisions of Insurance Code Chapter 848, the proposed rules focus on agency regulatory standards for review in three primary areas: solvency and organization, quality and efficiency, and competition. Integration and continuous administration of each of these standards by each HCC is crucial to successful attainment of stated legislative goals of: (1) improved quality and efficiency of health care in this state through implementation of innovative, collaborative health care delivery and payment models; (2) improved health care transparency; and (3) established incentives to improve the quality and efficiency of health care.

Solvency and organization review standards are necessary to ensure that the HCC maintains financial solvency through sufficient capitalization and reserves and complies with statutory formation and governance requirements.

Quality and efficiency review standards are necessary to ensure that the HCC provides adequate networks; increases collaboration; promotes improved outcomes, safety, and coordination of services; reduces preventable events; and contains costs without compromising the quality of patient care.

Competition-related review must be performed at least annually to ensure that: (1) there is no reduction of competition due to an HCC's size or composition; (2) pro-competitive benefits outweigh anticompetitive effects of increases in market power; and (3) HCCs do not violate the enumerated rights of physicians. An essential part of the department review of the HCC application is the determination of whether the applicant meets the SB 7 antitrust test. The attorney general must then conduct an independent antitrust review of the HCC application to determine if it meets the SB 7 antitrust test.

5. TAKINGS IMPACT ASSESSMENT. The department has determined that no private real property interests are affected by this proposal and that this proposal does not restrict or limit an owner's right to property that would otherwise exist in the absence of government action and, therefore, does not constitute a taking or require a takings impact assessment under the Government Code §2007.043.

6. REQUEST FOR PUBLIC COMMENT. To be considered, written comments on the proposal must be submitted no later than 5:00 p.m. on October 29, 2012, to Sara Waitt, General Counsel, by email to: chiefclerk@tdi.state.tx.us, or by mail to: Mail Code 113-2A, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104. An additional copy of the comments must be submitted simultaneously to Jeff Hunt and Doug Danzeiser by single email to: companylicense@tdi.state.tx.us, or by single mailing to Jeff Hunt, Company Licensing & Registration, Mail Code 305-2C, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104. The commissioner will consider proposed new 28 TAC Chapter 13, Subchapter E, §§13.401 – 13.404, 13.411 – 13.417, 13.421 – 13.426, 13.429, 13.431 – 13.432, 13.441, 13.451 – 13.455, 13.461, 13.471 – 13.474, 13.481 – 13.483, and 13.491 – 13.494 in a public hearing under Docket No. 2742 scheduled for October 18, 2012, at 9:30 a.m. in Room 100 of the William P. Hobby Jr. State Office Building, 333 Guadalupe Street, Austin, Texas. The department will consider written and oral comments presented at the hearing.

7. STATUTORY AUTHORITY. The new sections are proposed under Insurance Code §§848.054(b), 848.056(d), 848.108(c)(2), 848.108(d), 848.151, 848.152(d), and 36.001.

Section 848.054(b) requires the commissioner to adopt rules governing the application for certificate of authority to organize and operate an HCC.

Section 848.056(d) authorizes the commissioner by rule to extend the date by which an application is due and to require the disclosure of any additional information necessary

to implement and administer Chapter 848, including information necessary to antitrust review and oversight.

Section 848.108(c)(2) authorizes the commissioner to specify by rule functions in addition to those referenced in §848.108(c)(1) under which an HCC may assign responsibility to a delegated entity by agreement.

Section 848.108(d) authorizes the commissioner by rule to set maintenance requirements for reserves and capital in an amount and form in addition to amounts required under Chapter 1272 as are necessary for the liabilities and risks assumed by the HCC.

Section 848.151 authorizes the commissioner and the attorney general to adopt reasonable rules as necessary and proper to implement the requirements of Chapter 848.

Section 848.152(d) requires the commissioner to set fees and assessments in an amount sufficient to pay the reasonable expenses of the department and attorney general in administering Chapter 848, including the direct and indirect expenses incurred by the department and attorney general in examining and reviewing HCCs.

Section 36.001 provides that the commissioner of insurance may adopt any rules necessary and appropriate to implement the powers and duties of the department under the Insurance Code and other laws of this state.

8. CROSS REFERENCE TO STATUTE. The proposal affects the following statutes:

Rule	Statute
§13.401	Insurance Code §848.051, §848.151

§13.402	Insurance Code §848.001, §848.151
§13.403	Insurance Code §§848.054, 848.056, 848.060, 848.108, 848.151
§13.404	Insurance Code Chapter 848
§13.411	Insurance Code §§848.005, 848.054, 848.056, 848.060, 848.151, 848.152
§13.412	Insurance Code §§848.054, 848.056, 848.057, 848.151
§13.413	Insurance Code §§848.051 – 848.060, 848.106, 848.151, 848.153
§13.414	Insurance Code §§848.051 – 848.060, 848.151
§13.415	Insurance Code §§848.051 – 848.060, 848.106 – 848.108, 848.151, 848.153
§13.416	Insurance Code §§848.054, 848.056 – 848.060, 848.151, 848.153
§13.417	Insurance Code §§848.054, 848.056 – 848.058, 848.060, 848.151, 848.153
§13.421	Insurance Code §§848.054, 848.056 – 848.060, 848.151 – 848.153
§13.422	Insurance Code §§848.054, 848.056 – 848.058, 848.060, 848.151, 848.153

§13.423	Insurance Code §§848.056 – 848.058, 848.060, 848.101, 848.106, 848.151
§13.424	Insurance Code §§848.054, 848.056 – 848.060, 848.151 – 848.153
§13.425	Insurance Code §§848.053, 848.054, 848.056, 848.151
§13.426	Insurance Code §§848.004, 848.056 – 848.058, 848.151
§13.429	Insurance Code §§848.003, 848.004, 848.057, 848.058, 848.151
§13.431	Insurance Code §§848.057, 848.103, 848.108, 848.151
§13.432	Insurance Code §848.052, §848.151
§13.441	Insurance Code §§848.054, 848.057, 848.101, 848.104, 848.151, 848.201; Insurance Code Chapters 843 and 1301
§13.451	Insurance Code §§848.051, 848.052, 848.054, 848.056 – 848.058, 848.151
§13.452	Insurance Code §§848.051, 848.052, 848.054, 848.056 – 848.058, 848.151
§13.453	Insurance Code §§848.051, 848.052, 848.054, 848.056 – 848.058, 848.151

§13.454	Insurance Code §§848.051, 848.052, 848.054, 848.056 – 848.058, 848.151
§13.455	Insurance Code §§848.051, 848.052, 848.054, 848.056 – 848.058, 848.060, 848.151
§13.461	Insurance Code §§848.051 – 848.060, 848.151, 848.153
§13.471	Insurance Code §§848.057, 848.101, 848.103, 848.151
§13.472	Insurance Code §§848.057, 848.108, 848.151
§13.473	Insurance Code §§848.052, 848.053, 848.056, 848.057 848.060, 848.101, 848.104 – 848.106, 848.151; Insurance Code Chapter 1272
§13.474	Insurance Code §848.108, §848.151
§13.481	Insurance Code §§848.056 – 848.057, 848.060, 848.106, 848.151
§13.482	Insurance Code §§848.056 – 848.057, 848.060, 848.106, 848.151
§13.483	Insurance Code §§848.056 – 848.057, 848.060, 848.106, 848.151

§13.491	Insurance Code §§848.057, 848.060, 848.107, 848.151, 848.153
§13.492	Insurance Code §§848.057, 848.107, 848.151
§13.493	Insurance Code §§848.057, 848.107, 848.110, 848.151
§13.494	Insurance Code §§848.057, 848.107, 848.110, 848.151

9. TEXT.

DIVISION 1. GENERAL PROVISIONS

§13.401. Purpose. This subchapter implements Insurance Code Chapter 848 and other insurance laws of this state that apply to health care collaboratives to provide the framework to support the use of innovative health care collaborative payment and delivery systems in this state.

(1) Severability. If a court of competent jurisdiction holds that any provision of this subchapter or its application to any person or circumstance is invalid for any reason, the invalidity does not affect other provisions or applications of this subchapter that can be given effect without the invalid provision or application, and to this end the provisions of this subchapter are severable.

(2) Effect of rules. The sections in this subchapter govern the performance of appropriate statutory and regulatory functions and do not limit the exercise of statutory

authority by the commissioner of insurance.

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

(1) Affiliate--As defined in Insurance Code §848.001(1).

(2) Clinical director--Health professional who is:

(A) appropriately licensed;

(B) an employee of, or party to a contract with, an HCC; and

(C) responsible for clinical oversight of the utilization review program,

the credentialing of professional staff, and quality improvement functions.

(3) Common service--A service provided by two or more independent HCC participants.

(4) Confidential information--Information that relates to bidding, pricing, trade secrets, business planning documents, financial position and related operational results, profit and loss statements, contracts, salaries, employee benefits, or other competitively sensitive information.

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

(6) Entity--An artificial person, including a partnership, association, organization, trust, or corporation; the term does not include a securities broker performing no more than the usual and customary broker's function.

(7) Facility--

(A) an ambulatory surgical center licensed under Health and Safety Code Chapter 243;

(B) a birthing center licensed under Health and Safety Code Chapter 244; or

(C) a hospital licensed under Health and Safety Code Chapter 241 or 577.

(8) Financial statement--An HCC's annual statement of financial position and operating results, including a balance sheet, receipts, and disbursements, certified by an independent certified public accountant and prepared in accordance with Generally Accepted Accounting Principles.

(9) Health care collaborative or HCC--As defined in Insurance Code §848.001(2).

(10) Health care provider--As defined in Insurance Code §848.001(4).

(11) Health care services--As defined in Insurance Code §848.001(3).

(12) Health maintenance organization or HMO--As defined in Insurance Code §848.001(5).

(13) Hospital--As defined in Insurance Code §848.001(6).

(14) Individual--A natural person.

(15) Individual health care provider--A health care provider who is a natural person.

(16) Network--A health care delivery system in which an HCC provides or arranges to provide health care services directly or through contracts and subcontracts with governmental entities or private individuals or entities.

(17) Participant--Each physician or health care provider that has agreed to participate in the HCC.

(18) Physician--As defined in Insurance Code §848.001(8).

(19) Primary service area or PSA--For each common service and each participant, the area defined by the smallest number of postal ZIP codes from which the participant draws at least 75 percent of its patients for that service.

(20) Private payor--Any of the following:

(A) an insurer that writes health insurance policies;

(B) an HMO, to the extent that it pays physicians or health care providers for health care services under an HMO evidence of coverage or under a negotiated-rate contract with the physician or health care provider; or

(C) any other entity, including an insurer or third-party administrator for self-insured private or governmental employers, that provides, or offers to provide, health care services to a patient pursuant to a negotiated-rate contract that the entity negotiated with physicians or health care providers.

(21) Pro-competitive benefit--A benefit obtained from clinical or financial integration by the establishment and operation of the HCC. A pro-competitive benefit may

include use of electronic medical records, implementation of quality control procedures, utilization review, clinical protocols, coordination of care, and financial incentives to reduce costs or increase quality.

(22) Quality improvement or QI--A system to continuously examine, monitor, and revise processes and systems that support and improve administrative and clinical functions.

(23) Rural hospital--A hospital:

(A) that is paid under the Medicare hospital inpatient prospective payment system and is either located more than 35 miles from other like hospitals or is located in a rural area, and meets the criteria for sole community hospital status as specified by 42 CFR §412.92; or

(B) located in a rural area and that has been certified as a Medicare critical access hospital based on the criteria set forth in 42 CFR Part 485, Subpart F.

(24) Service area--A geographic area within which health care services are available and accessible to an HCC's patients who live, reside, or work within that geographic area and that complies with §13.473 of this title (relating to Organization of an HCC).

(25) Utilization review--As defined in Insurance Code §4201.002.

§13.403. Filing and Required Forms; How to Obtain Forms.

(a) All HCC filings for original or renewal application as required by this subchapter must be made to Company Licensing & Registration, Mail Code 305-2C, Texas

Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104, and copies of all HCC forms are available through that address. All forms also are available on the department website at www.tdi.texas.gov.

(b) All HCC forms for an original or renewal application filing may be submitted electronically in a format permitted by the department.

(c) Paragraphs (1) – (7) of this subsection identify the forms specified for use with the rules adopted under this subchapter. Each HCC or other individual or entity must use the form(s) as required by this title in accordance with the form’s instructions and content requirements and as appropriate to particular activities. The commissioner adopts by reference the following forms:

(1) Original/Renewal Application for Certificate of Authority to do the Business of a Health Care Collaborative (HCC) in the State of Texas;

(2) Health Care Collaborative Officers and Directors Page;

(3) Biographical Affidavit;

(4) Request to Convert to Renewal of Certificate of Authority to do the Business of a Health Care Collaborative (HCC) in the State of Texas;

(5) Financial Authorization and Release Form;

(6) Health Care Collaborative Payor Information Form; and

(7) Health Care Collaborative (HCC) Acquisition Form.

§13.404. Use of the Term “HCC,” Service Mark, Trademarks, d/b/a.

(a) While planning or developing an HCC, an organization may use the terms

“health care collaborative” or “HCC” as a part of the proposed HCC’s name provided the developmental status of the proposed HCC is clearly communicated in all dealings with employers, individuals, prospective contract holders, news media, and other individuals or entities.

(b) After the certificate of authority is issued, the HCC must include the name as it appears on the certificate of authority on all advertising and forms distributed to the public.

DIVISION 2. APPLICATION FOR CERTIFICATE OF AUTHORITY

§13.411. Filing Fee; Annual Assessments; Open Records.

(a) The application filing fee required by Insurance Code §848.152 must accompany the application required to be filed by Insurance Code §848.056 or §848.060.

(b) The fee for filing the original application for certificate of authority is \$10,000 and is nonrefundable.

(c) The fee for filing the annual renewal application for certificate of authority is \$5,000 and is nonrefundable.

(d) In addition to the filing fee addressed in this section, each HCC must pay to the department annually an assessment as set forth in §13.421(c)(1) – (6) of this title (relating to Examination; Fee for Expenses).

(e) Except as provided by Insurance Code §848.005(b), the application is public information subject to disclosure under the Government Code Chapter 552.

§13.412. Revisions During Review Process.

(a) Revisions during the review of the application must be addressed to: Company Licensing & Registration, Mail Code 305-2C, Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104.

(b) Each revision to the basic organizational document, bylaws, or officers' and employees' bond must be accompanied by a certification of the corporate secretary or corporate president of the applicant that the revision submitted is true, accurate, and complete.

(c) The department will conduct examinations in connection with each application and notify the applicant of the need for revisions necessary to meet the requirements of Insurance Code Chapter 848, this subchapter, and applicable insurance laws and regulations of this state. If the applicant does not make the necessary revisions, the department may withdraw the application on behalf of the applicant. If the time required for the revisions will exceed the time limit provided in Insurance Code §848.056(c), the applicant must request additional time within which to make the revisions. The applicant must specifically state the length of time requested, which may not exceed 90 days. The request for any extension must describe the need for the additional time in writing in sufficient detail for the commissioner to determine if good cause for the extension exists. The applicant may request additional extensions. The commissioner has discretion to grant or deny the request for an extension of time under Insurance Code §848.056.

§13.413. Contents of the Application.

(a) Order of contents. The application must include the items in the order listed in

this section.

(b) Original and copies. An applicant filing a nonelectronic application must submit two additional copies of the application along with the original application.

(c) General contents. An application must include:

(1) a declaration executed under oath or affirmation by an officer or other authorized representative of the HCC certifying that the collection of any confidential information for purposes of satisfying filing requirements of this subchapter was made in accordance with the confidentiality requirements of §13.426 of this title (relating to Confidentiality);

(2) a completed application for certificate of authority;

(3) the basic organizational documents and any amendments to them, complete with the original incorporation certificate with charter number and seal indicating certification by the secretary of state, if applicable;

(4) the bylaws, rules, or any similar documents regulating the conduct of the internal affairs of the applicant, certified by an officer or other authorized representative of the applicant HCC;

(5) a plan of operation for the HCC, including an overview, history, types of health care service offered, and operations provisions that include pro-competitive strategies of the HCC;

(6) information about officers, directors, and staff:

(A) a completed officers and directors page; and

(B) biographical data forms for all individuals who are to be

responsible for the day-to-day conduct of the affairs of the applicant;

(7) separate organizational charts or lists, as described in subparagraphs (A)

– (C) of this paragraph:

(A) charts clearly identifying the contractual relationships involved in the applicant’s health care delivery system and between the applicant and any affiliates, and a list of contracts to provide services between the applicant and the affiliates;

(B) a chart showing the internal organizational structure of the applicant’s management and administrative staff; and

(C) for the purposes of this paragraph, the information provided must clearly identify any relationship between the HCC and any affiliate or other organization if a common individual or entity directly or indirectly controls 10 percent or more of both the HCC and the affiliate or other organization;

(8) notice of the physical address in Texas of all books and records described in §13.415 of this title (relating to Documents to be Available for Quality of Care and Financial Examinations); and

(9) a description of the information systems, management structure, and personnel that demonstrates the applicant’s capacity to meet the needs of patients and participants and to meet the requirements of regulatory and contracting entities.

(d) Financial information. An application must include financial and financially-related information consisting of the following:

(1) projected financial statements, including a balance sheet, income statement, and cash flow statement. Additionally:

(A) the projected data must be provided for two consecutive annual reporting periods;

(B) the financial statements must include the identity and credentials of the individual making the projections; and

(C) the projected data must reflect compliance with §13.431 of this title (relating to Reserves and Working Capital Requirements);

(2) a balance sheet reflecting actual assets and liabilities, and net assets sufficient to comply with §13.431 of this title;

(3) the form of any contract between the applicant and any payor that addresses the applicant arranging for medical and health care services for the payor in exchange for payments in cash or in kind as provided in Insurance Code Chapter 848;

(4) if applicable, insurance or other protection, or both, against insolvency and:

(A) any reinsurance agreement and any other agreement described in Insurance Code §848.102 covering the cost of a potential significant event or catastrophe; and

(B) any other arrangements offering protection against insolvency;

(5) proof of the applicant's maintenance of a fidelity bond or similar officer and employee antifraud protection as provided in §13.473(d) of this title (relating to Organization of an HCC); and

(6) authorization for disclosure to the commissioner of the financial records of the applicant and affiliates to confirm assets.

(e) Provider and service area information. An application must include:

(1) a description and a map of the service area, with key and scale, that identifies the county or counties, or portions of the county or counties, to be served. If the original map is in color, all copies also must be in color;

(2) network configuration information, including maps demonstrating the location and distribution of the participants by physician type and provider type within the proposed service area by county, counties, or ZIP code(s); lists of participants in Excel-compatible format, including business address, county, license type and specialization, hospital admission privileges, and an indication of whether they are accepting new patients;

(3) the identity of any integrated practice group or independent practice association to which any participant belongs, including the group's name, business address, type of legal organization, and approximate number of members;

(4) for each participating facility:

(A) the facility's name and business address;

(B) a description of the services provided by the facility; and

(C) a statement as to whether the facility's agreement with the HCC

allows the facility to contract or affiliate with other HCCs;

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

(A) any individual listed on the officers and directors page;

(B) any delegated entity, delegated network, or delegated third party

as described in Insurance Code Chapter 1272; or any other physician or health care

provider, plus the form of any subcontract between those individuals or entities and any physician or health care provider to provide health care services. All contracts must include a hold-harmless provision that complies with Insurance Code §843.361 and §1301.060, as applicable, for the protection of patients covered by health benefit plans;

(C) any exclusive agent or agency; or

(D) any individual or entity who will perform management, marketing, administrative, data processing, or claims processing services; and

(6) a written description of the types of compensation arrangements, such as compensation based on fee-for-service arrangements, risk-sharing arrangements, prepaid funding arrangements, or capitated risk arrangements, made or to be made with physicians and health care providers in exchange for the provision of, or the arrangement to provide, health care services to patients, including any financial incentives for physicians and health care providers.

(f) Quality assurance and quality improvement information. An application must include a detailed description of the policies and processes contained in the quality assurance and quality improvement program required by §13.482 of this title (relating to Quality Assurance and Quality Improvement).

(g) Accreditation disclosure. If an HCC has attained accreditation from a nationally recognized accrediting body such as the National Committee for Quality Assurance or URAC, the HCC must disclose:

(1) the name of the accrediting body;

(2) the date accreditation was granted;

- (3) the accreditation level;
- (4) current accreditation status; and
- (5) a copy of the accreditation report.

(h) Antitrust analysis information required of all applicants. An application must include:

(1) for each participant in the HCC, disclosure of any known past or pending investigation, or administrative or judicial proceeding, in which it is alleged that the participant has engaged in any form of price-fixing or other antitrust violation, or health care fraud or abuse, including any governmental or private investigations, lawsuits, and any judgments, fines, or penalties relating to those allegations;

(2) identification of each common service provided by participants, grouped by:

(A) specific Medicare specialty code for each specialty of any participating physician or health care provider;

(B) specific major diagnostic category for inpatient services at a hospital; and

(C) specific outpatient category as established by the Centers for Medicare and Medicaid Services for outpatient services at a facility;

(3) identification of the PSA for each common service for each participant;

(4) the HCC's calculated market share for each common service in each PSA in which two or more participants serve patients for that service, utilizing the identification procedures and calculation steps set forth in §13.414 of this title (relating to

Limited Exemption from Certain Information Filing Requirements); and

(A) identifying the market participants and providing the data used in determining the market share; and

(B) highlighting each common service area in each PSA in which the market share exceeds 35 percent;

(5) identification of all physicians, physician group practices, or other entities the HCC applicant considers to be or have been competitors of the HCC or its participants in its proposed service area;

(6) for each pro-competitive benefit that the applicant anticipates will result from the establishment of the HCC:

(A) a description of the pro-competitive benefit;

(B) an explanation as to why the establishment of the HCC will help achieve the pro-competitive benefit or will help extend the pro-competitive benefit to new patient populations or service areas; and

(C) a description of how the HCC will assess whether the pro-competitive benefit has been achieved, including:

(i) the reference point to be used in determining the status prior to implementation of the pro-competitive benefit;

(ii) the standard to be used by the HCC in tracking progress toward achieving the pro-competitive benefit; and

(iii) the time period to be used in assessing whether the pro-competitive benefit has been achieved. If the time period is longer than one year, the

applicant must set forth interim benchmarks that will allow the commissioner to assess whether the HCC is making progress toward achieving the pro-competitive benefit; and

(D) for any pro-competitive benefit that the HCC expects to achieve as the result of financial integration, a description of the alternative payment methods the HCC anticipates using to create the financial, pro-competitive benefit;

(7) a description of the policies and procedures the HCC will establish and administer to ensure that none of its financial incentives will result in any limitation on medically necessary services; and

(8) a description of the confidentiality policies and procedures established and enforced by the HCC applicant as required by §13.426 of this title to protect the confidential information of a participant in the HCC from disclosure to other participants in the HCC. The description must include the types and specifications of safeguards and address confidential information collected in the process of preparing or submitting the HCC application.

(i) Market and market power information. HCC applicants ineligible for the limited information filing exemption. An HCC application for an applicant that does not qualify for the limited information filing exemption set forth in §13.414 of this title must also include additional information. For each PSA that does not fall within the limited filing exemption, for each participant in the PSA, the application must include:

(1) for each participant, the name of each private payor that individually accounts for five percent or more of the participant's business in the past year, measured by:

(A) revenue;

(B) billed charges, if revenue data is unavailable; or

(C) patient visits, if billed charges data is unavailable;

(2) for each participant referenced in paragraph (1) of this subsection, a completed Health Care Collaborative Payor Information Form;

(3) all business planning documents created within the previous 24 months relating to the HCC applicant's or its participants' plans relating to any health care service in each service area, including:

(A) market studies and forecasts;

(B) studies of patient origin and flow;

(C) market share studies;

(D) budgets;

(E) investment banker and other consultant reports;

(F) expansion or retrenchment plans;

(G) research and development documents; and

(H) presentations to management committees, executive committees, and boards of directors;

(4) the name of each individual responsible for negotiating contracts on behalf of participants with payors over the last five years, the name of the participant on whose behalf the individual negotiated, the time periods for which the individual was responsible for those negotiations, and, if known, the individual's current address and phone number;

(5) documents reflecting the applicant's price lists, pricing plans, pricing policies, pricing forecasts, pricing strategies, pricing analyses, and pricing decisions relating to any medical or health care service in the service area;

(6) for each individual or entity that has provided or stopped providing any competing health care service in the service area within the previous 36 months, the following items:

(A) name and address of the individual or entity;

(B) beginning date, or beginning and ending date, of the individual's or entity's provision of the health care service in the service area; and

(C) whether the individual or entity built a new facility, converted assets previously used for another purpose, or began using facilities that already were being used for the same purpose;

(7) documents reflecting participants' contribution margins or identifying or quantifying fixed or variable costs for the provision of any health care service in the service area;

(8) if the applicant believes that approval of the application is necessary for the future financial viability of one or more of the participants, for that participant, documents referencing its future viability, gross or net margins, ability to obtain financing for capital improvements, or other documents the applicant deems necessary for the evaluation of that participant's financial condition;

(9) all memoranda created within the previous 24 months relating to cost savings, economies, or other efficiencies that have been or could be achieved by any

participant through a joint venture, internal cost-cutting, or any associated transaction, regardless of whether the applicant establishes and operates the proposed HCC;

(10) identification of every physician or health care provider in its proposed PSA that the applicant has communicated with concerning the possibility of contracting with the HCC within the previous 12 months; and

(11) for each participant, for the previous 12 months, all agendas, minutes, summaries, handouts, and presentations made to the participant's: board of directors; executive committee; strategic or business planning committees; physician or health care provider recruitment committee; and any committee responsible for approving contracts with facilities, clinics, or private payors.

§13.414. Limited Exemption from Certain Information Filing Requirements.

(a) This section specifies circumstances under which an applicant is not required to provide the information specified in §13.413(i) of this title (relating to Contents of the Application) in filing an original renewal application for certificate of authority.

(b) An applicant is not required to provide the information specified in §13.413(i) of this title if:

(1) for each PSA in which two or more individual or group participants provide common services, the applicant's market share is 35 percent or less; and

(2) no contract between the HCC and any participating hospital restricts the HCC or hospital from contracting with other HCCs, networks, hospitals, physicians, physician groups, health care providers, or private payors.

(c) Notwithstanding the provisions of subsection (b) of this section, an HCC that has a contract with a physician or health care provider in a rural county as defined by the U.S. Census Bureau and that does not restrict that physician's or health care provider's ability to contract or deal with other HCCs, networks, physicians, or health care providers is not required to provide the information specified in §13.413(i) of this title, if the inclusion of the physician or health care provider alone causes the HCC's share of any common service to exceed 35 percent.

(d) Notwithstanding the provisions of subsection (b) of this section, an HCC that includes a rural hospital but does not restrict the hospital from contracting with other HCCs, networks, physicians, or health care providers is not required to provide the information specified in §13.413(i) of this title, if the inclusion of the rural hospital alone causes the HCC's share of any common service to exceed 35 percent.

(e) For purposes of this section, an HCC's market share is determined by aggregating the market shares of its participants, calculated as follows:

(1) for physicians or individual health care providers within a particular health care specialty, by dividing the number of physicians or individual health care providers in the specialty within the HCC by the total number of physicians or health care providers providing each of the common services within that health care specialty within a participating physician's or health care provider's PSA;

(2) for outpatient services at a facility, by dividing the number of physicians or health care providers participating in the HCC within each PSA by the total number of physicians or health care providers within each PSA that provide each common service;

(3) for hospital inpatient services, by dividing the number of staffed hospital beds by particular medical specialty within the hospital or group of hospitals as reported to the department of state health services in Texas, for each common service area, by the total number of staffed hospital beds by medical specialty within each participating hospital's PSA; and

(4) if an HCC's participants can be classified as falling within more than one of the categories set forth in paragraphs (1) – (3) of this subsection, calculations must be made for all of the categories within which the participants in the HCC provide services.

(f) Notwithstanding the definition of PSA in §13.402 of this title (relating to Definitions), a participant may calculate market share through reference to the HCC's PSA for a health care specialty rather than the participant's PSA if the participant demonstrates to the commissioner's satisfaction that analysis of competition within the HCC's PSA provides a more accurate measure of competition relating to the participant in the context of the HCC than the analysis of competition within the participant's PSA.

(g) Notwithstanding this section, on receipt of the original or renewal application, the commissioner has discretion to require an applicant to provide any or all of the information specified in §13.413(i) of this title or §13.461 of this title (relating to Commissioner's Authority to Require Additional Information), or both, when the commissioner deems the information reasonably necessary to conduct the review required under Insurance Code Chapter 848.

§13.415. Documents to be Available for Quality of Care and Financial Examinations.

(a) The following documents must be provided to the department on request and available for review at the HCC's office located within Texas:

(1) administrative: policy and procedure manuals, including procedures relating to confidentiality; patient materials; organizational charts; and key personnel information, such as resumes and job descriptions;

(2) quality improvement: program description and work plan as required by §13.481 of this title (relating to Quality Improvement Structure for HCCs); and, for renewal applications, program evaluations and meeting minutes for committees and subcommittees;

(3) utilization management: program description; policies and procedures; criteria used to determine medical necessity; templates of adverse determination letters and adverse determination logs for all levels of appeal, or, for renewal applications, examples of those letters and logs; and, for renewal applications, utilization management files;

(4) complaints and appeals: policies and procedures; and templates of letters, complaint logs, and appeal logs, or for renewal applications, examples of those letters and logs, including documentation and details of actions taken;

(5) health information systems: policies and procedures for accessing patient health records and a plan to provide for confidentiality of those records in accordance with applicable law;

(6) network configuration information: as outlined in and required by §13.413(e)(2) of this title (relating to Contents of the Application), demonstrating adequacy

of the physician and health care provider network;

(7) executed agreements, including:

(A) contracts with payors;

(B) management services agreements;

(C) administrative services agreements; and

(D) delegation agreements;

(8) executed participant contracts: copy of the first page, including the form number, and signature page of individual and group contracts;

(9) executed subcontracts: copy of the first page, including the form number, and signature page of all contracts with subcontracting physicians and providers;

(10) physician and health care provider manuals: current physician manual and current health care provider manual, which must be provided to each contracting physician and health care provider, respectively, and which must contain details of the requirements by which the physicians and health care providers will be governed;

(11) credentialing documentation: credentialing policies, procedures, and files that demonstrate compliance with §13.483 of this title (relating to Credentialing);

(12) reporting system: the statistical reporting system developed and maintained by the HCC that allows for compiling, developing, evaluating, and reporting statistics relating to the cost of operation, the pattern of utilization of services, and the accessibility and availability of services; and, for renewal applications, reports generated by the system concerning those components;

(13) claims systems: policies and procedures that demonstrate the capacity

to pay claims timely, if applicable, and to comply with all applicable statutes and rules; and, for renewal applications as applicable, evidence of timely claims payments and reports that substantiate compliance with all applicable statutes and rules regarding claims payment to physicians, health care providers, and patients;

(14) financial records: including statements; ledgers; checkbooks; inventory records; evidence of expenditures, investments, and debts; and related bank confirmations necessary to ascertain funding;

(15) compliance or accreditation: records regarding compliance with applicable statutes and rules or accreditation standards, including audits or examination reports by other entities, such as governmental authorities or accrediting agencies;

(16) satisfaction surveys: for renewal applications only, patient, physician, and provider satisfaction surveys; and patient disenrollment and termination logs;

(17) reports: for renewal applications only, any reports submitted by the HCC to a governmental entity; and

(18) other documents and information: any records requested pursuant to Insurance Code §848.153.

(b) The documents listed in this section must be maintained for at least five years.

§13.416. Review of Original or Renewal Application; Commissioner Discretion.

(a) An original application or renewal application will be processed pursuant to Insurance Code §§848.056 – 848.060 and 848.153.

(b) The department will conduct an examination as specified in §13.421(a) of this

title (relating to Examination; Fee for Expenses) in conjunction with each application. If a hearing is held in connection with an application, then the examination(s) will occur prior to the date of the hearing.

(c) Application review will include a determination of compliance with Insurance Code §848.057. The review of pro-competitive benefits of the proposed or existing HCC in relation to anticompetitive effects of market power increase will be in accordance with established antitrust principles of market power analysis.

(d) The commissioner has sole discretion to impose restrictions on an HCC applicant's certificate of authority that are deemed necessary to preserve competition. Examples of these restrictions include the following:

(1) prohibiting the HCC applicant from including "anti-steering," "guaranteed inclusion," "product participation," "price parity," or similar contractual clauses or provisions in its contracts with a private payor;

(2) prohibiting the HCC applicant from tying sales, explicitly or implicitly through pricing policies, of the HCC's services to a private payor's purchase of other services from physicians or health care providers outside of the HCC (and vice versa), including providers affiliated with HCC participants;

(3) prohibiting contracting with HCC participants on a basis that prevents or discourages them from contracting outside the HCC, either individually or through other HCCs or provider networks;

(4) prohibiting restrictions on a private payor's ability to provide its health plan enrollees with cost, quality, efficiency, and performance information used by the HCC

to aid enrollees in evaluating and selecting physicians and health care providers in the health plan;

(5) prohibiting sharing with or among the HCC's participants any competitively sensitive pricing or other data that could be used to set prices or other terms for services that the participants provide outside the HCC; and

(6) restricting the HCC's certificate of authority to certain geographic areas or health care services.

§13.417. Withdrawal of an Application.

(a) On written notice to the department, an applicant may request withdrawal of an application from consideration by the department.

(b) The department may in its discretion withdraw an application on behalf of the applicant if the department determines that the applicant has failed to respond in a timely manner to requests made by the department for additional information or if the application is incomplete.

**DIVISION 3. EXAMINATIONS; REGULATORY REQUIREMENTS FOR AN HCC AFTER
ISSUANCE OF CERTIFICATE OF AUTHORITY;
AND ADVERTISING AND SALES MATERIAL**

§13.421. Examination; Fee for Expenses.

(a) The department has authority to conduct examinations of HCCs under Insurance Code §848.153. The department will conduct examinations in conjunction with an application and as needed to oversee the HCC's activity. The scope of the examination

may vary based on the scope of an applicant's or HCC's activities and may include desk review. Any examination may include the review of one or more of the following components:

- (1) financial condition;
- (2) quality of health care services;
- (3) compliance with laws affecting the conduct of business; or
- (4) effect on market competition.

(b) The commissioner has authority under Insurance Code §848.152(d) to set and collect fees in an amount sufficient to pay the reasonable expenses of the department and attorney general in administering Insurance Code Chapter 848, including direct and indirect expenses incurred by the department, the attorney general, and their contractors in examining and reviewing HCCs. The department will maintain active oversight of individuals performing examination functions to assure that the examination fee reflects expenses that are reasonable and necessary. The examination fee will include the actual salary, fees, and expenses of the examiners directly attributable to the examination as follows:

(1) any actual salary amount included in an examination fee for an examiner who is a department employee will be the part of the annual salary attributable to each hour an examiner examines the HCC;

(2) any expenses included in an examination fee for an examiner who is a department employee will be actual expenses incurred by an examiner and attributable to the examination, including the actual cost of:

(A) transportation;

(B) lodging;

(C) meals;

(D) subsistence expenses;

(E) parking fees; and

(F) department overhead expense; and

(3) any amount included as an examination fee or expense by an examiner who is not a department employee will be determined according to the terms of the contract between the examiner and the department.

(c) An HCC must pay to the department annually an assessment as set forth in paragraphs (1) – (6) of this subsection.

(1) On or before January 31 of each year, each certified HCC must submit to the department a statement of its gross revenues for the previous calendar year.

(2) On or before January 31, 2014, and annually thereafter, the department will calculate the cost by fiscal year to administer Insurance Code Chapter 848 and this subchapter, including direct and indirect expenses incurred by the department and the attorney general attributable to carrying out their responsibilities under Chapter 848, but excluding examination expenses billed directly to an HCC.

(3) On or before April 1, 2014, and annually thereafter, the department will assess all certified HCCs on a pro rata basis for the expenses determined pursuant to paragraph (2) of this subsection, based on the total annual gross revenues reported by the HCCs. The assessment amount for each HCC will be adjusted by the amount of any

application fees received from the HCC.

(4) For purposes of reporting gross revenues relevant to this subsection, an HCC may choose to reduce its gross revenues in a clearly disclosed manner by amounts paid to individuals or entities unaffiliated with the HCC for the following items:

(A) drugs or biological supplies that, by law, require a prescription to be dispensed; and

(B) devices or medical supplies that, by law, require premarket approval by or premarket notification to the Food and Drug Administration.

(5) On receipt of an assessment pursuant to paragraph (3) of this subsection, the HCC must pay the assessment amount before the later of 30 days following receipt of the assessment or May 1.

(6) The department may issue additional assessments as necessary to fully fund the expense of regulation under Insurance Code Chapter 848 and this subchapter.

(d) When an HCC has been notified by the department of a pending examination under this section, it may request that it instead submit a renewal application and that the examination be converted into a renewal review.

(1) To initiate the request, the HCC must file the Request to Convert to Renewal of Certificate of Authority to Do the Business of a Health Care Collaborative (HCC) in the State of Texas form.

(2) The HCC must submit the request prior to the issuance of any draft examination report.

(3) If the department approves the request, the HCC must file an application

for renewal within 30 days of the approval to convert to renewal review. The application filing must comply with §13.424 of this title (relating to Certificate of Authority Renewal Requirements).

(4) The subsequent renewal date for the HCC will be 12 months following the approval date of the application to renew.

§13.422. Filing Requirements That Apply After Issuance of Certificate of Authority.

(a) After the issuance of a certificate of authority, each HCC must file certain information with the commissioner, either for approval prior to effectuation or for information only, as provided in this section.

(b) In accordance with Insurance Code §848.060(e), an HCC must report to the department a material change in the size, composition, or control of the HCC.

(c) An HCC must make the filings outlined in paragraphs (2) and (3) of this subsection and in §13.423 of this title (relating to Service Area Change Applications). These requirements include filing changes necessitated by federal or state law or regulations.

(1) Complete filings required. The department will not accept a filing for review until the filing is complete.

(2) Filings requiring approval. After the issuance of a certificate of authority, an HCC must file for approval with the commissioner a written request to implement or modify the following operations or documents and receive the commissioner's approval prior to effectuating those modifications:

(A) a description and a map of the service area, with key and scale, that identifies the county, counties, or portions of counties to be served;

(B) any material change in size, composition, or control of the HCC;

(C) proposed dividends for any calendar year that if declared and paid will, individually and in the aggregate, have a distribution value equal to or exceeding the greater of:

(i) 10 percent of the HCC's net asset value for the prior year; or

(ii) 10 percent of the HCC's net income for the prior year;

(D) any new or revised loan agreements evidencing loans made by the HCC to any affiliated individual or entity or to any physician or health care provider, whether providing services currently, previously, or potentially in the future; and any guarantees of any affiliated individual's or entity's or of any physician's or health care provider's obligations to any third party;

(E) a copy of any proposed material amendment to basic organizational documents; however, if the approved amendment must be filed with the secretary of state, an original or a certified copy of the document with the original file mark of the secretary of state must be filed with the commissioner;

(F) a copy of any material amendments to bylaws of the HCC, with a notarized certification bearing the original or electronic signature of the corporate secretary of the HCC that it is a true, accurate, and complete copy of the original;

(G) any name, or assumed name, on a form, as specified in §13.404 of this title (relating to Use of the Term "HCC," Service Mark, Trademarks, d/b/a); and

(H) original or renewal service contracts and management

agreements, the terms of which must comply with Insurance Code §823.101 as if the HCC were an insurer.

(3) Filings for information. Material filed under this paragraph is not to be considered approved, but may be subject to review for compliance with Texas law and consistency with other HCC documents. On or before 30 days after the effective date of a change, an HCC must file with the commissioner, for information only, deletions and modifications to the following previously approved or filed operations and documents:

(A) the list of officers and directors and a biographical data sheet for each individual listed on the officers and directors page and biographical affidavit forms in §13.413(c)(6)(A) and (B) of this title (relating to Contents of the Application);

(B) any change in the physical address of the books and records described in §13.415 of this title (relating to Documents to be Available for Quality of Care and Financial Examinations);

(C) any new trademark or service mark or any changes to an existing trademark or service mark;

(D) a copy of the form of any new contract or subcontracts or any substantive changes to previously filed copies of forms of all contracts described in §13.413(d)(3) and (e)(5) of this title, not including management agreements filed for approval, with amended contract forms accompanied by an additional copy of the contract form that reflects the revisions made;

(E) notice of the cancellation of any management contracts described in §13.413(e)(5)(D) of this title;

(F) any insurance contracts or amendments to those contracts, guarantees, or other protection against insolvency, including the stop-loss or reinsurance agreements, if changing the insurer or description of coverage, as described in §13.413(d)(4)(A) of this title;

(G) any change in the affiliate chart as described in §13.413(c)(7) of this title;

(H) modifications to any types of compensation arrangements, such as compensation based on fee-for-service arrangements, risk-sharing arrangements, prepaid funding arrangements, or capitated risk arrangements, made or to be made with physicians and health care providers in exchange for the provision of, or the arrangement to provide, health care services to patients, including any financial incentives for physicians and providers. The HCC must maintain the confidentiality of these compensation arrangements;

(I) any material change in network configuration; and

(J) a description of the quality assurance and quality improvement program, as set forth in §13.481 and §13.482 of this title (relating to Quality Improvement Structure for HCCs and Quality Assurance and Quality Improvement, respectively).

(4) Approval time period. Any modification for which commissioner's approval is required is considered approved unless disapproved within 60 days from the date the filing is determined by the department to be complete. The commissioner may

postpone the action for a period not to exceed 60 days, as necessary for proper consideration. The commissioner will notify the HCC by letter of any postponement. The commissioner, after notice and opportunity for hearing, may withdraw approval of a filing made under paragraph (2) of this subsection or reject any informational filing made under paragraph (3) of this subsection.

(5) Filing review procedure. Within 20 days from the department's receipt of an initial filing for commissioner's approval under this section, the department will determine whether the filing is complete or incomplete for purposes of acceptance for review and, if found to be incomplete, the department will issue a written notice in paper or electronic form to the HCC of its incomplete filing.

(A) Incomplete filing. The written notice of an incomplete filing will state that the filing is not complete and has not been accepted for review. In addition, the notice will specify the information, documentation, and corrections necessary to make the filing complete for purposes of this section. If a filing is resubmitted in whole or in part and is still incomplete, an additional written notice will be issued. The notice will specify the corrections or information necessary for completeness and state that the 60-day time period for official action will not begin until the date the department determines the filing to be complete. If a filing is not resubmitted within 30 days of the date of the written notice of incompleteness, the department will consider the filing withdrawn and will close it.

(B) Processing of complete filing. The department will in writing approve or disapprove a complete filing within the period of time set forth in paragraph (4) of this subsection, beginning on the date the filing is determined to be complete. The HCC

may waive in writing the deemed approval time line set forth in paragraph (4) of this subsection.

(C) Conversion to renewal review. If the filing by the HCC under this subsection is sufficiently material, the department may require the HCC to file an application for renewal before the date required by Insurance Code §848.060(a).

§13.423. Service Area Change Applications.

(a) An HCC must file an application for approval with the department before the HCC may expand or reduce an existing service area or add a new service area.

(b) If any of the following items are changed by a proposed service area expansion or reduction, the new item or any amendments to an existing item must be submitted for approval or filed for information, as specified in §13.422 of this title (relating to Filing Requirements That Apply After Issuance of Certificate of Authority):

(1) a description and a map with key and scale, showing both the currently approved service area and the proposed new service area as required by §13.413(e)(1) of this title (relating to Contents of the Application);

(2) a form of any new contracts or amendment of any existing contracts in the new area, as described in §13.413(e)(5) of this title;

(3) network configuration information, as required by §13.413(e)(2) of this title;

(4) a brief narrative description of the administrative arrangements and organizational charts as described in §13.413(c)(7) of this title and any other information

the HCC considers to be pertinent:

(5) biographical data sheets for any new management staff assigned to the new area;

(6) copies of leases, loans, agreements, and contracts to be used in the proposed new area, including information described in §13.422(c)(2)(D) of this title;

(7) separate and combined sources of financing and financial projections as described in §13.413(d)(1) – (3) of this title; and

(8) any new or amended reinsurance agreements, insurance, or other protection against insolvency, as specified in §13.413(d)(4) of this title.

(c) The department will not accept an application for review until the application is complete. An application to modify the certificate of authority is considered complete when all information required by §13.422 of this title, this section, and §13.481 and §13.482 of this title (relating to Quality Improvement Structure for HCCs and Quality Assurance and Quality Improvement, respectively), that is reasonably necessary for a final determination by the department has been filed with the department.

(d) A service area expansion or reduction application will be considered only if the HCC is in compliance with the requirements of §13.481 and §13.482 of this title, and §13.483 of this title (relating to Credentialing) in both the existing and proposed service areas.

(e) If the filing for proposed service area change might materially affect the HCC's ability to arrange for or provide health care services, or might materially change the antitrust analysis of the HCC, the department may require the HCC to file an application for

renewal before the date required by Insurance Code §848.060(a).

§13.424. Certificate of Authority Renewal Requirements.

(a) Not later than 180 days before its certificate anniversary date, the HCC must file with the commissioner an application to renew its certificate.

(b) The filing must include:

(1) the Original/Renewal Application for Certificate of Authority to do the Business of a Health Care Collaborative (HCC) in the State of Texas form; and

(2) the financial statements for the HCC, as of the close of the preceding calendar year.

(c) For purposes of this section, an HCC is not required at renewal to make a duplicate filing of any document or information item specified to be and filed as part of the original application for certificate of authority under §13.413 of this title (relating to Contents of the Application) that has not been amended, modified, revised, canceled, terminated, replaced, or otherwise changed since the original or most recent renewal certificate of authority was issued. A transmittal form specifically identifying the documents and items that have not changed since the original or most recent renewal certificate of authority was issued must be filed as a part of the renewal application and accompanied by an attestation executed by an officer or other authorized representative of the HCC certifying that the documents and items identified in the transmittal form have not changed.

(d) The provisions of subsection (c) of this section also apply to the duplicate filing of any document or information item specified to be and filed pursuant to provisions of

§13.422 of this title (relating to Filing Requirements That Apply After Issuance of Certificate of Authority) that has not changed since its filing was approved or accepted by the department, as applicable.

(e) The department will accept for review an application for renewal when the filing is complete.

(1) The department will send written notice of an incomplete initial filing within 20 days of the filing, stating that the filing is not complete and has not been accepted for review.

(2) The notice must specify the information, documentation, and corrections necessary to make the filing complete.

(f) If a completed application for renewal is filed under Insurance Code §848.060 and this section, the commissioner will conduct a review and take official action on the completed application in accordance with the provisions of Insurance Code §848.060. The review will be conducted under Insurance Code §848.057 as if the application for renewal were a new application.

§13.425. Compensation Arrangements.

(a) An HCC must comply with Insurance Code §848.053, including requirements relating to committee membership, charges, fees, distributions, or other compensation assessed for services provided by HCC participants, and to the sharing of the data among nonparticipating physicians and health care providers.

(b) An HCC must establish and enforce procedures to maintain the confidentiality of charge, fee, and payment data and information between HCC participants and any individual or entity outside of the HCC, including information to be transmitted to the department.

(c) A participant in an HCC is prohibited from using charge, fee, and payment data collected by the HCC in any negotiation of charges, fees, or payments if the HCC is not a party to the negotiation.

§13.426. Confidentiality.

(a) An HCC must establish and administer procedures and internal controls to safeguard and ensure against the sharing of any confidential information with or among participants.

(b) The requirements of this section include establishing and enforcing collection, custodial, retrieval, and transmittal procedures to ensure that information that the HCC or its participants must maintain as confidential is protected as confidential both as to entities and individuals outside the HCC, and between or among participants. The requirements of this section apply to confidential information that:

(1) the HCC maintains as custodian; or

(2) the HCC or any of its participants submit to the department under Insurance Code §848.057 or to the attorney general under Insurance Code §848.059.

§13.429. HCCs Subject to Insurance Code Chapters 541 and 542 and Related Rules.

HCCs must comply with Insurance Code Chapters 541 and 542 and rules promulgated by the department pursuant to Insurance Code Chapters 541 and 542, as applicable, in the same manner as insurance companies or HMOs.

DIVISION 4. FINANCIAL REQUIREMENTS

§13.431. Reserves and Working Capital Requirements.

(a) An HCC must maintain working capital composed of current assets with a ratio of current assets to current liabilities of 1.25:1, based on the greater of the prior year's actual liabilities or the projected liabilities for the subsequent year, subject to the following requirements, as applicable:

(1) an HCC consisting of physicians and one or more facilities must maintain unencumbered net equity of not less than \$200,000; and

(2) an HCC must base its ratio of assets to liabilities on the projected liabilities for the subsequent year if the HCC has not been certified for more than one year.

(b) An HCC must have reserves sufficient to operate and maintain the HCC and to arrange for services and expenses it incurs. An HCC must maintain financial reserves computed in accordance with Generally Accepted Accounting Principles in an amount not less than 100 percent of incurred but not paid claims of nonparticipating physicians and providers.

(c) Any HMO or insurer certified by the department that enters into a contract with an HCC pursuant to Insurance Code §848.103 must maintain a reserve that is:

- (1) equivalent in value to three months of prepaid funding or capitation payments;
- (2) phased in over a no-more-than 36-month period;
- (3) maintained separately from and in addition to all other reserves and liabilities of the HMO or insurer;
- (4) unencumbered and dedicated to assure its availability for its intended purpose; and
- (5) reported in the aggregate separately from all other reserves and liabilities of the HMO or insurer.

(d) For the purpose of meeting the minimum working capital requirements of this section, current assets of an HCC are limited to U.S. currency, certificates of deposit with fixed terms of one year or less, money market accounts, accounts receivable from government payors, and other accounts receivable that have remained due 90 days or less. Accounts receivable must be reported net of all allowances. Assets with a maturity period or fixed term that is greater than one year are not current assets for purposes of this section.

(e) For the purpose of meeting the minimum reserve and minimum net equity requirements of this section, investments in capital assets, mortgages, notes, and loan-backed securities must be excluded from the calculation of reserves and net equity in determining satisfaction of minimum requirements.

§13.432. Fiduciary Responsibility. A director, member of a committee, officer, or

representative of an HCC who is charged with the duty of handling or investing its funds is prohibited from intentionally:

(1) depositing or investing the funds, except in the corporate name of the HCC or in the name of a nominee of the HCC as may be allowed elsewhere in this subchapter; or

(2) taking or receiving to his or her own use any fee, brokerage, or commission for, or on account of, a loan made by or on behalf of the HCC, except that the individuals referenced in this section may receive reasonable interest on amounts loaned to the HCC.

DIVISION 5. HCC CONTRACT ARRANGEMENTS

§13.441. General Provisions.

(a) An HCC's contracts with physicians and health care providers must not impede application of provisions in Insurance Code Chapters 843 (Health Maintenance Organizations) and 1301 (Preferred Provider Benefit Plans), and in Chapter 11 of this title (relating to Health Maintenance Organizations) and Chapter 3, Subchapter X of this title (relating to Preferred Provider Plans), that impose requirements concerning relations with physicians or health care providers.

(b) An HCC is prohibited from using a financial incentive or making a payment to a physician or health care provider if the incentive or payment acts directly or indirectly as an inducement to limit medically necessary services.

(c) If an HCC participant's market share as calculated under §13.414 of this title

(relating to Limited Exemption from Certain Information Filing Requirements) exceeds 50 percent in a PSA for any service that no other HCC participant provides to patients in that PSA, the participant furnishing the service is a dominant provider for purposes of this subchapter. An HCC with a dominant provider is prohibited from:

(1) requiring a private payor to contract exclusively with the HCC; or

(2) otherwise restricting a private payor's ability to contract or deal with other HCCs, networks, physicians, or health care providers.

DIVISION 6. CHANGE OF CONTROL BY ACQUISITION OF OR MERGER WITH HCC

§13.451. Definitions. The following words and terms, for purposes of this division, have the following meanings unless the context clearly indicates otherwise.

(1) Control--The possession, direct or indirect, of the power to direct or cause the direction of the management and policies of an individual or entity, 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 an individual.

(2) Voting security--Any security presently entitling its owner or holder to vote in the direction or management of the affairs of an individual or entity, or any instrument presently convertible by its owner or holder into a voting security, or the right to acquire a voting security.

§13.452. Determination of Control. For purposes of this division:

(1) control is presumed to exist if any individual or entity, directly or indirectly, owns, controls, holds with the power to vote or holds irrevocable proxies representing, 10 percent or more of the voting securities or authority of any other individual or entity;

(2) this presumption may be rebutted by a showing made in the manner provided by Insurance Code §823.010 that control does not exist in fact; and

(3) the commissioner may determine, after furnishing all interested parties notice and opportunity for hearing and making specific findings of fact to support the determination, that control exists in fact where an individual or entity exercises directly or indirectly, either alone or pursuant to an agreement with one or more other individuals or entities, such a controlling influence over the management or policies of an authorized HCC as to be deemed to control the HCC.

§13.453. Filing Requirements.

(a) Unless an individual or entity has filed with the department the items as set forth in subsection (b) of this section, the individual or entity is prohibited from:

(1) acquiring an ownership interest in an entity that holds a certificate of authority as an HCC if the individual or entity is, or after the acquisition would be, directly or indirectly in control of the certificate holder; or

(2) otherwise acquiring control of or exercising any control over the certificate holder.

(b) An individual or entity described in subsection (a) of this section must, under oath or affirmation, file:

(1) a Biographical Affidavit form for each individual by whom or on whose behalf the acquisition of control is to be effected; and

(2) a Health Care Collaborative (HCC) Acquisition Form.

(c) The department may require a partnership, syndicate, or other group that is subject to the filing requirements specified in subsections (a) and (b) of this section to provide the information required by subsection (b) for each partner of the partnership, each member of the syndicate or group, and each individual or entity who controls the partner or member.

(d) If the partner, member, or entity is a corporation, or if the entity required to file the documents set forth in subsection (b) of this section is a corporation, the department may require that the information required under that subsection be provided regarding:

(1) the corporation;

(2) each individual who is an executive officer or director of the corporation;

and

(3) each individual or entity who is directly or indirectly the beneficial owner of more than 10 percent of the outstanding voting securities of the corporation.

§13.454. Commissioner Action.

(a) A proposed acquisition of control will be disapproved if, after notice and opportunity for hearing, the commissioner determines that:

(1) immediately following the change of control, the certificate holder would not be able to satisfy the requirements for the issuance of a certificate of authority;

(2) the competence, trustworthiness, experience, and integrity of the individuals who would control the operation of the certificate holder are such that it would not be in the interest of health care services consumers in this state to permit the acquisition of control; or

(3) the acquisition of control would violate this code or another law of this state, any law of another state, or of the United States.

(b) Notwithstanding subsection (a) of this section, a change in control is considered approved if the commissioner has not, before the 61st day after the date on which the department receives all information required by this division:

(1) acted on the proposed change of control; or

(2) required that the HCC file an application for renewal as a result of the proposed change of control.

§13.455. Change of Control with Increased Market Share. For any change in control of an authorized HCC that results in an increase to its market share in any PSA as provided in §13.414 of this title (relating to Limited Exemption from Certain Information Filing Requirements), the department may require that the HCC file an application for renewal before the date required by Insurance Code §848.060(a). An HCC may, in connection with a filing under this division, submit an application for renewal of certificate of authority.

DIVISION 7. ADMINISTRATIVE PROCEDURES

§13.461. Commissioner's Authority to Require Additional Information.

(a) The commissioner may require additional information from the HCC or any participant in the HCC as reasonably necessary to make any determination required by Insurance Code Chapter 848, this subchapter, and applicable insurance laws and regulations of this state.

(b) The commissioner may require any or all of the additional information set forth in subsection (c) of this section. An HCC or HCC participant is not required to create the items listed in subsection (c) of this section unless and except as the commissioner requires the items to be provided under this section. Once created, however, the documents must be maintained by the HCC or participant for at least five years.

(c) Additional information the commissioner may require includes the following:

(1) underlying documentation or data supporting any information, reports, or memoranda submitted to the department under the Insurance Code or this title;

(2) contact information for current participants or employees of the HCC, and last known contact information for former participants or employees;

(3) interviews by the department with individuals affiliated with the HCC or HCC participants;

(4) any participant's agendas, minutes, recordings, summaries, handouts, or presentations to the HCC;

(5) documents relating to past, current, or planned fees, risk-sharing, fee schedules, fee conversion factors, withholds, capitation, pricing plans, pricing strategies, or

other forms of payment;

(6) documents relating to planned additions to the participation in the HCC

or expansions of participants in the HCC;

(7) de-identified information regarding utilization of services by the HCC's

patients or participants, including both medical and financial information;

(8) current bylaws, rules, or regulations of an HCC participant's professional

staff or any of its departments or subunits;

(9) questionnaires submitted by participants to applicable professional

associations in connection with annual surveys of association members, and to any other

association, accreditation agency, or government agency, in connection with any annual or

other periodic survey of the participant;

(10) reports prepared by accreditation agencies in connection with

accreditation of the HCC or any HCC participant;

(11) revenue-and-cost reports, profitability reports, and other financial

reports;

(12) internal or external reports relating to quality of care at any health care

service location in each service area by the HCC or its participants, including:

(A) data or reports submitted to or received from or by quality rating

organizations;

(B) quality of care initiatives;

(C) quality assurance or quality improvement systems; and

(D) the effect of changes in health care service location quality on

patient volume and revenue;

(13) financial reports regularly prepared by or for the HCC applicant on any periodic basis relating to any arranged health care service;

(14) memoranda, excluding engineering and architectural plans and blueprints, relating to plans of the HCC applicant, or any participant, for the construction of new facilities, the closing of any existing facilities, or an expansion, a conversion, or a modification of current facilities;

(15) memoranda relating to plans of, or steps undertaken by the HCC applicant or any participant for any acquisition, divestiture, joint venture, alliance, or merger involving any participant in the service area other than the application for certificate of authority of the applicant;

(16) memoranda analyzing or discussing the effect of any merger, joint venture, acquisition, or consolidation of HCCs in the applicant's service area, including the HCC's application if approved, on the HCC's prices, costs, margins, service quality, or any other aspect of competitive performance, including:

(A) memoranda comparing the actual cost savings or other benefits of the transactions to those previously projected; and

(B) memoranda discussing how the benefits were or might be achieved;

(17) a description relating to the consolidation or realignment of any medical and health care services arranged by or through the applicant whether completed, in progress, or planned among the participants;

(18) the names and addresses of all contracting physicians, in Excel-compatible format;

(19) documents created or used by, for, or on behalf of the applicant for the purpose of soliciting physicians or health care providers to join the applicant as an employee or participant, promoting continued participation in the applicant, or otherwise offering, promoting, or advertising the applicant's services or activities on behalf of physicians or health care providers, and all documents supplied by the HCC to newly recruited physicians or health care providers;

(20) contracts between the HCC applicant or any of its participants and any private payor, all attachments to the contracts, and all documents relating to the contracts, including:

(A) documents sufficient to show the name, contact person, and telephone number of each health plan contracting with the applicant for physician services;

(B) documents relating to fees, fee schedules, fee conversion factors, withholds, capitation, pricing plans, pricing strategies, or other forms of payment;

(C) documents discussing actual or potential negotiations, offers, or responses to any contract, fee schedule, or risk-sharing arrangement with a third-party payor;

(D) copies of internal memoranda relating to:

(i) the development or negotiation of contracts with payors or

participants, and internal HCC decisions regarding negotiating positions;

(ii) competition to obtain contracts;

(iii) decisions to terminate contracts;

(iv) draft, contingent, or expired contracts, including contracts

not entered into, not yet finalized or in force, or no longer in force; and

(v) contract amendments or modifications; and

(E) the beginning date and termination date, as applicable, for each

contract;

(21) documents relating to plans, interests, or steps undertaken by the

HCC applicant for any acquisition, divestiture, joint venture, alliance, collaboration,

license, or merger with any HCC or other health care provider, including:

(A) any notes or minutes taken; or

(B) reports, memoranda, or correspondence regarding meetings

between the HCC applicant and any other HCC or other health care provider;

(22) documents reflecting:

(A) actual or planned lease, management contract, or other

agreement for the HCC applicant to operate a facility in the service area that is, or will be,

owned in whole or in part by another individual or entity; and

(B) formal or informal commercial or operational relationships or

affiliations that have existed, exist, or are planned between or among any facilities, or

facilities and any physician organizations in the service area, including purchases by the

HCC applicant of services from other facilities or from physician organizations, and vice

versa;

(23) for each participant, summaries and interpretations of contract terms and methodologies used to determine the payment due to the participant under a contract with a payor in effect at any time during the previous three years for each treatment, office visit, or other medical or health care service provided or delivered in the service area; and

(24) a list and description by Current Procedural Technology code, if available, of each medical or health care service arranged by or through the applicant in the HCC's service area, and for each code listed, a statement of:

(A) the number of procedures performed;

(B) the amount of revenue received by the applicant;

(C) the ZIP code for each patient receiving the procedure or service;

and

(D) the location of the office where the procedure or service was performed.

DIVISION 8. OTHER REQUIREMENTS

§13.471. Notification of Change in Payment Arrangements. An HCC must notify all affected payors in writing of a material change in the payment arrangement for physicians, health care providers, or both within 30 days of any change in the type of payment arrangement for any type of service (for example, from capitation to fee-for-service, from fee-for-service to capitation). The notification of the change must include a description of the payment arrangement that has been changed and a description of the new payment

arrangement.

§13.472. Requirements for Certain Delegation Contracts. An HCC that delegates responsibility by contract with a delegated entity, delegated network, or delegated third party, as those terms are defined in Insurance Code §1272.001 through reference to contracts with HMOs, must:

(1) submit to the department a monitoring plan setting out how the HCC will ensure that all delegated HCC functions are implemented in a manner consistent with full compliance by the HCC with all regulatory requirements of the department;

(2) conduct an on-site or desk audit of the delegated entity, delegated network, or delegated third party no less frequently than annually, or more frequently on indication of material noncompliance, to obtain information necessary to verify compliance with all regulatory requirements of the department. Written documentation of each audit required by this paragraph must be made available to the department on request; and

(3) take prompt action to correct any failure by the delegated entity, delegated network, or delegated third party to comply with regulatory requirements of the department relating to any matters delegated by the HCC and necessary to ensure the HCC's compliance with the regulatory requirements.

§13.473. Organization of an HCC.

(a) The governing body described in Insurance Code §848.052 must have ultimate responsibility for the development, approval, implementation, and enforcement of

administrative, operational, personnel, and patient care policies and procedures related to the operation of the HCC.

(b) The HCC must have a clinical director who:

(1) is currently licensed in Texas or otherwise authorized to practice in this state in the field of services offered by the HCC;

(2) resides in Texas;

(3) is available at all times to address complaints, clinical issues, utilization review, and any quality of care issues on behalf of the HCC;

(4) demonstrates active involvement in all quality management activities;

and

(5) is subject to the HCC's credentialing requirements, as appropriate.

(c) The HCC may establish one or more service areas within Texas. For each defined service area the HCC must:

(1) provide a delivery network that is adequate and complies with Insurance Code Chapter 848, and demonstrate to the department the ability to provide continuity, accessibility, availability, and quality of services within the HCC's service area as applicable to the services that the HCC has contracted or will contract to provide, including the following:

(A) participants that are sufficient in number, size, and geographic distribution to be capable of furnishing the contracted health care services, taking into account the number of potential patients, their characteristics, and their medical and health care needs, including the following:

(i) current utilization of covered health care services within the prescribed geographic distances outlined in this section; and

(ii) projected utilization of covered health care services;

(B) an adequate number of participants available and accessible to patients 24 hours a day, seven days a week;

(C) sufficient numbers and classes of participants to ensure choice, access, and quality of care;

(D) an adequate number of participating physicians who have admitting privileges at one or more participating hospitals to make any necessary hospital admissions;

(E) emergency care that is available and accessible 24 hours a day, seven days a week;

(F) services sufficiently available and accessible as necessary to ensure that the distance from any point in the HCC's designated service area to a point of service is not greater than:

(i) 30 miles in nonrural areas and 60 miles in rural areas for primary care and general hospital care; and

(ii) 75 miles for specialty care and specialty hospitals;

(G) urgent care available and accessible within 24 hours for health and behavioral health conditions;

(H) routine care available and accessible:

(i) within three weeks for health conditions; and

(ii) within two weeks for behavioral health conditions;

(l) preventive health services available and accessible:

(i) within two months for a child, or earlier if necessary for compliance with nationally recognized recommendations for specific preventive care services; and

(ii) within three months for an adult;

(2) specify the counties and ZIP codes, or any portions of any counties, included in the service area; and

(3) maintain separate cost center accounting for each service area to facilitate the reporting of divisional operations as required for HCC financial reporting.

(d) The HCC must maintain in force in its own name a fidelity bond on its officers and employees.

(1) The fidelity bond must be in an amount of at least \$100,000, or another amount prescribed by the commissioner, and issued by an insurer that holds a certificate of authority in this state.

(2) The fidelity bond must obligate the surety to pay any loss of money or other property the HCC sustains because of an act of fraud or dishonesty by an employee or officer of the HCC, acting alone or in concert with others, while employed or serving as an officer of the HCC.

(3) Subject to the same coverage amount and conditions required for a fidelity bond under this subsection, an HCC may, instead of obtaining a fidelity bond:

(A) obtain and maintain in force in its own name insurance coverage in a form and amount acceptable to the commissioner; or

(B) deposit with the office of the comptroller in Texas readily marketable liquid securities acceptable to the commissioner.

§13.474. Requirements for HMO or Insurer Delegation of Functions to HCCs.

(a) An HMO's delegation of functions to an HCC is subject to the requirements of Insurance Code Chapter 1272 and Chapter 11, Subchapter AA, of this title (relating to Delegated Entities).

(b) An insurer's delegation of functions to an HCC is subject to the requirements of Insurance Code Chapter 1272 and Chapter 11, Subchapter AA, of this title as if the insurer were an HMO.

(c) If a provision of this subchapter imposes a compliance requirement that is greater than or in conflict with those contained in Insurance Code Chapter 1272 or Chapter 11, Subchapter AA, of this title, the requirement of this subchapter governs.

(d) A delegation agreement between an HMO or insurer and an HCC must mandate that the HMO or insurer disclose in all provider listings distributed to insureds or enrollees those providers participating in the HCC.

(e) If an insurer contracts for services with an HCC on a basis other than fee-for-service, the insurer must disclose the nature of its payment arrangement with the HCC in either the insurance policy and certificates or in any provider listing distributed to insureds.

DIVISION 9. QUALITY AND COST OF HEALTH CARE SERVICES

§13.481. Quality Improvement Structure for HCCs.

(a) An HCC must develop and maintain an ongoing quality improvement (QI) program designed to objectively and systematically monitor and evaluate the quality and appropriateness of health care services that it arranges for or offers, and to pursue opportunities for improvement. Unless the HCC has no patients, the QI program must include the active involvement of one or more patient(s) who are not employees of the HCC.

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

(1) appoint a quality improvement committee (QIC) that includes the clinical director, practicing physicians, and, if applicable, other individual health care providers;

(2) approve the QI program;

(3) approve an annual QI plan;

(4) meet no less than semiannually to receive and review reports of the QIC or group of committees and take action when appropriate; and

(5) review the annual written report on the QI program.

(c) The QIC must evaluate the overall effectiveness of the QI program.

(1) The QIC may delegate QI activities to other committees that may, if applicable, include practicing physicians and individual health care providers and patients from the service area.

(A) All committees must collaborate and coordinate efforts to improve

the quality, availability, and accessibility of health care services.

(B) All committees must meet regularly and report the findings of each meeting, including any recommendations, in writing to the QIC.

(C) If the QIC delegates any QI activity to any subcommittee, then the QIC must establish a method to oversee each subcommittee.

(2) The QIC must use multidisciplinary teams when indicated to accomplish QI program goals. For example, an HCC could include only a narrow range of specialty health care services, making the use of multidisciplinary teams impractical.

§13.482. Quality Assurance and Quality Improvement.

(a) An HCC must establish, implement, and administer a continuous quality assurance and quality improvement program that includes defined policies and processes to:

(1) promote evidence-based medicine and best practices;

(2) secure patient engagement;

(3) promote coordination of care across a continuum of care; and

(4) measure and report the quality of health care services and impact on

cost.

(b) Unless otherwise approved by the commissioner, the program must include:

(1) appropriate practice evaluation tools applicable to the services provided

by the HCC, including:

(A) Consumer Assessment of Healthcare Providers and Systems

surveys developed by the Agency for Healthcare Research and Quality;

(B) Agency for Healthcare Research and Quality standards, as available; and

(C) National Quality Forum standards;

(2) periodic review; and

(3) policies for coordinating with the HCC's quality improvement committee

to make necessary updates and adjustments.

(c) The patient engagement process must include, as appropriate:

(1) evaluating the health needs of its enrolled population;

(2) communicating clinical knowledge to patients and patient representatives

clearly and understandably;

(3) promoting patient engagement, including engagement in treatment

decisions; and

(4) establishing written standards for patient communications.

(d) The processes to promote coordination of care across a continuum of care must include, as appropriate:

(1) a method or system to identify high-risk individuals; and

(2) processes to manage care throughout an episode of care and during

transitions.

(e) The processes for measuring and reporting quality of health care services and impact on cost must include:

(1) measurement and evaluation of health care services and processes

described in subsection (a)(1) – (3) of this section; and

(2) as appropriate, a process for medical peer review and arrangements for sharing pertinent medical records between participants and ensuring the record's confidentiality.

§13.483. Credentialing. An HCC must implement a documented process for selection and retention of contracted participants. The credentialing process must comply with the standards promulgated by the National Committee for Quality Assurance, URAC, or the Joint Commission on Accreditation of Hospital Organizations as appropriate, to the extent that those standards are applicable and do not conflict with other laws of this state.

DIVISION 10. COMPLAINT SYSTEMS; RIGHTS OF PHYSICIANS; LIMITATIONS ON PARTICIPATION

§13.491. Complaint Systems.

(a) Each HCC must implement and maintain a complaint system compliant with Insurance Code §848.107 and this division that provides reasonable procedures for resolving an oral or written complaint initiated by a complainant concerning the HCC or health care services arranged by, or offered through, the HCC.

(b) For purposes of this subchapter, a complaint is any oral or written expression of dissatisfaction by a complainant to an HCC regarding any aspect of the HCC's operation.

(c) The HCC's complaint system must address a complaint initiated:

(1) by or on behalf of a patient who sought or received health care

services by a participant; or

(2) by a participant.

(d) The complaint system for complaints initiated by or on behalf of patients must include a process for the notice and appeal of a complaint.

(e) The commissioner has discretion to examine a complaint system for compliance with Insurance Code §848.107 and this subchapter and will require the HCC to make corrections that the commissioner considers necessary.

§13.492. Complaints; Deadlines for Response and Resolution.

(a) Not later than seven calendar days after receipt of an oral or written complaint, the HCC must:

(1) acknowledge receipt of the complaint in writing;

(2) acknowledge the date of receipt; and

(3) provide a description of the HCC's complaint procedures, its appeal process for complaints filed by patients, and deadlines associated with each.

(b) An HCC must investigate each complaint received in accordance with the HCC's policies and in compliance with Insurance Code §848.107 and this subchapter.

(c) After an HCC has investigated a complaint, the HCC must issue a resolution letter to the complainant not later than the 30th calendar day after the HCC receives the written complaint or the close of any hearing held under §13.493(2) of this title (relating to Rights of Physicians) that:

(1) explains the HCC's resolution of the complaint;

(2) states the specific reasons for the resolution;

(3) states the specialization of any health care provider consulted; and

(4) states, if the complainant is a patient who is dissatisfied with the resolution of the complaint, that the complainant may file an appeal of the complaint resolution, or may file a complaint with the department.

(d) In situations in which a patient complaint has been appealed, the HCC must issue a decision letter after considering the appeal that includes specific reasons for the decision and states that if the complainant is dissatisfied with the resolution of the complaint, the appeal, or the complaint process, the complainant may file a complaint with the department.

(e) An HCC must maintain a complaint log that captures each complaint by category, including at least the following:

(1) quality of care or services;

(2) accessibility and availability of services, providers, or both;

(3) complaint procedures;

(4) physician and provider contracts;

(5) claims processing and bill payment disputes; and

(6) miscellaneous.

(f) Each HCC must maintain the complaint log required under subsection (e) of this section and documentation on each complaint, complaint proceeding, and action taken on the complaint until the third anniversary after the date the complaint was received.

§13.493. Rights of Physicians. Before a complaint against a physician under Insurance Code §848.107 is resolved, or before a physician's association with an HCC is involuntarily terminated, the HCC must provide the physician an opportunity to dispute the complaint or termination through a process that includes:

(1) written notice of the complaint or basis of the termination;

(2) opportunity for hearing not earlier than the 30th day after the physician receives notice under paragraph (1) of this section;

(3) the right to provide information at the hearing; and

(4) a written decision that includes specific facts and reasons for the decision.

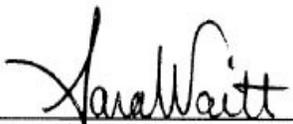
§13.494. Limitations and Prohibition.

(a) An HCC may limit a physician or physician group from participating in the HCC only if the limitation is based on an established development plan approved by the HCC board of directors. The HCC must provide each applicant physician or group with a copy of the development plan.

(b) An HCC is prohibited from taking a retaliatory or adverse action against a physician or health care provider that files a complaint with a regulatory authority regarding the action of an HCC.

10. CERTIFICATION. This agency certifies that legal counsel has reviewed the proposal and found it to be within the agency's legal authority to adopt.

Issued in Austin, Texas, on September 10, 2012.



Sara Waitt, General Counsel
Texas Department of Insurance