Delegated Entities & Delegated Third Parties
(Chapter 1272, Texas Insurance Code)

Delegated Entity[1] (DE) named in the Written Agreement: ____

Functions delegated by HMO to DE: ☐ Claims ☐ Utilization Review[2] (UR) ☐ Other _______________

Is the DE licensed as a Third Party Administrator[3] (TPA)? Yes ☐ No ☐ N/A ☐

Is the DE certified as a Utilization Review Agent[4] (URA)? Yes ☐ No ☐ N/A ☐

Monitoring Plan

Monitoring plan must contain:

☐ **Solvency Requirements-**A provision that allows the HMO to monitor compliance with the minimum solvency requirements established under Chapter 1272, Subchapter D, if applicable **[§1272.053]**

☐ **Tracking and Reporting Liabilities-**Description of financial practices for tracking and reporting liabilities incurred but not reported **[§1272.053]**

☐ **Summary of Payment to Providers-**Provision regarding summary of the total amount paid by the DE to providers on a monthly basis **[§1272.053]**

☐ **DE Must Provide Summary of Complaints to HMO-**Provision regarding summary of complaints, to be provided to HMO on a monthly basis, from providers and enrollees regarding delays in, or nonpayment of, claims including the status of each complaint **[§1272.053]**

☐ **Termination of Agreement-**Provision that written agreement cannot be terminated without cause by the DE or the HMO without 90 days written notice **[§1272.054]**

☐ **Hold Harmless Clause-**Provision prohibiting the DE and physicians and providers with whom DE has contracted from billing or attempting to collect from an enrollee under any circumstance for covered services (hold-harmless provision) **[§1272.055]**

☐ **Delegation Does Not Release HMO From Compliance of Law-**Provision that delegation does not release the HMO's responsibility and authority to comply with laws applicable to HMO including financial responsibilities **[§1272.056]**

☐ **DE Must Comply with Laws**-Provision that DE will comply with all statutory and regulatory requirements relating to any function, duty, responsibility, or delegation assumed by or carried out by the DE **[§1272.056]**

☐ **TDI Can Examine DE-**Provision that requires the DE to permit the commissioner to examine at any time any information relevant to: (A) the financial solvency of the DE; or (B) the ability of the DE to meet the entity's responsibilities in connection with any function delegated to the entity by the HMO **[§1272.057]**

☐ **TPA and URA Licenses-**Provision that requires the DE to provide the license number of any delegated third party[5] (DTP) performing any function that requires a license as a TPA under Chapter 4151, or a license as a URA under Article 21.58A, Insurance Code, or that requires any other license under the Insurance Code or another insurance law of this state **[§1272.058]**

☐ **Delegation to a DTP Must be in Writing-**Provision that requires that any agreement in which the DE directly or indirectly delegates to a DTP any function required by Chapters 843, 1271, or 1367 or Chapter 1452, Subchapter A, including the handling of funds, be in writing **[§1272.059]**

☐ **DTP Must Comply with Laws-**Provision that requires the DE, in contracting with a DTP directly or through a third party, to require the DTP to comply with the requirements of §1272.057 and any rules adopted by the commissioner implementing that subsection **[§1272.059]**

☐ **URA Responsibilities-**Provision that requires that:
- ☐ Enrollees will be notified at the time of enrollment which entity has UR responsibility **[§1272.060]**
- ☐ DE or 3rd party who has been delegated UR will comply with Art. 21.58A **[§1272.060]**
- ☐ DE or 3rd party shall forward UR decisions to HMO on a monthly basis **[§1272.060]**

☐ **DE Must Acknowledge HMO's Authority and Responsibility-**An acknowledgment and agreement by the DE that HMO:
- ☐ Is required to establish, operate, and maintain a health care delivery system, quality assurance system, provider credentialing system, and other systems and programs that meet statutory and regulatory standards **[§1272.061]**
- ☐ Is directly accountable for compliance with those standards **[§1272.061]**
- ☐ Is not precluded from contractually requesting that the DE provide proof of financial viability **[§1272.061]**

☐ **Role of DE that Subcontracts with DTPs-**An acknowledgment and agreement by the DE that the role of the DE when it subcontracts with DTPs, is limited to performing the HMO's delegated functions, using standards approved by the HMO and which are in compliance with applicable statutes and rules and subject to the HMO's oversight and monitoring of the DE's performance **[§1272.061]**

☐ **HMO May Cancel Delegation-**An acknowledgment and agreement by the DE that HMO may cancel delegation of delegated functions if the DE fails to meet monitoring standards **[§1272.061]**

☐ **DE Must Provide Samples of Contracts to HMO-**Provision that DE is required to make available to the HMO samples of contracts with providers to ensure compliance with the contractual requirements described by §§1272.054 and 1272.055. *[Note: The agreement may not require that the DE make available to the HMO contractual provisions relating to financial arrangements with the DE's providers]* **[§1272.062]**

☐ **Data DE Must Provide to HMO Regarding Delegated Functions-**Provision that HMO require DE to provide HMO on at least a quarterly basis, *[unless otherwise specified in the agreement]* the data necessary for the HMO to comply with TDI's reporting requirements regarding delegated functions performed under the delegation agreement including:
- ☐ A summary:
  - ☐ Describing the methods, including capitation, fee-for-service, or other risk arrangements, that the DE used to pay its providers **[§1272.062]**; and
  - ☐ The percentage of providers paid for each payment category **[§1272.062]**

- ☐ The period that claims and debts for medical services owed by the DE have been pending and the aggregate dollar amount of those claims and debts **[§1272.062]**

- ☐ Information that will enable the HMO to file claims for reinsurance, coordination of benefits, and subrogation, if required by the HMO's contract with the DE **[§1272.062]**

- ☐ Documentation *[except for confidential information under Subchapter A, Chapter 160, Occupations Code*], that relates to:
  - ☐ A regulatory agency's inquiry or investigation of the DE or of an individual provider with whom the DE contracts that relates to an HMO enrollee **[§1272.062]**; and
  - ☐ The final resolution of inquiry or investigation **[§1272.062]**

☐ **Report to HMO Regarding Complaints-**Provision that requires DE, upon receipt of a complaint, to report the complaint to the HMO within **2 business days**, except in the case of a complaint involving emergency care. In the case of a complaint involving **emergency care**, the DE will forward the complaint **immediately** to the HMO *[provided that nothing prohibits the DE from attempting to resolving the complaint]* **[§1272.063]**

-END OF MONITORING PLAN REQUIREMENTS-

Additional Requirements Related to Delegated Entities

Reporting Requirements (§1272.102)

The following information shall be provided to the DE by the HMO at least monthly *[unless otherwise provided in the agreement]* and in standard electronic format:

☐ The names, DOBs or SSNs of HMO's eligible enrollees, including the enrollees added and terminated since the previous reporting period

☐ The age, sex, benefit plan and any riders to that benefit plan, and employer for the eligible HMO enrollees

☐ If the HMO pays any claims for the DE, a summary of the number and amount of claims paid by the HMO on behalf of the DE during the previous reporting period *[Note: DE is not precluded from receiving, upon request, additional nonproprietary information regarding such claims]*

☐ If the HMO pays any claims for the DE, a summary of the number and amount of pharmacy prescriptions paid for each enrollee for which the DE has taken partial risk during the previous reporting period *[Note: DE is not precluded from receiving, upon request, additional nonproprietary information regarding such claims]*

☐ Information that enables the DE to file claims for reinsurance, coordination of benefits, and subrogation

☐ Patient complaint data that relates to the DE

In addition to the information required by Subsection (b), an HMO shall provide to a DE:

☐ Detailed risk-pool data, reported quarterly and on settlement

☐ The percent of premium attributable to hospital or facility costs, if hospital or facility costs impact the DE's costs, reported quarterly, and, if there are changes in hospital or facility contracts with the HMO, the projected impact of those changes on the percent of premium attributable to hospital and facility costs within 30 days of such changes

☐ A delegated entity may, on request, receive additional nonproprietary information regarding claims paid by a health maintenance organization on behalf of the entity

☐ An HMO shall provide information required under §1272.102(b)(1)-(5) in standard electronic format at least monthly unless the delegation agreement provides otherwise

Notice of Noncompliance or Hazardous Operating Condition (§1272.202)

An HMO that becomes aware of any information that the DE is not operating in accordance with its written agreement or is operating in a condition that renders the continuance of its business hazardous to the enrollees shall:

☐ Notify the DE in writing of those findings

☐ Request in writing a written explanation with documentation supporting its explanation of :
- ☐ The DE's apparent noncompliance with the written agreement; or
- ☐ The existence of the condition that renders the continuance of the DE's business hazardous to enrollees**;** and

☐ Provide the commissioner with copies of all notices and requests submitted to the DE and the responses and other documentation the HMO generates or receives in response to the notices and requests

Response to Notice (§1272.203)

☐ A DE shall respond to a request from a HMO under §1272.202 in writing not later than the 30th day after the date the request is received

Cooperation of HMO (§1272.204)

☐ The HMO shall cooperate with the DE to correct any failure by the DE to comply with TDI regulatory requirements relating to any matters:

- ☐ Delegated to the DE by the HMO; or
- ☐ Necessary for the HMO to ensure compliance with statutory or regulatory requirements

Contractual Requirements Affecting Delegated Entities and Limited Provider Networks

Access to Out-of-Network Services (§1272.301)

☐ A contract between an HMO and a Limited Provider Network (LPN)[6] or DE must provide that if medically necessary covered services are not available through network providers, the LPN or DE must, on request of a network provider, allow a referral to a non-network provider and shall fully reimburse the non-network provider at the usual and customary or an agreed-upon rate

Note: The referral shall be allowed not later than the 5th business day after the date any reasonably requested documentation is received by the LPN or DE. The enrollee may not be required to change his/her PCP or specialist providers to receive medically necessary covered services that are not available within the LPN or DE.

☐ A contract between an HMO and an LPN or DE must provide for a review by a specialist of the same or similar specialty as the type of provider to whom a referral is requested before the LPN or DE may deny a referral

☐ An enrollee may not be required to change the enrollee's primary care physician or specialist providers to receive medically necessary covered services that are not available within the LPN or through the DE

Note: A denial of out-of-network services under §1272.301 is subject to appeal under Article 21.58A, Insurance Code.

Continuity of Care (§1272.302)

☐ An HMO shall by contract establish penalties for DEs that do not provide timely information required under a monitoring plan as required by §1272.053

☐ A contract between an HMO and an LPN **or** DE must require that each contract between the LPN or DE and a physician or provider (collectively "provider") provide that:

- ☐ Reasonable advance notice be given to an enrollee of the impending termination from the LPN or DE of a provider who is currently treating the enrollee; **and**
- ☐ The termination of the provider contract, except for reason of medical competence or professional behavior, does not release the LPN or DE from the obligation to reimburse a provider who is treating an enrollee of special circumstance at a rate that is not less than the contract rate for that enrollee's care in exchange for continuity of ongoing treatment of an enrollee then receiving medically necessary treatment in accordance with the dictates of medical prudence

Note: A special circumstance shall be identified by the treating provider, who must request that the enrollee be permitted to continue treatment under the provider's care and agree not to seek payment from the patient of any amounts for which the enrollee would not be responsible if the provider were still in the LPN or DE.

☐ A contract between an LPN or DE and providers shall provide procedures for resolving disputes regarding the necessity for continued treatment by a provider

Note: §1272.302 does not extend the obligation of an LPN or DE to reimburse a terminated provider beyond the 90th day after the effective date of the termination, or beyond nine months in the case of an enrollee who at the time of the termination has been diagnosed with a terminal illness. However, the obligation of the LPN or DE to reimburse the terminated provider or, if applicable, the enrollee for services to an enrollee who at the time of the termination is past the 24th week of pregnancy, extends through delivery of the child, immediate postpartum care, and the follow-up checkup within the first six weeks of delivery.

TDI Duties Related to Delegated Entities

Examination by Department (§1272.205)

- On receipt of a notice under §1272.202 or if complaints are filed with TDI, TDI may examine the matters contained in the notice as well as any other matter relating to the financial solvency of the DE or the DE's ability to meet its responsibilities in connection with any function delegated to the entity by the HMO
- TDI on completion of examination shall report to the DE and the HMO the results of the its examination and any action TDI determines is necessary to ensure that the HMO meets its responsibilities under the HMO Act, the Insurance Code, any other insurance laws of this state, and rules adopted by the commissioner, and that the DE can meet its responsibilities in connection with any function delegated to the entity by the HMO *[Note: TDI may not report to the HMO any information regarding fee schedules, prices, cost of care, or other information not relevant to the monitoring plan]*

Response to Department Report; Corrective Plan (§1272.206)

The DE and the HMO shall respond to TDI's report and submit a corrective plan to TDI not later than the 30th day after the date the DE receives TDI's report

Request for Corrective Action (§1272.207)

TDI may request at any time that the DE take corrective action to comply with TDI's statutory and regulatory requirements that:

- Relate to any matters delegated by the HMO to the DE; or
- Are necessary to ensure the HMO's compliance with statutory and regulatory requirements

Authority of Commissioner to Issue Order (§1272.208)

Regardless of whether the DE complies with TDI's request for corrective action, the commissioner may order the HMO to take any action the commissioner determines is necessary to ensure that the HMO is in compliance with the Chapters 843, 1271, 1367 or 1452, Subchapter A including:

- Reassuming the functions delegated to the DE, including claims payments for services previously rendered to the HMO's enrollees;
- Temporarily or permanently ceasing assignment of new enrollees to the DE;
- Temporarily or permanently transferring enrollees to alternative delivery systems to receive services ; or
- Terminating the HMO's contract with the DE

Public Documents (§1272.209)

Reports and corrective plans required under §§1272.205(b) and 1272.206 shall be treated as public documents, except that health care provider fee schedules, prices, costs of care, or other information not relevant to the monitoring plan and any other information that is considered confidential by law shall be considered confidential

Record of Complaints; Report (§1272.210)

TDI shall maintain enrollee and provider complaints in a manner that identifies complaints made about LPNs and DEs. TDI shall periodically issue a report on the complaints received by TDI that includes a list of complaints by category, by action taken on the complaint, and by entity or network name and type. TDI shall make the report available to the public and shall include information to assist the public in evaluating the information contained in the report

Suspension or Revocation of License of TPA or URA (§1272.252)

The commissioner may suspend or revoke the license of any TPA or URA that fails to comply with Chapter 1272, Subchapters B, C or E

Sanctions and Penalties Against HMO (§1272.253

The commissioner may impose sanctions or penalties under Chapters 82, 83, and 84, Insurance Code, against an HMO that does not provide timely information required by Chapter 1272, Subchapter C

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[1] "Delegated entity" means an entity, other than an HMO authorized to engage in business under [chapter 1272], that by itself, or through subcontracts with one or more entities, undertakes to arrange for or provide medical care or health care to an enrollee in exchange for a predetermined payment on a prospective basis and that accepts responsibility for performing on behalf of the health maintenance organization a function regulated by [the HMO Act]. The term does not include: (A) an individual physician; or (B) a group of employed physicians, practicing medicine under one federal tax identification number, whose total claims paid to providers not employed by the group constitute less than 20 percent of the group's total collected revenue computed on a calendar year basis. See TIC §843.002(30).

[2] "Utilization review" means a system for prospective or concurrent review of the medical necessity and appropriateness of health care services being provided or proposed to be provided to an individual within this state. Utilization review shall not include elective requests for clarification of coverage. See art. 21.58A §2(20).

[3] "Administrator" means a person who, in connection with annuities or life, health, and accident benefits, including pharmacy benefits, collects premiums or contributions from or adjusts or settles claims for residents of this state. The term does not include a person described by Section 4151.002. See §4151.001(1).

[4] "Utilization review agent" means an entity that conducts utilization review for: (A) an employer with employees in this state who are covered under a health benefit plan or health insurance policy; (B) a payor; (C) an administrator. See art. 21.58A §2(21).

[5] "Delegated third party" means a third party other than a delegated entity that contracts with a delegated entity, either directly or through another third party, to: (A) accept responsibility for performing a function regulated by this chapter, Chapter 843, 1271, or 1367, or Subchapter A, Chapter 1452; or (B) receive, handle, or administer funds, if the receipt, handling, or administration is directly or indirectly related to a function regulated by this chapter, Chapter 843, 1271, or 1367, or Subchapter A, Chapter 1452. See §1272.001(3).

[6] "Limited provider network" means a subnetwork within an HMO delivery network in which contractual relationships exist between physicians, certain providers, independent physician associations, or physician groups that limits an enrollee's access to physicians and providers to those physicians and providers in the subnetwork. See §1272.001(5).