

RULES AND REGULATIONS
FOR
HEALTH MAINTENANCE ORGANIZATIONS
IN ARKANSAS

SECTION I. AUTHORITY. The following Rules and Regulations for Health Maintenance Organizations in Arkansas are duly adopted and promulgated by the Arkansas Department of Health pursuant to the authority expressly conferred by the laws of the State of Arkansas in Act 454 of 1975.

SECTION II. PURPOSE. These Rules and regulations have been prepared for the purpose of establishing a criterion for minimum standards for licensure and operation of Health Maintenance Organizations in Arkansas that is consistent with current trends in patient care practices. By necessity they are of regulatory nature, but are considered to be practical minimum design standards for these entities/facilities. These standards are not static and are subject to periodic revisions in the future as new knowledge and changes in patient care trends become apparent. However, it is expected that Health Maintenance Organizations will exceed these minimum requirements and that they will not be dependent upon future revisions in these standards as a necessary prerequisite for improved services. Health Maintenance Organizations have a strong moral responsibility for providing a progressive preventive health program which assures that adequate medical care is available and acceptable to all Enrollees.

These Rules and Regulations apply to certified Health Maintenance Organizations, as well as to applicants for a Health Maintenance Organization Certificate of Authority, and are promulgated to carry out Act 454 and to facilitate the full and uniform implementation, enforcement, and intent of the Act.

These Rules and Regulations explain the requirements a Health Maintenance Organization applicant must satisfy in order for the Arkansas Department of Health to certify to the Arkansas Insurance Department that the applicant's proposed plan of operation meets Arkansas Department of Health requirements.

These Rules and Regulations are adopted in the best interest of the public health, safety, and welfare. Compliance with these Rules and Regulations in no way conveys assurance of the quality of patient care, but rather provides the basic framework of capabilities required from which quality patient care may evolve.

Persons in the process of developing a Health Maintenance Organization shall periodically inform the Department of their developmental activities and make use of Department technical advice and assistance.

SECTION III. DEFINITIONS. As used in these Rules and Regulations, unless the content otherwise requires, the words and terms defined in Section III inclusive, have the meanings ascribed to them.

- A. **Act.** Arkansas Act 454 of 1975, as amended.
- B. **Administrator.** The person responsible for the management of the Health Maintenance Organization.
- C. **Case Management.** An activity which assists individuals in gaining and coordinating access to necessary services for enrolled members. The activity is designed to achieve the optimal patient outcome in the most cost-effective manner.
- D. **Certificate of Authority.** A document issued by the Commissioner of the Arkansas Insurance Department.
- E. **Commissioner.** The Commissioner of the Arkansas Insurance Department.
- F. **Consumer.** Solely for the purpose of the composition of the Governing Body/Oversight Committee, an individual who is a health care facility as a licensed Health Professional, or (iii) who has, or ever had, a direct, substantial financial or managerial interest in the rendering of Health Care Services other than the payment of a reasonable expense reimbursement or compensation as a member of the board of an HMO.
- G. **Credentials.** Certificates, diplomas, licenses, or other written documentation which establish proof of training.
- H. **Department.** The Arkansas Department of Health.
- I. **Director.** The Director of the Arkansas Department of Health.
- J. **Emergency Health Care Services.** Those Health Care Services which shall be available on a twenty-four hour basis to an individual with an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in (i) placing the patient's health in serious jeopardy; (ii) serious impairment to bodily functions; or (iii) serious dysfunction of any bodily organ or part.
- K. **Enrollee.** An individual who is contractually entitled to receive covered Health Care Services from an HMO.
- L. **Evidence of Coverage.** Any certificate, agreement, contract, identification card, or document indicating proof of coverage.
- M. **Health Care Plan.** Any arrangement whereby any person undertakes to provide, arrange for, pay for, or reimburse any part of the cost of any Health Care Services, and at least part of such arrangement is covered by an HMO.
- N. **Health Care Services.** Any services included in the furnishing to any individual of medical or dental care for the diagnosis, treatment, or healing human illness or injury.
- O. **Health Maintenance Organization (HMO).** Any person who undertakes to provide or arrange for Health Care Services to individuals who are enrolled in the HMO.
- P. **Health Professional.** Individuals engaged in the delivery of Health Care Services as are or may be described in the Rules and Regulations for Health Professionals.
- Q. **Hospital.** As defined in the currently certified Rules and Regulations for Hospitals and Related Insurance Organizations.
- R. **Inpatient Medical Care.** Shall include, but not be limited to medical and surgical care received in a hospital or other health care facility.
- S. **Limited Benefit HMO.** An HMO that elects to provide or arrange for the provisions of one (1) Health Care Plan that complies with all applicable provisions of these Rules and Regulations.
- T. **Medical Director.** A physician (M.D. or D.O.) licensed to practice in the State of Arkansas. The Medical Director shall provide medical direction of the HMO's health care activities and consultation to the HMO.
- U. **Outpatient Services.** Those covered services which may be rendered in, but are not limited to, clinics, offices, and radiation therapy centers.
- V. **Peer Review.** A review of the decisions and actions by one's peers within the organizational structure of the HMO.
- W. **Person.** Any natural or artificial person including, but not limited to individuals, partnerships, corporations, and trusts.

X. **Pharmacy.** A facility which possesses the appropriate permit from the Arkansas State Board of Pharmac
 Y. **Physical Plant.** The physical building, equipment, and fixtures of a Staff Model HMO. It shall includ
 Z. **Preventive Health Services.** Services designed to maintain an individual in optimum health and to prev
 AA.**Primary Care Physician.** A physician who supervises, coordinates, and provides initial and basic care t

BB. **Private Review Agency.** Any entity certified by the Department under Act 537 of 1989 perf
 to citizens of Arkansas including an HMO or any entity offering health insurance
 policies, contracts, or benefits in this State including a health insurer, non-profit health
 service plan, health insurance organization, preferred Provider organization, or
 managed care organization.

CC. **Provider.** Any person who is licensed in this State to furnish Health Care Services as a Hea

DD. **Quality Assurance Systems.** The planned and systematic management actions which assu

EE. **Retrospective Review.** A mechanism to review medical necessity and appropriateness of mec
 utilization review committee, recommendations of changes in Provider practice
 patterns based on analysis and review, and analyzation of care to Enrollees.

FF. **Service Area.** The geographic area as defined by county boundaries authorized by the Cer

GG. **Staff Model HMO.** An HMO that provides any of its Health Care Services through phy
 or leased by the HMO. It shall include a described Physical Plant.

HH. **Utilization Review Plan.** A system for the formal assessment of medical necessity, efficiency, :

SECTION IV. LICENSURE. No person shall perform any of the services or procedures or sell
 or dispense any goods or devices in the field of the healing arts for which a license is required
 under the laws of the State of Arkansas unless such person holds a valid license authorizing him
 or her to perform said procedures or render such services or dispense such good or devices. A
 valid license is a license from Arkansas or from the state where the services are provided. Except
 for ambulatory care facilities not required to be licensed by the State of Arkansas, the HMO shall

utilize only health care facilities that hold a valid license or are certified as a Provider or supplier of Medicare, Medicaid, or CLIA (Clinical Laboratory Improvement Amendments of 1988).

SECTION V. GENERAL REQUIREMENTS

- A. The HMO shall provide and/or arrange for the provision of Health Care Services which assure the E
- 1. Health Care Services for which Enrollees have contracted shall be provided or arranged for l
- 2. Facilities and personnel, both professional and non-professional, adequate (within generally a
- 3. These Health Care Services shall be provided at hours convenient to and adequate to meet the needs of Enrollees, including provision or arrangement for 24-hour emergency service. Th

4. The location of facilities and proximity shall enhance accessibility of service to the reasonably
 5. Owned facilities and/or leased facilities of a Staff Model HMO shall not present arch
 6. For initial Staff Model HMO applicants, plans and resources, both current and reasonably anti
 7. Continuity of service to Enrollees shall be enhanced by provision of a means for ensuring that
- B. There shall be a progressive preventive health program which shall be developed according to the prevalence of disease and to improve the general health of the HMO Enrollees.

SECTION VI. ISSUANCE OF CERTIFICATE OF AUTHORITY.

- A. Upon receipt of an application for issuance of a Certificate of Authority, the Commissioner shall transmit receipt of a Certificate of Authority.
- B. If the Director determines that the HMO does not meet such requirements, he shall specify in what respect he certifies to the Commissioner that such requirements are not met unless the proposed HMO has been given the opportunity to comment on the proposed findings of the deficiency or to furnish the required information. If requested by the proposed HMO, the Director shall hold a hearing on the finding of deficiency.
- C. These requirements shall also apply to applications and/or requests for amendments to the Certificate of Authority.

SECTION VII. CONTENT OF APPLICATION FOR CERTIFICATE OF AUTHORITY.

- A. No person shall operate an HMO without first obtaining a Certificate of Authority from the Commission
- B. In addition to the requirement of the Commissioner, an application for a Certificate of Authority shall include, at a minimum:
 - 1. Copies of the basic organizational documents such as certificates of incorporation, amendments thereto; byla
 - 2. A list of the names and addresses and official positions of the members of the board of dire
 - 3. A curriculum vita and/or resume of the Administrator and the Medical Director;
 - 4. A detailed description of the proposed HMO's potential ability to assure both the avai
 - 5. A description of the service area of the proposed HMO (geographic boundaries and den
 - 6. Information regarding proposed administrative site locations and hours of operation;
 - 7. Listing of Providers who have signed contracts and/or letters of intent to contract;
 - 8. A list of Health Care Services to be provided or arranged for by the HMO;
 - 9. A copy of the applicant's proposed form of evidence of coverage to be issued to Enrollees, s
 - 10. A form of the applicant's Provider contracts;
 - 11. A detailed description of the applicant's program for Preventive Health Services;
 - 12. A detailed description of the applicant's proposed grievance resolution system whereby the
 - 13. A detailed description of the applicant's ongoing quality assurance/improvement program;
 - 14. A detailed description of the applicant's capability to collect and analyze necessary data rela
 - 15. Job description for the Administrator, Medical Director, and senior personnel;
 - 16. A procedure for the referral of Enrollees to non participating Providers, when not othe
 - 17. A copy of the written procedures for provision and payment of Emergency Health Care Serv
 - 18. A detailed description of how medical records will be maintained for administrative prof

 - 19. For a Staff Model HMO, an organizational chart demonstrating the delegation of auth requisite expertise for their particular area of authority;
 - 20. For a Staff Model HMO, a statement of the number and qualifications of all support staf pathologists, physicians, ect.);

21. Any other pertinent information, as designated by the Director, and as required by other sect

SECTION VIII. ORGANIZATION.

- A. The Health Maintenance Organization shall be organized in a manner which demonstrates that it has tl
1. Emergency Health Care Services;
 2. Inpatient Hospital and medical-surgical care;
 3. Outpatient services;
 4. Preventive Health Services and health education services.
- These services are provided for the purposes of preventing, alleviating, curing, or healing human illne
- B. Those persons legally responsible for the operation of the HMO shall provide the following;

1. A copy of the agreement, contract, or policy which the HMO proposes to issue to
 2. The names of all Providers (giving their license number), business address, specialty
- information;
3. The appointment of a full-time Administrator;
 4. The appointment of a Medical Director. The position may be either full-time or part-time regulations, or other appropriate means to include provisions for the delivery of Health care Services by physicians and Providers, licensed or duly authorized to practice in the State of Arkansas. Other Providers, as required, to support the medical staff shall be available in order to assure that the Enrollee receives Health Care Services with continuity and without unreasonable periods of delay;
 5. An ongoing quality assurance/improvement program;
 6. Assurance that files are maintained to include current contracts for all participating
- C. Those persons legally responsible for the overall operation of the HMO shall have
1. Adoption and enforcement of all policies governing the HMO's management of Health Services of the HMO and to react to recommendations and/or findings of the quality assurance/improvement committee. Records, as well as minutes of meetings shall be maintained;
 2. Authority to employ and terminate the Administrator and Medical Director;
 3. Adoption of the HMO's procedures for maintenance and control of all books, records,
 4. Assurance that the HMO's Administrator is performing the duties of that position;
 5. Assurance that the HMO's Medical Director is performing the duties of that position
 6. Adoption of policies and procedures regarding the delivery of Health Care Services to
 7. Provision of reasonable access by the Medical Director; and
 8. Assurance that the HMO complies with applicable laws and regulations.
- D. The HMO shall be organized to accomplish its stated mission which shall include, as a minimum, provision of or arranging for the provision of Health Care Services.
- E. The HMO shall possess organizational and administrative capacity to provide or arrange for

SECTION IX. GOVERNING BODY.

- A. The governing body and/or oversight committee of any HMO shall include at least one (1) physician, and the committee shall also be residents of the State of Arkansas.
- B. Such governing body/oversight committee shall establish a mechanism to afford Enrollees an opportunity to appeal to the Director.

SECTION X. FACILITIES AND ENVIRONMENT.

A. Facilities owned and/or operated by the Health Maintenance Organization.

1. There shall be a described physical Plant for all such facilities.
2. There shall be sufficient equipment and supplies for examination, diagnosis, and treatment in
3. There shall be a listing which shall include the name and location of the facility or faci

Director and the Enrollees.

4. Such facilities shall comply with the applicable parts of the *Physical Environment* Seci
5. The Physical Plant shall comply with all applicable provisions of state and local fire safe

B. Contracted Providers of Services. If all or part of the HMO services are to be performed by contract wii

1. All Providers of service shall be licensed or registered according to applicable state and loca
2. All contracted services shall be clearly identifiable.

Any major changes in the scope of services to be offered to Enrollees shall be approved by the Director. Notification of changes shall be forwarded to the Director at least one month in advance of their anticipated implementation.

SECTION XI. SERVICES. The requirements of this Section are applicable to the categories of

services listed as available under the Health Care Plan. The HMO may wish to provide such services directly or arrange for their provision according to the specific requirements of the Plan. Outside resources with which a Staff Model HMO contracts shall be approved by the Director.

A. Emergency Health Care Services. Policies and procedures shall be developed pertaining to Emergency minimize the time for treatment in critical and/or urgent situations. All Enrollees shall have access to an HMO staff or an HMO contracted physician licensed to practice in the State of Arkansas. A physician shall be available at least by telephone on a twenty-four (24) hour basis, seven (7) days a week to respond to urgent calls from Enrollees. Emergency Health Care Services shall be available without restrictions as to where the services are provided. Physicians and Providers of care which employ triage nurses and/or mid-level practitioners to assess the health care needs of Enrollees shall also have policies in effect which describe the exact duties of the involved professionals.

B. Primary Care Physician Services. Policies and procedures shall be developed pertaining to Primary Ca Primary Care Physicians have admitting privileges and/or a referral arrangement at one or more participating Hospitals located within the HMO's Service Area to assure that necessary admissions are made. Such policies shall also meet the above requirements for the provision of Emergency Health Care Services and after hour access. The method by which Enrollees may secure Health Care Services after hours shall be clearly communicated in writing to Enrollees.

C. Inpatient Hospital and Medical Care. An agreement with at least one Hospital shall be obtained by the Service Area of the HMO to meet requirements of availability, accessibility, and continuity. Inpatient Hospital care shall be available and accessible twenty-four (24) hours a day, seven (7) days a week within the HMO's defined geographical Service Area. Hospitals which provide services shall be currently licensed by the Arkansas Department of Health.

D. Outpatient Services. Ambulatory Outpatient Services shall be provided. These services shall, as a n

E. Diagnostic Laboratory Services. Each HMO shall have available diagnostic laboratory services cor outside reference laboratories and/or accredited laboratories shall meet this requirement. All laboratory services shall meet the non-emergent, urgent, and emergency needs of Enrollees. Reference laboratory specimen services shall be convenient to Provider physicians through the strategic location of drawing stations or through a courier service which is under the management of the reference laboratory. Staff Model HMOs shall provide and/or arrange for the provision of laboratory services in clinical chemistry, pathology, microbiology, hematology, serology, and urinalysis.

F. Diagnostic Imaging. Diagnostic imaging services shall be available and accessible to all Enrollees. registered and inspected in accordance with Arkansas State law. Personnel who work with imaging machines shall comply with State law regarding monitoring.

G. Pharmacy Services. Pharmacy services shall be available and accessible within the Service Area of the by the HMO shall be under the supervision of the Director of Pharmacy Services and shall assure quality of and accessibility to pharmacy services. The plan shall include an acceptable drug utilization review and claims processing system. If a Staff Model HMO has a pharmacy department, a licensed pharmacist with a permit from the Arkansas State Board of

Pharmacy shall be employed to administer the pharmacy in accordance with all State and Federal laws regarding drugs and drug control. The pharmacy director shall develop policies and procedures for administration of the pharmacy department. There shall be a committee composed of physician(s), pharmacist(s), and other professional needed to regularly review the quality of pharmacy services of the HMO.

1. The committee shall be responsible for assuring that drug utilization review is performed
2. The committee shall assure that contracting pharmacies maintain medication profiles on the
3. The committee shall make recommendations of polices under which pharmacists provide pha

H. Home Health Care. If home health care is covered, it shall be available and accessible within the S

1. A skilled nursing home that is licensed by the State and certified by Medicare or Medicaid o
2. A Hospital with swing-beds that is licensed by the State and certified by Medicare;
3. A Hospital licensed by the State, a distinct part of which is a skilled nursing facility.

Nursing home care may be provided by facilities owned and operated by the HMO or by contract.

I. Nursing Home Care. If nursing home care is covered, it shall be available and accessible within the S

1. A skilled nursing home that is licensed by the State and certified by Medicare or Medicaid o
2. A Hospital with swing-beds that is licensed by the State and certified by Medicare;
3. A Hospital licensed by the State, a distinct part of which is a skilled nursing facility.

Nursing home care may be provided by facilities owned and operated by the HMO or by contract.

J. Other Services. Other covered services shall be in accordance with those specified in the Health Care

shall be provided directly by the HMO or through contracts with Providers or physicians who hold a valid license or are otherwise allowed to practice in the State of Arkansas. Such services shall be of sufficient number and locations and as approved by the Director to be readily available and accessible to Enrollees.

SECTION XII. PROFESSIONAL STAFFING.

- A. An HMO shall have sufficient numbers of physicians and other Health Professionals, either as employees or independent contractors, to provide the services required by the HMO.
- B. There shall be established a credentials committee charged with the responsibility of reviewing and certifying the qualifications of all Health Professionals who are employed by or contract with the HMO. The committee shall conduct reviews of said personnel at intervals necessary to assure appropriate licensure and certification.
- C. In addition to other requirements, the Medical Director of the HMO shall be involved in the implementation of the credentialing process.
- D. The HMO shall define procedures for taking corrective action against any Provider whose conduct is considered to be substandard.

SECTION XIII. MEDICAL RECORDS.

- A. The HMO shall maintain or cause the Provider to maintain an active record for each Enrollee who receives Health Care Services under the policies and procedures, as related to medical records, for the review of physicians and other Providers. The policies and procedures shall address, at a minimum, the retention, security, storage, confidentiality, transfer, release, and destruction of medical record information.
- B. Each medical record shall contain sufficient information and data to support diagnosis, plan of treatment, and evaluation of treatment.
- C. The HMO shall require that each entry be indelibly added to the Enrollee's record, dated, and signed or initialed by the Provider.
- D. The medical record for each Enrollee who has had a routine, scheduled appointment with one of the HMO Providers shall include, but not be limited to, the following information:
allergies and untoward reactions to drugs.
- E. The HMO shall require that the medical records for each Enrollee who receives Health Care Services include the following information:
1. Reason for the encounter;
2. Evidence of the Provider's assessment of the Enrollee's health problems;
3. Current diagnosis of the Enrollee, including the results of any diagnostic testing;
4. Plan of treatment, including any therapies and health education; and
5. Medical history relevant to the current episode of care if not available as Part D above.
- F. The HMO shall require each Provider site to document that all outcomes of ancillary reports, such as laboratory tests, are reviewed and deemed significant by the Provider who requested the report.
- G. Arrangements shall be made for the sharing of pertinent medical records among Providers participating in the HMO.

SECTION XIV. ENROLLEE RIGHTS.

A Health Maintenance Organization shall develop and adhere to written policies and procedures informing Enrollees of at least the following rights:

- A. An Enrollee has the right to timely and effective redress of grievances through a system established by the HMO.
- B. An Enrollee has the right to obtain current information concerning a diagnosis, treatment, and prognosis if available to an appropriate person on the Enrollee's behalf;
- C. An Enrollee has the right to be given the name, professional title, and function of any Provider who is involved in the Enrollee's care.

personnel providing Health Care Services to him/her;

- D. An Enrollee has the right to his/her informed consent before the start of any surgical procedure offered to him/her by
- E. An Enrollee has the right to refuse any medications, treatment, or other procedure offered to him/her by
- F. An Enrollee has the right to obtain Emergency Health Care Services without unnecessary delay;
- G. An Enrollee has the right to have all records pertaining to his/her medical care treated as confidential
- H. An Enrollee has the right to information in his/her medical records, consistent with state law. Nothing is to be
- I. An Enrollee has the right to be advised if a health care facility or any of the Providers participating in his/her care propose to engage in or perform human experimentation or research aff
- J. An Enrollee has the right to be informed of these rights listed in this Section; and
- K. No HMO may, in any event, cancel or refuse to renew an Enrollee solely on the basis of the health of an

SECTION XV. STATISTICAL INFORMATION.

There shall be a procedure for the HMO to compile, develop, evaluate, and report, as may be requested and in the form indicated by the Director, statistics relating to the cost of operation, the pattern of utilization of services, and the availability and accessibility of services. Sufficient information shall be maintained to support continuity and adequate quality of care to Enrollees.

- A. Each membership file shall include, as a minimum:
 - 1. Name of the individual and if other than the individual, also the name and address of the
 - 2. Individual's identification number;
 - 3. Date of birth;
 - 4. Sex;
 - 5. Effective date;
 - 6. Termination date and reason(s);
 - 7. Date of most recent verification of information; and
 - 8. Such other information as the Commissioner and Director may require.
 - B. Service area demographic characteristics which include the age, sex, and the geographic residence of
 - C. The HMO shall compile the number of medical services encounters, the number of Inpatient Medical Care
- Director.
- 1. Medical services shall mean those services provided for the prevention, diagnosis, treatment, a
 - 2. Direct ambulatory encounters shall mean face-to-face contacts between patients not con
- Services to the patient. The term "independent" is used to distinguish between Health Professionals who assume major responsibility for the care of individual Enrollees and all

other personnel who assist in providing that care.

- D. Enrollee surveys and comments, as well as other materials shall be made available to the Director;
- E. Each HMO shall annually, on or before the first day of March, file a report, verified by at least two persons required by the Director.

SECTION XVI. COMPLAINT/GRIEVANCE SYSTEM.

- A. Each HMO shall establish and maintain a complaint/grievance system approved by the Commissioner, after consultation with the Director, to provide reasonable procedures for the resolution of complaints.
- B. Each HMO shall provide a designated position/title with a designated telephone number and address for:
 - 1. Oral complaints and inquiries regarding complaints shall be entered into a written or automatic record.
 - 2. Enrollees with complaints which are not resolved shall be informed of the written grievance procedure.
- C. Each HMO shall have a written grievance procedure for prompt and effective resolution of Enrollee grievances.
 - 1. There shall be an initial level of investigation and review of any grievance;
 - 2. The initial review shall provide the opportunity for the Enrollee and any other party of interest to be heard.
 - 3. The decision of the initial review shall be binding unless the Enrollee appeals the decision in writing.
 - 4. The Enrollee shall be notified in writing of the decisions. If the outcome is adverse to the Enrollee, the HMO shall provide a written explanation of the decision.
- D. An Enrollee shall have the right to appeal a decision of the initial review to a second level review committee.
 - 1. The second level of review shall be conducted by a committee established by the HMO.
 - 2. The second level review committee shall have written procedures for investigating and resolving grievances.
 - 3. The Enrollee shall be notified in writing of the decision of the second level review. If the Enrollee is dissatisfied with the decision, the Enrollee may appeal the decision to the Commissioner of Health Care Services or the Director.
- E. The HMO shall specify time limits for receipt and disposition of grievances at each level of review. The HMO shall also specify the time limits for the appeal process.
- F. The HMO shall include a description of the complaint/grievance system in the Enrollee Handbook. Evidence of compliance with this requirement shall be made available to the Commissioner of Health Care Services or the Director upon request.
- G. At any stage of the grievance process, at the request of the Enrollee, the HMO may appoint a member of the grievance committee to represent the Enrollee.
- H. Each HMO shall submit to the Commissioner and the Director an annual report which shall include:
 - 1. A description of the procedures of such grievance/appeals system;
 - 2. The total number of grievances/appeals handled through such grievance/appeals system and the number of grievances/appeals not handled;
 - 3. For a Staff Model HMO, the number, amount, and disposition of malpractice claims settled;
 - 4. A summary of the disposition of grievances/appeals; (the copy to the Director shall also include a copy to the Commissioner of Health Care Services);
 - 5. Any such other information as reasonably required by the Commissioner or Director pursuant to the rules and regulations of the Department of Health Care Services.
- I. The Commissioner or Director may examine such grievance/appeals system subject to limitations concerning medical records of Enrollees.
- J. The Director shall investigate each complaint filed with the Department concerning Health Care Services.

SECTION XVII. UTILIZATION REVIEW.

- A. Each HMO shall develop a Utilization Review Plan that includes:
 - 1. A description of review standards and procedures to be used in evaluating proposed, ong
 - 2. The provisions by which patients, physicians, or hospitals may seek reconsideration or app
 - 3. The type, qualifications, and oversight of the personnel performing utilization review and
 - 4. The policies and procedures to insure that a utilization review representative is reas
 - 5. The policies and procedures to insure that all applicable state and federal laws to protect the confidentiality of individual medical records are followed;
 - 6. Compliance with all relevant provisions of rules and regulations promulgated pursuant to A
- B. If a private review agent performs the utilization review, that entity shall meet the requiremen

SECTION XVIII. QUALITY ASSURANCE/IMPROVEMENT SYSTEMS.

- A. Each HMO shall develop and implement a quality assurance/improvement (QA/I) program subject to a shall include organizational arrangements and ongoing procedures for the identification, evaluation, intervention, and follow-up of potential and actual problems in health care administration and delivery to Enrollees.
- B. The QA/I organizational arrangements and ongoing procedures shall be fully described in written form all individuals involved in the QA/I program and shall include, but not be limited to, the following:
 - 1. Provision for necessary staff to implement the program and evaluate the effectiveness of the
 - 2. Formation of a QA/I committee responsible for QA/I activities and utilization review activities
 - 3. Requirements of responsibility for all QA/I activities conducted by the HMO or for activities
 - 4. Accountability of the committee to the Administrator and to the persons legally responsibleimprove the program.
- C. As a minimum, studies undertaken, results, subsequent actions, and aggregate data on utilization and quality of services, rendered to Enrollees shall be compiled.
- D. There shall be participation, supervised by the Medical Director, of Providers and support staff appropriate
- E. Minutes or records of the QA/I committee shall be maintained.
- F. The QA/I procedures shall include defined methods for the identification and selection of clinical and HMO services. Methods shall be established by which potential problems are selected and scheduled for further study.
- G. Each HMO shall document the manner by which it examines actual and potential problems in health care
- H. The QA/I activities shall include the development of recommendations that are timely and appropriate
- I. There shall be evidence of adequate follow-up on recommendations and such follow-up shall meet the standards
- J. Review of quality of care shall not be limited to technical aspects of care alone, but shall also include appropriate
- K. The QA/I program shall include written guidelines which set forth the procedures for remedial action
 - 1. A listing of the types of problems which require remedial action;
 - 2. Specific remedial actions required, with time frames within which Providers of health care

3. The procedures used to assess the effectiveness of any remedial action;
 4. Procedures utilized by the HMO if remedial actions are not implemented as required, to include
- L. All records and minutes shall be available for review by Department representatives.

SECTION XIX. EXTERNAL QUALITY ASSURANCE/IMPROVEMENT ASSESSMENT.

- A. When the Department determines that a significant quality problem exists that is not being addressed in the HMO.
- B. The assessment shall be conducted by a person or persons hired by the HMO and not involved in
- C. The person or persons hired shall be an individual or organization with recognized experience in the appraisal

- D. The person or persons hired shall be approved by the Director and shall report at frequent intervals to
- E. The person or persons hired shall issue a written report of findings to the HMO's governing body. A cc

SECTION XX. RECORDS MAINTENANCE.

- A. Each HMO shall maintain all of its books, records, files, procedures, minutes, and any other required do
- B. All such records shall be maintained for a period corresponding to the time interval between each onsite

SECTION XXI. ONSITE QUALITY OF CARE REVIEWS.

- A. The Director shall conduct an examination concerning the quality and appropriateness of covered Health Plans. Such examination shall not be less frequent than once every three (3) years. Such examinations shall be subsequent to the issuance of a Certificate of Authority.
- B. The examination shall be based on, but not limited to, the following:
 - 1. The effectiveness of quality of care monitoring;
 - 2. A medical referral system which is both available and accessible;
 - 3. Continuing education programs to upgrade the expertise of all professional and non-professional staff;
 - 4. Other quality issues in relation to the number of Enrollees.
- C. Complaints concerning the quality of care shall be investigated by the Department without prior notice.
- D. Requirements concerning a statement of deficiencies cited on surveys and complaint investigations:
 - 1. The Department shall provide the HMO with a written statement of the survey outcome;
 - 2. If deficiencies are cited, a written plan of correction shall be returned to the Department with the survey;
 - 3. Deficiencies which represent an immediate health and safety concern to Enrollees shall be corrected immediately;
 - 4. All other deficiencies shall be corrected within sixty (60) days of receipt of the written statement.
- E. The department may impose disciplinary action in the following instances:

1. The HMO fails to develop an acceptable plan of correction for deficiencies within the time
 2. The HMO fails to implement and complete its plan of correction within the time frame app
 3. The HMO fails to notify the Department of changes in operation that would affect prev
 4. The HMO fails to provide the Department with required reports and other documents, as r
 5. The HMO fails to pay fees or other expenses required by these Rules and Regulations.
- F. Each affected HMO shall receive written notice of the Department's disciplinary action. A written resp
- G. Any charge of noncompliance shall be removed after determination that the HMO has corrected the deficiency(ies) which prompted the request for disciplinary action.

SECTION XXII. SEVERABILITY.

If any provision of these Rules and Regulations, or the application thereof to any person or circumstances is held invalid, such invalidity shall not affect other provisions or application of these Rules and Regulations which can give effect without the invalid provision or applications, and to this end the provisions hereto are declared to be severable.

SECTION XXIII. REPEAL.

All Regulations and parts of Rules and Regulations in conflict herewith are hereby repealed.

CERTIFICATION

This will certify that the foregoing Rules and Regulations for Health Maintenance Organizations in Arkansas were adopted by the Arkansas State Board of Health at a regular session of said Board held in Hot Springs, Arkansas on the 23rd day of July, 1998.

George Harper
Secretary, Arkansas State Board of Health
Acting Director, Arkansas Department of Health

Dated at Hot Springs, Arkansas, this 23rd day of July, 1998.

The foregoing Rules and Regulations, copy having been filed in by office, are hereby approved on this 26 day of August, 1998.

Mike Huckabee
Governor of the State of Arkansas

