TITLE 310. OKLAHOMA STATE DEPARTMENT OF HEALTH
CHAPTER 659. HEALTH MAINTENANCE ORGANIZATIONS

"Unofficial Version"

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[**Authority:** Title 63 O.S. Section 1-104, 1-105e, and 1-106.1; and Title 36 O.S. Section 6901 et seq.]
[**Source:** Codified July 12, 2004]

SUBCHAPTER 1. GENERAL PROVISIONS

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310:659-1-1. Purpose

This Chapter is intended to ensure that health maintenance organizations comply with provisions that the State Commissioner of Health is charged to enforce under the Health Maintenance Organizations Act of 2003, Title 36 O.S. Section 6901 et seq.
[**Source:** Added at 21 Ok Reg 2782, eff 7-12-2004]

310:659-1-2. Definitions

The following words or terms, when used in this Chapter, shall have the following meaning, unless the context clearly indicates otherwise:

"Commissioner" means the Commissioner of Health.

"Department" means the Oklahoma State Department of Health.

"HMO Act" means the Health Maintenance Organizations Act of 2003, Title 36 O.S. Section 6901 et seq.
[**Source:** Added at 21 Ok Reg 2782, eff 7-12-2004]

310:659-1-3. Application materials

The applicant for a certificate of authority shall include narratives and documentation sufficient to demonstrate compliance with the requirements of 36 O.S. Section 6907 in its application filed with the Oklahoma Insurance Commissioner pursuant to 36 O.S. Section 6903(C).
[**Source:** Added at 21 Ok Reg 2782, eff 7-12-2004]

310:659-1-4. Filing fee

Each HMO shall pay the Department a fee of $1,500.00 (One Thousand Five Hundred Dollars) for review of an application for certificate of authority. The fee shall be in the form of a check payable to the Oklahoma State Department of Health, and is due when the application is submitted to the Oklahoma Insurance Commissioner.

[**Source:** Added at 21 Ok Reg 2782, eff 7-12-2004]

310:659-1-5. Governing body oversight

The HMO's governing body or its designee shall be responsible for the quality assurance program. The governing body or designee shall approve and regularly evaluate this program. If the HMO contracts with other entities to operate the quality assurance program, then the governing body or designee may consider reports from those entities. The governing body or designee shall receive reports on the quality assurance program at least once every six (6) months.

[Source: Added at 21 Ok Reg 2782, eff 7-12-2004]

310:659-1-6. Managed care referral and non-formulary drugs

Each HMO shall be considered a managed care entity for the purposes of 63 O.S. Sections 2550.1, 2550.2, and 2550.4. Each HMO's quality assurance program shall ensure compliance with the requirements applicable to managed care plans for referrals to specialists and approvals of non-formulary or prior-authorized drugs.

[**Source:** Added at 21 Ok Reg 2782, eff 7-12-2004]

310:659-1-7. Administrative penalties

The Department shall assess an administrative penalty in the amount of One Hundred Dollars ($100.00) per occurrence for an HMO that has been found in violation of 36 O.S. Section 6907(H) or a malpractice carrier that has been found in violation of 36 O.S. Section 6907(H)(8). Each day that the violation continues shall be considered a separate occurrence.

[**Source:** Added at 21 Ok Reg 2782, eff 7-12-2004]

SUBCHAPTER 3. EXAMINATIONS

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310:659-3-1. Purpose

(a) The Department shall examine the quality of an HMO's health care services within the first 12 months of member enrollment. This review is for the purpose of confirming that all required processes, systems and protocols are in place and are being implemented pursuant to 36 O.S. Section 6907.

(b) The Department may conduct the examination or the Department may require the HMO to contract for the examination pursuant to 36 O.S. Sections 6907(E) and 6919(B). If the Department requires the HMO to contract for the examination, the HMO shall select an independent quality examiner that has been approved by the Department.

[**Source:** Added at 21 Ok Reg 2782, eff 7-12-2004]

310:659-3-2. Independent quality examiner

(a) The Department shall maintain a list of approved independent quality examiners who have demonstrated conformity to the following requirements:

(1) The examiner has written criteria and standards for assessing the quality of clinical care and the availability, accessibility and continuity of care;

(2) The examiner limits clinical judgements to physicians with experience in the delivery of health care in an HMO setting, and all final conclusions, opinions and recommendations shall be made or endorsed by physicians;

(3) The examiner has a training program for review team members to ensure uniform application of standards;

(4) The examiner ensures the confidentiality of medical and health care information; and

(5) The examiner institutes reasonable measures to ensure that review team members and their families have no financial interest in the HMO being examined or in any HMO operating in the geographic service area covered by the HMO being examined.

(b) Any person may file a request to be included on the Department's list of approved independent quality examiners. The request shall be in writing and shall demonstrate conformity to the requirements in (a) of this Section. The Department shall respond in writing within thirty (30) days after receiving the request. The Department at any time may remove approval status

from an examiner for failure to maintain compliance with (a) of this Section, or for providing to or accepting from an HMO any gift or favor other than a reasonable and usual charge for the performance of a quality examination.

(c) The examination process shall include:

(1) Preliminary reviews to familiarize the examiner with the requirements of this Chapter and the HMO;

(2) A site visit to review records and to interview HMO officers, the medical director, members of the governing body, members of the quality assurance committee, the patient care coordinator, a customer service representative, other providers, and HMO personnel;

(3) An on-site summation; and

(4) Written preliminary and final reports.

(d) The HMO and the quality examiner shall provide the Department access to observe record reviews, interviews, and the on-site summation.

[**Source:** Added at 21 Ok Reg 2782, eff 7-12-2004]

310:659-3-3. Reports

(a) The quality examiner shall prepare a report based upon the assessment team's findings. One (1) copy of each report shall be submitted to the Department. The report shall contain, at a minimum, the following information:

(1) An overview of the HMO's quality assurance program, an evaluation of recent quality assurance studies undertaken by the HMO, and the degree of implementation of the written quality assurance plan;

(2) A description of the HMO's quality assurance program;

(3) A description of the types and numbers of medical records reviewed, selection criteria, and review methods;

(4) A summary of charts that met and did not meet the established review criteria;

(5) Recommendations for follow-up, when indicated; and

(6) A listing of the names and titles of individuals that conducted and analyzed the review.

(b) The HMO shall forward to the Department a complete and unaltered copy of the final report within five (5) working days after the HMO receives the report from the quality examiner.

[Source: Added at 21 Ok Reg 2782, eff 7-12-2004]

310:659-3-4. Conflict of interest

(a) An independent quality examiner contracted by an HMO or a qualified person contracted by the Department pursuant to 36 O.S. Section 6929 shall:

(1) Have knowledge and expertise in the area they are contracted to review; and

(2) Have no history of disciplinary action or sanctions related to quality of care, fraud, or other criminal activity.

(b) No contracted examiner or qualified person shall have any material, professional, familial or financial conflict of interest with:

(1) The HMO;

(2) Any officer, director, or management employee of the HMO;

(3) Any provider contracted with the HMO; or

(4) Any other HMO in the service area.

(c) A potential reviewer or qualified person shall disclose information regarding potential conflicts of interest to all parties to the review.

[**Source:** Added at 21 Ok Reg 2782, eff 7-12-2004]