

**RULES
OF
DEPARTMENT OF HEALTH
DIVISION OF HEALTH CARE FACILITIES**

**CHAPTER 1200-8-33
STANDARDS FOR QUALITY OF CARE FOR HEALTH
MAINTENANCE ORGANIZATIONS**

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1200-8-33-.01 DEFINITIONS. All terms contained in these rules shall have the same meaning as defined in the Health Maintenance Organization Act of 1986, as amended. See T.C.A. §56-32-202. As used in these rules, unless the context dictates otherwise, the definitions are as follows:

- (1) Basic health care services. All those health services which a defined population might reasonably require in order to be in good health, including as a minimum, but not limited to, emergency care, inpatient hospital and physician care, ambulatory physician care and outpatient preventive medical services.
- (2) Centers for Medicare & Medicaid Services (CMS) is a federal agency within the U.S. Department of Health and Human Services. CMS runs the Medicare and Medicaid programs which are national health care programs that benefit about seventy-five (75) million Americans. With the Health Resources and Services Administration, CMS runs the State Children's Health Insurance Program (SCHIP), a program that is expected to cover many of the approximately ten (10) million uninsured children in the United States.
- (3) Certificate of Authority (COA or license). The license issued by the Tennessee Department of Commerce and Insurance that permits a person or organization to establish and operate a health maintenance organization.
- (4) Clean claim. A claim received by an HMO for adjudication, and which requires no further information, adjustment or alteration by the provider of the services in order to be processed and paid by the health insurer. A claim is clean if it has no defect or impropriety (including any lack of any required substantiating documentation) or particular circumstance requiring special treatment that prevents timely payment from being made on the claim under this section.
- (5) Department. The Tennessee Department of Health (TDH).
- (6) Department of Commerce and Insurance. The Tennessee Department of Commerce and Insurance (TDCI).
- (7) Department of Health. The Tennessee Department of Health (TDH).
- (8) Emergency Care. Health services and care provided for a medical condition (illness, disease, accident, or injury) manifesting itself by acute symptoms of sufficient severity (including severe pain), that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to potentially result in (a) placing the person's health

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- in serious jeopardy, (b) serious impairment to bodily functions, or (c) dysfunction of a bodily organ or part.
- (9) Enrollee. An individual who is enrolled in a health maintenance organization.
 - (10) Governing Body. The board of directors or other person or entity that governs the operation of the health maintenance organization in the State of Tennessee.
 - (11) Grievance. A written complaint as defined in T.C.A. §56-32-210(a)(2)(A). A grievance usually expresses dissatisfaction with a decision or action of the health maintenance organization or its providers (e.g., coverage decisions, pre-authorization requests, quality of care, accessibility of care) and seeks resolution.
 - (12) Health care services. Any services included in the furnishing to any individual of medical or dental care, or hospitalization, or incidental to the furnishing of such care or hospitalization, as well as the furnishing to any person of any and all other services for the purpose of preventing, alleviating, curing, or healing human illness, injury or physical disability.
 - (13) Health Maintenance Organization (HMO). Any person or organization that undertakes to provide or arrange for basic health care services to enrollees on a prepaid basis. The person or organization may provide physician services directly through physician employees or under arrangements with individual physicians or a group or groups of physicians. The person or organization may also provide or arrange for other health care services on a prepayment or other financial basis. An HMO may also provide or arrange for additional health care services.
 - (14) Member. An individual who is enrolled in a health maintenance organization (i.e., an enrollee).
 - (15) National Committee for Quality Assurance (NCQA). An independent 501(c)(3) non-profit organization whose mission is to improve health care quality.

Authority: T.C.A. §§4-5-202, 4-5-204, 56-7-2355, 56-32-202, 56-32-203, 56-32-215, 56-32-218, and 68-1-103.

Administrative History: Original rules filed April 14, 2003; effective June 28, 2003.

1200-8-33-.02 REVIEW OF CERTIFICATE OF AUTHORITY APPLICATIONS.

- (1) When a health maintenance organization applies to the Department of Commerce and Insurance for a Certificate of Authority, the health maintenance organization shall submit documentation to the Tennessee Department of Health, Division of Health Care Facilities, demonstrating to the Commissioner of Health, or the Commissioner's designee, proof of capability to provide or arrange for the provision of basic health care services efficiently, effectively and economically and to ensure that the HMO provider network can reasonably be expected to meet its obligations to enrollees and prospective enrollees. The applicant shall meet the network adequacy requirements established pursuant to T.C.A. §56-7-2356. (This provision does not apply to applicants intending only to conduct a TennCare Program Line of Business. Network adequacy review for TennCare Program Lines of Business is conducted by the TennCare Bureau). The Commissioner of Health shall report such commissioner's findings to the Commissioner of Commerce and Insurance, who may then deny the application for a certificate of authority, as provided in T.C.A. §§56-32-204 and 56-32-218(b). In order to meet the requirements, the HMO must have the capability to provide basic health care services (or additional health care services, as applicable) efficiently, effectively and economically. The health maintenance organization shall submit the following for review:

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- (a) Copy of the Application for Certificate of Authority and accompanying documentation submitted to the Department of Commerce and Insurance, including:
 1. Copy of the organizational documents of the applicant;
 2. Copy of the by-laws;
 3. Biographical data on corporate officers and directors;
 4. Sample copy of contracts between the health maintenance organization and participating providers (primary care physicians, physician specialists, hospitals, etc.);
 5. Copy of the form of Evidence of Coverage to be issued to members;
 6. Copy of the form or group contract, if any, to be issued to employers, unions, trustees, etc.;
 7. Detailed description of the complaint and grievance procedure to be used; and
 8. Description of the proposed method of marketing, including advertising material to be used in soliciting subscribers.

- (b) Other information to demonstrate the applicant's proof of capability to provide basic health care services (or additional health care services, as applicable) efficiently, effectively and economically, including:
 1. Location of proposed operational sites and hours of operation;
 2. Organizational chart showing key personnel, (chief executive officer, medical director, quality improvement director, utilization management director, etc.) and the delegation of authority and control of the health care delivery system;
 3. List of counties in the proposed service area and projected member enrollment by county;
 4. List of contracting physicians, hospitals, pharmacies, and other providers in the proposed service area, categorized by county, including the provider's name, location (city), and specialty (if applicable);
 - (i) This list is to be submitted to the Division of Health Care Facilities for review when the health maintenance organization has signed contracts with such providers. After the network has been reviewed, an on-site visit will be scheduled to verify the signed contracts. This on-site visit will occur when the health maintenance organization has an adequate number of members to evaluate the operation of the health maintenance organization.
 5. Descriptions of the quality improvement program and the utilization management program;
 6. Member handbook (or description of member policies and procedures);
 7. Physician application form and a description of the policies and procedures used to approve and ensure the credentials of said Physicians;

(Rule 1200-8-33-.02, continued)

8. Physician handbook (or description of physician policies and procedures);
 9. Description of the payment methodology for primary care physicians and physician specialists; and
 10. Job description and work schedule for the medical director and medical director's curriculum vitae.
- (c) Any other information that the Department determines is needed to demonstrate the applicant's proof of capability to provide basic health care services (or additional health care services, as applicable) efficiently, effectively and economically.
- (2) The review process by the Division of Health Care Facilities shall consist of a review of the medical management, quality improvement, utilization management, and other programs and a review of the network of hospitals, physicians, pharmacies, and other providers in the proposed service area. When the health maintenance organization has developed a provider network and has signed contracts, it shall submit a list of contracting physicians, hospitals, pharmacies, and other providers, categorized by county, including the provider's name, location (city), and specialty (if applicable). The network will be reviewed and an on-site visit will be scheduled to verify the signed contracts.
- (3) When the review has been completed a letter shall be sent to the Department of Commerce and Insurance indicating whether or not the health maintenance organization's proposal meets the requirements of the Department of Health.

Authority: T.C.A. §§4-5-202, 4-5-204, 56-32-203, 56-32-204, 56-32-215, 56-32-218, and 68-1-103.
Administrative History: Original rules filed April 14, 2003; effective June 28, 2003.

1200-8-33-.03 REVIEW OF GEOGRAPHIC SERVICE AREA EXPANSION REQUESTS.

- (1) When a health maintenance organization applies for a service area expansion, the following information shall be submitted to the Tennessee Department of Health, Division of Health Care Facilities for review:
 - (a) List of counties to be added to the current service area and projected member enrollment by county;
 - (b) List of contracting physicians, hospitals, pharmacies, and other providers in the expanded geographic service area, categorized by county, including the provider's name, location (city), and specialty (if applicable). This list is to be submitted to the Division of Health Care Facilities for review when the health maintenance organization has signed contracts with such providers;
 - (c) Description of the medical management, quality improvement, and utilization management programs for the expanded service area; and
 - (d) Any other information which the Department determines is needed to demonstrate the applicant's proof of capability to provide basic health care services (or additional health care services, as applicable) efficiently, effectively and economically.
- (2) The review process by the Division of Health Care Facilities shall consist of a review of the medical management, quality improvement, utilization management, and other programs and a review of the network of hospitals, physicians, pharmacies, and other providers in the expanded service area. When the health maintenance organization has developed a provider network and has signed contracts, it

(Rule 1200-8-33-.03, continued)

shall submit a list of contracting physicians, hospitals, pharmacies, and other providers, categorized by county, including the provider's name, location (city), and specialty (if applicable). The network will be reviewed and an on-site visit will be scheduled to verify the signed contracts.

- (3) When the review has been completed a letter shall be sent to the Department of Commerce and Insurance indicating whether or not the health maintenance organization's proposal meets the requirements of the Department of Health. A copy of this letter will be placed in the health maintenance organization's file.

Authority: T.C.A. §§4-5-202, 4-5-204, 56-32-203, 56-32-215, 56-32-218, and 68-1-103. **Administrative History:** Original rules filed April 14, 2003; effective June 28, 2003.

1200-8-33-.04 SURVEYS OF HEALTH MAINTENANCE ORGANIZATIONS. The Commissioner of Health or the Commissioner's designee may make an examination concerning a health maintenance organization's capability to provide health care services efficiently, effectively and economically, and any providers with whom such organization has contracts, agreements, or other arrangements as often as is reasonably necessary for the protection of the interests of the people of this state. Such examinations of health maintenance organizations shall occur not less frequently than once every three (3) years and shall occur whenever necessary to respond to complaints from the public or whenever the Department determines that it is in the best interest of the public health and safety. The Commissioner of Health shall report findings to the Commissioner of Commerce and Insurance, who may then suspend or revoke a certificate of authority issued to the health maintenance organization as provided in T.C.A. §56-32-216.

Authority: T.C.A. §§4-5-202, 4-5-204, 56-32-215, 56-32-218, and 68-1-103. **Administrative History:** Original rules filed April 14, 2003; effective June 28, 2003.

1200-8-33-.05 REPORTING BY HEALTH MAINTENANCE ORGANIZATIONS. A health maintenance organization shall notify the Tennessee Department of Health, Division of Health Care Facilities when operational sites are relocated or when separate or branch operational sites are established.

Authority: T.C.A. §§4-5-202, 4-5-204, 56-32-215, 56-32-218, and 68-1-103. **Administrative History:** Original rules filed April 14, 2003; effective June 28, 2003.

1200-8-33-.06 STANDARDS FOR HEALTH MAINTENANCE ORGANIZATIONS.

- (1) Standard I: Quality Improvement Program.
 - (a) The health maintenance organization shall implement a comprehensive quality improvement program designed to continually assess and improve the quality of care and services provided to members.
 - (b) There shall be a comprehensive written quality improvement program which contains:
 1. Written goals and objectives that demonstrates that structures and processes are clearly defined and responsibility is assigned to appropriate individuals;
 2. A statement that the governing body is accountable for the quality of care and services delivered and is responsible for ongoing oversight of quality improvement activities;

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3. A description of the organizational structure that shows the functional and reporting relationships of the quality improvement and other major departments to management and to the governing body;
 4. A description of the activities and responsibilities of the personnel responsible for quality improvement. A designated physician must have substantial involvement in the implementation of the quality improvement program. A designated behavioral health care practitioner must be involved in the implementation of the behavioral health care aspects of the quality care program;
 5. A description of the structure, function, and membership of the quality improvement committee and any subcommittees, and the frequency of meetings, and proof that the program specifically addresses the behavioral health care aspects of the program. The description of the quality improvement program must also include a section that addresses the improvement of patient safety;
 6. A description of the methodology for ongoing monitoring and evaluation of the quality of care and services and of the accessibility and availability of such care and services;
 7. A provision for annual review of the quality improvement program by the governing body, updating as necessary, and for the review and approval of objectives, scope and planned prospects or activities that address the quality and safety of clinical care and the quality of service for the year;
 8. A provision for an annual quality improvement work plan that describes planned activities and time frames and provides for ongoing monitoring of problems that have been identified and for program evaluation; and
 9. A description of any delegated quality improvement activities and of the process by which such delegated activities will be monitored and evaluated. A health maintenance organization may delegate authority for performing the quality improvement function to another entity; however, the health maintenance organization shall maintain responsibility for ensuring the function is being performed according to its expectations and these standards.
- (c) The medical director shall oversee the quality improvement program.
- (d) There shall be a quality improvement committee that:
1. Oversees and is involved in all quality improvement activities;
 2. Has regular meetings, no less frequently than quarterly;
 3. Has written minutes or records of its meetings, including a description of problems or issues discussed, recommendations made, and actions taken;
 4. Submits written quality improvement reports no less frequently than annually to the governing body;
 5. Includes participation by physicians providing health care services to members and a behavioral health care practitioner must be involved in the implementation of the behavioral health care aspects of the quality improvement program;

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6. Has planned monitoring of previously identified issues including tracking of issues over time; and
 7. The quality improvement program must have adequate resources (e.g., personnel, analytical capabilities, data resources) that are adequate to meet its needs.
- (e) The governing body shall demonstrate oversight of the quality improvement program by:
1. Formally adopting a written quality improvement program that designates the organizational structure responsible for implementing quality improvement activities;
 2. Reviewing and approving the quality improvement program annually; and
 3. Maintaining written minutes of committee meetings which indicate receipt of reports from the quality improvement committee, including summaries of member satisfaction surveys, grievances, medical care evaluation studies, and an annual report summarizing quality improvement activities.
- (f) The health maintenance organization shall be responsible for ensuring that contracting providers (e.g., hospitals, home health agencies, and ancillary service providers) have adequate quality improvement programs.
- (g) Quality improvement activities shall be coordinated and linked with other organizational activities (e.g., utilization management, member's services, marketing).
- (h) The health maintenance organization shall have a sufficient number of qualified personnel to support a comprehensive quality improvement program.
- (i) The health maintenance organization shall perform medical care evaluation studies focused on improving the quality of care and services and relevant to the membership of the health maintenance organization. The quality improvement program must also address improving patient safety.
1. The health maintenance organization shall establish a process for the identification and selection of topics for study;
 2. The health maintenance organization shall complete a minimum of one (1) medical care evaluation study every twelve (12) months;
 3. When required by NCQA standards, a medical care evaluation study shall be written up in an appropriate format that includes the survey methodology, the intent of the study, an analysis of the data, results and conclusions, and any recommendations for improving care and services;
 4. The health maintenance organization shall establish a process to follow up and evaluate recommended changes for improving care and services and shall specify the individual to whom the responsibility is assigned;
 5. The health maintenance organization shall provide a summary of medical care evaluation studies to providers and to the governing body and upon request, make available to its members and practitioners information about its quality improvement program, including a

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description of the quality improvement program and an analysis report on whether the health maintenance organization is meeting its goals;

6. Contracts with practitioners shall specifically require that practitioners cooperate with quality improvement activities; that the health maintenance organization has access to the practitioner's medical records; and that the health maintenance organization shall allow open practitioner-patient communication regarding appropriate treatment alternatives without penalizing practitioners for discussing medically necessary or appropriate care with the patient;
7. Contracts with providers must specifically require that providers cooperate with quality improvement activities and that health maintenance organizations have access to provider's medical records;
8. Health maintenance organizations will use data collection, measurement and analysis to track clinical issues that are relevant to its population; and
9. At a minimum, health maintenance organizations must adopt or establish quantitative measures to assess performance and to identify and prioritize areas for improvement for three (3) clinical issues, including at least one (1) behavioral health issue.

(2) Standard 2: Utilization Management Program.

- (a) The health maintenance organization shall have a comprehensive utilization management program that reviews services for medical necessity and that monitors and evaluates on an ongoing basis the appropriateness of care and services.
- (b) There shall be a written utilization management program that includes the following:
 1. A description of the activities and responsibilities of the personnel responsible for utilization management activities;
 2. A description of the review process for the determination of the medical necessity of care and services;
 3. A provision for periodic review of the utilization management program and updating as necessary. At a minimum, the health maintenance organization must annually evaluate the consistency by which the health care professionals involved in utilization management review apply the criteria in decision making; and
 4. A description of any delegated utilization management activities and of the process by which such delegated activities will be monitored and evaluated.
- (c) The health maintenance organization shall have a sufficient number of qualified personnel to support a comprehensive utilization management program.
- (d) The health maintenance organization shall establish policies and procedures for medical necessity reviews.
 1. The health maintenance organization shall develop or adopt written medical necessity review criteria that are based on sound medical evidence or judgement and shall review

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- such criteria periodically and update them as needed. The written description shall specifically address the behavioral health care aspects of the program:
- (i) The health maintenance organization shall include the organization's physician providers in the review and the adoption of medical necessity criteria; and
 - (ii) Health care service providers shall make medical necessity review criteria available for review.
2. Medical necessity reviews shall be supervised or performed by qualified medical professionals:
 - (i) Decisions requiring clinical judgment and denials based on lack of medical necessity shall be made by qualified licensed medical professionals;
 - (ii) Denials of pre-authorization for inpatient hospital or ambulatory surgical treatment center services based on medical necessity, or denials of continued stay in a hospital based on medical necessity, shall be made by a licensed physician;
 - (iii) The medical director shall oversee the medical necessity review process and shall be accessible and available for consultation as needed;
 - (iv) Licensed, board-certified, physician consultants from appropriate medical and surgical specialties shall be accessible and available for consultation as needed. A psychiatrist, doctoral-level clinical psychologist, or certified/licensed addiction medicine specialist shall review any denial of behavioral health care that is based on medical necessity;
 - (v) A designated senior physician shall have substantial involvement in utilization management implementation; and
 - (vi) A designated behavioral health care practitioner shall have substantial involvement in the implementation of the behavioral health care aspects of the utilization management program.
 3. The medical necessity review process shall be timely and shall include a provision for expedited reviews in urgent situations.
 4. The reason for denial of a service shall be available to the member and to the physician or other provider involved in the request for, or the delivery of, the service.
 5. The health maintenance organization shall establish a process for monitoring the consistency of medical necessity review.
 6. A health maintenance organization may delegate authority for performing the utilization management function to another entity; however, the health maintenance organization shall maintain responsibility for ensuring that the function is being performed according to the health maintenance organization's expectations and these requirements. If the health maintenance organization delegates behavioral health care, the health maintenance organization shall include the scope of behavioral health utilization management activities in the utilization management program description.

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- (e) Data on utilization of health care services, including preventive health services, shall be collected and analyzed on an ongoing basis to identify over-utilization and under-utilization of services.
 - (f) The health maintenance organization shall be responsible for any delegated utilization management activities. The health maintenance organization shall review and approve the delegated utilization management program and shall monitor and evaluate delegated activities on an ongoing basis. Documentation of such monitoring and evaluation must be maintained and available for review during surveys.
- (3) Standard 3: Management Information System.
- (a) The health maintenance organization shall have a data collection and reporting system that is adequate and reasonable to support comprehensive quality improvement and utilization management programs and timely processing of claims.
 - (b) The management information system shall have the capability to generate ad hoc reports and reports by diagnosis, procedure code, and provider in a timely manner.
 - (c) The management information system shall have adequate safeguards to ensure the confidentiality of member information.
- (4) Standard 4: Availability and Accessibility of Health Care.
- (a) The health maintenance organization shall develop and implement policies and procedures to adequately ensure the availability and accessibility of health care services for its members.
 - (b) The health maintenance organization shall establish and maintain a network of hospitals, primary care physicians, physician specialists, pharmacies, and other medical care providers adequate and reasonable in number and in geographic distribution to meet the basic health service needs of its members without excessive time and travel requirements. The HMO shall file a network adequacy standards description update with the Commissioners of Tennessee Department of Health and Tennessee Department of Commerce and Insurance annually. See T.C.A. §56-7-2356(a).
 - 1. The health maintenance organization shall have a sufficient number of primary care physicians to adequately meet the health care needs of members in accordance with the standards set out by the NCQA or the Bureau of TennCare for managed care plans, as applicable. To meet this requirement, there must be a reasonable distribution of primary care physicians throughout the counties constituting the service area;
 - 2. The health maintenance organization shall ensure that members do not have to travel more than thirty (30) miles distance or thirty (30) minutes travel time at a reasonable speed for primary care physician services. The Health Maintenance Organization shall also ensure that members do not have to travel more than approximately thirty (30) minutes to the nearest participating hospital. The Department may waive the requirement for travel time to the nearest participating hospital, in a specific geographic area if, in the opinion of the Commissioner or the Commissioner's designee, the above time standard is not feasible; and
 - 3. The health maintenance organization shall establish and maintain a comprehensive network of physician specialists adequate and reasonable in number, in specialty, and in geographic distribution to meet the health services needs of its members without

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excessive time and travel requirements. The health maintenance organization shall ensure that appointments for specialty care are available in a timely manner.

- (c) The health maintenance organization shall ensure that after hours medical consultation is available and accessible by telephone from the primary care provider or the primary care provider's on-call designee whenever the primary care provider's office is closed. The health maintenance organization shall ensure that there is a reasonable callback response time.
 - (d) The health maintenance organization shall ensure that emergency care, including ambulance service, is available and accessible twenty-four (24) hours per day, seven (7) days per week. The health maintenance organization shall have policies and procedures that permit the member to obtain emergency care at any available emergency care facility.
 - (e) The health maintenance organization shall establish written policies and procedures for the provision of emergency and urgent care services when the member is outside the usual service area.
 - (f) The health maintenance organization shall have written standards for:
 - 1. Waiting time for appointments for urgent care (e.g., the same day or within twenty-four (24) hours based on physician assessment of need);
 - 2. Waiting time for appointments for routine care;
 - 3. In-office waiting time; and
 - 4. Waiting time for after-hours telephone call-back response from the provider.
 - (g) The health maintenance organization shall establish an adequate and timely system for medically necessary referrals for specialty care. Such system shall provide for expedited referrals in urgent situations.
 - (h) The health maintenance organization shall develop and implement policies and procedures to ensure that members have the right to receive services without discrimination due to age, sex, race, color, religion, and national origin.
 - (i) The hours of operation and service availability for behavioral health care must reflect the needs of members needing behavioral health care.
 - (j) The health maintenance organization shall establish policies and procedures that allow members to change primary care providers after a reasonable waiting period and that also provide for expedited transfers in urgent situations.
- (5) Standard 5: Member Services.
- (a) The health maintenance organization shall ensure that members have reasonable access to member services. The health maintenance organization shall:
 - 1. Maintain reasonable hours of operation during the traditional workweek (Monday through Friday);

(Rule 1200-8-33-.06, continued)

2. Have toll-free telephone service for members to contact member services and shall monitor and evaluate the number of times callers reach a live/non-automated staff member and shall monitor and evaluate the abandonment rates which are not to exceed five percent (5%) at any given time; and
 3. Have a sufficient number of qualified personnel in member services to ensure reasonable accessibility by members.
- (6) Standard 6: Member Rights and Responsibilities.
- (a) The health maintenance organization shall have a written policy on member rights and responsibilities, including, but not limited to:
 1. A description of the member's right to:
 - (i) Be a part of the decision-making process regarding health care services;
 - (ii) File complaints, grievances, and appeals and the right to timely resolution of them;
 - (iii) Receive services without discrimination due to age, sex, race, color, religion, national origin, etc.;
 - (iv) Give informed consent; and
 - (v) Confidentiality of medical information except as permitted by law.
 2. A description of the member's responsibility to:
 - (i) Be knowledgeable about the health maintenance organization's policies and procedures regarding benefits and how to obtain those benefits; and
 - (ii) Cooperate with health care providers and to comply with appropriate instructions and guidelines.
- (7) Standard 7: Member Information.
- (a) The health maintenance organization shall provide all members with written information that includes, but is not limited to, the following:
 1. General information about the health maintenance organization;
 2. Information about how to access member services (phone numbers, hours of operations, etc.);
 3. A description of covered services or benefits and any limitations, exceptions, or exclusions (including pre-existing condition restrictions);
 4. A list of participating providers (physicians, hospitals, etc.) by county that designates the provider's office address and telephone number;
 5. The procedure for enrolling with a primary care physician and the procedure for changing primary care physicians (including any applicable waiting period);

(Rule 1200-8-33-.06, continued)

6. Information about how to obtain emergency care, urgent care, routine care, care after hours, and behavioral health care;
 7. The procedure for obtaining referrals for specialty care, ancillary services, (e.g., physical therapy, home health services), prescription drugs, and inpatient hospital care;
 8. Information about how to obtain services when the member is outside the usual service area;
 9. A description of members' rights and responsibilities;
 10. Information about how to file a complaint, a grievance, or an appeal, and information about the procedure for resolution of complaints and grievances in a timely manner;
 11. The procedure for notifying members when benefits and primary care physicians are changed or terminated;
 12. The policies and procedures regarding disenrollment of a member, or a loss of eligibility by a member;
 13. Information about how to enroll a newborn and how to obtain services for a newborn;
 14. Information about co-payments or other charges applicable to members and the policy on payment of such charges; and
 15. Information about health promotion and preventive health services.
- (b) Written information provided to members by the health maintenance organization shall be clearly written and easy to understand.
- (8) Standard 8: Member Satisfaction.
- (a) The health maintenance organization shall monitor the satisfaction of members with services and access to services. The health maintenance organization shall:
 1. Conduct periodic member satisfaction surveys no less frequently than annually and shall aggregate and analyze information gathered through such surveys; and
 2. Provide summaries of member satisfaction surveys to physician providers and to the governing body.
 3. For government funded managed care plans, in lieu of the health maintenance organization conducting these surveys, the government funding agency may conduct these surveys directly or through a contractor.
- (9) Standard 9: Complaints and Grievances.
- (a) The health maintenance organization shall establish policies and procedures for registering and resolving complaints and grievances in a timely manner. Enrollee grievance procedures shall comply with both T.C.A. §56-32-210 and T.C.A. §56-32-227 (Independent Review of "medical necessity" denial decisions). Title XVIII and XIX enrollee grievance and appeal procedures are

(Rule 1200-8-33-.06, continued)

governed by federal standards as enacted by the Centers for Medicare and Medicaid for managed care organizations or by the state Title XIX agency, as applicable. The health maintenance organization shall:

1. Document the substance of oral complaints and resolutions in a written or computerized log;
 2. Document grievances in a written or computerized log that includes actions taken and final disposition;
 3. Establish an appeal process for grievances that has, at a minimum, two (2) levels of review, including:
 - (i) The right of the member to have a grievance reviewed by a grievance committee;
 - (ii) The right of the member to provide information to the grievance committee for review;
 - (iii) The right of the member, if dissatisfied with the initial decision, to request in writing a second level of review by a committee of different individuals; and
 - (iv) The right of the member or the member's designee to personally appear before the grievance committee.
 4. Inform a member of the appeal process when the member has a grievance that cannot be satisfactorily resolved in a timely manner;
 5. Establish time frames for resolution of grievances that comply with the time frames set forth in T.C.A. §56-32-210 (c)(5), (7), and (8) and shall monitor to ensure timeliness of resolution; and
 6. Aggregate and analyze information about complaints and grievances and shall provide a summary to the governing body.
- (b) The member grievance process shall not include binding arbitration or mediation.
- (c) The HMO must either:
1. Advise members of their right to seek review of the matter by the Commissioner of Commerce & Insurance or a designee of the Commissioner, as set forth in T.C.A. §56-32-210(e); or
 2. With reference to TennCare Program HMO's, the HMO must advise members of their right to contest denials, delays, suspension, reduction or termination of services as set out in the Rules & Regulations of the TennCare Program found at 1200-13-12-.11 or its successor regulations.
- (10) Standard 10: Health Promotion. The health maintenance organization shall implement a health promotion program designed to encourage its members to improve their health status by seeking appropriate services and by developing healthy lifestyles.
- (11) Standard 11: Medical Director.

(Rule 1200-8-33-.06, continued)

- (a) The health maintenance organization shall have a medical director who is responsible for oversight and general coordination of the overall health care delivery system.
 - (b) The medical director shall:
 - 1. Have a valid unencumbered Tennessee medical license;
 - 2. Oversee the medical management, quality improvement program, and utilization management programs and shall be readily accessible for medical consultation to support such programs; and
 - 3. Be available full-time during usual business hours, unless the Department grants a waiver for a part-time medical director. If a waiver is so granted, the health maintenance organization shall ensure that the part-time medical director is available a minimum of twenty (20) hours per week during usual business hours and that the part-time medical director or another designated physician is readily accessible for medical consultation to support the medical management, quality improvement and utilization management programs at other times.
- (12) Standard 12: Credentialing.
- (a) The health maintenance organization shall establish policies and procedures for credentialing and re-credentialing physicians, dentists, and other licensed, registered, or certified independent practitioners.
 - 1. The health maintenance organization shall establish a credentialing committee to review the credentials of physicians, dentists, and other licensed or certified independent practitioners and to make recommendations regarding credentialing;
 - 2. The initial credentialing procedure shall include completion of an application; the applicant must attest to the accuracy and completeness of the application. The health maintenance organization must collect and verify the applicant's credentials before review by the credentialing committee. The attestation must not be older than 180 calendar days at the time of the credentialing decision. The application shall include questions that provide information about the following:
 - (i) Malpractice claims history by accessing the National Provider Data Bank;
 - (ii) Suspension or loss of a DEA certificate;
 - (iii) Suspension or loss of hospital privileges;
 - (iv) Censure by state medical licensure boards;
 - (v) History of chemical dependency or substance abuse;
 - (vi) History of criminal convictions, other than minor traffic violations;
 - (vii) Medical school, dental school, residency training, post-graduate training, or other professional training, as applicable; and

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- (viii) Work history.
3. The credentialing procedure shall also include:
 - (i) Verification of a valid license, registration, or certification to practice within the state;
 - (ii) Verification of current, adequate malpractice coverage;
 - (iii) Review of malpractice claims history from the National Practitioner's Data Bank;
 - (iv) Verification of a valid DEA certificate for prescribing physicians and dentists;
 - (v) Review of information on sanctioning activity by Medicare and Medicaid; and
 - (vi) Review of information from the National Practitioner Data Bank.
 4. The health maintenance organization shall establish policies and procedures for re-credentialing physicians, dentists, and other licensed, registered, or certified independent practitioners.
 - (i) Re-credentialing for physicians, dentists, and other licensed, registered or certified independent practitioners shall be performed at least every three (3) years;

The three (3) year re-credentialing cycle begins with the date of the initial credentialing decision. The three (3) year credentialing cycle is counted to the month of credentialing and not the exact date of credentialing.
 - (ii) The re-credentialing procedure shall include the requirements for initial credentialing listed in 1200-8-33-.06(12)(a)2,3; and
 - (iii) The re-credentialing procedure shall also include information about substandard or inappropriate care or access obtained from sources such as office site visits, medical record reviews, quality improvement and utilization management activities, member complaints, and member satisfaction surveys.
 5. The health maintenance organization shall maintain an updated credentialing file for each physician, dentist, and other licensed, registered, or certified independent practitioner included in the health maintenance organization's provider network. The credentialing file shall include:
 - (i) A copy of the completed application (credentialing or re-credentialing) signed and dated by the applicant, including supporting documentation;
 - (ii) Documentation that the applicant (credentialing or re-credentialing) has been reviewed and approved by the health maintenance organization's medical director and by the credentialing committee; and
 - (iii) Documentation of re-credentialing every three (3) years.
 6. The health maintenance organization shall be responsible for any delegated credentialing activities. The health maintenance organization shall review and approve the delegated

(Rule 1200-8-33-.06, continued)

credentialing program and shall monitor and evaluate delegated credentialing activities on an ongoing basis. Documentation of such monitoring and evaluation must be maintained and available for review during surveys. However, delegated credentialing activities by health maintenance organization programs providing Title XVIII and XIX benefits shall be conducted in accordance with the requirements of the Centers for Medicare and Medicaid and the state Title XIX agency, as applicable.

- (b) The health maintenance organization must assess the hospitals, home health agencies, skilled nursing facilities, nursing homes, ambulatory surgical treatment centers and facilities providing mental health and substance abuse services with which it contracts regardless of the number of health maintenance members treated at the facilities. Before contracting, the health maintenance organization must verify that the organizational providers have met all of the state and federal licensing and regulatory requirements. The health maintenance organization must also confirm whether a recognized accrediting body has approved the organizational provider. The health maintenance organization must determine which accrediting bodies will be recognized for different types of organizational providers.
 - 1. For non-accredited facilities, the health maintenance organization must develop selection process and assessment criteria for each type of non-accredited organization provider with which it contracts. The health maintenance organization must ensure that the organizational provider credentials its practitioners. In the case of non-accredited facilities where the health maintenance organization is required to perform a site visit, the health maintenance organization can substitute a (CMS) Centers for Medicare and Medicaid Services or state review as a site visit. If the CMS/state review is used in lieu of a site visit, the health maintenance organization must verify that the review has been done and meets the health maintenance organization's own standards. The health maintenance organization must obtain and keep on file the CMS/state report from the facility.
 - (i) After the initial assessment of hospitals, home health agencies, skilled nursing facilities, nursing homes, ambulatory surgical treatment centers and facilities providing mental health and substance abuse services, the health maintenance organization must confirm at least every three (3) years that the organizational provider continues to be in good standing with state/federal regulatory bodies and, if applicable, reviewed and approved by an accrediting body.
 - (c) The health maintenance organization shall establish policies and procedures for restricting, suspending, or terminating the privileges of a practitioner or facility for inappropriate or substandard care and shall establish a grievance and appeal process that ensures resolution in a timely manner.
 - (d) The health maintenance organization shall establish policies and procedures for notifying appropriate state and other authorities when a practitioner's or facility's privileges are suspended or terminated due to serious deficiencies in the appropriateness or quality of care.
- (13) Standard 13: Office and Medical Record Requirements.
 - (a) The health maintenance organization shall establish standards for physicians' offices and other facilities that provide ambulatory care and shall establish a process to monitor for compliance with the standards.
 - (b) The health maintenance organization shall establish standards for medical records and shall monitor medical records for compliance with the standards.

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1. Medical records shall be readily retrievable, organized, complete, and legible, and shall reflect sound medical record-keeping practices that permit effective and confidential patient care;
 2. Medical records shall include a written record that is dated and signed for each member encounter;
 3. Medical records shall reflect appropriate health care management;
 4. Adequate safeguards shall be in place to assure the confidentiality of medical records;
 5. The health maintenance organization shall require members to authorize release of medical records, which relate to medical care or services provided by or through the health maintenance organization, for review by the health maintenance organization and by appropriate state authorities;
 6. The health maintenance organization shall require physicians and other providers to make available medical records, which relate to medical care or services provided by or through the health maintenance organization to its members, for review by the health maintenance organization and by appropriate state authorities; and
 7. The health maintenance organization shall have a process to assess and improve, as needed, the quality of medical record keeping.
- (c) The health maintenance organization shall perform office site visits to ensure accessibility and compliance with facility and medical records standards.
1. Office site visits shall be performed at the time of initial credentialing or within ninety (90) days thereof and shall be performed periodically thereafter; and
 2. Office site visits shall be performed for all primary care physicians and for physicians who provide a high volume of specialty care to members.
- (14) Standard 14: Confidentiality. The health maintenance organization shall establish policies and procedures to ensure the confidentiality of medical information about its members.
- (15) Standard 15: Practice Guidelines.
- (a) The health maintenance organization shall establish practice guidelines for preventive health and other services which are based on sound medical evidence or judgement.
 - (b) The health maintenance organization shall establish a process by which physicians providing health services to organization members participate in the review and adoption of practice guidelines or standards and in their periodic review and update.
 - (c) The health maintenance organization shall require clinical practice protocols, which are based on sound medical evidence or judgement, for primary care nurse practitioners, if such practitioners are utilized in the provision of primary care services. These protocols shall be reviewed at least annually, updated as appropriate and signed and dated by the supervising physician and the nurse practitioner.

(Rule 1200-8-33-.06, continued)

- (d) The health maintenance organization shall establish procedures for the review of new medical technologies, including medical procedures, devices, and drugs. The review process shall include participation by physicians who provide health services to organization members.
- (16) Standard 16: Provider Information.
- (a) The health maintenance organization shall distribute to all providers an appropriate provider manual.
 - (b) The health maintenance organization shall distribute to all physician providers an appropriate physician provider manual or other written documentation that appropriately informs physicians about the following:
 - 1. General information about the health maintenance organization;
 - 2. Information about how to access provider services (phone numbers, hours of operations, etc.);
 - 3. A list of participating providers (physicians, hospitals, etc.) categorized by county that designates the provider's office address, telephone number, and other pertinent information (e.g., medical specialty of physicians);
 - 4. Information about the policies and procedures regarding emergency care, urgent care, and after-hours care;
 - 5. Information about the policies on waiting times for appointments for urgent and routine care and in-office waiting times;
 - 6. The procedure for obtaining referrals for specialty care, ancillary services (e.g., physical therapy, home health services), prescription drugs, and inpatient hospital care;
 - 7. Information about the policies and procedures affecting the provision of services to members when they are outside the usual service area;
 - 8. A description of the quality improvement and utilization management programs;
 - 9. A statement of the need for providers to participate in quality improvement and utilization management activities;
 - 10. A description of how physician performance will be monitored and evaluated;
 - 11. A description of the credentialing and re-credentialing processes, including office site visits;
 - 12. A description of the policies and procedures for restricting, suspending, or terminating provider privileges for inappropriate or substandard care and a description of the grievance and appeal process; and
 - 13. Information about preventive health and other practice guidelines.
 - (i) The health maintenance organization shall have preventive health guidelines for prevention or early detection of illness and disease.

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- (ii) The health maintenance organization shall have guidelines for the following categories:
 - (I) Prenatal and perinatal care;
 - (II) Preventive care for infants up to twenty-four (24) months;
 - (III) Preventive care for children and adolescents, aged 2-19 years;
 - (IV) Preventive care for adults, aged 20-64 years; and
 - (V) Preventive care for the elderly, aged 65 or older.
 - (iii) Each guideline shall describe the prevention or early detection, intervention, and the recommended frequency and conditions under which the intervention is required. The health maintenance organization will document the scientific basis or authority upon which the preventive health guidelines are based.
 - (iv) Practitioners from the health maintenance organization who have appropriate knowledge shall be involved in the adoption of the preventive health guidelines.
 - (v) The preventive health guidelines must be reviewed and updated at least every two (2) years, where appropriate.
- (17) Standard 17: Physician Satisfaction. The health maintenance organization shall monitor the satisfaction of physician providers with the health maintenance organization's policies and procedures.
- (a) The health maintenance organization shall monitor the physicians' satisfaction with access to provider services, with policies and procedures affecting the practice of medicine, and with the payment of claims through specific physician satisfaction surveys performed no less frequently than annually; and
 - (b) Information gathered through physician satisfaction surveys shall be aggregated and analyzed, and a summary shall be provided to physician providers and to the governing body through the quality improvement committee.
- (18) Standard 18: Enrollment of Employers and Members. A health maintenance organization may not market its services to businesses or employers in counties of Tennessee outside the service area approved by the Tennessee Department of Commerce and Insurance.
- (19) Standard 19: Consumer Right-to-Know. Compliance with the requirements of the "Health Care Consumer Right-To-Know Act" of 1998 will be verified annually for all Health Maintenance Organizations in Tennessee by the Department of Health.
- (a) The World Wide Web will be used to conduct an annual audit for each HMO pursuant to T.C.A. §§63-51-105, 63-51-110, 63-51-111, and 63-51-113.
 - (b) The results of each annual HMO evaluation will be reported to the Tennessee Department of Commerce and Insurance with a copy placed in each HMO's file.

(Rule 1200-8-33-.06, continued)

Authority: T.C.A. §§4-5-202, 4-5-204, 56-32-215, 56-32-218, 63-51-119, and 68-1-103. **Administrative History:** Original rules filed April 14, 2003; effective June 28, 2003.