



STATE OF ARIZONA
DEPARTMENT OF INSURANCE

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CHARLES R. COHEN
Director of Insurance

REGULATORY BULLETIN 2001-6

To: Health Care Services Organizations, Hospital, Medical, Dental and Optometric Service Organizations, Health Care Provider Organizations and Interested Parties

From: Charles R. Cohen
Director of Insurance

Date: June 15, 2001

Re: **Transition of Regulatory Authority over Health Care Services Organizations**

Introduction

The regulatory scheme governing health care service organizations (HCSOs or HMOs) in Arizona was enacted in the 1970s. Since then the regulatory responsibility has been bifurcated between the Department of Insurance (the Department) and the Department of Health Services (DHS). In 2000, the Arizona legislature enacted Senate Bill 1330, which altered the scheme by transferring all DHS responsibilities to the Department, effective July 1, 2001. For a more detailed summary of SB 1330, please see Circular Letter 2000-6.

This Regulatory Bulletin (i) outlines the projected temporary and permanent rule making process for the Department's new authority, (ii) explains how the Department is integrating HMO oversight with other related responsibilities, and (iii) describes the agency structure in place at the Department as of July 1, 2001.

Proposed Rule Making Process

On June 7, 2001, the Department filed with the Secretary of State temporary exempt rules for the Department's regulation of HMOs. The statutory authority for filing exempt rules is found in SB 1330, § 26. The Department anticipates the exempt rules will be published in the Arizona Administrative Register on June 29, 2001 and will become effective July 1, 2001.

The text of these rules is very similar to the text of rules originally promulgated by DHS at Arizona Administrative Code, §§ R9-12-101 to R9-12-116. The purpose of these temporary rules is to assure the Department has the authority to enforce the extant regulatory standards while progressing with the complex process of updating the standards. The Department made technical changes in the temporary rules to substitute references to the Department for references to DHS and comply with current rulewriting standards. The Department also modified the rules as needed to reflect changes in certain statutory requirements or definitions. A copy of these temporary rules is attached as Exhibit I to this Regulatory Bulletin.

The Department intends to promulgate a permanent set of HMO oversight rules under the formal rulemaking process as quickly as practicable. Accordingly, the Department filed the Notice of Docket Opening for regular rulemaking for HMO rules on June 7, 2001.

In developing permanent rules, the Department initially plans to focus on defining “basic health care services” and setting key standards for network adequacy, quality assurance, member services and HMO management. The Department will consider many factors including:

- The content of the original DHS rules;
- Regulatory requirements established by other jurisdictions;
- Standards established by HMO accreditation entities such as NCQA;
- Specific characteristics of the Arizona health care community;
- Specific characteristics of the Arizona health insurance and managed care market place;
- Specific characteristics of Arizona rural areas.

Before filing proposed permanent rules with the Secretary of State, the Department plans to obtain comment on draft rules and related issues from the Department’s Managed Care Advisory Group and other designated advisors. The Managed Care Advisory Group is made up of representatives of a wide spectrum of stakeholders interested in HMO regulation, including health care services organizations, associations representing institutional, individual and network providers, employers, business interests and representatives of consumer organizations. In accordance with the Administrative Procedures Act (ARS § 41-1021 et. seq.), after the proposed rules are filed with the Secretary of State, there will be public hearings with an opportunity to comment on the rules and a hearing before the Governor’s Regulatory Review Council before the rules become effective.

Given the apparently comprehensive need for new administrative standards, the complexity of the issues and the amount of material the Department must consider in drafting rules, the Department expects it will take at least a year from July 1, 2001 to file a set of proposed rules with the Secretary of State. The Department also expects it may be appropriate to go through the rule making process in two or more stages, covering different subjects or different levels of detail in successive rule-making stages.

Integration of HMO Oversight Program with Other Regulatory Activity

Oversight of Prepaid Dental Plans

As with HMO regulation, the regulation of prepaid dental plan organizations (PDPOs) has been bifurcated between the Department of Insurance (the Department) and the Department of Health Services. In 2000, the Arizona legislature enacted Senate Bill 1172, which altered the regulatory oversight of PDPOs by transferring all DHS responsibilities for PDPOs to the Department, effective July 1, 2001.

The Department will establish the prepaid dental oversight program in its Life & Health Division and will integrate this regulatory authority with the development of its HMO oversight program. This will allow the Department to gain efficiencies from the similar statutory requirements for operation and regulation of HMOs and PDPOs. In addition, SB 1172 transferred two FTEs from DHS to the Department. The person managing the prepaid dental oversight program in place at DHS until July 1, 2001 will fill one position. That transfer will allow the brand new HMO oversight program to benefit from the knowledge and experience of those involved in prepaid dental oversight at DHS.

Administration of HB 2600, including the Timely Pay and Grievance Law

In 2000, the Arizona Legislature enacted House Bill 2600, or the Managed Care Accountability Act, which took effect January 1, 2001. HB 2600 contained or amended many statutory provisions that the Department will administer in connection with its HMO oversight program. These include establishing bonding or deposit requirements and contracting requirements for

third party intermediaries, (ARS § 20-120)¹ and extending the prohibitions on balance billing (ARS § 20-1072). Possibly the most significant such provision is Section 34 of the Act, known as the timely pay and grievance law (ARS §§ 20-3101,3102). This new law establishes time limits and procedures for health insurers to pay providers and resolve provider grievances. The timely pay and grievance law applies to all health insurers, not just HMOs. For a more detailed summary of HB 2600, please see Circular Letter 2000-6.

The Department has established its timely pay and grievance enforcement program in the Life & Health Division and will integrate this regulatory authority with its HMO oversight. Timely pay and grievance issues are highly related to network adequacy and financial condition.

Agency Structure for HMO Oversight

Staffing

The Department's HMO oversight program will be part of its Life & Health Division. For fiscal year 2000-2001, the legislature appropriated four full time equivalent (FTE) positions to the Insurance Department to carry out its new HMO oversight responsibilities. All four positions were created and filled as follows:

Title	Name	Phone	Responsibilities
Assistant Director, Life & Health Division	Alexandra Shafer	602-912-8464	Development and administration of new HMO oversight, timely pay and prepaid dental programs; Administration of traditional of life and health insurance functions.
Managed Care Program Manager	Laura Weng	602-912-8464	Supervisory oversight of HMO oversight and timely pay/grievance programs; Lead role in developing quality assurance and other standards; Lead role in developing HMO examination and enforcement processes.
Network Adequacy Administrator	Anita Thompson	602-912-8464	Lead role in developing and enforcing network adequacy standards; Lead role in timely pay/grievance enforcement.
Rules Analyst	Margaret McClelland	602-912-8456	Lead role in drafting managed care/HMO, timely pay and related rules, as well as coordinating rule-making process.

For fiscal year 2001-2002, the legislature appropriated three additional FTEs for the Department to carry out its HMO oversight responsibilities and one FTE specifically for the Department's timely pay and grievance responsibilities. For fiscal year 2002-2003, the legislature appropriated one more FTE for timely pay and grievance responsibilities. The Department projects those positions as follows:

Title	Name	Phone Number	Responsibilities
Health Care Insurance Analyst II			Compiling information on regulatory standards; analyzing/

¹ The Department's Financial Affairs Division and Life & Health Division are jointly administering the third party intermediary law. The Financial Affairs Division is administering the bonding and deposit requirements. The Life & Health Division is administering the contracting requirements and addressing questions relating to the statutory definition of "third party intermediary".

Title	Name	Phone Number	Responsibilities
			reporting on HMO compliance; developing/monitoring corrective action plans.
Health Care Insurance Analyst II			Compiling information on regulatory standards; analyzing/reporting on HMO compliance; developing/monitoring corrective action plans.
Health Care Insurance Analyst I			Analyzing/reporting on health insurers' semi-annual grievance reports and other compliance data, developing/ monitoring corrective action plans.
Administrative Support Assistant			Providing administrative and clerical support to managed care, timely pay, prepaid dental and related division functions.
Health Care Insurance Analyst II (FY 2002-2003)			Analyzing/reporting on health insurers' semi-annual grievance reports and other compliance data; developing/ monitoring corrective action plans; supporting timely pay rulemaking.

Examination Function

Currently the Department conducts financial and market conduct examinations of all types of insurers. To some extent, these existing examination functions support the HMO oversight program. For example, findings relating to financial liquidity in the financial examination of an HMO may support the Department's network adequacy enforcement activities with the same HMO. At the same time, HMO timely pay information may be critical in shaping the scope of a financial or market conduct examination of the same HMO. The Department intends, however, to develop a managed care examination function with expertise specific to (i) HMO oversight, including quality of care, network adequacy and other subjects of the rulemaking process described above, and (ii) administration of the timely pay and grievance law. This will require careful delineation and coordination of the Department's examination programs to ensure useful synergies and to avoid duplication and inefficiencies.

Over the coming months, the Department will work with the Department of Administration Procurement Office to prepare a Request for Proposals from independent contractors who are qualified to conduct examinations relating to HMO quality of care and network adequacy as well as the timely pay and grievance law. In the meantime, the Department will continue to use existing examination functions to carry out its new responsibilities. For example, we expect to use the established market conduct examination functions to support timely pay and grievance enforcement. The Department's compliance analysis of complaints and grievance data received from providers starting January 1, 2001, semi-annual grievance reports to be received from HMOs starting October 1, 2001 and other information will determine which HMOs or other health care insurers are targeted. Possible examination scopes include claims review and payment processes (ARS § 20-3102(A) – (E)), the existence and efficacy of internal grievance systems (ARS § 20-3102(F), (G)), and the payment adjustment limitation (ARS § 20-3102(I)).

The HMO oversight program can be contacted at:

Arizona Department of Insurance
Life & Health Division
2910 North 44th Street, Second Floor
Phoenix, AZ 85282

Telephone: 602-912-8464
Fax: 602-912-8453
E-mail address: providerinfo@id.state.az.us

This Regulatory Bulletin and any Regulatory Bulletins or Circular Letters referred to above, as well as a pamphlet summarizing the timely pay and grievance law referred to above, are available on the Department's website at www.state.az.us/id. Timely pay and grievance law information is also available by telephone on the Department's Provider Information Line at 602-912-8468.

Any person who has questions regarding this Regulatory Bulletin may contact Alexandra Shafer, Assistant Director of the Department's Life & Health Division, at 602-912-8464.

**Regulatory Bulletin 2001-6
Exhibit I**

Temporary Health Care Services Organization Oversight Rules

NOTICE OF EXEMPT RULEMAKING
TITLE 20. COMMERCE, BANKING AND INSURANCE
CHAPTER 6. DEPARTMENT OF INSURANCE
ARTICLE 19. HEALTH CARE SERVICES ORGANIZATIONS OVERSIGHT

PREAMBLE

1.

<u>Sections Affected</u>	<u>Rulemaking Action</u>
Article 19	New Article
R20-6-1901	New Section
R20-6-1902	New Section
R20-6-1903	New Section
R20-6-1904	New Section
R20-6-1905	New Section
R20-6-1906	New Section
R20-6-1907	New Section
R20-6-1908	New Section
R20-6-1909	New Section
R20-6-1910	New Section
R20-6-1911	New Section

2.

The specific authority for the rulemaking, including both the authorizing statute (general) and the statutes the rules are implementing (specific):

Authorizing statutes: A.R.S. §§ 20-1051, 20-1053, 20-1054, 20-1057, 20-1058, 20-1059, 20-1064, 20-1065, 20-1379, 20-2301, and Laws 2000, Chapter 356, § 26

Implementing statutes: A.R.S. §§ 20-1053, 20-1054, 20-1058, 20-1059, 20-1064, 20-1065, and Laws 2000, Chapter 356, § 26

3.

The effective date of the rules:

July 1, 2001

4. **List all previous notices appearing in the register addressing the proposed rules:**

None

5. **The name and address of agency personnel with whom persons may communicate regarding the rulemaking:**

Name: Margaret L. McClelland
Address: Arizona Department of Insurance
2910 North 44th Street
Phoenix, AZ 85018
Telephone Number: (602)912-8456
Fax Number: (602)912-8452

6. **An explanation of the rule, including the agency's reasons for initiating the rule, including the statutory citation to the exemption from the regular rulemaking procedures:**

The regulatory scheme governing health care service organizations (HCSOs) was enacted in the early 1970s. Under that regulatory scheme, in effect until June 30, 2001, the regulatory responsibility is bifurcated between the Arizona Department of Insurance (ADOI) and the Arizona Department of Health Services (ADHS). ADOI is the lead, or enforcement agency. ADOI is the licensing authority, oversees financial condition, certain aspects of market conduct, policy forms and advertising and disciplinary matters. ADHS oversees the health services content of the health care plan, and determines whether the HCSO constitutes an "appropriate mechanism to achieve an effective health care plan". ADHS promulgated rules in 1975 defining "basic health care services" and standards to determine whether an HCSO is an effective health care plan. Those rules have remained in effect.

In the 1970s when the current regulatory scheme was enacted, there was a low degree of HCSO penetration into the health insurance marketplace. In the current marketplace, HCSOs have achieved a high degree of market penetration, and have become extremely complex systems for the financing and delivery of health care. The complexity of the business often exceeds the effectiveness and flexibility of the current regulatory

system.

Under the current regulatory scheme, ADHS does not actively enforce its rules after initial licensure. ADOI has no authority to regulate the delivery of health services. This causes gaps in the regulatory system and has left a growing consensus that regulatory responsibility should be consolidated in a single agency. Consequently, in 2000, the legislature passed S.B.1330. Under SB 1330, effective July 1, 2001, all authority for regulation of HCSOs will be consolidated under ADOI. The principal effect of the consolidated regulatory structure will be to bring new responsibilities to ADOI. The ADOI will define basic health services and maintain, make determinations under and enforce rules that establish whether an HCSO provides for basic health care services and whether it constitutes an effective mechanism to achieve an effective health care plan. ADOI retains authority to review, approve, suspend or revoke certificates of authority for HCSOs.

The text of these temporary exempt rules, effective July 1, 2001, is essentially the same substantively as the text that existed under ADHS. Technical changes have been made to the rules to change references from ADHS to ADOI and to comply with current rule writing standards. Some changes have been made to reflect superceding changes in statutory authority and definitions. At the same time that the Department files this temporary exempt rulemaking, it will also file a Notice of Docket Opening for a permanent rulemaking regulating HCSOs to comply with Title 41, Chapter 6, Arizona Revised Statutes.

Statutory authority for this exemption is found at Laws 2000, Chapter 356, § 26

7. A showing of good cause why the rule is necessary to promote a statewide interest if the rule will diminish a previous grant of authority of a political subdivision of this state:

Not applicable.

8. The summary of the economic , small business and consumer impact:

Not applicable.

9. A description of the changes between the proposed rules, including supplemental notices,

and final rules (if applicable):

Not applicable.

10. A summary of the principle comments and the agency response to them:

Not applicable.

11. Any other matters prescribed by statute that are applicable to the specific agency or to any specific rule or class of rules:

Not applicable.

12. Incorporation by reference and their location in the rules:

None.

13. Was this rule previously adopted as an emergency rule?

No.

14. The full text of the rule follows:

TITLE 20. COMMERCE, BANKING, AND INSURANCE

CHAPTER 6. DEPARTMENT OF INSURANCE

ARTICLE 19. HEALTH CARE SERVICES ORGANIZATIONS OVERSIGHT

Section

- R20-6-1901. Applicability
- R20-6-1902. Definitions
- R20-6-1903. Documentation
- R20-6-1904. Service Agreements
- R20-6-1905. Examination and Review
- R20-6-1906. Health Care Plan
- R20-6-1907. Geographic Area
- R20-6-1908. Chief Executive Officer
- R20-6-1909. Medical Director
- R20-6-1910. Medical Records
- R20-6-1911. Quality Assurance

ARTICLE 1. APPROVAL OF PLANS, FACILITIES, PERSONNEL AND SERVICE AREAS

R20-6-1901. Applicability

- A.** These rules apply to all proposed and existing health care services organizations (HCSOs).
- B.** The Department shall not issue a certificate of authority to an HCSO unless the HCSO meets the requirements of this Article.
- C.** An existing HCSO shall not be required to re-file all information already on file with the

Department, but it shall modify its operations and procedures as may be necessary to comply with this Article and file all additional information necessary to make statements complete and current.

R20-6-1902. Definitions

In this Article, the following definitions apply:

"Chief executive officer" means the person who has the authority and responsibility for the operation of the health care services organization in accordance with applicable legal requirements and policies approved by the governing authority.

"Department" means the Department of Insurance.

"Governing authority" means a person or body such as a board of trustees or board of directors in whom the ultimate authority and responsibility for the direction of the health care services organization is vested.

"HCSO" means a health care services organization.

"Primary care" means initial treatment or screening of enrollees.

"Primary care physician" means a general practitioner, family physician, internist or pediatrician.

R20-6-1903. Documentation

The chief executive officer (CEO) shall ensure that the HCSO's policies, procedures, plans, class specifications, orders, reports, minutes of meetings, contracts, agreements, records, and duty schedules are in writing, compiled and indexed in one or more manuals, and readily available for inspection by the Director.

R20-6-1904. Service Agreements

The HCSO shall have a written service agreement with each primary care physician who provides services on a continuing basis, except for HCSO employees, that specifies the terms and conditions for services provided to the HCSO.

R20-6-1905. Examination and Review

The Director may inspect an HCSO facility and the facility of any primary care physician with whom the HCSO contracts for services.

R20-6-1906. Health Care Plan

- A.** The applicant shall submit a statement to the Department that describes the proposed health care plan, facilities, and personnel.
- B.** The HCSO shall have an organized system for the delivery of health care services contained in subsection (F) of this Section that includes the following:
 - 1. Physicians, registered nurses and other professional and technical personnel who provide services under the plan;
 - 2. Procedure that promotes a continuing relationship between an enrollee and the same primary care physician; and
 - 3. A procedure for referrals that ensures continuity of care to enrollees.
- C.** The HCSO shall list:
 - 1. The proposed or actual enrollment;
 - 2. The number and names of physicians that will serve the enrollees and the board eligibility or certification of each physician, if any;
 - 3. The number and type of support staff that will serve enrollees; and

4. The plan for providing specialty medical services to enrollees.
- D.** All care provided by the HCSO, whether provided by its own personnel or on a contract basis, shall be by a licensed:
1. Practitioner of the healing arts;
 2. Health care institution; or
 3. Clinical laboratory.
- E.** The health care services described in subsections (F)(1), (2), (3), and (6) of this Section shall be provided 7 days per week, and 24 hours per day.
- F.** The health care plan shall provide, within the geographic area served, at least the following basic health care services that shall be covered by the monthly charges set forth in the evidence of coverage:
1. Emergency care that includes emergency services defined in A.R.S. § 20-2801(3);
 2. Inpatient general hospital care;
 3. Physician care that includes necessary diagnostic and therapeutic services provided by a person who has a current, and valid Arizona license to practice medicine and surgery;
 4. Outpatient care that includes preventive, diagnostic, and therapeutic services, including primary care, furnished by, or under the direction of, a physician, laboratory, or radiology services. Primary care may include services provided by the following:
 - a. A physician's assistant who has a current and valid registration under the applicable provisions of A.R.S. Title 32, Chapters 13, 17 and 25, to provide patient services as specified in the job description or approved program; or
 - b. A registered nurse certified by the Arizona State Board of Nursing, to function in specialty areas under A.R.S. § 32-1601(B)(6).
 5. Health maintenance care designed to prevent illness and to improve the general health of enrollees, offered when medically necessary or indicated that shall include the following:
 - a. Immunizations;

- b. Health education; and
- c. Periodic health examinations, excluding certified health examinations for insurance qualification, school attendance, and employment. The periodic examinations shall include screening for vision and hearing and shall be offered when medically necessary or indicated, and on at least on the following schedule:
 - i. Enrollees aged 0 - 1 year -- 1 exam every 4 months
 - ii. 2 - 5 years -- 1 exam every year
 - iii. 6 - 40 years -- 1 exam every 5 years
 - iv. 41 - 50 years -- 1 exam every 3 years
 - v. 51 - 60 years -- 1 exam every 2 years
 - vi. 61 years and over -- 1 exam every year
 - vii. A medical history and health examination offered to each new enrollee within 12 months after enrollment.

6. Emergency ambulance services under A.R.S. § 20-2801(2), and other ambulance services when approved by a plan physician.

G. The HCSO shall provide appropriate coverage for out-of-area emergency care to enrollees when traveling outside the area served by the HCSO.

R20-6-1907. Geographic Area

A. The applicant shall submit a statement that describes the geographic area in which it will provide services that are reasonably convenient to prospective enrollees.

1. The applicant shall attach a map to the statement that describes the boundaries of the proposed geographic area and the location of each facility in which primary care will be provided under the plan; and

2. The applicant shall describe the proposed geographic area in at least one of the following ways:

- a. Legal description;

- b. Local governmental jurisdiction such as city or county;
 - c. Census tracts ;
 - d. Street boundaries; or
 - e. Area within a specified radius of a specified intersection, or a specified primary care center.
- B.** All advertising matter and sales material provided to prospective enrollees shall include a description of the geographic area in terms readily understandable by the general public.

R20-6-1908. Chief Executive Officer

- A.** The governing authority shall appoint a CEO who shall have appropriate education and experience to manage the HCSO. The governing authority shall define the authority and duties of the CEO in writing. The CEO shall be the appointed representative of the governing authority and shall be the executive officer of the HCSO.
- B.** The CEO shall have at least the following duties and responsibilities:
- 1. Management of the HCSO;
 - 2. Establish and implement policies and procedures of the HCSO;
 - 3. Act as liaison between the governing authority and the providers of healthcare and other services to the HCSO; and
 - 4. Establish a written plan of authority that will be in place in the CEO's absence.
- C.** When there is a change of CEO, the governing authority shall notify Department within 10 days after the effective date of change.
- D.** The HCSO shall assure that all HCSO employees and health practitioners covered by service agreements are knowledgeable about and qualified to perform the duties assigned to them through employment or by contract.
- E.** The HCSO shall designate a central place of business within the major geographic area served at

which the CEO shall be based and from which the HCSO shall direct administrative activities.

R20-6-1909. Medical Director

- A.** The HCSO shall designate a physician as medical director.
- B.** The medical director shall be responsible for planning and implementing the method for the continuing review and evaluation of health care provided by the HCSO and the continuing education of its providers of health care services. The medical director may also serve as the CEO, if the medical director has appropriate education and experience to manage the HCSO.
- C.** The medical director's responsibilities shall include:
 - 1. Supervision of medical staff;
 - 2. Performance planning and evaluation of staff;
 - 3. Coordination of activities of medical staff; and
 - 4. Development of medical care policies.

R20-6-1910. Medical Records

- A.** The HCSO shall maintain a medical record system that is capable of readily providing necessary information and assures continuity of enrollee care.
- B.** The HCSO shall maintain a centralized medical record in accordance with acceptable professional standards. The record shall include records that detail all symptoms presented, diagnoses made and medical treatment the HCSO provided to each enrollee during the term of enrollment. This requirement applies to all HCSO services provided to enrollees, whether provided by employees of the HCSO or non-employees at the request of the HCSO.
- C.** The HCSO shall designate a person to be generally responsible for administration of records.
- D.** The HCSO shall ensure that medical records are kept confidential and that only authorized personnel shall have access to the records.

- E.** Medical records shall not be removed from the premises where they are filed, except by subpoena, court order, or written permission or request of the patient who is the subject of the records. The HCSO may route the record, including X-ray film, to practitioners of the healing arts for consultation or evaluation.
- F.** Under A.R.S. § 20-1058(D) and A.R.S. § 20-1064, the HCSO shall make records available for review by the Director or representatives of the Director. During routine surveys, the Department representatives shall review medical records of the HCSO on a random sample basis or upon complaint or special investigations, specific medical records may be reviewed.
- G.** The HCSO shall ensure that complete records are preserved for at least 10 years. If the enrollee is a minor, the record shall be maintained for at least two years after the enrollee has reached majority.
- H.** If an enrollee discontinues enrollment in the HCSO, the HCSO shall furnish, to the enrollee, upon written request, a written summary covering all pertinent phases of health care provided during enrollment. The summary shall include a copy of pertinent reports and results of diagnostic tests that might be used for comparative purposes, a record of immunizations and the last periodic health examination to another provider of health care services, as specified by the enrollee. This summary shall be furnished within 30 days after the enrollee requests disenrollment. The HCSO may charge a reasonable fee for the summary, based upon the cost of providing it.

R20-6-1911. Quality Assurance

- A.** The HCSO shall provide an effective method for a continuing review and evaluation of the health care provided to ensure that treatment and level of care were appropriate and adequate, that the quality of health care provided met acceptable standards, and that corrective action occurred or will occur, if indicated.
- B.** The HCSO shall have a quality assurance committee that includes at least the chief executive

officer, or designee, the medical director, practitioners of the healing arts, and allied health professionals. Services performed by practitioners of the healing arts shall be reviewed and evaluated by colleagues within their disciplines. The committee shall adopt administrative procedures covering frequency of meetings, types of records to be kept, and arrangements for committee reports and dissemination of the reports.

C. The HCSO shall have a quality assurance that includes procedures to be used for each of the following:

1. Establishment of standards for health care;
2. Monitoring of care provided;
3. Analysis of problems identified;
4. Correction of deficiencies including a time schedule for correction and a link to a continuing education program; and
5. Follow-up and periodic reassessment of the plan.