STATE OF OKLAHOMA

2nd Session of the 45th Legislature (1996)

COMMITTEE SUBSTITUTE
FOR
SENATE BILL NO. 1238 By: Monson

COMMITTEE SUBSTITUTE

(Public health and safety - Managed Care Plan Quality Assurance Act - codification -

effective date)

BE IT ENACTED BY THE PEOPLE OF THE STATE OF OKLAHOMA:

SECTION 1. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 2531 of Title 63, unless there is created a duplication in numbering, reads as follows:

This act shall be known and may be cited as the "Managed Care Plan Quality Assurance Act".

SECTION 2. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 2532 of Title 63, unless there is created a duplication in numbering, reads as follows:

As used in this act:

1. "Consumer" means someone in the general public who may or may not be a covered person or a purchaser of health care including, but not limited to, employers;

2. "Covered person" means a member, enrollee, subscriber, covered life or other person eligible to receive benefits under a health benefit plan issued by a managed care plan;

3. "Managed care plan" means a health maintenance organization (HMO) or preferred provider organization (PPO);

4. "Provider" means a facility, physician, or other health care professional licensed, accredited, or certified to perform specified health care services, as required by the laws of this state;

5. "Quality assessment" means the assessment of health care provided required pursuant to Section 3 of this act; and

6. "Quality improvement" means the internal improvement system required pursuant to Section 4 of this act.

SECTION 3. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 2533 of Title 63, unless there is created a duplication in numbering, reads as follows:

As a condition of doing business in this state, each managed care plan shall:

1. Establish and operate management processes to assess the quality of health care provided to covered persons as required by this act. Such processes shall include systematic collection and analysis of relevant data, in accordance with paragraph 2 of this section. Each managed care plan shall communicate findings in a timely manner to applicable regulatory agencies, providers and consumers as provided for in paragraph 2 of this section and Section 6 of this act;

2. Comply with standards established by the State Board of Health and the Oklahoma Health Care Authority for the collection and reporting of information related to the quality of health care; and

3. File a written description of its quality assessment program with the State Commissioner of Health in a form prescribed by the Commissioner.

SECTION 4. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 2534 of Title 63, unless there is created a duplication in numbering, reads as follows:

A. The provisions of this section apply to each managed care plan that:

1. Purports to assure quality or has contractual or employment arrangements with providers for the purpose, in whole or in part, of coordinating or assuring the quality of any or all portions of the health care delivered to covered persons; or

2. Pays for, reimburses covered persons for, or establishes copayments for which covered persons are responsible for a portion of the cost of, health care services of participating and nonparticipating providers at different rates.

B. Managed care plans shall maintain an internal quality management and improvement system that:

1. Is clearly defined, documented in writing, and assigned to appropriate individuals;

2. Benefits covered persons; and

3. Includes:

a. principles and processes to foster the continuous improvement of the health care provided to covered persons, including, but not limited to:

(1) the provision of information on health care treatment protocols to providers, developed with appropriate clinical input, and

(2) the measurement of provider performance,

b. an organizational structure for designing, measuring, assessing, and improving the processes and outcomes of health care consistent with the provisions of this act and under the direction of the medical director or his or her designee with the same or similar level of professional licensure or certification, and

c. a delineation of objectives, system structure including lines of authority and accountability, types of studies to be performed, and an annual effectiveness review.

C. The quality improvement system of a managed care plan shall include, but not be limited to, the following functions, which shall be performed no less than annually:

1. An analysis of patterns of care related to processes or outcomes, including, when appropriate, focused review of individual situations to discern the cause of variation. The managed care plan must establish priorities for areas to be reviewed based upon the population served by the plan and consideration of at least the following components:

a. an evaluation and identification of areas of health care likely to affect large numbers of covered persons,

b. an evaluation of aggregate data concerning conditions, procedures, or treatments that could place the health of covered persons at serious risk,

c. an evaluation of variations in practice patterns,

d. the use of a range of methods to identify and evaluate underutilization and over-utilization of health care services,

e. the evaluation of courses of treatment and outcomes of health care consistent with reference data bases such as current medical research, knowledge, standards, and practice guidelines, and

f. the use of covered person and provider-specific information from multiple sources, such as utilization management, claims processing, covered person satisfaction, and grievances or complaints; and

2. An evaluation of accessibility of health care services according to standards established by the State Board of Health or established by the managed care plan with the approval of the State Commissioner of Health.

D. 1. A managed care plan shall assure that contracting, employed, or affiliated providers actively participate in developing, implementing, and evaluating the quality improvement system and that covered persons have the opportunity to have meaningful input into the quality improvement process.

2. A managed care plan shall use various mechanisms to improve performance, including communication of quality improvement program findings to staff, providers, and covered persons.

3. Periodically, but no less than annually, a managed care plan shall evaluate the strategies used to improve health care received by covered persons and to affect change in such health care.

E. A managed care plan's quality improvement system shall document efforts in improvement of quality and outcomes of health care, by comparing progress with internal goals and external benchmarks adopted by the managed care plan.

F. The quality improvement system shall have the capacity to identify exemplary and problematic patterns of health care in the aggregate and for individual providers. The plan shall have written procedures for taking action when the information collected indicates areas for improvement relating to problems or potential problems, including referral to enforcement agencies as required by law. These procedures shall include a plan for increasing the intensity of actions and improvements based on a lack of appropriate practice changes and shall be made available to providers.

SECTION 5. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 2535 of Title 63, unless there is created a duplication in numbering, reads as follows:

A. The managed care plan shall document and communicate information about its quality assessment and quality improvement systems, as applicable at a minimum:

1. In marketing materials intended for prospective covered persons, the managed care plan shall include a summary of its quality assessment and quality improvement activities;

2. In the certificate of coverage or covered person handbook provided to newly enrolled covered persons, the managed care plan shall include a description of its quality assessment and quality improvement procedures and a statement of patient rights and responsibilities with respect to those procedures; and

3. The managed care plan shall provide information on its quality assessment and quality improvement system's activities and progress in meeting internal goals, as well as external benchmarks, annually to providers and covered persons, as appropriate.

B. Each managed care plan shall be required to:

1. File with and have approved prior to use by the State Commissioner of Health a written description of its quality assessment and quality improvement programs, along with the materials provided to providers and consumers in accordance with subsection A of this section; or

2. File the materials specified in paragraph 1 of this subsection with the Commissioner along with a signed certification by a managed care plan officer that the filing meets the requirements of this act. Such filings shall be available for review by the public upon request, subject to a reasonable fee, with the exception of those materials specified in Section 7 of this act. In addition, all materials filed shall be retained by the managed care plan for at least three (3) years from the date the material has been used or until the material has been examined as part of a market conduct examination, whichever is longer.

C. The Commissioner may exempt from the requirements of subsection B of this section any material when, in the opinion of the Commissioner, this requirement may not be reasonably applied.

SECTION 6. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 2536 of Title 63, unless there is created a duplication in numbering, reads as follows:

A. As used in this section:

1. "Quality assessment activities" means those activities undertaken by a managed care plan for the purpose of evaluating the quality of, cost of, or necessity for hospitalization or health care; and

2. "Managed care plan" means the managed care plan, any person acting as an agent of the plan, any person under a contract or other formal agreement with the plan, and any person who participates or assists the managed care plan with respect to the quality assessment activities.

B. The records and materials that a managed care plan produces or considers in implementing quality assessment activities, including, but not limited to, records, notes, studies, analyses, exhibits, and proceedings, are confidential and not considered public records within the meaning of the Oklahoma Open Records Act, Section 24A.1 et seq. of Title 51 of the Oklahoma Statutes, are not subject to discovery or introduction into evidence in a civil action against a hospital, provider, or managed care plan that results from matters that are the subject of quality assessment activities for the purpose of proving that the hospital, provider, or the managed care plan breached the applicable standard of care. The records and materials that a managed care plan produces or considers in quality assessment activities shall be available for examination by the State Commissioner of Health in order to determine compliance with this act.

SECTION 7. This act shall become effective November 1, 1996.

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