

STATE OF OKLAHOMA

1st Session of the 47th Legislature (1999)

COMMITTEE SUBSTITUTE
FOR
HOUSE BILL NO. 1681

By: Seikel of the House

and

Monson of the Senate

COMMITTEE SUBSTITUTE

An Act relating to managed care plans; requiring managed care plans to make certain referrals under certain circumstances; directing certain persons be authorized as primary care providers under certain circumstances; directing authorization for nonformulary prescriptions under certain circumstances; directing managed care plans to take certain action to ensure continuity of care when a provider is terminated or a new covered person is enrolled; establishing conditions; providing for coverage for clinical trials under certain circumstances; creating the Oklahoma Managed Care External Review Act; defining terms; providing for right for external review of decisions made by certain entity subject to certain conditions; providing for certain exemptions; requiring certain entities to establish internal reviews; expanding the duties of the State Board of Health and the State Department of Health; directing the promulgation of certain rules for certain internal reviews; establishing procedures and requirements for certain external reviews; providing for certain determinations by certain external review organizations; requiring certification of certain external review organizations; directing certain certification rules and standards; prohibiting certification of certain entities; making certain requirements for expert reviewers; prohibiting and providing for certain conflict of interest; providing for construction of act; amending Sections 5 and 6, Chapter 347, O.S.L. 1992 as last amended by Sections 6 and 7, Chapter 389, O.S.L. 1998 (63 O.S. Supp. 1998, Sections 1-119 and 1-120) which relate to the Oklahoma Health Care Information System Act; adding to the duties of the Division of Health Care Information; requiring hospital and related institutions quality and service effectiveness data and reports; providing criteria and contents; providing for publication and distribution of reports; providing for codification; and providing an 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 6060.7 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. In any case where a managed care plan has no participating providers to provide a covered benefit, the managed care plan shall arrange for a referral to a provider with the necessary expertise and ensure that the covered person obtains the covered benefit at no greater cost to the covered person than if the benefit were obtained from participating providers.

B. A managed care plan shall have a procedure by which a new covered person upon enrollment in a managed care product, or a covered person in a managed care product upon diagnosis, with:

1. A life-threatening condition or disease; or

2. A degenerative and disabling condition or disease,

either of which requires specialized medical care over a prolonged period of time, may receive a referral to a specialist with expertise in treating the life-threatening or degenerative and disabling disease or condition who shall be responsible for and capable of providing and coordinating the insured's primary and specialty care. If the managed care plan, or primary care provider in consultation with the managed care plan and the specialist, if any, determines that the covered person's care would most appropriately be coordinated by such a specialist, the managed care plan shall refer the covered person to such specialist. In no event shall a managed care plan be required to permit a covered person to elect to have a nonparticipating specialist, except pursuant to the provisions of subsection A of this section. Such referral shall be pursuant to a treatment plan approved by the managed care plan, in consultation with the primary care provider if appropriate, the specialist, and the covered person or the covered person's designee. Such specialist shall be permitted to treat the covered person without a referral from the covered person's primary care provider

and may authorize such referrals, procedures, tests and other medical services as the covered person's primary care provider would otherwise be permitted to provide or authorize, subject to the terms of the treatment plan. If a managed care plan refers a covered person to a nonparticipating provider, services provided pursuant to the approved treatment plan shall be provided at no additional cost to the covered person beyond what the covered person would otherwise pay for services received within the network of the managed care plan.

C. A managed care plan that does not allow direct access to all specialists shall establish and implement a procedure by which a covered person may receive a standing referral to a specialist. The procedure shall provide for a standing referral to a specialist if a primary care provider determines in consultation with a specialist that a covered person needs continuing care from a specialist. The referral shall be made pursuant to a treatment plan approved by the managed care plan in consultation with the primary care provider, a specialist, and the covered person. The treatment plan may limit the number of visits to the specialist, limit the period of time that the visits are authorized, or require that the specialist provide the primary care provider with regular reports on the health care provided to the covered person.

D. When a managed care plan uses a formulary for prescription drugs, such managed care plan shall include a written procedure whereby covered persons can obtain, without penalty and in a timely fashion, specific drugs and medications not included in the formulary when:

1. The formulary's equivalent has been ineffective in the treatment of the covered person's disease or condition; or

2. The formulary's drug causes or is reasonably expected to cause adverse or harmful reactions in the covered person.

SECTION 2. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6060.8 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. Every managed care plan shall establish procedures governing termination of participating providers. The procedures shall include assurance of continued coverage of services at the contract price by a terminated provider for up to one hundred twenty (120) calendar days in cases where it is medically necessary for the member to continue treatment with the terminated provider. In cases of the pregnancy of a member, medical necessity shall be deemed to have been demonstrated and coverage of services by the terminated provider shall continue to the postpartum evaluation of the member, up to six (6) weeks after delivery. The policy shall clearly state that the determination as to the medical necessity of a covered person's continued treatment with a terminated provider shall be subject to the appeal procedures of the managed care plan.

B. 1. If the covered person's health care provider leaves the managed care plan's in-network benefits portion of its network of providers for a managed care product for reasons other than those for which the provider would not be eligible to receive a hearing pursuant to the grievance procedures established by the managed care plan for participating providers, the managed care plan shall permit the covered person to continue an ongoing course of treatment with the covered person's current health care provider during a transitional period of:

- a. up to ninety (90) days from the date of notice to the covered person of the provider's disaffiliation from the managed care plan's network, or
- b. if the covered person has entered the second trimester of pregnancy at the time of the provider's disaffiliation, for a transitional period that

includes the provision of postpartum care directly related to the delivery.

2. Notwithstanding the provisions of paragraph 1 of this subsection, continuing care shall be authorized by the managed care plan during the transitional period only if the health care provider agrees:

- a. to continue to accept reimbursement from the managed care plan at the rates applicable prior to the start of the transitional period as payment in full,
- b. to adhere to the managed care plan's quality assurance requirements and to provide to the insurer necessary medical information related to such care, and
- c. to otherwise adhere to the managed care plan's policies and procedures including, but not limited to, procedures regarding referrals and obtaining preauthorization and a treatment plan approved by the managed care plan.

C. 1. If a new covered person whose health care provider is not a member of the managed care plan's in-network benefits portion of the provider network enrolls in the managed care product, the managed care plan shall permit the covered person to continue an ongoing course of treatment with the covered person's current health care provider during a transitional period of up to sixty (60) days from the effective date of enrollment, if:

- a. the covered person has a life-threatening disease or condition or a degenerative and disabling disease or condition, or
- b. the covered person has entered the second trimester of pregnancy at the time of enrollment, in which case the transitional period shall include the provision of postpartum care directly related to the delivery.

2. If a covered person elects to continue to receive care from such health care provider pursuant to paragraph 1 of this subsection, such care shall be authorized by the managed care plan for the transitional period only if the health care provider agrees:

- a. to accept reimbursement from the managed care plan at rates established by the insurer as payment in full, which rates shall be no more than the level of reimbursement applicable to similar providers within the in-network benefits portion of the managed care plan's network for such services,
- b. to adhere to the managed care plan's quality assurance requirements and agrees to provide to the covered person necessary medical information related to such care, and
- c. to otherwise adhere to the managed care plan's policies and procedures including, but not limited to, procedures regarding referrals and obtaining preauthorization and a treatment plan approved by the managed care plan.

3. In no event shall this section be construed to require a managed care plan to provide coverage for benefits not otherwise covered or to diminish or impair preexisting condition limitations contained within the covered person's contract.

SECTION 3. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6060.9 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. A managed care plan shall authorize the participation of a covered person in a clinical trial when:

1. Treatment is being provided pursuant to a Phase II, III or IV clinical trial which has been approved by the National Institute of Health in cooperation with the Food and Drug Administration in the form of an Investigational New Drug (IND) exemption; the

Department of Veteran's Affairs; or a qualified nongovernmental research entity as identified in the guidelines for National Institute of Health support grants;

2. The proposed therapy has been reviewed and approved by a qualified institutional review board (IRB);

3. The facility and personnel providing the treatment are capable of doing so by virtue of their experience, training, and volume of patients treated to maintain expertise;

4. The patients receiving the investigational treatment meet all protocol requirements;

5. There is no clearly superior, noninvestigational alternative to the protocol treatment; and

6. The available clinical or preclinical data provide a reasonable expectation that the protocol treatment will be at least as efficacious as the noninvestigational alternative.

B. The coverage of new therapy treatment provided pursuant to a Phase II clinical trial shall not be required for only such portion of that treatment as is provided as part of the Phase II clinical trial and is otherwise funded by a national agency, the Veteran's Administration, the Department of Defense, or funded by commercial organizations such as the biotechnical or pharmaceutical industry or manufacturers of medical devices. Any portions of a Phase II trial which are customarily funded by government, biotechnical or pharmaceutical or medical device industry sources in Oklahoma or in other states shall continue to be so funded in Oklahoma and coverage pursuant to this section shall supplement, not supplant, such customary funding.

SECTION 4. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6471 of Title 36, unless there is created a duplication in numbering, reads as follows:

Sections 4 through 13 of this act shall be known and may be cited as the "Oklahoma Managed Care External Review Act".

SECTION 5. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6472 of Title 36, unless there is created a duplication in numbering, reads as follows:

As used in the Oklahoma Managed Care External Review Act:

1. "Health benefit plan" means an individual or group hospital or medical insurance coverage, not-for-profit hospital or medical service or indemnity plan, a prepaid health plan, a health maintenance organization, a preferred provider plan, the State and Education Employees Group Insurance Plan, coverage provided by a Multiple Employer Welfare Arrangement or self-insured plan;

2. "Insured person" means an individual who received medical care and treatment through a health benefit plan. In the case of a minor child, the term includes the parent or legal guardian of the child and, in the case of an incapacitated or partially incapacitated person, the legal guardian of the person;

3. "Designee of an insured person" means an individual designated by an insured person to represent the interests of the insured person, including the insured person's physician;

4. "Independent review organization" means an entity certified by the State Department of Health to conduct external reviews;

5. "Internal review" means procedures established by a health benefit plan, pursuant to the provisions of Section 4 of this act, for an internal reevaluation of an initial decision to deny reimbursement for or coverage of a medical treatment or service that is otherwise a covered benefit and a determination by the health benefit plan to grant or deny coverage or reimbursement; and

6. "External review" means a review of a decision by a health benefit plan to deny reimbursement for or coverage of a medical treatment or service that is otherwise a covered benefit by an independent review organization upon the request of an insured person or the representative of an insured person and a

determination to uphold or reverse the denial of coverage or reimbursement made by the health benefit plan.

SECTION 6. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6473 of Title 36, unless there is created a duplication in numbering, reads as follows:

An insured person or the parent, guardian, or representative of the insured person shall have the right to an external review by an independent review organization of a decision under a health benefit plan to deny reimbursement for or coverage of a medical treatment or service that is otherwise a covered benefit when:

1. All applicable internal appeals procedures established by the health benefit plan have been exhausted;
2. The denial is based on a determination by the health benefit plan that the service or treatment is not medically necessary, medically appropriate, or medically effective;
3. The cost of the service or treatment for which coverage or reimbursement was denied by the health benefit plan exceeds Two Thousand Five Hundred Dollars (\$2,500.00); and
4. The insured person or the representative of the insured person agrees to the terms and conditions of external review as provided by Section 5 of this act.

SECTION 7. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6474 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. Except as specifically provided by this section, every health benefit plan that is offered, issued or renewed after November 1, 1999 shall provide for an external review process by an independent review organization in accordance with the provisions of the Oklahoma Managed Care External Review Act. The following shall not be subject to the provisions of the Oklahoma Managed Care External Review Act:

1. Health benefit plans that do not deny coverage of or reimbursement for a medical service or treatment on the grounds that the medical service or treatment is not medically necessary, medically appropriate, or is medically ineffective;

2. Health benefit plans and health care provided pursuant to Titles XVIII, XIX or XXI of the federal Social Security Act; and

3. Workers' compensation benefits or coverage subject to Title 85 of the Oklahoma Statutes.

B. Every health benefit plan subject to this act shall establish internal appeals procedures in accordance with rules promulgated by the State Board of Health and the Insurance Commissioner. The State Board of Health and the Insurance Commissioner shall respectively promulgate rules for internal review procedures for the health benefit plans subject to licensure or regulation by the State Department of Health and the Insurance Department and subject to the provisions of the Oklahoma Managed Care External Review Act. The rules shall include provisions for expedited internal review procedures in emergency situations. In the development and promulgation of the rules, the State Board of Health and the Insurance Commissioner shall collaborate on the development and promulgation of the rules in order to avoid unnecessary conflict between the rules of the two agencies and duplication of effort by the health benefit plans.

C. Upon the verbal or written request of an insured person or the representative of an insured person, every health benefit plan shall immediately provide the requester with clear information about the terms, conditions and procedures of the internal review process or the external review process, or both.

SECTION 8. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6475 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. An insured person or representative of an insured person shall be required to pay One Hundred Dollars (\$100.00) toward the cost of the external review.

1. The payment is due at the time the preliminary screening is completed and the insured person or the representative of the insured person is notified of a determination by the independent review organization to accept the appeal for a full external review.

2. Whenever the insured person or the representative of the insured person prevails at the completion of the external review, the payment shall be refunded.

3. The health benefit plan shall be responsible for the remaining costs related to the external review process.

B. The determination of the independent review organization is binding on the health benefit plan, the covered person, and the health care provider for the covered person. A condition of completing the external review process shall be the agreement by the parties to waive the right to file a court action to resolve the issue in dispute, either during or at the completion of the external review process.

C. The number of appeals for an external review by a covered person or a representative of a covered person shall be limited to one external review per condition or treatment.

D. The health benefit plan may, at its discretion, determine that additional information provided by the insured person or the representative or physician of the insured person justifies a reconsideration of the denial of coverage or reimbursement. Upon notice to the covered person or the representative of the covered person and the independent review organization, a decision by the health benefit plan to grant coverage or reimbursement shall terminate the external review.

E. Nothing in the Oklahoma Managed Care External Review Act shall:

1. Create any new private right or cause of action for or on behalf of any covered person; or

2. Render the health benefit plan liable for damages arising from any act or omission of the independent review organization.

F. Independent review organizations and expert reviewers assigned by an independent review organization to conduct an external review are not liable for damages arising from determinations made pursuant to the Oklahoma Managed Care External Review Act. This provision shall not apply to an act or omission that is made in bad faith or that involves gross negligence.

G. After an appeal has been accepted for external review by an independent review organization, an informed consent form signed by the insured person or the representative of the insured person acknowledging that they have received a copy of the terms and conditions of the external review process as provided by this section and understand and consent to them shall be required prior to initiating a full external review.

H. A health benefit plan shall not remove a physician from its plan or refuse to renew the physician with the plan or otherwise discipline a physician for advocating on behalf of an insured person in either an internal or an external review.

SECTION 9. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6476 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. An appeal from a decision by a health benefit plan to deny coverage or reimbursement for a service or treatment and request for an external review shall be initiated in writing by the insured person or the representative of the insured person. The request shall be delivered to the health benefit plan within thirty (30) days after receipt of written notification from the health benefit plan of the denial after completion of the internal review process.

B. Upon receipt of the request for an external review, the health benefit plan shall immediately notify an independent review organization selected from a list of independent review organizations certified by the State Department of Health and inform the covered person or the representative of the covered person as to the independent review organization selected.

C. Within five (5) business days of notification as to the independent review organization, the insured person or representative of the insured person shall provide the independent review organization with the following documents:

1. A written request for an external review of the decision by the health benefit plan to deny coverage or reimbursement and a statement of the reasons for the request;

2. A copy of the final decision of denial made by the health benefit plan; and

3. A fully executed release authorizing the independent review organization to obtain necessary medical records from the health benefit plan and any relevant health care providers.

D. Upon receipt of a written request for an external review and the documentation as provided by subsection C of this section, the independent review organization shall conduct a preliminary review of the appeal and shall accept it for a full review when the independent review organization determines that:

1. The individual on whose behalf the appeal is made is or was an insured person or is the representative of an insured person;

2. The subject of the coverage desired or for which reimbursement is asked is a covered service, or treatment or a service or treatment provided by contract to the insured person;

3. The insured person or the representative of the insured person has exhausted the internal review procedures of the health benefit plan; and

4. The insured person or the representative of the insured person has notified the health benefit plan of the request for an external review.

E. Upon the completion of the preliminary review, the independent review organization shall immediately make written notification of its determination whether or not to accept the appeal for full external review to the insured person or the designee of the insured person, the health benefit plan and, if possible, the physician of the insured person. If the appeal is not accepted for full external review, a statement of the reasons for nonacceptance shall be included with the notification.

SECTION 10. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6477 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. Upon receipt of notification of acceptance of an appeal for full external review from an independent review organization, the health benefit plan shall provide the independent review organization with the following documents within five (5) business days after receipt of a request for an external review:

1. Any information that was submitted to the health benefit plan by the insured person or the representative or physician of the insured person in support of the request for coverage or reimbursement pursuant to the internal review process; and

2. A copy of the contract provisions upon which the denial of coverage or reimbursement was based, any statement by the health benefit plan explaining the reasons for the decision of the health plan not to provide coverage or to deny reimbursement, and any other relevant documents used by the health benefit plan in reaching its decision.

B. Upon the request of the covered person or the representative of the insured person, the health benefit plan shall provide the

information required by subsection B of this section to the insured person or the representative or physician of the insured person.

C. The independent review organization shall notify the insured person or the representative of the insured person of any additional information it requires within five (5) business days after receipt of the information submitted by the health benefit plan. The insured person or the representative of the insured person shall submit the additional information, or an explanation as to why the additional information cannot be submitted, within five (5) business days of receipt of the request for additional information.

D. The independent review organization shall maintain the confidentiality of medical records submitted to it in accordance with state and federal law, and shall maintain the confidentiality of proprietary information submitted by the health benefit plan.

E. The independent review organization shall make a written determination on the appeal stating the reasons why the desired service or treatment, or reimbursement for service or treatment, should or should not be made by the health benefit plan. The determination shall be delivered to the insured person or designee of the insured person, the physician of the insured person, and the health benefit plan of its determination within thirty (30) days after acceptance of the appeal for external review and receipt of the documentation required by this section.

F. When the physician of the insured person certifies in writing that the times provided for by this section could jeopardize the life or health of the patient, the decision shall be rendered as rapidly as warranted by the condition of the patient but shall in no event exceed seventy-two (72) hours.

SECTION 11. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6478 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. The determination of the independent review organization as to the resolution of the appeal shall be based upon a review of the written record before it. In reaching this determination, the independent review organization shall apply any applicable health benefit plan policy or contract provisions, taking into consideration all pertinent medical records, consulting physician reports, medical and scientific evidence, and other documentation submitted by the parties.

B. Medical and scientific evidence includes, but is not limited to, the following sources:

1. Peer-reviewed scientific studies published by medical journals that meet nationally recognized requirements for scientific manuscripts in that most of the published articles are submitted for review by experts who are not part of the editorial staff;

2. Peer-reviewed literature, biomedical compendia, and other medical literature that meet the criteria of the National Institute of Health's National Library of Medicine for indexing in index medicus, excerpta medicus ("EMBASE"), medline, and Medlars data base of health services technology assessment research ("HSTAR");

3. Medical journals recognized by the United States Secretary of Health and Human Services, pursuant to Section 1861(t)(2) of the Federal Social Security Act;

4. The following standard reference compendia:

- a. the American Hospital Formulary Service-Drug Information,
- b. the American Medical Association Drug Evaluation,
- c. the American Dental Association Accepted Dental Therapeutics, and
- d. the United States Pharmacopoeia-Drug Information.

5. Findings, studies or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes, including the Federal Agency for Health

Care Policy and Research, National Institutes for Health, the National Cancer Institute, the National Academy of Sciences, the Health Care Financing Administration, the Congressional Office of Technology Assessment, and the national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health services.

SECTION 12. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6479 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. The State Board of Health shall promulgate rules for the certification of independent review organizations. The rules promulgated by the Board shall:

1. Establish minimum standards that:

- a. ensure the independence of the review organization and the review process,
- b. ensure the independence of the health care professionals providing analyses, recommendations, and other information requested of them,
- c. provide for the confidentiality of medical records,
- d. provide for expedited appeals in emergency situations, and
- e. ensure fair business practices by the independent review organizations.

B. Any independent review organization accredited by a nationally recognized accrediting organization for the accreditation of external review organizations shall be deemed to meet the standards promulgated by the Board.

C. The State Department of Health shall certify, refuse to certify, renew certification and refuse to renew certification of independent review organizations and shall enforce the rules promulgated by the Board.

D. The following organizations are not eligible for certification as an independent review organization:

1. Professional trade associations of health care providers or their subsidiaries or affiliates; or

2. Health plans or health plan associations or their subsidiaries or affiliates.

SECTION 13. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6480 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. Persons assigned by an independent review organization as expert reviewers shall be physicians and shall:

1. Be expert in the medical condition of the insured person and have knowledge regarding the recommended service or treatment through actual clinical experience;

2. Hold a nonrestricted license in a state of the United States;

3. Be currently certified by a recognized American medical specialty board in the areas appropriate to the subject of review; and

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

B. Neither the expert reviewer nor the independent review organization shall have any material, professional, familial or financial conflict of interest with:

1. The health benefit plan;

2. Any officer, director, or management employee of the health benefit plan;

3. The physician, the physician's medical group, or the independent practice association proposing the treatment or service;

4. The institution at which the treatment or service would be provided;

5. The development or manufacture of the principal drug, device, procedure or other therapy proposed for the insured person whose treatment is under review; or

6. The insured person or representative of the insured person who requested the external review.

C. Potential expert reviewers shall disclose any information regarding a potential conflict of interest to the independent review organization.

D. As used in this section, the term "conflict of interest" shall not be interpreted to include a contract under which an academic medical center, or other similar medical center, provides health services to covered persons.

SECTION 14. AMENDATORY Section 5, Chapter 347, O.S.L. 1992, as last amended by Section 6, Chapter 389, O.S.L. 1998 (63 O.S. Supp. 1998, Section 1-119), is amended to read as follows:

Section 1-119. A. 1. The Division of Health Care Information shall, with the advice of the Health Care Information Advisory Committee and in accordance with the rules of the State Board of Health, collect health care information from information providers.

2. The information to be collected about information providers may include, but shall not be limited to:

- a. financial information including, but not limited to, consumption of resources to provide services, reimbursement, costs of operation, revenues, assets, liabilities, fund balances, other income, rates, charges, units of service, wage and salary data,
- b. service information including, but not limited to, occupancy, capacity, and special and ancillary services,
- c. physician profiles in the aggregate by clinical specialties and nursing services,

- d. discharge data including, but not limited to, completed discharge data sets or comparable information for each patient discharged from the facility after the effective date of this act, ~~and~~
- e. ambulatory care data including, but not limited to, provider-specific and encounter data, and
- f. hospitals and related institutions quality and service effectiveness.

3. The Division shall establish a phase-in schedule for the collection of health care data. The phase-in schedule shall provide that prior to January 1, 1994, only data currently collected shall be required to be submitted to the Division. Thereafter, in the collection of health care data, the Division shall whenever possible utilize existing health data resources and avoid duplication in the collection of health care data.

4. Except as provided by Section 1-120 of this title and as otherwise authorized by the provisions of the Oklahoma Health Care Information System Act, the provisions of the Oklahoma Health Care Information System Act shall not be construed to lessen or reduce the responsibility of the information provider with regard to:

- a. the accuracy of the data or information submitted,
- b. liability for release of the data or information to the Division, data processor or as otherwise authorized by this section, or
- c. the preservation of confidentiality of such data or information until submitted to the Division.

B. Upon the request of the State Department of Health, every state agency, board or commission shall provide the Division of Health Care Information with the health care data and other health care information requested at no charge to the Department or the Division. Except as otherwise provided by the Health Care Information System Act for the purpose of statistical and similar

reports, information which is required by state or federal law to be confidential shall not be transferred to any entity by the Division unless a separate written agreement for such transfer has been executed with the state agency, board or commission providing the information to the Division.

C. The University of Oklahoma College of Public Health, the Department of Human Services, the Department of Mental Health and Substance Abuse Services and the Oklahoma Health Care Authority are hereby authorized to have access to the health care information system established pursuant to the Oklahoma Health Care Information System Act, in accordance with a mutual interagency agreement between the State Department of Health and each specified entity on an individual basis.

SECTION 15. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1-119.1 of Title 63, unless there is created a duplication in numbering, reads as follows:

A. The Division of Health Care Information of the State Department of Health shall prepare and issue reports at least annually to the Legislature and to the general public regarding hospitals and related institutions quality and service effectiveness.

1. The Division shall, for every hospital and related institution within Oklahoma and within appropriate regions and subregions within Oklahoma and for those inpatient and outpatient services which, when ranked by order of frequency, account for at least sixty-five percent (65%) of all covered services and which, when ranked by order of total payments, account for at least sixty-five percent (65%) of total payments, prepare and issue reports that include but are not limited to the following:

- a. comparisons among all hospitals and related institutions of payments received, charges, population-based admission or incidence rates, and

service effectiveness, such comparisons to be grouped according to diagnosis and severity, and to identify each hospital and related institution by name and type or speciality,

- b. comparisons among all hospitals and related institutions of inpatient and outpatient charges and payments for room and board, ancillary services, drugs, equipment and supplies and total services, such as comparisons to be grouped according to hospitals and related institutions quality and service effectiveness and according to diagnosis and severity, and to identify each health care facility by name and type,
- c. the incidence rate of selected medical or surgical procedures, the hospitals and related institutions service effectiveness and the payments received for those providers, identified by the name and type or specialty, for which these elements vary significantly from the norms for all hospitals and related institutions,
- d. the number of physicians, by specialty, on the staff of each hospital and related institution, and
- e. the status of the hospitals and related institutions with respect to accreditation and licensure.

2. The Division shall maintain a file of written statements submitted by data sources who wish to provide an explanation of data that they feel might be misleading or misinterpreted. The Division shall provide access to such file to any person and shall, where practical, in its reports and data files indicate the availability of such statements. When the Division agrees with such statements, it shall correct the appropriate data and comments in its data files and subsequent reports.

3. In preparing reports pursuant to this section, the Division shall ensure that factors which have the effect of either reducing a hospital's or related institution's revenue or increasing costs, and other factors beyond a hospital's or related institution's control which reduced competitiveness in the market place, are explained in the reports. It shall also ensure that any clarifications and dissents submitted by individual hospitals and related institutions are noted in any reports that include release of data on the individual hospital or related institution.

4. The Division shall publish all reports required by this section in at least one newspaper of general circulation in each subregion within the state, reports on the hospitals and related institutions in that subregion, and subregions adjacent to it. In addition, the Division shall advertise annually the availability of these reports and the charge for duplication in at least one newspaper of general circulation in each subregion within the state at least once in each calendar quarter.

B. In addition to other information required to be submitted to the Division by the Oklahoma Health Care Information System Act, hospitals and related institutions are hereby required to submit and the Division is hereby authorized to collect, in accordance with submission dates and schedules established by the Division, the following additional data, provided such data is not available to the Division from public records or other data collected by the Division:

1. The incidence of medical and surgical procedures in the population for individual hospitals and related institutions;

2. Mortality rates for specified diagnoses and treatments, grouped by severity, for individual facilities;

3. Rates of infection for specified diagnoses and treatments, grouped by severity, for individual facilities;

4. Morbidity rates for specified diagnoses and treatments, grouped by severity, for individual facilities;

5. Readmission rates for specified diagnoses and treatments, grouped by severity, for individual facilities;

6. Rate of incidence of postdischarge professional care for selected diagnoses and procedures, grouped by severity, for individual facilities;

7. The number of registered nurses providing direct patient care for individual facilities;

8. The number of unlicensed personnel utilized to provide direct patient care for individual facilities;

9. The average number of patients per registered nurse providing direct patient care for individual facilities;

10. The methods used for determining and adjusting staffing levels and patient care needs for individual facilities; and

14. Any other data the Division requires to carry out its responsibilities pursuant to this section.

C. The Division shall define a methodology to measure and report on hospitals and related institutions service quality and effectiveness. The Division may adopt a nationally recognized methodology of quantifying and collecting data on hospitals and related institutions quality and provider service effectiveness until such time as the Division has the capability of developing its own methodology and standard data elements.

SECTION 16. AMENDATORY Section 6, Chapter 347, O.S.L. 1992, as last amended by Section 7, Chapter 389, O.S.L. 1998 (63 O.S. Supp. 1998, Section 1-120), is amended to read as follows:

Section 1-120. A. Except as otherwise provided by Section 1-119 of this title and Section 15 of this act, the individual forms, computer tapes, or other forms of data collected by and furnished to the Division of Health Care Information or to a data processor pursuant to the Oklahoma Health Care Information System Act, Section

1-115 et seq. of this title, shall be confidential and shall not be public records as defined in the Open Records Act, Section 24A.1 et seq. of Title 51 of the Oklahoma Statutes.

B. After approval by the State Department of Health, the compilations prepared for release or dissemination from the data collected, except for a report prepared at the request of an individual data provider containing information concerning only its transactions, shall be public records. The Division shall establish a Health Care Information Advisory Committee as provided in Section 1-122 of this title, to assist with determinations related to data collection, and information to be released and disseminated to the public.

C. The confidentiality of identifying information is to be protected and the pertinent statutes, rules and regulations of the State of Oklahoma and of the federal government relative to confidentiality shall apply.

D. Identifying information shall not be disclosed, and shall not be used for any purpose except for the creation and maintenance of anonymous medical case histories for statistical reporting and data analysis.

E. The Division or other state agency receiving information pursuant to the Oklahoma Health Care Information System Act shall be subject to the same confidentiality restrictions imposed by state or federal law as the public or private agency providing the information and is prohibited from taking any administrative, investigative or other action with respect to any individual on the basis of the identifying information. The Division data analyzer or other state agency receiving information pursuant to the Oklahoma Health Care Information System Act is further prohibited from identifying, directly or indirectly, any individual in any report of scientific research or long-term evaluation, or otherwise disclosing identities in any manner.

F. Except as otherwise authorized by the Oklahoma Health Care Information System Act, identifying information submitted to the Division which would directly or indirectly identify any person shall not be disclosed by the Division either voluntarily or in response to any legal process, unless directed to by a court of competent jurisdiction, granted after application showing good cause therefor with notice of the hearing to the Division. In assessing good cause the court shall only grant such application if it seeks to challenge the statistical efficacy of a finding made by the Division or alleges a violation of confidentiality by the Division. Such application shall then be granted only when the public interest and the need for disclosure outweighs the injury to the person, to the physician-patient relationship, and to the treatment services. Upon the granting of such order, the court, in determining the extent to which any disclosure of all or any part of any record is necessary, shall impose appropriate safeguards against unauthorized disclosure.

G. Any person who submits or receives data as required or authorized by the Oklahoma Health Care Information System Act shall be immune from liability in any civil action for any action taken as required by the provisions of the Oklahoma Health Care Information System Act. This immunity is in addition to any other immunity for the same or similar acts to which the person is otherwise entitled.

SECTION 17. This act shall become effective November 1, 1999.

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