STATE OF OKLAHOMA

2nd Session of the 55th Legislature (2016)

SENATE BILL 1363 By: David

AS INTRODUCED

An Act relating to health care provider compensation; amending 36 O.S. 2011, Sections 6097 and 6913, as amended by Section 19, Chapter 275, O.S.L. 2014 (36 O.S. Supp. 2015, Section 6193), which relate to compensation for medical practitioners and liability of subscriber for health maintenance organization's debts; establishing compensation scheme for certain providers; defining out-of-network practitioners; prohibiting certain actions; and providing an effective date.

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

SECTION 1. AMENDATORY 36 O.S. 2011, Section 6907, is amended to read as follows:

Section 6907. A. Every health maintenance organization shall establish procedures that ensure that health care services provided to enrollees shall be rendered under reasonable standards of quality of care consistent with prevailing professionally recognized standards of medical practice. The procedures shall include mechanisms to assure availability, accessibility and continuity of care.

B. The health maintenance organization shall have an ongoing internal quality assurance program to monitor and evaluate its health care services, including primary and specialist physician services and ancillary and preventive health care services across all institutional and noninstitutional settings. The program shall include, but need not be limited to, the following:

1. A written statement of goals and objectives that emphasizes improved health status in evaluating the quality of care rendered to enrollees;

2. A written quality assurance plan that describes the following:

a. the health maintenance organization's scope and purpose in quality assurance,

b. the organizational structure responsible for quality assurance activities,

c. contractual arrangements, where appropriate, for delegation of quality assurance activities,

d. confidentiality policies and procedures,

e. a system of ongoing evaluation activities,

f. a system of focused evaluation activities,

g. a system for credentialing and recredentialing providers, and performing peer review activities, and

h. duties and responsibilities of the designated physician responsible for the quality assurance activities;

3. A written statement describing the system of ongoing quality assurance activities including:

a. problem assessment, identification, selection and study,

b. corrective action, monitoring, evaluation and reassessment, and

c. interpretation and analysis of patterns of care rendered to individual patients by individual providers;

4. A written statement describing the system of focused quality assurance activities based on representative samples of the enrolled population that identifies method of topic selection, study, data collection, analysis, interpretation and report format; and

5. Written plans for taking appropriate corrective action whenever, as determined by the quality assurance program, inappropriate or substandard services have been provided or services that should have been furnished have not been provided.

C. The organization shall record proceedings of formal quality assurance program activities and maintain documentation in a confidential manner. Quality assurance program minutes shall be available to the State Commissioner of Health.

D. The organization shall ensure the use and maintenance of an adequate patient record system which will facilitate documentation and retrieval of clinical information for the purpose of the health maintenance organization's evaluating continuity and coordination of patient care and assessing the quality of health and medical care provided to enrollees.

E. Enrollee clinical records shall be available to the State Commissioner of Health or an authorized designee for examination and review to ascertain compliance with this section, or as deemed necessary by the State Commissioner of Health.

F. The organization shall establish a mechanism for periodic reporting of quality assurance program activities to the governing body, providers and appropriate organization staff.

G. The organization shall be required to establish a mechanism under which physicians participating in the plan may provide input into the plan's medical policy including, but not limited to, coverage of new technology and procedures, utilization review criteria and procedures, quality, credentialing and recredentialing criteria, and medical management procedures.

H. As used in this section "credentialing" or "recredentialing", as applied to physicians and other health care providers, means the process of accessing and validating the qualifications of such persons to provide health care services to the beneficiaries of a health maintenance organization.

"Credentialing" or "recredentialing" may include, but need not be limited to, an evaluation of licensure status, education, training, experience, competence and professional judgment. Credentialing or recredentialing is a prerequisite to the final decision of a health maintenance organization to permit initial or continued participation by a physician or other health care provider.

1. Physician credentialing and recredentialing shall be based on criteria as provided in the uniform credentialing application required by Section 1-106.2 of Title 63 of the Oklahoma Statutes, with input from physicians and other health care providers.

2. Organizations shall make information on credentialing and recredentialing criteria available to physician applicants and other health care providers, participating physicians, and other participating health care providers and shall provide applicants with a checklist of materials required in the application process.

3. When economic considerations are part of the credentialing and recredentialing decision, objective criteria shall be used and shall be available to physician applicants and participating physicians. When graduate medical education is a consideration in the credentialing and recredentialing process, equal recognition shall be given to training programs accredited by the Accrediting Council on Graduate Medical Education and by the American Osteopathic Association. When graduate medical education is considered for optometric physicians, consideration shall be given

for educational accreditation by the Council on Optometric Education.

4. Physicians or other health care providers under consideration to provide health care services under a managed care plan in this state shall apply for credentialing and recredentialing on the uniform credentialing application and provide the documentation as outlined by the plan's checklist of materials required in the application process.

5. A health maintenance organization (HMO) shall determine whether a credentialing or recredentialing application is complete. If an application is determined to be incomplete, the plan shall notify the applicant in writing within ten (10) calendar days of receipt of the application. The written notice shall specify the portion of the application that is causing a delay in processing and explain any additional information or corrections needed.

6. In reviewing the application, the health maintenance organization (HMO) shall evaluate each application according to the plan's checklist of materials required in the application process.

7. When an application is deemed complete, the HMO shall initiate requests for primary source verification and malpractice history within seven (7) calendar days.

8. A malpractice carrier shall have twenty-one (21) calendar days within which to respond after receipt of an inquiry from a health maintenance organization (HMO). Any malpractice carrier that

fails to respond to an inquiry within the allotted time frame may be assessed an administrative penalty by the State Commissioner of Health.

9. Upon receipt of primary source verification and malpractice history by the HMO, the HMO shall determine if the application is a clean application. If the application is deemed clean, the HMO shall have forty-five (45) calendar days within which to credential or recredential a physician or other health care provider. As used in this paragraph, "clean application" means an application that has no defect, misstatement of facts, improprieties, including a lack of any required substantiating documentation, or particular circumstance requiring special treatment that impedes prompt credentialing or recredentialing.

10. If a health maintenance organization is unable to credential or recredential a physician or other health care provider due to an application's not being clean, the HMO may extend the credentialing or recredentialing process for sixty (60) calendar days. At the end of sixty (60) calendar days, if the HMO is awaiting documentation to complete the application, the physician or other health care provider shall be notified of the delay by certified mail. The physician or other health care provider may extend the sixty-day period upon written notice to the HMO within ten (10) calendar days; otherwise the application shall be deemed withdrawn.

11. In no event shall the entire credentialing or recredentialing process exceed one hundred eighty (180) calendar days.

12. A health maintenance organization shall be prohibited from solely basing a denial of an application for credentialing or recredentialing on the lack of board certification or board eligibility and from adding new requirements solely for the purpose of delaying an application.

13. Any HMO that violates the provisions of this subsection may be assessed an administrative penalty by the State Commissioner of Health.

I. Health maintenance organizations shall not discriminate against enrollees with expensive medical conditions by excluding practitioners with practices containing a substantial number of these patients.

J. Health maintenance organizations shall, upon request, provide to a physician whose contract is terminated or not renewed for cause the reasons for termination or nonrenewal. Health maintenance organizations shall not contractually prohibit such requests.

K. No HMO shall engage in the practice of medicine or any other profession except as provided by law nor shall an HMO include any provision in a provider contract that precludes or discourages a health maintenance organization's providers from:

1. Informing a patient of the care the patient requires, including treatments or services not provided or reimbursed under the patient's HMO; or

2. Advocating on behalf of a patient before the HMO.

L. Decisions by a health maintenance organization to authorize or deny coverage for an emergency service shall be based on the patient presenting symptoms arising from any injury, illness, or condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a reasonable and prudent layperson could expect the absence of medical attention to result in serious:

1. Jeopardy to the health of the patient;

2. Impairment of bodily function; or

3. Dysfunction of any bodily organ or part.

M. Health maintenance organizations shall not deny an otherwise covered emergency service based solely upon lack of notification to the HMO.

N. Health maintenance organizations shall compensate a provider for patient screening, evaluation, and examination services that are reasonably calculated to assist the provider in determining whether the condition of the patient requires emergency service. <u>The compensation will be based upon costs that are usual, customary and common to the specific geographic area where the provider is located and will be limited for reimbursement at a level no greater than</u>

that of an in-network service amount. If the provider determines that the patient does not require emergency service, coverage for services rendered subsequent to that determination shall be governed by the HMO contract.

O. Providers that choose to not contract with an HMO are deemed "out of network". Any out-of-network provider who provides emergency services to an HMO enrollee may not charge the enrollee for amounts other than applicable copayments or deductibles.

P. If within a period of thirty (30) minutes after receiving a request from a hospital emergency department for a specialty consultation, a health maintenance organization fails to identify an appropriate specialist who is available and willing to assume the care of the enrollee, the emergency department may arrange for emergency services by an appropriate specialist that are medically necessary to attain stabilization of an emergency medical condition, and the HMO shall not deny coverage for the services due to lack of prior authorization.

~~P.~~ Q. The reimbursement policies and patient transfer requirements of a health maintenance organization shall not, directly or indirectly, require a hospital emergency department or provider to violate the federal Emergency Medical Treatment and Active Labor Act. If a member of an HMO is transferred from a hospital emergency department facility to another medical facility, the HMO shall reimburse the transferring facility and provider for

services provided to attain stabilization of the emergency medical condition of the member in accordance with the federal Emergency Medical Treatment and Active Labor Act.

SECTION 2. AMENDATORY 36 O.S. 2011, Section 6913, as amended by Section 19, Chapter 275, O.S.L. 2014 (36 O.S. Supp. 2015, Section 6913), is amended to read as follows:

Section 6913. A. 1. Before issuing any certificate of authority, the Insurance Commissioner shall require that the health maintenance organization have an initial net worth of One Million Five Hundred Thousand Dollars ($1,500,000.00) and that the HMO shall thereafter maintain the minimum net worth required under paragraph 2 of this subsection.

2. Except as provided in paragraphs 3 and 4 of this subsection, every health maintenance organization shall maintain a minimum net worth equal to the greater of:

a. One Million Five Hundred Thousand Dollars ($1,500,000.00),

b. two percent (2%) of annual premium revenues as reported on the most recent annual financial statement filed with the Commissioner on the first One Hundred Fifty Million Dollars ($150,000,000.00) of premium and one percent (1%) of annual premium on the premium in excess of One Hundred Fifty Million Dollars ($150,000,000.00),

c. an amount equal to the sum of three (3) months of uncovered health care expenditures as reported on the most recent financial statement filed with the Commissioner, or

d. an amount equal to the sum of:

(1) eight percent (8%) of annual health care expenditures, except those paid on a capitated basis or managed hospital payment basis, as reported on the most recent financial statement filed with the Commissioner, and

(2) four percent (4%) of annual hospital expenditures paid on a managed hospital payment basis, as reported on the most recent financial statement filed with the Commissioner.

3. Every health maintenance organization licensed before November 1, 2003, shall maintain a minimum net worth of the greater of Seven Hundred Fifty Thousand Dollars ($750,000.00) or:

a. twenty-five percent (25%) of the amount required by paragraph 2 of this subsection by December 31, 2003,

b. fifty percent (50%) of the amount required by paragraph 2 of this subsection by December 31, 2004,

c. seventy-five percent (75%) of the amount required by paragraph 2 of this subsection by December 31, 2005, and

d. one hundred percent (100%) of the amount required by paragraph 2 of this subsection by December 31, 2006.

4. a. In determining net worth, no debt shall be considered fully subordinated unless the subordination clause is in a form acceptable to the Commissioner. An interest obligation relating to the repayment of any subordinated debt shall be similarly subordinated.

b. The interest expenses relating to the repayment of a fully subordinated debt shall be considered covered expenses.

c. A debt incurred by a note meeting the requirements of this section, and otherwise acceptable to the Insurance Commissioner, shall not be considered a liability and shall be recorded as equity.

B. 1. Unless otherwise provided below, each health maintenance organization shall deposit with the Commissioner or, at the discretion of the Commissioner, with any organization or trustee acceptable to the Commissioner through which a custodial or controlled account is utilized, cash, securities, or any combination of these or other measures that are acceptable to the Commissioner, which at all times shall have a value of not less than Five Hundred Thousand Dollars ($500,000.00).

2. The deposit shall be an admitted asset of the health maintenance organization in the determination of net worth.

3. All income from deposits shall be an asset of the organization. A health maintenance organization that has made a securities deposit may withdraw that deposit or any part thereof after making a substitute deposit of cash, securities, or any combination of these or other measures of equal amount and value. Any securities shall be approved by the Commissioner before being deposited or substituted.

4. The deposit shall be used to protect the interests of the health maintenance organization's enrollees and to ensure continuation of health care services to enrollees of a health maintenance organization that is in rehabilitation or conservation. The Commissioner may use the deposit for administrative costs directly attributable to a receivership or liquidation. If a health maintenance organization is placed in receivership or liquidation, the deposit shall be an asset subject to the provisions of the Uniform Insurers Liquidation Act.

5. The Insurance Commissioner may reduce or eliminate the deposit requirement if a health maintenance organization deposits with the Commissioner or other official body of the state or jurisdiction of domicile for the protection of all subscribers and enrollees of the health maintenance organization, wherever located, cash, acceptable securities or surety, and delivers to the Commissioner a certificate to that effect, duly authenticated by the appropriate state official holding the deposit.

C. 1. Every health maintenance organization shall, when determining liabilities, include an amount estimated in the aggregate to provide for:

a. any unearned premium,

b. the payment of all claims for incurred health care expenditures, whether reported or unreported, that are unpaid and for which the organization is or may be liable, and

c. the expense of adjustment or settlement of those claims.

2. The liabilities shall be computed in accordance with rules promulgated by the Commissioner upon reasonable consideration of the ascertained experience and character of the health maintenance organization.

D. 1. Every contract between a health maintenance organization and a participating provider of health care services shall be in writing and shall provide that, in the event the health maintenance organization fails to pay for health care services as set forth in the contract, a subscriber or an enrollee shall not be liable to the provider for any sums owed by the health maintenance organization.

2. In the event that the participating provider contract has not been reduced to writing as required by this subsection or that the contract fails to contain the required prohibition, the participating provider shall not collect or attempt to collect from

a subscriber or an enrollee sums owed by the health maintenance organization.

3. No participating provider or the provider's agent, trustee or assignee may maintain an action at law against a subscriber or enrollee to collect sums owed by the health maintenance organization.

4. Providers that choose to not contract with an HMO are deemed "out of network". Any out-of-network provider who provides emergency services to an HMO enrollee may not charge the enrollee for amounts other than applicable copayments or deductibles.

E. The Commissioner shall require that each health maintenance organization have a plan for handling insolvency that allows for continuation of benefits for the duration of the contract period for which premiums have been paid and continuation of benefits to subscribers or enrollees who are confined on the date of insolvency in an inpatient facility until their discharge or expiration of benefits. In considering such a plan, the Commissioner may require:

1. Insurance to cover the expenses to be paid for continued benefits after an insolvency;

2. Provisions in provider contracts that obligate the provider to provide services for the duration of the period after the health maintenance organization's insolvency for which premium payment has been made and until the enrollees' discharge from inpatient facilities;

3. Insolvency reserves;

4. Acceptable letters of credit; or

5. Any other arrangements to ensure continuation of benefits as specified above.

F. An agreement to provide health care services between a provider and a health maintenance organization shall require that if the provider terminates the agreement, the provider shall give the organization at least ninety (90) days' advance notice of such termination.

SECTION 3. This act shall become effective November 1, 2016.

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