TITLE 310. OKLAHOMA STATE DEPARTMENT OF HEALTH
CHAPTER 659. HEALTH MAINTENANCE ORGANIZATIONS

RULEMAKING ACTION:

Notice of proposed PERMANENT rulemaking.

PROPOSED RULES:

Subchapter 1. General Provisions
310:659-1-1. Purpose [REVOKED]
310:659-1-2. Definitions [REVOKED]
310:659-1-3. Application materials [REVOKED]
310:659-1-4. Filing fee [REVOKED]
310:659-1-5. Governing body oversight [REVOKED]
310:659-1-6. Managed care referral and non-formulary drugs [REVOKED]
310:659-1-7. Administrative penalties [REVOKED]
Subchapter 3. Examinations
310:659-3-1. Purpose [REVOKED]
310:659-3-2. Independent quality examiner [REVOKED]
310:659-3-3. Report [REVOKED]
310:659-3-4. Conflict of interest [REVOKED]

SUMMARY:

This chapter of rule is being revoked because the Health Maintenance Act, Title 36. O.S. 6901 et seq. of the Oklahoma Insurance Code gives the Oklahoma Insurance Department regulatory authority over health maintenance organizations.

AUTHORITY:

Commissioner of Health, Title 63 O.S. §§ 1-104, 1-105, and 1-106.1; Title 36 O.S. Section 6901 et seq.

COMMENT PERIOD:

January 17, 2023 through the close of the Department's normal business hours, 5 PM, on February 17, 2023. Interested persons may informally discuss the proposed rules with the contact person identified below; or may, through the close of the Department's normal business hours, 5 PM, on February 17, 2023 submit written comments to the contact person identified below, or may, at the hearing, ask to present written or oral views.

PUBLIC HEARING:

Pursuant to 75 O.S. § 303(A), the public hearing for the proposed rulemaking in this chapter shall be on February 17, 2023 at the Oklahoma State Department of Health Auditorium, 123 Robert S. Kerr Avenue, Oklahoma City, Oklahoma 73102 from 9:30 AM to 12:30 PM. The meeting may adjourn earlier if all attendees who signed up to comment have completed giving their comments. The alternate date and time in the event of an office closure due to inclement weather is February 21, 2023 in the Auditorium, from 9:30 AM to 12:30 PM. Those wishing to present oral comments should be present at that time to register to speak. The hearing will close at the conclusion of those registering to speak. Interested persons may attend for the purpose of submitting data, views or concerns, orally or in writing, about the rule proposal described and summarized in this Notice. Validated parking will be provided for the parking lot located at the east corner of Broadway and Robert S. Kerr Avenue, subject to availability.

REQUESTS FOR COMMENTS FROM BUSINESS ENTITIES:

Business entities affected by these proposed rules are requested to provide the agency with information, in dollar amounts if possible, on the increase in the level of direct costs such as fees, and indirect costs such as reporting, recordkeeping, equipment, construction, labor, professional services, revenue loss, or other costs expected to be incurred by a particular entity due to compliance with the proposed rule. Business entities may submit this information in writing through February 17, 2023, to the contact person identified below.

COPIES OF PROPOSED RULES:

The proposed rules may be obtained for review from the contact person identified below or via the agency website at www.ok.gov/health.

RULE IMPACT STATEMENT:

Pursuant to 75 O.S., § 303(D), a rule impact statement is available through the contact person identified below or via the agency website at www.ok.gov/health.

CONTACT PERSON:

Audrey C. Talley, Agency Rule Liaison, Oklahoma State Department of Health, 123 Robert S. Kerr Avenue, Oklahoma City, OK 73102, phone (405) 426-8563, e-mail AudreyT@health.ok.gov.

INITIAL RULE IMPACT STATEMENT
(This document may be revised based on comment received during the public comment period.)

TITLE 310. CHAPTER 659. HEALTH MAINTENANCE ORGANIZATIONS

1. **DESCRIPTION:**
The rule change will revoke all of this rule chapter. This chapter of rule is being revoked because the Health Maintenance Act, Title 36. O.S. 6901 et seq. of the Oklahoma Insurance Code gives the Oklahoma Insurance Department regulatory authority over health maintenance organizations.

2. **DESCRIPTION OF PERSONS AFFECTED AND COST IMPACT RESPONSE:**

HMOS's should not experience any cost impact since they are currently subject to comprehensive regulation by the Oklahoma Insurance Department. The revocation of this chapter will result in minimal to no impact of cost.

3. **DESCRIPTION OF PERSONS BENEFITING, VALUE OF BENEFIT AND EXPECTED HEALTH OUTCOMES:**

There are no expected negative health outcomes affiliated with the revocation of Chapter 659. This will provide clarity as to applicability to HMO's of the laws and rules established the Oklahoma Insurance Department.

4. **ECONOMIC IMPACT, COST OF COMPLIANCE AND FEE CHANGES:**

There is not economic impact or cost to the agency.

5. **COST AND BENEFITS OF IMPLEMENTATION AND ENFORCEMENT TO THE AGENCY.**

There is no estimated cost by revoking these rules by the agency.

6. **IMPACT ON POLITICAL SUBDIVISIONS:**

There is no impact for political subdivisions.

7. **ADVERSE EFFECT ON SMALL BUSINESS:**

There will be no impact on small businesses

8. **EFFORTS TO MINIMIZE COSTS OF RULE:**

There are no less costly means currently identified.

9. **EFFECT ON PUBLIC HEALTH AND SAFETY:**

No effect on public health and safety as projected.

10. **DETRIMENTAL EFFECTS ON PUBLIC HEALTH AND SAFETY WITHOUT ADOPTION:**

There are no detrimental effects on public health and safety.

11. **PREPARATION AND MODIFICATION DATES**:
This rule impact statement was prepared on October, 11, 2022.

TITLE 310. OKLAHOMA STATE DEPARTMENT OF HEALTH
CHAPTER 659. HEALTH MAINTENANCE ORGANIZATIONS [REVOKED]

SUBCHAPTER 1. GENERAL PROVISIONS [REVOKED]

310:659-1-1. Purpose [REVOKED]

~~This Chapter is intended to ensure that health maintenance organizations comply with provisions that the State Commissioner of Health is charged to enforce under the Health Maintenance Organizations Act of 2003, Title 36 O.S. Section 6901 et seq.~~

310:659-1-2. Definitions [REVOKED]

~~The following words or terms, when used in this Chapter, shall have the following meaning, unless the context clearly indicates otherwise:~~
~~"Commissioner" means the Commissioner of Health.~~
~~"Department" means the Oklahoma State Department of Health.~~
~~"HMO Act" means the Health Maintenance Organizations Act of 2003, Title 36 O.S. Section 6901 et seq.~~

310:659-1-3. Application materials [REVOKED]

~~The applicant for a certificate of authority shall include narratives and documentation sufficient to demonstrate compliance with the requirements of 36 O.S. Section 6907 in its application filed with the Oklahoma Insurance Commissioner pursuant to 36 O.S. Section 6903(C).~~

310:659-1-4. Filing fee [REVOKED]

~~Each HMO shall pay the Department a fee of $1,500.00 (One Thousand Five Hundred Dollars) for review of an application for certificate of authority. The fee shall be in the form of a check payable to the Oklahoma State Department of Health, and is due when the application is submitted to the Oklahoma Insurance Commissioner.~~

310:659-1-5. Governing body oversight [REVOKED]

~~The HMO's governing body or its designee shall be responsible for the quality assurance program. The governing body or designee shall approve and regularly evaluate this program. If the HMO contracts with other entities to operate the quality assurance program, then the governing body or designee may consider reports from those entities. The governing body or designee shall receive reports on the quality assurance program at least once every six (6) months.~~

310:659-1-6. Managed care referral and non-formulary drugs [REVOKED]

~~Each HMO shall be considered a managed care entity for the purposes of 63 O.S. Sections 2550.1, 2550.2, and 2550.4. Each HMO's quality assurance program shall ensure compliance with the requirements applicable to managed care plans for referrals to specialists and approvals of non-formulary or prior-authorized drugs.~~

310:659-1-7. Administrative penalties [REVOKED]

~~The Department shall assess an administrative penalty in the amount of One Hundred Dollars ($100.00) per occurrence for an HMO that has been found in violation of 36 O.S. Section 6907(H) or a malpractice carrier that has been found in violation of 36 O.S. Section 6907(H)(8). Each day that the violation continues shall be considered a separate occurrence.~~

SUBCHAPTER 3. EXAMINATIONS [REVOKED]

310:659-3-1. Purpose [REVOKED]

~~(a) The Department shall examine the quality of an HMO's health care services within the first 12 months of member enrollment. This review is for the purpose of confirming that all required processes, systems and protocols are in place and are being implemented pursuant to 36 O.S. Section 6907.~~

~~(b) The Department may conduct the examination or the Department may require the HMO to contract for the examination pursuant to 36 O.S. Sections 6907(E) and 6919(B). If the Department requires the HMO to contract for the examination, the HMO shall select an independent quality examiner that has been approved by the Department.~~

310:659-3-2. Independent quality examiner [REVOKED]

~~(a) The Department shall maintain a list of approved independent quality examiners who have demonstrated conformity to the following requirements:~~

~~(1) The examiner has written criteria and standards for assessing the quality of clinical care and the availability, accessibility and continuity of care;~~

~~(2) The examiner limits clinical judgements to physicians with experience in the delivery of health care in an HMO setting, and all final conclusions, opinions and recommendations shall be made or endorsed by physicians;~~

~~(3) The examiner has a training program for review team members to ensure uniform application of standards;~~

~~(4) The examiner ensures the confidentiality of medical and health care information; and~~

~~(5) The examiner institutes reasonable measures to ensure that review team members and their families have no financial interest in the HMO being examined or in any HMO operating in the geographic service area covered by the HMO being examined.~~

~~(b) Any person may file a request to be included on the Department's list of approved independent quality examiners. The request shall be in writing and shall demonstrate conformity to the requirements in (a) of this Section. The Department shall respond in writing within thirty (30) days after receiving the request. The Department at any time may remove approval status from an examiner for failure to maintain compliance with (a) of this Section, or for providing to or accepting from an HMO any gift or favor other than a reasonable and usual charge for the performance of a quality examination.~~

~~(c) The examination process shall include:~~

~~(1) Preliminary reviews to familiarize the examiner with the requirements of this Chapter and the HMO;~~

~~(2) A site visit to review records and to interview HMO officers, the medical director, members of the governing body, members of the quality assurance committee, the patient care coordinator, a customer service representative, other providers, and HMO personnel;~~

~~(3) An on-site summation; and~~

~~(4) Written preliminary and final reports.~~

~~(d) The HMO and the quality examiner shall provide the Department access to observe record reviews, interviews, and the on-site summation.~~

310:659-3-3. Reports [REVOKED]

~~(a) The quality examiner shall prepare a report based upon the assessment team's findings. One (1) copy of each report shall be submitted to the Department. The report shall contain, at a minimum, the following information:~~

~~(1) An overview of the HMO's quality assurance program, an evaluation of recent quality assurance studies undertaken by the HMO, and the degree of implementation of the written quality assurance plan;~~

~~(2) A description of the HMO's quality assurance program;~~

~~(3) A description of the types and numbers of medical records reviewed, selection criteria, and review methods;~~

~~(4) A summary of charts that met and did not meet the established review criteria;~~

~~(5) Recommendations for follow-up, when indicated; and~~

~~(6) A listing of the names and titles of individuals that conducted and analyzed the review.~~

~~(b) The HMO shall forward to the Department a complete and unaltered copy of the final report within five (5) working days after the HMO receives the report from the quality examiner.~~

310:659-3-4. Conflict of interest [REVOKED]

~~(a) An independent quality examiner contracted by an HMO or a qualified person contracted by the Department pursuant to 36 O.S. Section 6929 shall:~~

~~(1) Have knowledge and expertise in the area they are contracted to review; and~~

~~(2) Have no history of disciplinary action or sanctions related to quality of care, fraud, or other criminal activity.~~

~~(b) No contracted examiner or qualified person shall have any material, professional, familial or financial conflict of interest with:~~

~~(1) The HMO;~~

~~(2) Any officer, director, or management employee of the HMO;~~

~~(3) Any provider contracted with the HMO; or~~

~~(4) Any other HMO in the service area.~~

~~(c) A potential reviewer or qualified person shall disclose information regarding potential conflicts of interest to all parties to the review.~~