

STATE OF OKLAHOMA

1st Session of the 45th Legislature (1995)

HOUSE BILL NO. 1994

By: Boyd (Laura)

AS INTRODUCED

An Act creating the Oklahoma Medicaid Managed Care Standards Act; providing legislative findings and purpose; defining terms; requiring establishment of selection and contract process; providing for rules; providing for termination; specifying contents; providing for credentialing; providing procedures and process; specifying certain levels of coverage; prohibiting certain interference; providing for disputes; providing for denial of coverage; requiring grievance procedure; providing for termination; requiring certain plans; requiring contents; requiring certain reporting; providing for rules; 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 5050.1 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 Oklahoma Medicaid Managed Care Standards Act.

SECTION 2. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 5050.2 of Title 63, unless there is created a duplication in numbering, reads as follows:

A. The Legislature of this state hereby finds and declares that as this state's health care market becomes increasingly dominated by health plans that utilize various managed care techniques which include decisions regarding coverage and the appropriateness of health care, it is a vital state governmental function to ensure that Medicaid recipients receive skilled assessment and treatment by managed care plans that have a sound medical, mental health and behavioral services policy and that are fiscally secure.

B. The purpose of the Oklahoma Medicaid Managed Care Standards Act is to establish requirements for the professional operation of managed care entities providing health care services to Medicaid recipients.

C. Standards are required to ensure consumer protection, provider fairness, utilization review safeguards, coverage options for all enrollees, and coordination of care among all service entities whether public or private.

SECTION 3. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 5050.3 of Title 63, unless there is created a duplication in numbering, reads as follows:

For the purposes of the Oklahoma Medicaid Managed Care Standards Act:

1. "Qualified managed care plan for Medicaid recipients" means a managed care plan for Medicaid recipients that the Administrator certifies, upon application by the program, as meeting the requirements of the Oklahoma Medicaid Managed Care Standards Act;

2. "Qualified Medicaid utilization review program" means a utilization review program that the Administrator certifies, upon application by the program, as meeting the requirements of the Oklahoma Medicaid Managed Care Standards Act;

3. "Medicaid utilization review program" means a system of reviewing the medical necessity, appropriateness or quality of health care services and supplies provided pursuant to a health plan or a managed care plan for Medicaid recipients using specified guidelines;

4. "Managed care plan for Medicaid recipients" means a plan operated by a Medicaid managed care entity that provides for the financing and delivery of health care services to Medicaid recipients enrolled in such plan through:

- a. arrangements with selected providers to furnish health care services,
- b. standards for the selection of participating providers, and
- c. organizational arrangements for ongoing quality assurance, utilization review programs, and dispute resolution;

5. "Medicaid managed care entity" includes but is not limited to an insurance company operating a managed care plan for Medicaid recipients and licensed to do business in this state, hospital, medical service plan, prepaid health plan, health maintenance organization, employer or employee organization or managed care contractor, that operates a managed care plan for Medicaid recipients and the University of Oklahoma Health Sciences Center;

6. "Managed care contractor" means a person that:

- a. establishes, operates or maintains a network of participating providers,
- b. conducts or arranges for Medicaid utilization review activities, and
- c. contracts with an insurance company operating a managed care plan for Medicaid recipients and licensed to do business in this state, a hospital or medical service plan, an employer, an employee organization or

any other entity providing coverage for health care services to operate a managed care plan for Medicaid recipients;

7. "Emergency medical services and care" means medical screening, examination, evaluation, or in the case of alcohol and other drug inpatient treatment or detoxification, by a physician or by other appropriate personnel or licensed service providers;

8. "Participating health services provider" means a physician, hospital, pharmacy, laboratory or other appropriately state licensed or otherwise state-recognized provider of mental and/or behavioral health care services, that has entered into an agreement with a Medicaid managed care entity to provide such services to consumers enrolled in a managed care plan for Medicaid recipients;

9. "Medicaid recipient" means a person who has been determined by the Department of Human Services to be eligible to receive Medicaid services;

10. "Authority" means the Oklahoma Health Care Authority;

11. "Board" means the Oklahoma Health Care Authority Board; and

12. "Administrator" means the chief administrative officer of the Health Care Authority Board.

SECTION 4. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 5050.4 of Title 63, unless there is created a duplication in numbering, reads as follows:

A. The Board shall establish a process for selection of managed care plans for Medicaid recipients, and of utilization review programs meeting the requirements of the Oklahoma Medicaid Managed Care Standards Act. The Administrator may contract with the University of Oklahoma Health Sciences Center for medical, health care, mental health care or behavioral services, provided the University Hospitals Authority meets or exceeds the licensure standards for health maintenance services organizations prescribed

by the State Department of Health pursuant to Sections 2501 through 2510 of Title 63 of the Oklahoma Statutes.

B. The Administrator shall promulgate rules which establish procedures for the periodic review and recertification of qualified managed care plans for Medicaid recipients and qualified Medicaid utilization review programs.

C. The Administrator shall terminate the contract with any qualified managed care plan for Medicaid recipients or a qualified Medicaid utilization review program if the Administrator determines that such plan or program no longer meets the applicable requirements for licensure specified by Section 2503 of Title 63 of the Oklahoma Statutes.

SECTION 5. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 5050.5 of Title 63, unless there is created a duplication in numbering, reads as follows:

A. The Board shall establish standards for contracting and selecting qualified managed care plans for Medicaid recipients.

B. Plans for Medicaid recipients residing in urban areas must provide written information to the recipients as to the terms and conditions of the health plan so that they can make informed decisions about accepting a certain system of health care delivery. All written plan descriptions must be in a readable and understandable format. This format must be standardized so that Medicaid recipients can compare the attributes of the plans. Specific items that must be included are:

1. Coverage provisions, benefits, and any exclusions by category of service, provider or physician, and if applicable, by specific service;

2. Any and all prior authorization or other review requirements including preauthorization review, concurrent review, post-service review, post payment review and any procedures that may lead the

Medicaid recipient to be denied coverage for or not be provided a particular service; and

3. Explanation of how plan limitations impact enrollees including but not limited to information on enrollee financial responsibility for payment for copayment or other noncovered or out-of-plan services.

C. All plans must:

1. Except for the University of Oklahoma Health Sciences Center, be licensed and comply with all licensure requirements prescribed by Sections 2501 through 2510 of Title 63 of the Oklahoma Statutes;

2. Demonstrate that they have adequate access to physicians and other providers, so that all covered health care services will be provided in a timely fashion. The provisions of this paragraph shall not be waived and shall be met in all areas where the plan has enrollees;

3. Meet financial reserve requirements that are established to assure proper payment for covered services provided;

4. Establish a mechanism, with defined rights, under which health care providers participating in the plan submit input into the plan's policy regarding medical care, mental health care and behavioral services, including but not limited to coverage of new technology and procedures, utilization review criteria and procedures, quality and credentialing criteria, and medical management procedures;

5. Establish standards which govern the recruitment practices of Medicaid managed care entities and methods for evaluating those practices including but not limited to patient surveys and complaints. Medicaid managed care entities shall submit recruitment plans to the Authority for review and approval; and

6. Allow patients to obtain the services of the closest provider in the case of emergency medical situations.

SECTION 6. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 5050.6 of Title 63, unless there is created a duplication in numbering, reads as follows:

A. All managed care plans for Medicaid recipients shall have a system for verification and examination of the credentials of each of its health care providers.

B. Such a credentialing process shall begin upon application of a physician to the plan for inclusion and shall include the following requirements:

1. Each application shall be reviewed by a credentialing committee with appropriate representation of the applicant's medical specialty;

2. Credentialing shall be based on objective standards of quality with input from physicians credentialed in the plan and such standards shall be available to applicants and enrollees. When economic considerations are part of the decision, objective criteria must be used and must be available to applicants, participating physicians and enrollees. Any economic profiling of physicians must be adjusted to recognize case mix, severity of illness, age of patients and other features of a physician's practice that may account for higher than or lower than expected costs. Profiles must be made available to those so profiled. When graduate medical education is a consideration in credentialing, equal recognition will be given to training programs accredited by the Accrediting Council on Graduate Medical Education and by the American Osteopathic Association;

3. Plans shall be prohibited from discrimination against enrollees with expensive medical conditions by excluding practitioners with practices containing a substantial number of such patients;

4. All decisions shall be made on the record, and the applicant shall be provided with all reasons used if the application is denied or the contract not renewed;

5. Plans shall not be allowed to include clauses in physician or other traditional provider contracts that allow for the plan to terminate the contract "without cause";

6. Plans shall allow for reciprocal termination contracts;

7. The same standards and procedures used for an application for credentials shall also be used in those cases where the plan seeks to reduce or withdraw such credentials. Prior to initiation of a proceeding leading to termination of a contract "for cause", the physician shall be provided notice, an opportunity for discussion, and an opportunity to enter into and complete a corrective action plan, except in cases where there is imminent harm to patient health or an action by a state medical board or other government agency that effectively impairs the physician's ability to practice medicine within the jurisdiction;

8. There shall be an appeal process for providers from all adverse decisions. Procedures shall be established to ensure that all applicable federal and state laws designed to protect the confidentiality of provider and individual medical records are followed; and

9. All managed care plans must provide for notice and a hearing prior to denial or withdrawal of a health care provider's credentials.

a. A health care provider must be given notice that states:

- (1) the reasons for the denial or withdrawal,
- (2) the health care provider's right to request a hearing, and
- (3) a summary of the rights of the health care provider in the hearing.

- b. If the health care provider requests a hearing, the health care provider must be given a notice that states:
 - (1) the place, time and date of the hearing, which may not be less than thirty (30) days nor more than ninety (90) days after the date of the notice, and
 - (2) the names of the witnesses, if any, expected to testify at the hearing on behalf of the managed care plan for Medicaid recipients.
- c. A hearing must be held before an arbitrator mutually acceptable to the health care provider and the managed care plan or before a hearing officer who is appointed by the managed care plan who is not in direct economic competition with the health care provider. The right to the hearing is forfeited if the health care provider fails, without good cause, to appear.
- d. In the hearing, the health care provider may:
 - (1) be represented by experts of the health care provider's choice,
 - (2) have a record made of the proceedings, with copies available upon payment of reasonable charges associated with the preparation thereof,
 - (3) call, examine and cross-examine witnesses, regardless of the admissibility of the testimony in a court of law, and
 - (4) submit a written statement at the close of the hearing.
- e. Upon completion of the hearing, the arbitrator or hearing officer shall issue a written recommendation, including a statement of the basis for the recommendation. The managed care plan shall issue a

decision, including a statement of the basis for its decision.

SECTION 7. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 5050.7 of Title 63, unless there is created a duplication in numbering, reads as follows:

Medicaid managed care entities shall be required to fulfill the conditions of existing state insurance law mandating minimum levels of coverage for health care services. Nothing in the Oklahoma Medicaid Managed Care Standards Act shall prohibit Medicaid managed care entities from subcontracting with licensed or certified health care providers.

SECTION 8. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 5050.8 of Title 63, unless there is created a duplication in numbering, reads as follows:

Any time a Medicaid managed care entity denies access for specific covered treatment or treatment modality or denies continuation of existing treatment, and if so requested by the patient in writing, the denial shall be provided in writing to the patient, the referral source and the health care provider providing treatment and shall set forth the specific reasons for denial and the name of the individual making that decision.

SECTION 9. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 5050.9 of Title 63, unless there is created a duplication in numbering, reads as follows:

A. The Authority shall establish a grievance procedure to handle complaints and grievances regarding the provision of health care services for Medicaid recipients.

B. Medicaid managed care entities shall routinely advise patients of the grievance procedure and how to initiate the process.

C. At the point of denial of health services, the Medicaid managed care entities shall readvise the patient of the grievance

procedure and of how to initiate the process if so requested by the patient.

D. The patient may not be excluded from the grievance review. The patient may be represented or assisted by counsel, a representative from a physician, a family member or other person designated by the patient. The patient or person designated by the patient shall be afforded the opportunity to present the case at any grievance review as specified by the Authority.

E. Each Medicaid managed care entity shall compile and maintain records on inquiries requiring corrective action, complaints and grievances regarding health care services.

SECTION 10. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 5050.10 of Title 63, unless there is created a duplication in numbering, reads as follows:

The Authority shall ensure that disruptions of service due to the transfer of any client to a new managed care system or from the managed care system to the fee-for-service system is minimized to the greatest extent possible.

SECTION 11. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 5050.11 of Title 63, unless there is created a duplication in numbering, reads as follows:

A. As part of registration with the Authority, the Medicaid managed care entity shall submit a plan, which shall include but not be limited to:

1. A proposed program network demonstrating the full continuum of care, geographic availability, cultural sensitivity and planning for special needs populations; and

2. A method to provide measures of performance within each of these categories.

B. Plans will be reviewed and approved by the Authority.

C. Each Medicaid managed care entity doing business in this state shall include in its annual report an assessment of its success in meeting the goals established in its plan.

SECTION 12. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 5050.12 of Title 63, unless there is created a duplication in numbering, reads as follows:

A. As part of its annual reporting requirements to the Authority, each Medicaid managed care entity shall report its ownership status, whether a parent organization or a subsidiary organization, and if a subsidiary organization, then its parent organization; each Medicaid managed care entity shall fully disclose its financial arrangements and considerations between it and any other Medicaid managed care entity or health care provider performing work for that Medicaid managed care entity; and each Medicaid managed care entity shall include, for itself and its subcontractors, the following information: the total number of members, the numbers receiving benefits, the treatment benefits provided by type of service, the level of care, the length of stay within each type of service, the names and addresses of all subcontracting organizations handling this benefit and the names of all treatment facilities utilized within the reporting year.

B. The Authority shall review these annual reports for general compliance and to determine that the Medicaid managed care entities are providing treatment to their members and are providing the full continuum of services as required under existing state insurance law mandating minimum levels of coverage for health care services.

SECTION 13. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 5050.13 of Title 63, unless there is created a duplication in numbering, reads as follows:

The Authority shall promulgate rules to implement the Oklahoma Medicaid Managed Care Standards Act. The Authority shall specifically require Medicaid managed care entities subject to the

Oklahoma Medicaid Managed Care Standards Act to submit for departmental review and approval as to simplicity and clarity of language in all subscriber forms, benefit handbooks or other material setting forth rights and duties. The Authority shall establish filing fees for Medicaid managed care entities required under the Oklahoma Medicaid Managed Care Standards Act at a level adequate to support all costs of implementing the Oklahoma Medicaid Managed Care Standards Act.

SECTION 14. This act shall become effective November 1, 1995.

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