

STATE OF OKLAHOMA

2nd Session of the 47th Legislature (2000)

HOUSE BILL HB2627

By: Jones

AS INTRODUCED

An Act relating to health care; amending Section 3, Chapter 336, O.S.L. 1993, as last amended by Section 4, Chapter 348, O.S.L. 1999 (56 O.S. Supp. 1999, Section 1010.3), which relates to the Oklahoma Medicaid Healthcare Options Act; directing waivers from the managed care program for certain participants having certain severe chronic conditions; establishing certain condition for waiver; and providing an effective date.

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

SECTION 1. AMENDATORY Section 3, Chapter 336, O.S.L. 1993, as last amended by Section 4, Chapter 348, O.S.L. 1999 (56 O.S. Supp. 1999, Section 1010.3), is amended to read as follows:

Section 1010.3 A. 1. There is hereby established the Oklahoma Medicaid Healthcare Options System. The Oklahoma Health Care Authority shall be responsible for converting the present system of delivery of the Oklahoma Medicaid Program to a managed care system.

2. The System shall be administered by the Oklahoma Health Care Authority and shall consist of a statewide system of managed care contracts with participating providers for the provision of hospitalization, eye care, dental care and medical care coverage to members and the administration, supervision, monitoring and evaluation of such contracts. The contracts for the managed care health plans shall be awarded on a competitive bid basis.

3. The System shall use both full and partial capitation models to service the medical needs of eligible persons. The highest priority shall be given to the development of prepaid capitated

health plans provided, that prepaid capitated health plans shall be the only managed care model offered in the high density population areas of Oklahoma City and Tulsa.

B. The Oklahoma Medicaid Healthcare Options System shall initiate a process to provide for the orderly transition of the operation of the Oklahoma Medicaid Program to a managed care program within the System.

C. The System shall develop managed care plans for all persons eligible for Title XIX of the federal Social Security Act, 42 U.S.C., Section 1396 et seq., as follows:

1. On or before January 1, 1996, managed care plans shall be developed for a minimum of fifty percent (50%) of the participants in the Temporary Assistance for Needy Families (TANF) program and participants categorized as noninstitutionalized medically needy. On or before July 1, 1997, all participants in the Temporary Assistance for Needy Families (TANF) program and participants categorized as noninstitutionalized medically needy shall be enrolled in a managed care plan;

2. On or before July 1, 1999, managed care plans shall be developed for all participants categorized as aged, blind or disabled. Implementation of the requirements of this paragraph shall include waivers from the managed care program for participants with severe chronic conditions, including but not limited to cerebral palsy, spina bifida, severe developmental disabilities, muscular dystrophy, multiple sclerosis and Hoffman syndrome, that will enable such participants to remain with their current health care and durable medical goods providers when the provider is willing to continue to accept the current Medicaid fee-for-service reimbursement rate;

3. On or before July 1, 2001, managed care plans shall be developed for all participants who are institutionalized; and

4. On or before July 1, 2000, a proposal for a Medicaid waiver to implement a managed care pilot program for participants with long-term care needs shall be developed and presented to the Joint Legislative Oversight Committee established in Section 1010.7 of this title. The pilot program shall provide a continuum of services for participants including, but not limited to, case management, supportive assistance in residential settings, homemaker services, home-delivered meals, adult day care, respite care, skilled nursing care, specialized medical equipment and supplies, and institutionalized long-term care. Payment for these services shall be on a capitated basis. The Joint Legislative Oversight Committee shall review the waiver application for the pilot program on or before December 1, 2000. In no instance shall the waiver application be presented to the Health Care Financing Administration prior to the review by the Committee.

D. The Oklahoma Health Care Authority shall apply for any federal Medicaid waivers necessary to implement the System. The application made pursuant to this subsection shall be designed to qualify for federal funding primarily on a prepaid capitated basis. Such funds may only be used for eye care, dental care, medical care and related services for eligible persons.

E. Effective July 1, 1995, except as specifically required by federal law, the System shall only be responsible for providing care on or after the date that a person has been determined eligible for the System, and shall only be responsible for reimbursing the cost of care rendered on or after the date that the person was determined eligible for the System.

SECTION 2. This act shall become effective November 1, 2000.

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