STATE OF OKLAHOMA

1st Session of the 49th Legislature (2003)

CONFERENCE COMMITTEE SUBSTITUTE
FOR ENGROSSED
SENATE BILL 610 By: Robinson of the Senate

and

Leist of the House

CONFERENCE COMMITTEE SUBSTITUTE

An Act relating to poor persons, insurance and public health and safety; amending 56 O.S. 2001, Sections 1010.1, 1010.2, 1010.4 and 1010.5, which relate to the Oklahoma Medicaid Healthcare Options Act; renaming act; acknowledging certain conditions; establishing related provisions; directing the Oklahoma Health Care Authority to apply for certain waivers for specified purposes and to negotiate to accomplish specified goals; providing for phase in of waivers based on funding availability; expanding certain definition; expanding implementation provisions; amending 36 O.S. 2001, Sections 6060.3, 6060.4, 6060.5 and 6060.8, which relate to mandated health insurance coverage; modifying definition; deleting applicability to the state Medicaid program; clarifying language; amending Section 1, Chapter 489, O.S.L. 2002, and 63 O.S. 2001, Section 5009 (63 O.S. Supp. 2002, Section 5007.1), which relate to managed care system development; deleting certain requirements related to the Medicaid fee for service program; authorizing certain fee or premium; providing that nonpayment of such fee or premium shall constitute a debt to the state, subject to recovery; providing for ending of coverage due to nonpayment; requiring comparison of data; limiting information requested; requiring transmission of specified information by electronic file; requiring compliance with request by specified time period; construing application of provisions of section of law; limiting request for data to once per specified time period; requiring maintenance of specified file system; requiring promulgation of specified rules; providing for codification; repealing 56 O.S. 2001, Sections 206, 207 and 208, which relate to medical assistance programs; providing effective dates; and declaring an emergency.

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

SECTION 1. AMENDATORY 56 O.S. 2001, Section 1010.1, is amended to read as follows:

Section 1010.1 A. Sections 1010.1 through 1010.7 of this title shall be known and may be cited as the "Oklahoma Medicaid ~~Healthcare Options~~ Program Reform Act of 2003".

B. ~~In order to establish a coordinated approach to delivering and monitoring health care services and to ensure an efficient and appropriate level of quality health care services to eligible persons requiring such services, there is hereby established a statewide managed care system of comprehensive health care delivery through the Oklahoma Medicaid Program, which shall include, but not be limited to, prepaid capitated plans and primary case management plans, and which shall be offered in all geographic areas of the state~~ Recognizing that many Oklahomans do not have health care benefits or health care coverage, that many small businesses cannot afford to provide health care benefits to their employees, and that, under Federal law, barriers exist to providing Medicaid benefits to the uninsured, the Oklahoma Legislature hereby establishes provisions to lower the number of uninsured, assist businesses in their ability to afford health care benefits and coverage for their employees, and eliminate barriers to providing health coverage to eligible enrollees under federal law.

C. The Oklahoma Health Care Authority shall provide coverage under the state Medicaid program to children under the age of eighteen (18) years whose family incomes do not exceed one hundred eighty-five percent (185%) of the federal poverty level.

D. 1. The Authority is hereby directed to apply for a waiver or waivers to the Centers for Medicaid and Medicare Services (CMS) that will accomplish the purposes outlined in subsection B of this section. The Authority is further directed to negotiate with CMS to include in such waiver authority provisions to accomplish the following goals:

a. increased access to health care for Oklahomans,

b. reform of the Oklahoma Medicaid Program to promote personal responsibility with regard to health care services and appropriate utilization of health care benefits through the use of cost sharing,

c. the purchase of health care coverage using "buy-in" arrangements for small employers and/or voucher arrangements for employer-sponsored insurance purchasing, and

d. development of flexible health care benefit packages based upon patient need and cost.

2. The Authority may phase in any waiver or waivers it receives based upon available funding.

SECTION 2. AMENDATORY 56 O.S. 2001, Section 1010.2, is amended to read as follows:

Section 1010.2 A. As used in the Oklahoma Medicaid ~~Healthcare Options~~ Program Reform Act of 2003:

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

2. "Board" means the Oklahoma Health Care Authority Board;

3. "Administrator" means the chief executive officer of the Oklahoma Health Care Authority;

4. "Eligible person" means any person who meets the minimum requirements established by:

a. rules promulgated by the ~~Department of Human Services~~ Oklahoma Health Care Authority Board pursuant to the requirements of Title XIX of the federal Social Security Act, 42 U.S.C., Section 1396 et seq.,

b. a waiver under the provisions of this act, or

c. any state law authorizing the purchase of small employer buy-in coverage;

5. "Member" means an eligible person who enrolls in the Oklahoma Medicaid Healthcare Options System;

6. "Nonparticipating provider" means a person who provides hospital or medical care pursuant to the Oklahoma Medicaid Program but does not have a managed care health services contract or subcontract within the Oklahoma Medicaid Healthcare Options System;

7. "Prepaid capitated" means a mode of payment by which a health care provider directly delivers health care services for the duration of a contract to a maximum specified number of members based on a fixed rate per member, regardless of the actual number of members who receive care from the provider or the amount of health care services provided to any member;

8. "Participating provider" means any person or organization who contracts with the Authority for the delivery of hospitalization, eye care, dental care, medical care and other medically related services to members or any subcontractor of such provider delivering services pursuant to the Oklahoma Medicaid Healthcare Options System; and

9. "System" means the Oklahoma Medicaid Healthcare Options System established by the Oklahoma Medicaid ~~Healthcare Options~~ Program Reform Act of 2003.

SECTION 3. AMENDATORY 56 O.S. 2001, Section 1010.4, is amended to read as follows:

Section 1010.4 A. The Oklahoma Health Care Authority shall take all steps necessary to implement the Oklahoma Medicaid Healthcare Options System as required by the Oklahoma Medicaid ~~Healthcare Options~~ Program Reform Act of 2003.

B. The implementation of the System shall include, but not be limited to, the following:

1. Development of operations plans for the System which include reasonable access to hospitalization, eye care, dental care, medical care and other medically related services for members~~,~~ including, but not limited to, access to twenty-four-hour emergency care;

2. Contract administration and oversight of participating providers;

3. Technical assistance services to participating providers and potential ~~participating~~ providers;

4. Development of a complete plan of accounts and controls for the System including, but not limited to, provisions designed to ensure ~~that~~ necessary and reasonable usage of covered health and medical services provided through the System ~~are not used unnecessarily or unreasonably~~;

5. Establishment of peer review and utilization study functions for all participating providers;

6. Technical assistance for the formation of medical care consortiums to provide covered health and medical services under the System. Development of service plans and consortiums may be on the basis of medical referral patterns;

7. Development and management of a provider payment system;

8. Establishment and management of a comprehensive plan for ensuring the quality of care delivered by the System;

9. Establishment and management of a comprehensive plan to prevent fraud against the System by members, eligible persons and participating providers ~~of the System~~;

10. Coordination of benefits provided under the Oklahoma Medicaid ~~Healthcare Options~~ Program Reform Act of 2003 to any member;

11. Development of a health education and information program;

12. Development and management of a participant enrollment system;

13. Establishment and maintenance of a claims resolution procedure to ensure that a submitted claim is resolved within forty-five (45) days of the date the claim is correctly submitted;

14. Establishment of standards for the coordination of medical care and patient transfers;

15. Provision for the transition of patients between participating providers and nonparticipating providers;

16. Provision for the transfer of members and persons who have been determined eligible from hospitals which do not have contracts to care for such persons;

17. Specification of enrollment procedures including, but not limited to, notice to providers of enrollment. Such procedures may provide for varying time limits for enrollment in different situations;

18. Establishment of uniform forms and procedures to be used by all participating providers;

19. Methods of identification of members to be used for determining and reporting eligibility of members; ~~and~~

20. Establishment of a comprehensive eye care and dental care system which:

a. includes practitioners as participating providers,

b. provides for quality care and reasonable and equal access to such practitioners, and

c. provides for the development of service plans, referral plans and consortiums which result in referral practices that reflect timely, convenient and cost-effective access to such care for members in both rural and urban areas~~.~~;

21. a. Development of a program for Medicaid eligibility and services for individuals who are in need of breast or cervical cancer treatment and who:

(1) have family incomes that are below one hundred eighty-five percent (185%) of the federal poverty level,

(2) have not attained the age of sixty-five (65) years,

(3) have no or have inadequate health insurance or health benefit coverage for treatment of breast and cervical cancer, and

(4) meet the requirements for treatment and have been screened for breast or cervical cancer.

b. The program shall include presumptive eligibility and shall provide for treatment throughout the period of time required for treatment of the individual's breast or cervical cancer,

c. On or before July 1, 2002, the Oklahoma Health Care Authority shall coordinate with the State Commissioner of Health to develop procedures to implement the program, contingent upon funds becoming available; and

22. Establishment of co-payments, premiums and enrollment fees, and the establishment of policy for those members who do not pay co-payments, premiums or enrollment fees.

C. Except for reinsurance obtained by providers, the Authority shall coordinate benefits provided under the Oklahoma Medicaid ~~Healthcare Options~~ Program Reform Act of 2003 to any eligible person who is covered by workers' compensation, disability insurance, a hospital and medical service corporation, a health care services organization or other health or medical or disability insurance plan, or who receives payments for accident-related injuries, so that any costs for hospitalization and medical care paid by the System are recovered first from any other available third party payors. The System shall be the payor of last resort for eligible persons.

D. Prior to the development of the plan of accounts and controls required by this section and periodically thereafter, the Authority shall compare the scope, utilization rates, utilization control methods and unit prices of major health and medical services provided in this state with health care services in other states to

identify any unnecessary or unreasonable utilization within the System. The Authority shall periodically assess the cost effectiveness and health implications of alternate approaches to the provision of covered health and medical services through the System in order to reduce unnecessary or unreasonable utilization.

E. The Authority may contract distinct administrative functions to one or more persons or organizations who may be participating providers within the System.

F. Contracts for managed health care plans, authorized pursuant to paragraph 2 of subsection A of Section 1010.3 of this title and necessary to implement the System, and other contracts entered into prior to July 1, 1996, shall not be subject to the provisions of the Oklahoma Central Purchasing Act.

G. The Oklahoma Health Care Authority Board shall promulgate rules:

1. Establishing appropriate competitive bidding criteria and procedures for contracts awarded pursuant to the Oklahoma Medicaid ~~Healthcare Options~~ Program Reform Act of 2003;

2. Which provide for the withholding or forfeiture of payments to be made to a participating provider by the Oklahoma Medicaid Healthcare Options System for the failure of the participating provider to comply with a provision of the participating provider's contract with the System or with the provisions of promulgated rules or law; and

3. Necessary to carry out the provisions of the Oklahoma Medicaid ~~Healthcare Options~~ Program Reform Act of 2003. Such rules shall consider the differences between rural and urban conditions on the delivery of hospitalization services, eye care, dental care and medical care.

SECTION 4. AMENDATORY 56 O.S. 2001, Section 1010.5, is amended to read as follows:

Section 1010.5 As a condition of the contract with any proposed or potential participating provider pursuant to the Oklahoma Medicaid ~~Healthcare Options~~ Program Reform Act of 2003, the Oklahoma Health Care Authority shall require such contract terms as are necessary, in its judgment, to ensure adequate performance by a participating provider of the provisions of each contract executed pursuant to the Oklahoma Medicaid ~~Healthcare Options~~ Program Reform Act of 2003. Required contract provisions shall include, but are not limited to:

1. The maintenance of deposits, performance bonds, financial reserves or other financial providers which have posted other security, equal to or greater than that required by the System, with a state agency for the performance of managed care contracts if funds would be available from such security for the System upon default by the participating provider;

2. A requirement that whenever the state appropriates funds for specific purposes, including, but not limited to, increases in reimbursement rates, a participating provider and any subcontractor shall apportion such funds pursuant to legislative directive;

3. Requirements that all records relating to contract compliance shall be available for inspection by the Authority or are submitted in accordance with rules promulgated by the Oklahoma Health Care Authority Board and that such records be maintained by the participating provider for five (5) years. Such records shall also be made available by a participating provider on request of the secretary of the United States Department of Health and Human Services, or its successor agency;

4. Authorization for the Authority to directly assume the operations of a participating provider under circumstances specified in the contract. Operations of the participating provider shall be assumed only as long as it is necessary to ensure delivery of uninterrupted care to members enrolled with the participating

provider and accomplish the orderly transition of those members to other providers participating in the System, or until the participating provider reorganizes or otherwise corrects the contract performance failure. The operations of a participating provider shall not be assumed unless, prior to that action, notice is delivered to the provider and an opportunity for a hearing is provided; and

5. ~~Requirement~~ A requirement that, if the Authority finds that the public health, safety or welfare requires emergency action, it may assume the operations of the participating provider on notice to the participating provider and pending an administrative hearing which it shall promptly institute. Notice, hearings and actions pursuant to this subsection shall be in accordance with Article II of the Administrative Procedures Act.

SECTION 5. AMENDATORY 36 O.S. 2001, Section 6060.3, is amended to read as follows:

Section 6060.3 A. Every health benefit plan contract issued, amended, renewed or delivered in this state on or after July 1, 1996, that provides maternity benefits shall provide for coverage of:

1. A minimum of forty-eight (48) hours of inpatient care at a hospital, or a birthing center licensed as a hospital, following a vaginal delivery, for the mother and newborn infant after childbirth, except as otherwise provided in this section;

2. A minimum of ninety-six (96) hours of inpatient care at a hospital following a delivery by caesarean section for the mother and newborn infant after childbirth, except as otherwise provided in this section; and

3. a. Postpartum home care following a vaginal delivery if childbirth occurs at home or in a birthing center licensed as a birthing center. The coverage shall provide for one home visit within forty-eight (48)

hours of childbirth by a licensed health care provider whose scope of practice includes providing postpartum care. Visits shall include, at a minimum:

(1) physical assessment of the mother and the newborn infant,

(2) parent education, to include, but not be limited to:

(a) the recommended childhood immunization schedule,

(b) the importance of childhood immunizations, and

(c) resources for obtaining childhood immunizations,

(3) training or assistance with breast or bottle feeding, and

(4) the performance of any medically necessary and appropriate clinical tests.

b. At the mother's discretion, visits may occur at the facility of the plan or the provider.

B. Inpatient care shall include, at a minimum:

1. Physical assessment of the mother and the newborn infant;

2. Parent education, to include, but not be limited to:

a. the recommended childhood immunization schedule,

b. the importance of childhood immunizations, and

c. resources for obtaining childhood immunizations;

3. Training or assistance with breast or bottle feeding; and

4. The performance of any medically necessary and appropriate clinical tests.

C. A plan may limit coverage to a shorter length of hospital inpatient stay for services related to maternity and newborn infant care provided that:

1. In the sole medical discretion or judgment of the attending physician licensed by the Oklahoma State Board of Medical Licensure and Supervision or the State Board of Osteopathic Examiners or the certified nurse midwife licensed by the Oklahoma Board of Nursing providing care to the mother and to the newborn infant, it is determined prior to discharge that an earlier discharge of the mother and newborn infant is appropriate and meets medical criteria contained in the most current treatment standards of the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists that determine the appropriate length of stay based upon:

a. evaluation of the antepartum, intrapartum and postpartum course of the mother and newborn infant,

b. the gestational age, birth weight and clinical condition of the newborn infant,

c. the demonstrated ability of the mother to care for the newborn infant postdischarge, and

d. the availability of postdischarge follow-up to verify the condition of the newborn infant in the first forty-eight (48) hours after delivery.

A plan shall adopt these guidelines by July 1, 1996; and

2. The plan covers one home visit, within forty-eight (48) hours of discharge, by a licensed health care provider whose scope of practice includes providing postpartum care. Such visits shall include, at a minimum:

a. physical assessment of the mother and the newborn infant,

b. parent education, to include, but not be limited to:

(1) the recommended childhood immunization schedule,

(2) the importance of childhood immunizations, and

(3) resources for obtaining childhood immunizations,

c. training or assistance with breast or bottle feeding, and

d. the performance of any medically necessary and clinical tests.

At the mother's discretion, visits may occur at the facility of the plan or the provider.

D. The plan shall include, but is not limited to, notice of the coverage required by this section in the plan's evidence of coverage, and shall provide additional written notice of the coverage to the insured or an enrollee during the course of the insured's or enrollee's prenatal care.

E. In the event the coverage required by this section is provided under a contract that is subject to a capitated or global rate, the plan shall be required to provide supplementary reimbursement to providers for any additional services required by that coverage if it is not included in the capitation or global rate.

F. No health benefit plan subject to the provisions of this section shall terminate the services of, reduce capitation payments for, refuse payment for services, or otherwise discipline a licensed health care provider who orders care consistent with the provisions of this section.

G. As used in this section, "health benefit plan" means individual or group hospital or medical insurance coverage, a not-for-profit hospital or medical service or indemnity plan, a prepaid health plan, a health maintenance organization plan, a preferred provider organization plan, the State and Education Employees Group Health Insurance Plan, ~~any program funded under Title XIX of the Social Security Act or such other publicly funded program,~~ and coverage provided by a Multiple Employer Welfare Arrangement (MEWA) or employee self-insured plan except as exempt under federal ERISA provisions.

H. The Insurance Commissioner shall promulgate any rules necessary to implement the provisions of this section.

SECTION 6. AMENDATORY 36 O.S. 2001, Section 6060.4, is amended to read as follows:

Section 6060.4 A. A health benefit plan delivered, issued for delivery or renewed in this state on or after January 1, 1998, that provides benefits for the dependents of an insured individual shall provide coverage for each child of the insured, from birth through the date such child is eighteen (18) years of age for:

1. Immunization against:

a. diphtheria,

b. hepatitis B,

c. measles,

d. mumps,

e. pertussis,

f. polio,

g. rubella,

h. tetanus,

i. varicella,

j. haemophilus influenzae type B, and

k. hepatitis A; and

2. Any other immunization subsequently required for children by the State Board of Health.

B. Benefits required pursuant to subsection A of this section shall not be subject to a deductible, ~~copayment~~ co-payment, or coinsurance requirement.

C. 1. For purposes of this section, "health benefit plan" means a plan that:

a. provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, and

b. is offered by any insurance company, group hospital service corporation, the ~~Oklahoma~~ State and Education Employees Group Insurance ~~Program~~ Board, ~~the Oklahoma Medicaid Program,~~ or health maintenance organization that delivers or issues for delivery an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an evidence of coverage, or, to the extent permitted by the Employee Retirement Income Security Act of 1974, 29 U.S.C., Section 1001 et seq., by a multiple employer welfare arrangement as defined in Section 3 of the Employee Retirement Income Security Act of 1974, or any other analogous benefit arrangement.

2. The term "health benefit plan" shall not include:

a. a plan that provides coverage:

(1) only for a specified disease,

(2) only for accidental death or dismemberment,

(3) for wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury, or

(4) as a supplement to liability insurance,

b. a Medicare supplemental policy as defined by Section 1882(g)(1) of the Social Security Act (42 U.S.C., Section 1395ss),

c. worker's compensation insurance coverage,

d. medical payment insurance issued as part of a motor vehicle insurance policy,

e. a long-term care policy, including a nursing home fixed indemnity policy, unless a determination is made that the policy provides benefit coverage so

comprehensive that the policy meets the definition of a health benefit plan, or

f. short-term health insurance issued on a nonrenewable basis with a duration of six (6) months or less.

SECTION 7. AMENDATORY 36 O.S. 2001, Section 6060.5, is amended to read as follows:

Section 6060.5 A. This section shall be known and may be cited as the "Oklahoma Breast Cancer Patient Protection Act".

B. Any health benefit plan that is offered, issued or renewed in this state on or after January 1, 1998, that provides medical and surgical benefits with respect to the treatment of breast cancer and other breast conditions shall ensure that coverage is provided for not less than forty-eight (48) hours of inpatient care following a mastectomy and not less than twenty-four (24) hours of inpatient care following a lymph node dissection for the treatment of breast cancer.

C. Nothing in this section shall be construed as requiring the provision of inpatient coverage where the attending physician in consultation with the patient determines that a shorter period of hospital stay is appropriate.

D. Any plan subject to subsection B of this section shall also provide coverage for reconstructive breast surgery performed as a result of a partial or total mastectomy~~, except as prohibited by federal laws or regulations pertaining to Medicaid~~. Because breasts are a paired organ, any such reconstructive breast surgery shall include coverage for all stages of reconstructive breast surgery performed on a nondiseased breast to establish symmetry with a diseased breast when reconstructive surgery on the diseased breast is performed, provided that the reconstructive surgery and any adjustments made to the nondiseased breast must occur within twenty-four (24) months of reconstruction of the diseased breast.

E. In implementing the requirements of this section, a health benefit plan may not modify the terms and conditions of coverage based on the determination by an enrollee to request less than the minimum coverage required pursuant to subsections B and D of this section.

F. A health benefit plan shall provide notice to each insured or enrollee under such plan regarding the coverage required by this section in the plan's evidence of coverage, and shall provide additional written notice of the coverage to the insured or enrollee as follows:

1. In the next mailing made by the plan to the employee;

2. As part of any yearly informational packet sent to the enrollee; or

3. Not later than December 1, 1997;

whichever is earlier.

G. As used in this act, "health benefit plan" means any plan or arrangement as defined in subsection G of Section 6060.3 of ~~Title 36 of the Oklahoma Statutes~~ this title.

H. The Insurance Commissioner shall promulgate any rules necessary to implement the provisions of this section.

SECTION 8. AMENDATORY 36 O.S. 2001, Section 6060.8, is amended to read as follows:

Section 6060.8 A. Any health benefit plan that is offered, issued or renewed in this state on or after January 1, 2000, ~~which~~ that provides coverage to men forty (40) years ~~old~~ of age or older in this state~~,~~ shall offer coverage for annual screening for the early detection of prostate cancer in men over the age of fifty (50) years and in men over the age of forty (40) years who are in high-risk categories. The coverage shall not be subject to policy deductibles. The coverage shall not exceed~~: The~~ the actual cost of the prostate cancer screening up to a maximum of Sixty-five Dollars ($65.00) per screening.

B. The benefit required to be provided by subsection A of this section shall in no way diminish or limit diagnostic benefits otherwise allowable under a health benefit plan.

C. The prostate cancer screening coverage shall be offered as follows:

1. The screening shall be performed by a qualified medical professional including, but not limited to, a urologist, internist, general practitioner, doctor of osteopathy, nurse practitioner, or physician assistant;

2. The screening shall consist, at a minimum, of the following tests:

a. a prostate-specific antigen blood test, and

b. a digital rectal examination;

3. At least one screening per year shall be covered for any man fifty (50) years of age or older; and

4. At least one screening per year shall be covered for any man from forty (40) to fifty (50) years of age who is at increased risk of developing prostate cancer as determined by a physician.

D. As used in this section, "health benefit plan" means group hospital or medical insurance coverage, a not-for-profit hospital or medical service or indemnity plan, a prepaid health plan, a health maintenance organization plan, a preferred provider organization plan, the State and Education Employees Group Health Insurance Plan, ~~any program funded under Title XIX of the Social Security Act, or such other publicly funded program,~~ and coverage provided by a Multiple Employer Welfare Arrangement (MEWA) or employee self-insured plan except as exempt under federal ERISA provisions. The term shall not include short-term, accident, fixed indemnity, or specified disease policies, disability income contracts, limited benefit or credit disability insurance, workers' compensation insurance coverage, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to

fault and which is required by law to be contained in any liability insurance policy or equivalent self-insurance.

SECTION 9. AMENDATORY Section 1, Chapter 489, O.S.L. 2002 (63 O.S. Supp. 2002, Section 5007.1), is amended to read as follows:

Section 5007.1 A. This act shall be known and may be cited as the "Oklahoma Medicaid Accountability and Outcomes Act".

B. 1. Subject to the availability of funds, the Joint Legislative Oversight Committee for the Oklahoma Health Care Authority shall enter into a contract for a study of the ~~state~~ Oklahoma Medicaid ~~program~~ Program. The contract shall be executed with an organization having nationally recognized expertise in the area of health care and health care service delivery.

2. The study shall include the entire ~~state~~ Oklahoma Medicaid ~~program~~ Program, including the Medicaid managed care programs and services delivered pursuant to the Oklahoma Medicaid ~~Healthcare Options~~ Program Reform Act of 2003.

3. The purpose of the study shall be to evaluate access to care, health care outcomes, and the quality and cost of health care and related services delivered through the ~~state~~ Oklahoma Medicaid ~~program~~ Program.

4. A report of the study and findings shall be made to the Oklahoma Health Care Authority Board, the Governor, and the appropriate committees of the Oklahoma State Senate and the Oklahoma House of Representatives.

SECTION 10. AMENDATORY 63 O.S. 2001, Section 5009, is amended to read as follows:

Section 5009. A. On and after July 1, 1993, the Oklahoma Health Care Authority shall be the state entity designated by law to assume the responsibilities for the preparation and development for converting the present delivery of the Oklahoma Medicaid Program to a managed care system. The system shall emphasize:

1. Managed care principles, including a capitated, prepaid system with either full or partial capitation, provided that highest priority shall be given to development of prepaid capitated health plans;

2. Use of primary care physicians to establish the appropriate type of medical care a Medicaid recipient should receive; and

3. Preventative care.

The Authority shall also study the feasibility of allowing a private entity to administer all or part of the managed care system.

B. On and after January 1, 1995, the Authority shall be the designated state agency for the administration of the Oklahoma Medicaid Program.

1. The Authority shall contract with the Department of Human Services for the determination of Medicaid eligibility and other administrative or operational functions related to the Oklahoma Medicaid Program as necessary and appropriate.

2. To the extent possible and appropriate, upon the transfer of the administration of the Oklahoma Medicaid Program, the Authority shall employ the personnel of the Medical Services Division of the Department of Human Services.

3. The Department of Human Services and the Authority shall jointly prepare a transition plan for the transfer of the administration of the Oklahoma Medicaid Program to the Authority. The transition plan shall include provisions for the retraining and reassignment of employees of the Department of Human Services affected by ~~said~~ the transfer. The transition plan shall be submitted to the Governor, the President Pro Tempore of the Senate and the Speaker of the House of Representatives on or before January 1, 1995.

C. In order to provide adequate funding for the unique training and research purposes associated with the demonstration program conducted by the entity described in paragraph 7 of subsection B of

Section 6201 of Title 74 of the Oklahoma Statutes, and to provide services to persons without regard to their ability to pay, the Oklahoma Health Care Authority shall analyze the feasibility of establishing a Medicaid reimbursement methodology for nursing facilities to provide a separate Medicaid payment rate sufficient to cover all costs allowable under Medicare principles of reimbursement for the facility to be constructed or operated, or constructed and operated, by the organization described in paragraph 7 of subsection B of Section 6201 of Title 74 of the Oklahoma Statutes.

D. For the purpose of reducing inequities between the health care benefits available to Medicaid beneficiaries in the rural and the urban areas of the state and to improve the health care available to rural beneficiaries, the Authority shall~~:~~

~~1. Amend the Medicaid fee-for-service program to:~~

~~a. increase the hospital inpatient day limit,~~

~~b. increase the hospital reimbursement rate for:~~

~~(1) emergency room services,~~

~~(2) ambulatory surgical services,~~

~~(3) maternity services for mother and child, and~~

~~(4) critical access hospital services, and~~

~~c. increase the reimbursement rate for services provided to eligible persons including, but not limited to:~~

~~(1) dental services,~~

~~(2) home health services,~~

~~(3) ambulance services,~~

~~(4) laboratory services, and~~

~~(5) services provided by other Medicaid-authorized medical service providers, including, but not limited to optometrists, chiropractors, opticians, psychologists, speech pathologists and occupational therapists; and~~

~~2. Implement~~ implement financial incentives for physicians to practice in underserved rural communities, which may include, but shall not be limited to, increases in physician reimbursement rates.

SECTION 11. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 5051.4 of Title 63, unless there is created a duplication in numbering, reads as follows:

The Oklahoma Health Care Authority is hereby authorized to charge an enrollment fee and/or premium for the provision of health care coverage under the Oklahoma Medicaid Program Reform Act of 2003. Such charges, if unpaid, create a debt to the state and are subject to recovery by the Authority by any legal action against an enrollee, the heirs or next of kin of the enrollee in the event of the death of the enrollee. The Authority may end coverage for the nonpayment of such enrollment and/or premium pursuant to rules promulgated by the Oklahoma Health Care Authority Board.

SECTION 12. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 5051.5 of Title 63, unless there is created a duplication in numbering, reads as follows:

A. 1. On or after November 1, 2003, any entity that provides health insurance in this state including, but not limited to, a licensed insurance company, not-for-profit hospital service or medical indemnity corporation or a health maintenance organization, is hereby required to compare data from its files with data in files provided to the entity by the Oklahoma Health Care Authority. Data files requested by or provided to the Authority shall be limited to information necessary to determine whether a state Medicaid program recipient has health coverage with an insurer.

2. The insurer shall transmit to the Authority an electronic file of all identified subscribers or policyholders, or their dependents, for whom there is data corresponding to the information contained in subsection C of this section.

B. 1. An insurer shall comply with a request under the provisions of this subsection no later than sixty (60) days after the date of transmission by the Authority and shall only be required to provide the Authority with the information required by subsection C of this section. The provisions of this section shall apply to a plan administrator in the same manner and to the same extent as an insurer.

2. The Authority may make such request for data from an insurer no more than once every six (6) months, as determined by the date of the Authority's original request.

C. Each insurer shall maintain a file system containing the name, address, group policy number, coverage type, social security number, and date of birth of each subscriber or policyholder, and each dependent of the subscriber or policyholder covered by the insurer, including policy effective and termination dates, claim submission address, and employer's mailing address.

D. The Oklahoma Health Care Authority Board shall promulgate rules governing the exchange of information under this section. Such rules shall be consistent with all laws relating to the confidentiality or privacy of personal information or medical records including, but not limited to, provisions under the federal Health Insurance Portability and Accountability Act (HIPAA).

SECTION 13. REPEALER 56 O.S. 2001, Sections 206, 207 and 208, are hereby repealed.

SECTION 14. Section 12 of this act shall become effective November 1, 2003.

SECTION 15. Sections 1 through 11 and 13 of this act shall become effective July 1, 2003.

SECTION 16. It being immediately necessary for the preservation of the public peace, health and safety, an emergency is hereby

declared to exist, by reason whereof this act shall take effect and be in full force from and after its passage and approval.

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