STATE OF OKLAHOMA

1st Session of the 49th Legislature (2003)

CONFERENCE COMMITTEE SUBSTITUTE
FOR ENGROSSED
SENATE BILL 649 By: Coffee of the Senate

and

Tyler and Askins of the House

CONFERENCE COMMITTEE SUBSTITUTE

An Act relating to health care; amending 56 O.S. 2001, Sections 1010.1, 1010.2 and 1010.3, which relate to the Oklahoma Medicaid Healthcare Options Act; amending term and definition; requiring the Oklahoma Health Care Authority to make certain application; requiring the Authority to offer certain plan or plans upon approval; amending 63 O.S. 2001, Sections 5005 and 5009, which relate to the Oklahoma Health Care Authority Act; modifying terms; amending Section 2, Chapter 489, O.S.L. 2002 (63 O.S. Supp. 2002, Section 5009.5), which relates to actuarial certification; modifying certain capitation payments; stating purpose; 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 Act".

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.

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.

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 Act:

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 rules promulgated by the Department of Human Services pursuant to the requirements of Title XIX of the federal Social Security Act, 42 U.S.C., Section 1396 et seq.;

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~~ 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 Act.

SECTION 3. AMENDATORY 56 O.S. 2001, 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. On or before December 31, 2003, the Oklahoma Health Care Authority shall make application to CMS for an amendment to their current Section 1115 Waiver, pursuant to 42 CFR § 438.52(b), or include as a part of the renewal of the current Section 1115 Waiver an amendment to allow a single capitated health plan or plans to be offered to areas currently not served by such capitated health plans. Upon approval of the application by CMS, the Oklahoma Health Care Authority shall offer a single capitated health plan or plans, where appropriate, no later than the next plan year.

4. 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. Except as hereinafter provided, 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;

3. On or before July 1, 2001, managed care plans shall be developed for all participants who are institutionalized; provided, however, this requirement shall not apply to individuals who are developmentally disabled; 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. 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 4. AMENDATORY 63 O.S. 2001, Section 5005, is amended to read as follows:

Section 5005. For purposes of the Oklahoma Health Care Authority Act:

1. "Administrator" means the chief executive officer of the Authority;

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

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

4. "Health services provider" means health insurance carriers, ~~pre-paid~~ <u>capitated</u> health plans, hospitals, physicians and other health care professionals, and other entities who contract with the Authority for the delivery of health care services to state and

education employees and persons covered by the state Medicaid program; and

5. "State-purchased health care" or "state-subsidized health care" means medical and health care, pharmaceuticals and medical equipment purchased with or supported by state and federal funds through the Oklahoma Health Care Authority, the Department of Mental Health and Substance Abuse Services, the State Department of Health, the Department of Human Services, the Department of Corrections, the Department of Veterans Affairs, other state agencies administering state-purchased or state-subsidized health care programs, the Oklahoma State Regents for Higher Education, the State Board of Education and local school districts.

SECTION 5. 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 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 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 6. AMENDATORY Section 2, Chapter 489, O.S.L. 2002 (63 O.S. Supp. 2002, Section 5009.5), is amended to read as follows:

Section 5009.5 Contracted Medicaid managed care plan capitation rates shall be certified as actuarially sound and shall reflect any Legislative or Authority programmatic or administrative changes. The results of the actuarial certification shall be disclosed to the public at least thirty (30) days prior to implementation of the modification.

The capitation payments made to Medicaid Managed Care Plans during the fiscal year ending June 30, 2004, shall be made in the month following the month in which the capitated services are provided. The savings generated in the fiscal year ending June 30, 2004, by this delay in capitation payments shall be used to restore the SoonerCare Plus benefits, as provided by the Oklahoma Health Care Authority as such benefits existed on December 1, 2002.

SECTION 7. 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 resolution shall take effect and be in full force from and after its passage and approval.

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