ENGROSSED HOUSE
BILL NO. 2553

By: Eddins of the House

and

Cain of the Senate

An Act relating to Medicaid; amending 56 O.S. 2001, Sections 1010.3 and 1010.4, as amended by Section 3, Chapter 464, O.S.L. 2003 (56 O.S. Supp. 2003, Section 1010.4), which relate to Oklahoma Medicaid Healthcare Options Systems; modifying process of implementing the System; deleting obsolete language; and providing an effective date.

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

SECTION 1. 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. The System ~~shall~~ may 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.~~ B. 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; and

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.~~ C. 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.~~ D. 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. AMENDATORY 56 O.S. 2001, Section 1010.4, as amended by Section 3, Chapter 464, O.S.L. 2003 (56 O.S. Supp. 2003, 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 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 providers;

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

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;

10. Coordination of benefits provided under the Oklahoma Medicaid 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;

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 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 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 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 3. This act shall become effective November 1, 2004.

Passed the House of Representatives the 1st day of March, 2004.

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Presiding Officer of the House of Representatives

Passed the Senate the ____ day of _____, 2004.

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Presiding Officer of the Senate