

1 STATE OF OKLAHOMA

2 2nd Session of the 54th Legislature (2014)

3 HOUSE BILL 2788

By: McCullough

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5
6 AS INTRODUCED

7 An Act relating to Medicaid; amending 56 O.S. 2011,
8 Sections 1003, as last amended by Section 1, Chapter
9 106, O.S.L. 2013 and 1004, as amended by Section 2,
10 Chapter 244, O.S.L. 2012 (56 O.S. Supp. 2013,
11 Sections 1003 and 1004), which relate to Medicaid
12 fraud; expanding scope of authority of the Medicaid
13 fraud control unit; modifying required display
14 information; modifying scope of access to records by
15 the Attorney General; defining terms; establishing
16 managed care program; requiring application for
17 Medicaid waiver; providing for selection of managed
18 care plans; requiring Medicaid recipients to be
19 enrolled in certain plan; providing exceptions;
20 providing services to be covered under managed care
21 plan; establishing long-term care managed care
22 program; providing for codification; and providing an
23 effective date.
24

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

SECTION 1. AMENDATORY 56 O.S. 2011, Section 1003, as
last amended by Section 1, Chapter 106, O.S.L. 2013 (56 O.S. Supp.
2013, Section 1003), is amended to read as follows:

Section 1003. A. There is hereby created within the Office of
the Attorney General, a Medicaid fraud control unit.

1 B. The Medicaid fraud control unit shall be the state entity to
2 which all cases of suspected Medicaid fraud, whether the suspected
3 fraud is committed by a provider, a Medicaid recipient, or both a
4 provider and a Medicaid recipient, shall be referred by the Oklahoma
5 Health Care Authority or its fiscal agents for the purposes of
6 investigation, civil action, criminal action or referral to the
7 district attorney. Provided however, nothing contained in the
8 Oklahoma Medicaid Program Integrity Act shall prohibit the Oklahoma
9 Health Care Authority from investigating or additionally referring
10 to other proper law enforcement agencies cases of suspected Medicaid
11 fraud, nor the Attorney General from pursuing cases of suspected
12 Medicaid fraud without a referral from the Oklahoma Health Care
13 Authority if there is credible evidence of fraud. The Oklahoma
14 Health Care Authority shall be authorized to require providers to
15 display information about how to report providers and Medicaid
16 recipients suspected of fraudulent activity relating to the Oklahoma
17 Medicaid Program. The Oklahoma Health Care Authority shall require
18 that signs be posted in any and all locations where services
19 provided by the Oklahoma Medicaid Program are delivered to Medicaid
20 recipients. The sign shall make reference to the Attorney General's
21 Medicaid Fraud Control Unit hotline and provide the current phone
22 number for the hotline, and shall be placed in a conspicuous
23 location within a provider's office. The sign shall contain

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1 notification that all reports to the hotline may be filed
2 anonymously by persons suspecting fraudulent activity.

3 C. 1. In carrying out these responsibilities, the Attorney
4 General shall have all the powers necessary to comply with federal
5 laws and regulations relative to the operation of a Medicaid fraud
6 unit, the power to cross-designate assistant United States attorneys
7 as assistant attorneys general, the power to investigate cases of
8 patient abuse, the power to issue or cause to be issued subpoenas or
9 other process in aid of investigations and prosecutions, the power
10 to administer oaths and take sworn statements under penalty of
11 perjury, the power to serve and execute in any county, search
12 warrants which relate to investigations authorized by the Oklahoma
13 Medicaid Program Integrity Act and shall have all the powers of a
14 district attorney.

15 2. Subpoenas ad testificandum or duces tecum issued pursuant to
16 the Oklahoma Medicaid Program Integrity Act may be served by the
17 Attorney General, any peace officer, or any competent person over
18 eighteen (18) years of age, and may require attendance or production
19 at any place in this state. A refusal to obey such subpoena, or
20 willful failure to appear, be sworn, testify, or produce records at
21 the place and time specified shall constitute contempt and shall be
22 enforced by the district court of the county where issued or the
23 county where served, at the election of the Attorney General, as if
24 it was a contempt on that court.

1 D. The Attorney General shall have authority to collect all
2 fines, penalties, amounts of restitution, or interest accruing on
3 any amount of restitution to be made and any penalties to be paid
4 from and after default in the payment thereof levied pursuant to the
5 provisions of the Oklahoma Medicaid Program Integrity Act, the
6 Oklahoma Medicaid False Claims Act, or any other charge, cause of
7 action, prelitigation settlement or other settlement which recovers
8 money wrongfully paid by the Oklahoma Health Care Authority on a
9 claim submitted to the Oklahoma Health Care Authority. However,
10 this subsection is not in any way intended to affect the contempt
11 power of any court. Funds collected by the Attorney General
12 pursuant to this section shall be deposited as follows:

13 1. Restitution recovered and interest thereon shall be returned
14 to the Oklahoma Health Care Authority for deposit to the Oklahoma
15 Health Care Authority Medicaid Program Fund created pursuant to
16 Section 5020 of Title 63 of the Oklahoma Statutes;

17 2. Costs of investigation, litigation, attorney fees, and other
18 expenses shall be retained by the Office of the Attorney General and
19 shall be deposited in the Attorney General's Medicaid Fraud
20 Revolving Fund created pursuant to subsection E of this section; and

21 3. Fines and penalties and other funds recovered and interest
22 thereon shall be deposited in the Attorney General's Medicaid Fraud
23 Revolving Fund; provided, the balance in the Attorney General's
24 Medicaid Fraud Revolving Fund shall not exceed an amount equal to

1 fifty percent (50%) of the current-year budget for operating costs
2 of the Medicaid Fraud Control Unit. Any funds exceeding that amount
3 shall be deposited as follows:

- 4 a. seventy-five percent (75%) to the General Revenue
5 Fund, and
- 6 b. twenty-five percent (25%) to the Attorney General's
7 Evidence Fund created pursuant to Section 19 of Title
8 74 of the Oklahoma Statutes.

9 E. There is hereby created in the State Treasury a revolving
10 fund for the Office of the Attorney General, to be designated the
11 "Attorney General's Medicaid Fraud Revolving Fund". The fund shall
12 be a continuing fund, not subject to fiscal year limitations, and
13 shall consist of any monies designated to the fund by law. All
14 monies accruing to the credit of said fund are hereby appropriated
15 and may be budgeted and expended by the Attorney General for
16 activities related to the Medicaid Fraud Control Unit. Expenditures
17 from said fund shall be made upon warrants issued by the State
18 Treasurer against claims filed as prescribed by law with the
19 Director of the Office of Management and Enterprise Services for
20 approval and payment.

21 SECTION 2. AMENDATORY 56 O.S. 2011, Section 1004, as
22 amended by Section 2, Chapter 244, O.S.L. 2012 (56 O.S. Supp. 2013,
23 Section 1004), is amended to read as follows:

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1 Section 1004. A. No potential Medicaid recipient shall be
2 eligible for medical assistance unless such recipient has, in
3 writing, authorized the Oklahoma Health Care Authority and the
4 Attorney General to examine all records maintained as required by
5 the Oklahoma Medicaid Program by the recipient, or of those
6 receiving or having received Medicaid benefits through the
7 recipient, whether the receipt of such benefits would be allowed by
8 the Oklahoma Medicaid Program or not.

9 B. 1. Each application to participate as a provider in the
10 Oklahoma Medicaid Program, each report stating income or expense
11 upon which rates of payment are or may be based, and each invoice
12 for payment for a good or a service provided to recipient, shall
13 contain a statement that all matters stated therein are true and
14 accurate, signed by the provider or his or her agent. Any person
15 who signs this statement or causes another to sign this statement
16 knowing the statement to be false shall be guilty of perjury. For
17 purposes of this subsection, an individual who signs on behalf of a
18 provider shall be presumed to have the authorization of the provider
19 and to be acting at his or her direction.

20 2. All providers subject to the Oklahoma Medicaid Program are
21 required to maintain at their or its principal place of Medicaid
22 business all such records at least for a period of six (6) years
23 from the date of claimed provision of any goods or services to any
24 Medicaid recipient.

1 C. The Attorney General shall be allowed access to all records
2 of persons and Medicaid recipients under the Oklahoma Medicaid
3 Program which are held by a provider, a Medicaid recipient or the
4 Oklahoma Health Care Authority for the purpose of investigating
5 whether any person may have committed the crime of Medicaid fraud,
6 or for use or potential use in any legal, administrative, or
7 judicial proceeding. In carrying out the purposes of the Oklahoma
8 Medicaid Program Integrity Act, the Attorney General may take
9 possession of records held by a provider or Medicaid recipient by
10 subpoena, in which case copies of those records obtained by the
11 Attorney General which are necessary for ~~the~~ a provider to continue
12 doing business shall be supplied to the provider, or the Attorney
13 General may elect to require that the provider supply the Medicaid
14 fraud control unit within the office of the Attorney General with
15 copies of the records. Upon request, the Attorney General shall be
16 granted access to records, including electronic data, held by the
17 Oklahoma Health Care Authority for the purpose of investigating
18 whether any person or entity may have committed the crime of
19 Medicaid fraud.

20 D. Records obtained or created by the Authority or the Attorney
21 General pursuant to the Oklahoma Medicaid Program Integrity Act
22 shall be classified as confidential information and shall not be
23 subject to the Oklahoma Open Records Act or to outside review or
24 release by any individual except, if authorized by the Attorney

1 General, in relation to legal, administrative, or judicial
2 proceeding.

3 E. No person holding such records may refuse to provide the
4 Authority or the Attorney General with access to such records on the
5 basis that release would violate any recipient's right of privacy,
6 any recipient's privilege against disclosure or use, or any
7 professional or other privilege or right. The disclosure of patient
8 information as required by the Oklahoma Medicaid Program Integrity
9 Act shall not subject any physician or other health services
10 provider to liability for breach of any confidential relationship
11 between a patient and a provider.

12 SECTION 3. NEW LAW A new section of law to be codified
13 in the Oklahoma Statutes as Section 1011.12 of Title 56, unless
14 there is created a duplication in numbering, reads as follows:

15 As used in this act, the following definitions apply:

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

17 2. "Managed care plan" means a health insurer, specialty plan,
18 health maintenance organization authorized under the Oklahoma
19 Insurance Code, or a Medicaid-authorized provider service network
20 under contract with the Authority to provide services in the
21 Medicaid program;

22 3. "Prepaid plan" means a managed care plan that is licensed or
23 certified as a risk-bearing entity or is an approved provider
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1 service network, and is paid a prospective per-member, per-month
2 payment by the Authority;

3 4. "Provider service network" means an Authority-approved
4 entity of which a controlling interest is owned by a health care
5 provider, or group of affiliated providers, or a public agency or
6 entity that delivers health services. Health care providers include
7 state-licensed health care professionals or licensed health care
8 facilities, federally qualified health care centers and home health
9 care agencies;

10 5. "Specialty plan" means a managed care plan that serves
11 Medicaid recipients who meet specified criteria based on age,
12 medical condition or diagnosis;

13 6. "Comprehensive long-term care plan" means a managed care
14 plan, provider-sponsored organization, health maintenance
15 organization or coordinated care plan, that provides long-term care
16 services as outlined in this act;

17 7. "Long-term care plan" means a managed care plan that
18 provides the services described in this act for the long-term care
19 managed care program; and

20 8. "Long-term care provider service network" means a provider
21 service network a controlling interest of which is owned by one or
22 more licensed nursing homes, assisted living facilities with
23 seventeen or more beds, home health agencies, community care for the
24 elderly lead agencies or hospices.

1 SECTION 4. NEW LAW A new section of law to be codified
2 in the Oklahoma Statutes as Section 1011.13 of Title 56, unless
3 there is created a duplication in numbering, reads as follows:

4 The Medicaid program is established as a statewide, integrated
5 managed care program for all covered services, including long-term
6 care services. The Authority shall apply for and implement both a
7 1932(a) Medicaid State Plan Amendment and a 1915(b) Medicaid waiver
8 as necessary to implement the program. Before submitting the waiver
9 or state plan amendment, the Authority shall provide public notice
10 and the opportunity for public comment and include public feedback
11 to the U.S. Department of Health and Human Services.

12 SECTION 5. NEW LAW A new section of law to be codified
13 in the Oklahoma Statutes as Section 1011.14 of Title 56, unless
14 there is created a duplication in numbering, reads as follows:

15 A. Services in the Medicaid managed care program shall be
16 provided by managed care plans that are capable of coordinating
17 and/or delivering all covered services to enrollees.

18 B. The Authority shall select managed care plans to participate
19 in the Medicaid program using invitations to negotiate. The
20 procurement method must give the state the most flexibility and
21 broadest power to negotiate value and provide potential bidder the
22 most flexibility to innovate. Separate and simultaneous
23 procurements shall be conducted in each region to be established by
24 the Authority.

1 C. The Authority shall consider quality factors in the
2 selection of managed care plans, including:

3 1. Accreditation by a nationally recognized accrediting body;

4 2. Documentation of policies and procedures for preventing
5 fraud and abuse;

6 3. Experience serving, and achieving quality standards for,
7 similar populations;

8 4. Availability/accessibility of primary and specialty care
9 physicians in the network; and

10 5. Provision of additional benefits, particularly dental care
11 and disease management, and other initiatives that improve health
12 outcomes.

13 D. After negotiations are conducted, the Authority shall select
14 the managed care plans that are determined to be responsive and
15 provide the best value to the state. Preference shall be given to
16 plans that have signed contracts with primary and specialty
17 physicians in sufficient numbers to meet the specific standards
18 established pursuant to this act.

19 E. To ensure managed care plan participation in all regions,
20 the Authority shall award an additional contract in a more populous
21 region to each plan with a contract award in a more rural region.
22 If a plan terminates its contract in a more rural region, the
23 additional contract in the more populous region is automatically
24 terminated in one hundred eighty (180) days. The plan must also

1 reimburse the Authority for the cost of enrollment changes and other
2 transition activities.

3 F. The Authority may not execute contracts with managed care
4 plans at payment rates not supported by the General Appropriations
5 Act.

6 SECTION 6. NEW LAW A new section of law to be codified
7 in the Oklahoma Statutes as Section 1011.15 of Title 56, unless
8 there is created a duplication in numbering, reads as follows:

9 A. The Authority shall select managed care plans through the
10 procurement process described in this act.

11 B. Participation by specialty plans is subject to the
12 procurement requirements in this act. The enrollment of a specialty
13 plan in a region may not exceed ten percent (10%) of the enrollees
14 of that region. However, a specialty plan whose target population
15 includes no more than ten percent (10%) of the enrollees of that
16 region is not subject to the regional plan number limits of this
17 section.

18 C. Participation by a Medicare Advantage Preferred Provider
19 Organization, Medicare Advantage Provider-Sponsored Organization,
20 Medicare Advantage Health Maintenance Organization, Medicare
21 Advantage Coordinated Care Plan or Medicare Advantage Special Needs
22 Plan is not subject to the procurement requirements if the Medicaid
23 enrollees of the plan consist exclusively of dually eligible
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1 recipients who are enrolled in the plan in order to receive Medicare
2 benefits.

3 SECTION 7. NEW LAW A new section of law to be codified
4 in the Oklahoma Statutes as Section 1011.16 of Title 56, unless
5 there is created a duplication in numbering, reads as follows:

6 A. The Authority shall establish a five-year contract with each
7 managed care plan selected through the procurement process described
8 in this act. A plan contract may not be renewed; however, the
9 Authority may extend the term of a plan contract to cover any delays
10 during the transition to a new plan.

11 B. The Authority shall establish such contract requirements as
12 are necessary for the operation of the statewide managed care
13 program. In addition to any other provisions the Authority may deem
14 necessary, the contract must require:

15 1. Physician compensation: Managed care plans are expected to
16 coordinate care, manage chronic disease and prevent the need for
17 more costly services. Effective care management should enable plans
18 to redirect available resources and increase compensation for
19 physicians;

20 2. Hospital compensation: Managed care plans and hospitals
21 shall negotiate mutually acceptable rates, methods and terms of
22 payment. Payment rates may be updated periodically;

23 3. Access:
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- 1 a. The Authority shall establish specific, population-
2 based standards for the number, type and regional
3 distribution of providers in managed care plan
4 networks to ensure access to care for both adults and
5 children. Consistent with standards established by
6 the Authority, provider networks may include providers
7 located outside the region. Plans may limit the
8 providers in their networks based on credentials,
9 quality indicators and price.
- 10 b. Each plan shall establish and maintain an accurate and
11 complete electronic database of contracted providers,
12 including information about licensure or registration,
13 locations and hours of operation, or specialty
14 credentials and other certifications. The database
15 must be available online to both the Authority and the
16 public and have the capability to compare the
17 availability of providers to network adequacy
18 standards and to accept and display feedback from
19 patients of each provider.
- 20 c. Each managed care plan must publish any prescribed
21 drug formulary or preferred drug list on the plan's
22 website in a manner that is accessible to and
23 searchable by enrollees and providers. The plan must
24 update the list within twenty-four (24) hours after

1 making a change. Each plan must ensure that the prior
2 authorization process for prescribed drugs is readily
3 accessible to health care providers, including posting
4 appropriate contact information on its website and
5 providing timely responses to providers;

6 4. Encounter data: The Authority shall maintain and operate a
7 Medicaid encounter data system to collect, process, store and report
8 on covered services provided to all Medicaid recipients enrolled in
9 prepaid plans. The Authority shall make encounter data available to
10 those plans accepting enrollees who are assigned to them from other
11 plans leaving a region;

12 5. Continuous improvement: The Authority shall establish
13 specific performance standards and expected milestones or timelines
14 for improving performance over the term of the contract.

15 a. Each managed care plan shall establish an internal
16 health care quality-improvement system, including
17 enrollee satisfaction and disenrollment surveys. The
18 quality-improvement system must include incentives and
19 disincentives for network providers.

20 b. Each plan must collect and report Health Plan Employer
21 Data and Information Set (HEDIS) measures, as
22 specified by the Authority. These measures must be
23 published on the plan's website in a manner that
24 allows recipients to reliably compare the performance

1 of plans. The Authority shall use the HEDIS measures
2 as a tool to monitor plan performance.

3 c. Each managed care plan must be accredited by the
4 National Committee for Quality Assurance, the Joint
5 Commission, or another nationally recognized
6 accrediting body, or have initiated the accreditation
7 process within one (1) year after the contract is
8 executed;

9 6. Program integrity: Each managed care plan shall establish
10 program integrity functions and activities to reduce the incidence
11 of fraud and abuse, including, at a minimum:

- 12 a. a provider credentialing system and ongoing provider
13 monitoring,
- 14 b. procedures for reporting instances of fraud and abuse,
15 and
- 16 c. designation of a program integrity compliance officer;

17 7. Grievance resolution: Consistent with federal law, each
18 managed care plan shall establish and the Authority shall approve an
19 internal process for reviewing and responding to grievances from
20 enrollees. Each plan shall submit quarterly reports on the number,
21 description and outcome of grievances filed by enrollees;

22 8. Penalties: Managed care plans will incur penalties for
23 withdrawal and enrollment reduction, failure to comply with
24

1 encounter data reporting requirements, and/or termination of a
2 regional contract due to noncompliance;

3 9. Prompt payment: Managed care plans shall comply with the
4 prompt payment requirements of the Oklahoma Insurance Code;

5 10. Electronic claims: Managed care plans, and their fiscal
6 agents or intermediaries, shall accept electronic claims in
7 compliance with federal standards; and

8 11. Itemized payment: Any claims payment to a provider by a
9 managed care plan, or by a fiscal agent or intermediary of the plan,
10 must be accompanied by an itemized accounting of the individual
11 claims included in the payment including, but not limited to, the
12 enrollee's name, the date of service, the procedure code, the amount
13 of reimbursement and the identification of the plan on whose behalf
14 the payment is made.

15 C. The Authority is responsible for verifying the achieved
16 savings rebate for all Medicaid prepaid plans. The achieved savings
17 rebate is established by determining pretax income as a percentage
18 of revenues and applying the following income-sharing ratios:

19 1. One hundred percent (100%) of income, up to and including
20 five percent (5%) of revenue, shall be retained by the plan;

21 2. Fifty percent (50%) of income above five percent (5%) and up
22 to ten percent (10%) shall be retained by the plan, and the other
23 fifty percent (50%) refunded to the state; and

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1 3. One hundred percent (100%) of income above ten percent (10%)
2 of revenue shall be refunded to the state.

3 D. Each managed care plan must accept any medically needy
4 recipient who selects or is assigned to the plan and provide that
5 recipient with continuous enrollment for twelve (12) months. After
6 the first month of qualifying as a medically needy recipient and
7 enrolling in a plan, and contingent upon federal approval, the
8 enrollee shall pay the plan a portion of the monthly premium equal
9 to the enrollee's share of the cost as determined by the Authority.
10 The Authority shall pay any remaining portion of the monthly
11 premium. Plans are not obligated to pay claims for medically needy
12 patients for services provided before enrollment in the plan.
13 Medically needy patients are responsible for payment of incurred
14 claims that are used to determine eligibility. Plans must provide a
15 grace period of at least ninety (90) days before disenrolling
16 recipients who fail to pay their shares of the premium.

17 SECTION 8. NEW LAW A new section of law to be codified
18 in the Oklahoma Statutes as Section 1011.17 of Title 56, unless
19 there is created a duplication in numbering, reads as follows:

20 A. Prepaid plans shall receive per-member, per-month payments
21 negotiated pursuant to the procurements described in this act.
22 Payments shall be risk-adjusted rates based on historical
23 utilization and spending data, projected forward and adjusted to
24 reflect the eligibility category, geographic area and clinical risk

1 profile of the recipients. In negotiating rates with the plans, the
2 Authority shall consider any adjustments necessary to encourage
3 plans to use the most cost-effective modalities for treatment of
4 chronic disease.

5 B. Provider service networks may be prepaid plans and receive
6 per-member, per-month payments. The fee-for-service option shall be
7 available to a provider service network only for the first two (2)
8 years of its operation.

9 C. The Authority may not approve any plan request for a rate
10 increase unless sufficient funds to support the increase have been
11 authorized in the General Appropriations Act.

12 SECTION 9. NEW LAW A new section of law to be codified
13 in the Oklahoma Statutes as Section 1011.18 of Title 56, unless
14 there is created a duplication in numbering, reads as follows:

15 A. All Medicaid recipients shall be enrolled in a managed care
16 plan unless specifically exempted under this act. Each recipient
17 shall have a choice of plans and may select any available plan
18 unless that plan is restricted by contract to a specific population
19 that does not include the recipient. Medicaid recipients shall have
20 thirty (30) days in which to make a choice of plans.

21 B. The Authority shall implement a choice counseling system to
22 ensure recipients have timely access to accurate information on the
23 available plans. The counseling system shall include plan-to-plan
24 comparative information on benefits, provider networks, drug

1 formularies, quality measures and other data points as determined by
2 the Authority. Choice counseling must be made available through
3 face-to-face interaction, on the Internet, by telephone, and in
4 writing and through other forms of relevant media. Materials must
5 be provided in a culturally relevant manner, consistent with federal
6 requirements. The Authority shall contract for any or all choice
7 counseling functions.

8 C. After a recipient has enrolled in a managed care plan, the
9 recipient shall have ninety (90) days to voluntarily disenroll and
10 select another plan. After ninety (90) days, no further changes may
11 be made except for good cause.

12 D. The Authority shall automatically enroll into a managed care
13 plan those Medicaid recipients who do not voluntarily choose a plan.
14 Except as otherwise outlined in this act, the Authority may not
15 engage in practices that are designed to favor one managed care plan
16 over another.

17 1. The Authority shall automatically enroll recipients in plans
18 that meet or exceed the performance or quality standards established
19 in this act and may not automatically enroll recipients in a plan
20 that is deficient in those performance or quality standards.

21 2. If a specialty plan is available to accommodate a specific
22 condition or diagnosis of a recipient, the Authority shall assign
23 the recipient to that plan.

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1 3. In the first year of the first contract term only, if a
2 recipient was previously enrolled in a plan that is still available
3 in the region, the Authority shall automatically enroll the
4 recipient in that plan unless an applicable specialty plan is
5 available.

6 4. A newborn of a mother enrolled in a plan at the time of the
7 birth of the child shall be enrolled in the plan of the mother.
8 Upon birth, such a newborn is deemed enrolled in the managed care
9 plan, regardless of the administrative enrollment procedures, and
10 the managed care plan is responsible for providing Medicaid services
11 to the newborn. The mother may choose another plan for the newborn
12 within ninety (90) days after the birth of the child.

13 5. Otherwise, the Authority shall automatically enroll
14 recipients based on the following criteria:
15 a. whether the plan has sufficient network capacity to
16 meet the needs of the recipients,
17 b. whether the recipient has previously received services
18 from one of the primary care providers of the plan,
19 and
20 c. whether primary care providers in one plan are more
21 geographically accessible to the residence of the
22 recipient than those in other plans.

23 E. Recipients with access to private health care coverage shall
24 opt out of all managed care plans and use Medicaid financial

1 assistance to pay for their share of the cost in such coverage. The
2 amount of financial assistance provided for each recipient may not
3 exceed the amount of the Medicaid premium that would have been paid
4 to a managed care plan for that recipient. The Authority shall seek
5 federal approval to require Medicaid recipients with access to
6 employer-sponsored health care coverage to enroll in that coverage
7 and use Medicaid financial assistance to pay for the recipient's
8 share of the cost for such coverage. The amount of financial
9 assistance provided for each recipient may not exceed the amount of
10 the Medicaid premium that would have been paid to a managed care
11 plan for that recipient.

12 SECTION 10. NEW LAW A new section of law to be codified
13 in the Oklahoma Statutes as Section 1011.19 of Title 56, unless
14 there is created a duplication in numbering, reads as follows:

15 A. All Medicaid recipients shall receive covered services
16 through the statewide managed care program except for exempt
17 populations as outlined in Section 1932(a)(2) of the Social Security
18 Act. These exempt populations may voluntarily enroll in the
19 statewide managed care program. Populations who only receive
20 limited services from Medicaid shall not be included in the
21 statewide managed care program.

22 B. Participants in the medically needy program shall enroll in
23 managed care plans. Medically needy recipients shall meet the share
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1 of the cost by paying the plan premium, up to the share of the cost
2 amount.

3 SECTION 11. NEW LAW A new section of law to be codified
4 in the Oklahoma Statutes as Section 1011.20 of Title 56, unless
5 there is created a duplication in numbering, reads as follows:

6 A. Managed care plans shall cover, at a minimum, the following:

7 1. Advanced registered nurse practitioner services;

8 2. Ambulatory surgical treatment center services;

9 3. Birthing center services;

10 4. Chiropractic services;

11 5. Dental services;

12 6. Early periodic screening diagnosis and treatment services
13 for recipients under twenty-one (21) years of age;

14 7. Emergency services;

15 8. Family planning services and supplies (plans may elect not
16 to provide these services);

17 9. Healthy start services;

18 10. Hearing services;

19 11. Home health agency services;

20 12. Hospice services;

21 13. Hospital inpatient services;

22 14. Hospital outpatient services;

23 15. Laboratory and imaging services;

24 16. Medical supplies, equipment, prostheses and orthoses;

- 1 17. Mental health services;
- 2 18. Nursing care;
- 3 19. Optical services and supplies;
- 4 20. Optometrist services;
- 5 21. Physical, occupational, respiratory and speech therapy
- 6 services;
- 7 22. Physician services, including physician assistant services;
- 8 23. Podiatric services;
- 9 24. Prescription drugs;
- 10 25. Renal dialysis services;
- 11 26. Respiratory equipment and supplies;
- 12 27. Rural health clinic services;
- 13 28. Substance abuse treatment services; and
- 14 29. Transportation to access covered services.

15 B. Managed care plans may customize benefit packages for
16 nonpregnant adults, vary cost-sharing provisions and provide
17 coverage for additional services. The Authority shall evaluate the
18 proposed benefit packages to ensure services are sufficient to meet
19 the needs of the enrollees of the plan and to verify actuarial
20 equivalence.

21 C. Each plan operating in the managed care program shall
22 establish a program to encourage and reward healthy behaviors. At a
23 minimum, each plan must establish a medically approved smoking
24 cessation program, a medically directed weight loss program, and a

1 medically approved alcohol or substance abuse recovery program.
2 Each plan must identify enrollees who smoke, are morbidly obese, or
3 are diagnosed with alcohol or substance abuse in order to establish
4 written agreements to secure the commitment of the enrollee to
5 participation in these programs.

6 SECTION 12. NEW LAW A new section of law to be codified
7 in the Oklahoma Statutes as Section 1011.21 of Title 56, unless
8 there is created a duplication in numbering, reads as follows:

9 A. The Authority shall make payments for long-term care home-
10 and community-based and residential services, and for primary and
11 acute medical assistance and related services for recipients
12 eligible for long-term care, using a managed care model.

13 B. The Aging Services Division of the Oklahoma Department of
14 Human Services shall assist the Authority in developing
15 specifications for the invitation to negotiate and the model
16 contract; determine clinical eligibility for enrollment in managed
17 long-term care plans; monitor plan performance and measure quality
18 of service delivery; assist clients and families to address
19 complaints with the plans; facilitate working relationships between
20 plans and providers serving elders and disabled adults; and perform
21 other functions specified in a memorandum of agreement.

22 SECTION 13. NEW LAW A new section of law to be codified
23 in the Oklahoma Statutes as Section 1011.22 of Title 56, unless
24 there is created a duplication in numbering, reads as follows:

1 A. Medicaid recipients who meet all of the following criteria
2 are eligible to receive long-term care services and must receive
3 long-term care services by participating in the long-term care
4 managed care program. The recipient must be:

5 1. Sixty-five (65) years of age or older, or eighteen (18)
6 years of age or older and eligible for Medicaid by reason of a
7 disability; or

8 2. Determined to require nursing facility care.

9 B. Medicaid recipients who, on the date long-term care managed
10 care plans become available in their region, reside in a nursing
11 home facility or are enrolled in an existing long-term care Medicaid
12 waiver program are eligible to participate in the long-term care
13 managed care program for up to twelve (12) months without being
14 reevaluated for their need for nursing facility care.

15 C. The Authority shall make offers for enrollment to eligible
16 individuals based on a wait-list prioritization and subject to
17 availability of funds. Before enrollment offers, the Authority
18 shall determine that sufficient funds exist to support additional
19 enrollment into plans.

20 SECTION 14. NEW LAW A new section of law to be codified
21 in the Oklahoma Statutes as Section 1011.23 of Title 56, unless
22 there is created a duplication in numbering, reads as follows:

23 Long-term care plans shall, at a minimum, cover the following:

24 1. Nursing facility care;

- 1 2. Services provided in assisted living facilities;
- 2 3. Hospice;
- 3 4. Adult day care;
- 4 5. Medical equipment and supplies, including incontinence
- 5 supplies;
- 6 6. Personal care;
- 7 7. Home accessibility adaptation;
- 8 8. Behavior management;
- 9 9. Home-delivered meals;
- 10 10. Case management;
- 11 11. Therapies, including occupational, speech, respiratory and
- 12 physical;
- 13 12. Intermittent and skilled nursing;
- 14 13. Medication administration;
- 15 14. Medication management;
- 16 15. Nutritional assessment and risk reduction;
- 17 16. Caregiver training;
- 18 17. Respite care;
- 19 18. Transportation; and
- 20 19. Personal emergency response system.

21 SECTION 15. NEW LAW A new section of law to be codified
22 in the Oklahoma Statutes as Section 1011.24 of Title 56, unless
23 there is created a duplication in numbering, reads as follows:
24

1 A. Provider service networks must be long-term care provider
2 service networks. Other eligible plans may be long-term care plans
3 or comprehensive long-term care plans.

4 B. The Authority shall select managed care plans through the
5 procurement process described in this act.

6 C. In addition to the criteria established in this act, the
7 Authority shall consider the following factors in the selection of
8 long-term care managed care plans:

9 1. Evidence of the employment of executive managers with
10 expertise and experience in serving aged and disabled persons who
11 require long-term care;

12 2. Whether a plan has established a network of service
13 providers dispersed throughout the region and in sufficient numbers
14 to meet specific service standards established by the Authority for
15 specialty services for persons receiving home- and community-based
16 care;

17 3. Whether a plan is proposing to establish a comprehensive
18 long-term care plan and whether the plan has a contract to provide
19 managed medical assistance services in the same region;

20 4. Whether a plan offers consumer-directed care services to
21 enrollees; and

22 5. Whether a plan is proposing to provide home- and community-
23 based services in addition to the minimum benefits required by this
24 act.

1 D. Participation by a Medicare Advantage Special Needs Plan is
2 not subject to the procurement requirements if the plan's Medicaid
3 enrollees consist exclusively of dually eligible recipients who are
4 enrolled in the plan in order to receive Medicare benefits.

5 SECTION 16. NEW LAW A new section of law to be codified
6 in the Oklahoma Statutes as Section 1011.25 of Title 56, unless
7 there is created a duplication in numbering, reads as follows:

8 A. In addition to the requirements earlier in this act, plans
9 and providers participating in the long-term care managed care
10 program must comply with the requirements of this section.

11 B. Managed care plans may limit the providers in their networks
12 based on credentials, quality indicators and price. Each selected
13 plan must offer a network contract to all of the following providers
14 in the region:

- 15 1. Nursing homes;
- 16 2. Hospices; and
- 17 3. Aging network service providers that have previously
18 participated in home- and community-based waivers serving elders or
19 community-service programs administered by the Aging Services
20 Division of the Oklahoma Department of Human Services.

21 C. Except as provided in this section, providers may limit the
22 managed care plans they join. Nursing homes and hospices that are
23 enrolled Medicaid providers must participate in all managed care
24

1 plans selected by the Authority in the region in which the provider
2 is located.

3 D. Each managed care plan shall monitor the quality and
4 performance of each participating provider using measures adopted by
5 and collected by the Authority and any additional measures mutually
6 agreed upon by the provider and the plan.

7 E. The Authority shall establish, and each managed care plan
8 must comply with, specific standards for the number, type and
9 regional distribution of providers in the plan's network.

10 F. Managed care plans and providers shall negotiate mutually
11 acceptable rates, methods and terms of payment. Plans shall pay
12 nursing homes an amount equal to the nursing-facility-specific
13 payment rates set by the Authority; however, mutually acceptable
14 higher rates may be negotiated for medically complex care. Plans
15 must ensure that electronic nursing home and hospice claims that
16 contain sufficient information for processing are paid within ten
17 (10) business days after receipt.

18 SECTION 17. NEW LAW A new section of law to be codified
19 in the Oklahoma Statutes as Section 1011.26 of Title 56, unless
20 there is created a duplication in numbering, reads as follows:

21 A. In addition to the payment provisions in this act, the
22 Authority shall provide payment to plans in the long-term care
23 managed care program pursuant to this section.

24

1 B. Payment rates to plans shall be blended for some long-term
2 care services.

3 C. Payment rates for plans must reflect historic utilization
4 and spending for covered services projected forward and adjusted to
5 reflect the level-of-care profile for enrollees in each plan. The
6 Authority shall periodically adjust payment rates to account for
7 changes in the level-of-care profile for each managed care plan
8 based on encounter data.

9 1. Level-of-care 1 consists of recipients residing in or who
10 must be placed in a nursing home.

11 2. Level-of-care 2 consists of recipients at imminent risk of
12 nursing home placement, as evidenced by the need for the constant
13 availability of routine medical and nursing treatment and care, who
14 require extensive health-related care and services because of mental
15 or physical incapacitation.

16 3. Level-of-care 3 consists of recipients at imminent risk of
17 nursing home placement, as evidenced by the need for the constant
18 availability of routine medical and nursing treatment and care, who
19 have a limited need for health-related care and services and are
20 mildly medically or physically incapacitated.

21 D. The Authority shall make an incentive adjustment in payment
22 rates to encourage the increased utilization of home- and community-
23 based services and a commensurate reduction of institutional
24 placement. The incentive adjustment shall continue until no more

1 than thirty-five percent (35%) of the enrollees of the plan are
2 placed in institutional settings. The Authority shall annually
3 report to the Legislature the actual change in the utilization mix
4 of home- and community-based services compared to institutional
5 placements and provide a recommendation for utilization-mix
6 requirements for future contracts.

7 SECTION 18. NEW LAW A new section of law to be codified
8 in the Oklahoma Statutes as Section 1011.27 of Title 56, unless
9 there is created a duplication in numbering, reads as follows:

10 A. The Authority shall automatically enroll into a long-term
11 care managed care plan those Medicaid recipients who do not
12 voluntarily choose a plan. Except as otherwise provided in this
13 act, the Authority may not engage in practices designed to favor one
14 managed care plan over another.

15 B. The Authority shall automatically enroll recipients in plans
16 that meet or exceed the performance or quality standards established
17 in this act, or by the Authority through contract, and may not
18 automatically enroll recipients in a plan that is deficient in those
19 performance or quality standards.

20 1. If a recipient is deemed dually eligible for Medicaid and
21 Medicare services and is currently receiving Medicare services from
22 a Medicare Advantage Preferred Provider Organization, Medicare
23 Advantage Provider-Sponsored Organization or Medicare Advantage
24 Special Needs Plan, the Authority shall automatically enroll the

1 recipient in such plan for Medicaid services if the plan is
2 currently participating in the long-term care managed care program.

3 2. Otherwise, the Authority shall automatically enroll
4 recipients based on the following criteria:

5 a. whether the plan has sufficient network capacity to
6 meet the needs of the recipients,

7 b. whether the recipient has previously received services
8 from one of the plan's home- and community-based
9 service providers, and

10 c. whether the home- and community-based providers in one
11 plan are more geographically accessible to the
12 residence of the recipient than those in other plans.

13 C. If a recipient is referred for hospice services, the
14 recipient has thirty (30) days during which the recipient may select
15 to enroll in another managed care plan to access the hospice
16 provider of the recipient's choice.

17 D. If a recipient is referred for placement in a nursing home
18 or assisted living facility, the plan must inform the recipient of
19 any facilities within the plan that have specific cultural or
20 religious affiliations and, if requested by the recipient, make a
21 reasonable effort to place the recipient in the facility of the
22 recipient's choice.

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SECTION 19. This act shall become effective November 1, 2014.

54-2-8151 SD 01/08/14