

1 **HOUSE OF REPRESENTATIVES - FLOOR VERSION**

2 STATE OF OKLAHOMA

3 1st Session of the 54th Legislature (2013)

4 COMMITTEE SUBSTITUTE
5 FOR
6 HOUSE BILL NO. 1552

By: McCullough of the House

and

Griffin of the Senate

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10 COMMITTEE SUBSTITUTE

11 [Medicaid - managed care program - managed care
12 plans - long-term care managed care program -
13 effective date]

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

17 SECTION 1. NEW LAW A new section of law to be codified
18 in the Oklahoma Statutes as Section 1011.12 of Title 56, unless
19 there is created a duplication in numbering, reads as follows:

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

- 21 1. "Authority" means the Oklahoma Health Care Authority;
22 2. "Managed care plan" means a health insurer, specialty plan,
23 health maintenance organization authorized under the Oklahoma

1 Insurance Code, or a Medicaid-authorized provider service network
2 under contract with the Authority to provide services in the
3 Medicaid program;

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

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

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

18 6. "Comprehensive long-term care plan" means a managed care
19 plan, provider-sponsored organization, health maintenance
20 organization, or coordinated care plan, that provides long-term care
21 services as outlined in this act;

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

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

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

12 The Medicaid program is established as a statewide, integrated
13 managed care program for all covered services, including long-term
14 care services. The Authority shall apply for and implement both a
15 1932(a) Medicaid State Plan Amendment and a 1915(b) Medicaid waiver
16 as necessary to implement the program. Before submitting the waiver
17 or state plan amendment, the Authority shall provide public notice
18 and the opportunity for public comment and include public feedback
19 to the U.S. Department of Health and Human Services.

20 SECTION 3. NEW LAW A new section of law to be codified
21 in the Oklahoma Statutes as Section 1011.14 of Title 56, unless
22 there is created a duplication in numbering, reads as follows:
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1 A. Services in the Medicaid managed care program shall be
2 provided by managed care plans that are capable of coordinating
3 and/or delivering all covered services to enrollees.

4 B. The Authority shall select managed care plans to participate
5 in the Medicaid program using invitations to negotiate. The
6 procurement method must give the state the most flexibility and
7 broadest power to negotiate value, and provide potential bidder the
8 most flexibility to innovate. Separate and simultaneous
9 procurements shall be conducted in each region to be established by
10 the Authority.

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

13 1. Accreditation by a nationally recognized accrediting body;

14 2. Documentation of policies and procedures for preventing
15 fraud and abuse;

16 3. Experience serving, and achieving quality standards for,
17 similar populations;

18 4. Availability/accessibility of primary and specialty care
19 physicians in the network; and

20 5. Provision of additional benefits, particularly dental care
21 and disease management, and other initiatives that improve health
22 outcomes.

1 D. After negotiations are conducted, the Authority shall select
2 the managed care plans that are determined to be responsive and
3 provide the best value to the state. Preference shall be given to
4 plans that have signed contracts with primary and specialty
5 physicians in sufficient numbers to meet the specific standards
6 established pursuant to this act.

7 E. To ensure managed care plan participation in all regions,
8 the Authority shall award an additional contract in a more populous
9 region to each plan with a contract award in a more rural region.
10 If a plan terminates its contract in a more rural region, the
11 additional contract in the more populous region is automatically
12 terminated in one hundred eighty (180) days. The plan must also
13 reimburse the Authority for the cost of enrollment changes and other
14 transition activities.

15 F. The Authority may not execute contracts with managed care
16 plans at payment rates not supported by the General Appropriations
17 Act.

18 SECTION 4. NEW LAW A new section of law to be codified
19 in the Oklahoma Statutes as Section 1011.15 of Title 56, unless
20 there is created a duplication in numbering, reads as follows:

21 A. The Authority shall select managed care plans through the
22 procurement process described in this act.
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1 B. Participation by specialty plans is subject to the
2 procurement requirements in this act. The enrollment of a specialty
3 plan in a region may not exceed ten percent (10%) of the enrollees
4 of that region. However, a specialty plan whose target population
5 includes no more than ten percent (10%) of the enrollees of that
6 region is not subject to the regional plan number limits of this
7 section.

8 C. Participation by a Medicare Advantage Preferred Provider
9 Organization, Medicare Advantage Provider-Sponsored Organization,
10 Medicare Advantage Health Maintenance Organization, Medicare
11 Advantage Coordinated Care Plan, or Medicare Advantage Special Needs
12 Plan is not subject to the procurement requirements if the plan's
13 Medicaid enrollees consist exclusively of dually eligible recipients
14 who are enrolled in the plan in order to receive Medicare benefits.

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

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

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

5 1. Physician compensation: Managed care plans are expected to
6 coordinate care, manage chronic disease, and prevent the need for
7 more costly services. Effective care management should enable plans
8 to redirect available resources and increase compensation for
9 physicians;

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

13 3. Access:

14 a. The Authority shall establish specific, population-
15 based standards for the number, type, and regional
16 distribution of providers in managed care plan
17 networks to ensure access to care for both adults and
18 children. Consistent with standards established by
19 the Authority, provider networks may include providers
20 located outside the region. Plans may limit the
21 providers in their networks based on credentials,
22 quality indicators, and price.

1 b. Each plan shall establish and maintain an accurate and
2 complete electronic database of contracted providers,
3 including information about licensure or registration,
4 locations and hours of operation, or specialty
5 credentials and other certifications. The database
6 must be available online to both the Authority and the
7 public and have the capability to compare the
8 availability of providers to network adequacy
9 standards and to accept and display feedback from each
10 provider's patients.

11 c. Each managed care plan must publish any prescribed
12 drug formulary or preferred drug list on the plan's
13 website in a manner that is accessible to and
14 searchable by enrollees and providers. The plan must
15 update the list within twenty-four (24) hours after
16 making a change. Each plan must ensure that the prior
17 authorization process for prescribed drugs is readily
18 accessible to health care providers, including posting
19 appropriate contact information on its website and
20 providing timely responses to providers;

21 4. Encounter data: The Authority shall maintain and operate a
22 Medicaid encounter data system to collect, process, store, and
23 report on covered services provided to all Medicaid recipients
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1 enrolled in prepaid plans. The Authority shall make encounter data
2 available to those plans accepting enrollees who are assigned to
3 them from other plans leaving a region;

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

7 a. Each managed care plan shall establish an internal
8 health care quality improvement system, including
9 enrollee satisfaction and disenrollment surveys. The
10 quality improvement system must include incentives and
11 disincentives for network providers.

12 b. Each plan must collect and report Health Plan Employer
13 Data and Information Set (HEDIS) measures, as
14 specified by the Authority. These measures must be
15 published on the plan's website in a manner that
16 allows recipients to reliably compare the performance
17 of plans. The Authority shall use the HEDIS measures
18 as a tool to monitor plan performance.

19 c. Each managed care plan must be accredited by the
20 National Committee for Quality Assurance, the Joint
21 Commission, or another nationally recognized
22 accrediting body, or have initiated the accreditation
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1 process, within one (1) year after the contract is
2 executed;

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

6 a. a provider credentialing system and ongoing provider
7 monitoring,

8 b. procedures for reporting instances of fraud and abuse,
9 and

10 c. designation of a program integrity compliance officer;

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

16 8. Penalties: Managed care plans will incur penalties for
17 withdrawal and enrollment reduction, failure to comply with
18 encounter data reporting requirements, and/or termination of a
19 regional contract due to noncompliance;

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

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

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

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

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

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

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

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

13 SECTION 6. NEW LAW A new section of law to be codified
14 in the Oklahoma Statutes as Section 1011.17 of Title 56, unless
15 there is created a duplication in numbering, reads as follows:

16 A. Prepaid plans shall receive per-member, per-month payments
17 negotiated pursuant to the procurements described in this act.
18 Payments shall be risk-adjusted rates based on historical
19 utilization and spending data, projected forward and adjusted to
20 reflect the eligibility category, geographic area, and clinical risk
21 profile of the recipients. In negotiating rates with the plans, the
22 Authority shall consider any adjustments necessary to encourage
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1 plans to use the most cost-effective modalities for treatment of
2 chronic disease.

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

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

10 SECTION 7. NEW LAW A new section of law to be codified
11 in the Oklahoma Statutes as Section 1011.18 of Title 56, unless
12 there is created a duplication in numbering, reads as follows:

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

19 B. The Authority shall implement a choice counseling system to
20 ensure recipients have timely access to accurate information on the
21 available plans. The counseling system shall include plan-to-plan
22 comparative information on benefits, provider networks, drug
23 formularies, quality measures, and other data points as determined
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1 by the Authority. Choice counseling must be made available through
2 face-to-face interaction, on the Internet, by telephone, and in
3 writing and through other forms of relevant media. Materials must
4 be provided in a culturally relevant manner, consistent with federal
5 requirements. The Authority shall contract for any or all choice
6 counseling functions.

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

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

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

20 2. If a specialty plan is available to accommodate a specific
21 condition or diagnosis of a recipient, the Authority shall assign
22 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 child's birth shall be enrolled in the mother's plan. Upon birth,
8 such a newborn is deemed enrolled in the managed care plan,
9 regardless of the administrative enrollment procedures, and the
10 managed care plan is responsible for providing Medicaid services to
11 the newborn. The mother may choose another plan for the newborn
12 within ninety (90) days after the child's birth.

13 5. Otherwise, the Authority shall automatically enroll based on
14 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 plan's primary care providers, and
- 19 c. whether primary care providers in one plan are more
20 geographically accessible to the recipient's residence
21 than those in other plans.

22 E. Recipients with access to private health care coverage shall
23 opt out of all managed care plans and use Medicaid financial
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1 assistance to pay for his/her share of the cost in such coverage.
2 The amount of financial assistance provided for each recipient may
3 not exceed the amount of the Medicaid premium that would have been
4 paid to a managed care plan for that recipient. The Authority shall
5 seek 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 8. 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 9. 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 services:

- 8 1. Advanced registered nurse practitioner services;
- 9 2. Ambulatory surgical treatment center services;
- 10 3. Birthing center services;
- 11 4. Chiropractic services;
- 12 5. Dental services;
- 13 6. Early periodic screening diagnosis and treatment services
14 for recipients under age twenty-one (21);
- 15 7. Emergency services;
- 16 8. Family planning services and supplies (plans may elect not
17 to provide these services);
- 18 9. Healthy start services;
- 19 10. Hearing services;
- 20 11. Home health agency services;
- 21 12. Hospice services;
- 22 13. Hospital inpatient services;
- 23 14. Hospital outpatient services;

15. Laboratory and imaging services;
16. Medical supplies, equipment, prostheses, and orthoses;
17. Mental health services;
18. Nursing care;
19. Optical services and supplies;
20. Optometrist services;
21. Physical, occupational, respiratory, and speech therapy services;
22. Physician services, including physician assistant services;
23. Podiatric services;
24. Prescription drugs;
25. Renal dialysis services;
26. Respiratory equipment and supplies;
27. Rural health clinic services;
28. Substance abuse treatment services; and
29. Transportation to access covered services.

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

1 C. Each plan operating in the managed care program shall
2 establish a program to encourage and reward healthy behaviors. At a
3 minimum, each plan must establish a medically approved smoking
4 cessation program, a medically directed weight loss program, and a
5 medically approved alcohol or substance abuse recovery program.
6 Each plan must identify enrollees who smoke, are morbidly obese, or
7 are diagnosed with alcohol or substance abuse in order to establish
8 written agreements to secure the enrollees' commitment to
9 participation in these programs.

10 SECTION 10. NEW LAW A new section of law to be codified
11 in the Oklahoma Statutes as Section 1011.21 of Title 56, unless
12 there is created a duplication in numbering, reads as follows:

13 A. The Authority shall make payments for long-term care home-
14 and community-based and residential services, and for primary and
15 acute medical assistance and related services for recipients
16 eligible for long-term care, using a managed care model.

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

3 SECTION 11. NEW LAW A new section of law to be codified
4 in the Oklahoma Statutes as Section 1011.22 of Title 56, unless
5 there is created a duplication in numbering, reads as follows:

6 A. Medicaid recipients who meet all of the following criteria
7 are eligible to receive long-term care services and must receive
8 long-term care services by participating in the long-term care
9 managed care program. The recipient must be:

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

13 2. Determined to require nursing facility care.

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

20 C. The Authority shall make offers for enrollment to eligible
21 individuals based on a wait-list prioritization and subject to
22 availability of funds. Before enrollment offers, the Authority
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1 shall determine that sufficient funds exist to support additional
2 enrollment into plans.

3 SECTION 12. NEW LAW A new section of law to be codified
4 in the Oklahoma Statutes as Section 1011.23 of Title 56, unless
5 there is created a duplication in numbering, reads as follows:

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

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

2 17. Respite care;

3 18. Transportation; and

4 19. Personal emergency response system.

5 SECTION 13. NEW LAW A new section of law to be codified
6 in the Oklahoma Statutes as Section 1011.24 of Title 56, unless
7 there is created a duplication in numbering, reads as follows:

8 A. Provider service networks must be long-term care provider
9 service networks. Other eligible plans may be long-term care plans
10 or comprehensive long-term care plans.

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

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

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

19 2. Whether a plan has established a network of service
20 providers dispersed throughout the region and in sufficient numbers
21 to meet specific service standards established by the Authority for
22 specialty services for persons receiving home and community-based
23 care;

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

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

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

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

13 SECTION 14. NEW LAW A new section of law to be codified
14 in the Oklahoma Statutes as Section 1011.25 of Title 56, unless
15 there is created a duplication in numbering, reads as follows:

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

19 B. Managed care plans may limit the providers in their networks
20 based on credentials, quality indicators, and price. Each selected
21 plan must offer a network contract to all the following providers in
22 the region:

23 1. Nursing homes;
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1 2. Hospices; and

2 3. Aging network service providers that have previously
3 participated in home- and community-based waivers serving elders or
4 community-service programs administered by the Aging Services
5 Division of the Oklahoma Department of Human Services.

6 C. Except as provided in this section, providers may limit the
7 managed care plans they join. Nursing homes and hospices that are
8 enrolled Medicaid providers must participate in all managed care
9 plans selected by the Authority in the region in which the provider
10 is located.

11 D. Each managed care plan shall monitor the quality and
12 performance of each participating provider using measures adopted by
13 and collected by the Authority and any additional measures mutually
14 agreed upon by the provider and the plan.

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

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

3 SECTION 15. NEW LAW A new section of law to be codified
4 in the Oklahoma Statutes as Section 1011.26 of Title 56, unless
5 there is created a duplication in numbering, reads as follows:

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

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

11 C. Payment rates for plans must reflect historic utilization
12 and spending for covered services projected forward and adjusted to
13 reflect the level-of-care profile for enrollees in each plan. The
14 Authority shall periodically adjust payment rates to account for
15 changes in the level-of-care profile for each managed care plan
16 based on encounter data.

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

19 2. Level-of-care 2 consists of recipients at imminent risk of
20 nursing home placement, as evidenced by the need for the constant
21 availability of routine medical and nursing treatment and care, who
22 require extensive health-related care and services because of mental
23 or physical incapacitation.

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

6 D. The Authority shall make an incentive adjustment in payment
7 rates to encourage the increased utilization of home- and community-
8 based services and a commensurate reduction of institutional
9 placement. The incentive adjustment shall continue until no more
10 than thirty-five percent (35%) of the plan's enrollees are placed in
11 institutional settings. The Authority shall annually report to the
12 Legislature the actual change in the utilization mix of home- and
13 community-based services compared to institutional placements and
14 provide a recommendation for utilization mix requirements for future
15 contracts.

16 SECTION 16. NEW LAW A new section of law to be codified
17 in the Oklahoma Statutes as Section 1011.27 of Title 56, unless
18 there is created a duplication in numbering, reads as follows:

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

1 B. The Authority shall automatically enroll recipients in plans
2 that meet or exceed the performance or quality standards established
3 in this act, or by the Authority through contract, and may not
4 automatically enroll recipients in a plan that is deficient in those
5 performance or quality standards.

6 1. If a recipient is deemed dually eligible for Medicaid and
7 Medicare services and is currently receiving Medicare services from
8 a Medicare Advantage Preferred Provider Organization, Medicare
9 Advantage Provider-Sponsored Organization, or Medicare Advantage
10 Special Needs Plan, the Authority shall automatically enroll the
11 recipient in such plan for Medicaid services if the plan is
12 currently participating in the long-term care managed care program.

13 2. Otherwise, the Authority shall automatically enroll based on
14 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 plan's home- and community-based
19 service providers, and
- 20 c. whether the home- and community-based providers in one
21 plan are more geographically accessible to the
22 recipient's residence than those in other plans.

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

5 D. If a recipient is referred for placement in a nursing home
6 or assisted living facility, the plan must inform the recipient of
7 any facilities within the plan that have specific cultural or
8 religious affiliations and, if requested by the recipient, make a
9 reasonable effort to place the recipient in the facility of the
10 recipient's choice.

11 SECTION 17. This act shall become effective November 1, 2013.

12
13 COMMITTEE REPORT BY: COMMITTEE ON APPROPRIATIONS AND BUDGET, dated
14 03/04/2013 - DO PASS, As Amended and Coauthored.