STATE OF OKLAHOMA

2nd Session of the 58th Legislature (2022)

CONFERENCE COMMITTEE SUBSTITUTE
FOR ENGROSSED
SENATE BILL NO. 1337 By: McCortney of the Senate

and

McEntire, Randleman, and Sims of the House

CONFERENCE COMMITTEE SUBSTITUTE

An Act relating to the state Medicaid program; providing legislative intent; amending 56 O.S. 2021, Section 4002.2, which relates to definitions used in the Ensuring Access to Medicaid Act; modifying, adding, and eliminating certain definitions; requiring the Oklahoma Health Care Authority to enter into certain contracts; requiring legislative authorization for certain contracts; requiring the Authority to issue requests for proposals to cover specified Medicaid populations; requiring specification of services covered and not covered; requiring program implementation by specified date subject to certain condition; requiring certain coordination of services; requiring certain federal approval prior to program implementation; requiring certain bids; allowing certain entities to be awarded contracts; specifying number of contracts to be awarded; requiring selection of provider-led entity for statewide coverage except under specified condition; requiring the Authority to develop certain preferential scoring methodology; providing factors for developed methodology; authorizing selection of provider-led entity for urban region under certain conditions; allowing extension of contracts in certain situations; requiring new contracts to be

made after the end of the contract term; authorizing certain delay in contract implementation; requiring the Authority to develop process for assignment of members to contracted entities; stipulating requirements for American Indians and Alaska Natives; stipulating procedures for continuity of member care management in event of contract termination; granting certain right to Medicaid members; requiring contracted entity to provide certain notification; directing assignment of members to primary care provider under certain condition; requiring development of certain assignment process; amending 56 O.S. 2021, Section 4002.4, which relates to network adequacy standards; requiring time and distance standards; removing certain requirements; modifying terminology; increasing contracting requirements for certain providers; requiring certain expansion of provider-led entity coverage area; requiring approval of the Authority; requiring the Authority to develop certain contract terms; requiring contracted entities to meet all requirements; requiring the Authority to develop certain methods and processes; amending 56 O.S. 2021, Section 4002.5, which relates to duties of contracted entities; making contracted entity responsible for all administrative functions for enrolled members; requiring contracted entity to hold certificate of authority as health maintenance organization; requiring contracted entity to have certain shared governance structure consisting of specified members; modifying terminology; providing certain construction; prohibiting certain contracting practices by contracted entity; requiring the use of certain drug formulary; ensuring broad access to pharmacies; requiring submission of data through state-designated entity for health information exchange; amending 56 O.S. 2021, Section 4002.6, which relates to determination and review requirements; mandating compliance by contracted entity with prior authorization requirements; requiring the Authority to establish certain requirements; modifying terminology; modifying peer-to-peer review procedures; directing establishment of internal and external review and appeal requirements; directing the Authority to establish requirements for internal and external reviews; amending 56 O.S. 2021, Section 4002.7, which relates to requirements for

processing and adjudicating claims; directing the Authority to establish certain requirements; modifying terms; amending 56 O.S. 2021, Section 4002.8, which relates to uniform procedures for review and appeal for adverse determinations; modifying terms; amending 56 O.S. 2021, Section 4002.10, which relates to readiness review; modifying terms; removing certain requirements; amending 56 O.S. 2021, Section 4002.11, which relates to scorecard comparing contracted entities and dental benefit managers; limiting certain reporting criteria; modifying scoring time period; modifying terms; amending 56 O.S. 2021, Section 4002.12, which relates to reimbursement of providers; imposing termination date on minimum reimbursement rates; modifying terms; modifying value-based payment criteria; setting certain requirements for certain services and providers; directing establishment of incentive payment for certain providers; requiring the Authority to specify time frame for attainment of certain percentage of value-based contracts; requiring capitation rates to be updated annually, actuarily sound, and risk-adjusted; authorizing the Authority to establish symmetric risk corridor; directing the Authority to establish process for recovery of certain funds; requiring certain determination and monitoring by the Authority; requiring contracted entity to meet certain primary care spending level; requiring dental benefit manager to maintain certain advisory committee; exempting dental providers from mandatory capitated contracts with dental benefit managers; requiring the Authority to ensure sustainability of transformed Medicaid delivery system; requiring the Authority to develop plan to preserve or increase supplemental payments; directing the Authority to preserve and expand levels of funding through directed payments subject to certain conditions; requiring the Authority to submit certain reports to specified individuals and entities; stipulating criteria of reports; amending 56 O.S. 2021, Section 4002.13, which relates to the Quality Advisory Committee; renaming committee; modifying terms; requiring transformed Medicaid delivery system to include uniform defined measures and goals; requiring contracted entities to use established quality metrics; allowing use of additional quality metrics subject to certain

agreement; requiring the Authority to develop processes for determining quality metrics; authorizing the Authority to use consultants, organizations, or third-party measures to develop outcome measures; subjecting quality metrics to accountability measures and penalties; amending 56 O.S. 2021, Section 4004, which relates to federal approval; directing the Authority to take certain action to seek federal approval; requiring obtainment of certain federal approval prior to implementation of certain contracts; amending 63 O.S. 2021, Section 5009, which relates to the Oklahoma Medicaid program; removing obsolete provisions relating to conversion of delivery system; amending 36 O.S. 2021, Section 624, which relates to insurance premium tax; directing certain proceeds to specified fund; providing certain construction; creating Medicaid Health Improvement Revolving Fund; specifying funding sources; stating allowed expenses; stipulating process for expenditures; renumbering 56 O.S. 2021, Section 4004, as amended by Section 20 of this act; repealing 56 O.S. 2021, Sections 1010.2, 1010.3, 1010.4, 1010.5, and 1010.8, which relate to the Oklahoma Medicaid Program Reform Act of 2003; repealing 56 O.S. 2021, Sections 4002.3 and 4002.9, which relate to the Ensuring Access to Medicaid Act; repealing 63 O.S. 2021, Sections 5009.5, 5011, and 5028, which relate to the Oklahoma Health Care Authority Act; providing for codification; providing a conditional effective date; providing an effective date; and declaring an emergency.

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

SECTION 1. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 4002.1a of Title 56, unless there is created a duplication in numbering, reads as follows:

It is the intent of the Legislature to transform the state's current Medicaid program to provide budget predictability for the taxpayers of this state while ensuring quality care to those in need. The state Medicaid program shall be designed to achieve the following goals:

1. Improve health outcomes for Medicaid members and the state as a whole;

2. Ensure budget predictability through shared risk and accountability;

3. Ensure access to care, quality measures, and member satisfaction;

4. Ensure efficient and cost-effective administrative systems and structures; and

5. Ensure a sustainable delivery system that is a provider-led effort and that is operated and managed by providers to the maximum extent possible.

SECTION 2. AMENDATORY 56 O.S. 2021, Section 4002.2, is amended to read as follows:

Section 4002.2. As used in ~~this act~~ the Ensuring Access to Medicaid Act:

1. "Adverse determination" has the same meaning as provided by Section 6475.3 of Title 36 of the Oklahoma Statutes;

2. "Accountable care organization" means a network of physicians, hospitals, and other health care providers that provides coordinated care to Medicaid members;

3. "Claims denial error rate" means the rate of claims denials that are overturned on appeal;

~~3.~~ 4. "Capitated contract" means a contract between the Oklahoma Health Care Authority and a contracted entity for delivery of services to Medicaid members in which the Authority pays a fixed, per-member-per-month rate based on actuarial calculations;

5. "Children's Specialty Plan" means a health care plan that covers all Medicaid services other than dental services and is designed to provide care to:

a. children in foster care,

b. former foster care children up to twenty-five (25) years of age,

c. juvenile justice involved children, and

d. children receiving adoption assistance;

6. "Clean claim" means a properly completed billing form with Current Procedural Terminology, 4th Edition or a more recent edition, the Tenth Revision of the International Classification of Diseases coding or a more recent revision, or Healthcare Common Procedure Coding System coding where applicable that contains information specifically required in the Provider Billing and

Procedure Manual of the Oklahoma Health Care Authority, as defined in 42 C.F.R., Section 447.45(b);

~~4.~~ 7. "Commercial plan" means an organization or entity that undertakes to provide or arrange for the delivery of health care services to Medicaid members on a prepaid basis and is subject to all applicable federal and state laws and regulations;

8. "Contracted entity" means an organization or entity that enters into or will enter into a capitated contract with the Oklahoma Health Care Authority for the delivery of services specified in this act that will assume financial risk, operational accountability, and statewide or regional functionality as defined in this act in managing comprehensive health outcomes of Medicaid members. For purposes of this act, the term contracted entity includes an accountable care organization, a provider-led entity, a commercial plan, a dental benefit manager, or any other entity as determined by the Authority;

9. "Dental benefit manager" means an entity ~~under contract with the Oklahoma Health Care Authority to manage and deliver dental benefits and services to enrollees of the capitated managed care delivery model of the state Medicaid program~~ that handles claims payment and prior authorizations and coordinates dental care with participating providers and Medicaid members;

~~5.~~ 10. "Essential community provider" ~~has the same meaning as provided by~~ means:

a. a Federally Qualified Health Center,

b. a community mental health center,

c. an Indian Health Care Provider,

d. a rural health clinic,

e. a state-operated mental health hospital,

f. a long-term care hospital serving children (LTCH-C),

g. a teaching hospital owned, jointly owned, or affiliated with and designated by the University Hospitals Authority, University Hospitals Trust, Oklahoma State University Medical Authority, or Oklahoma State University Medical Trust,

h. a provider employed by or contracted with, or otherwise a member of the faculty practice plan of:

(1) a public, accredited medical school in this state, or

(2) a hospital or health care entity directly or indirectly owned or operated by the University Hospitals Trust or the Oklahoma State University Medical Trust,

i. a county department of health or city-county health department,

j. a comprehensive community addiction recovery center,

k. a hospital licensed by the State of Oklahoma including all hospitals participating in the Supplemental Hospital Offset Payment Program,

l. a Certified Community Behavioral Health Clinic (CCBHC),

m. a provider employed by or contracted with a primary care residency program accredited by the Accreditation Council for Graduate Medical Education,

n. any additional Medicaid provider as approved by the Authority if the provider either offers services that are not available from any other provider within a reasonable access standard or provides a substantial share of the total units of a particular service utilized by Medicaid members within the region during the last three (3) years, and the combined capacity of other service providers in the region is insufficient to meet the total needs of the Medicaid members, or

o. any provider not otherwise mentioned in this paragraph that meets the definition of "essential community provider" under 45 C.F.R., Section 156.235;

~~6. "Managed care organization" means a health plan under contract with the Oklahoma Health Care Authority to participate in and deliver benefits and services to enrollees of the capitated managed care delivery model of the state Medicaid program;~~

~~7.~~ 11. "Material change" includes, but is not limited to, any change in overall business operations such as policy, process or protocol which affects, or can reasonably be expected to affect, more than five percent (5%) of enrollees or participating providers of the ~~managed care organization or dental benefit manager~~ contracted entity;

~~8.~~ 12. "Governing body" means a group of individuals appointed by the contracted entity who approve policies, operations, profit/loss ratios, executive employment decisions, and who have overall responsibility for the operations of the contracted entity of which they are appointed;

13. "Local Oklahoma provider organization" means any state provider association, accountable care organization, Certified Community Behavioral Health Clinic, Federally Qualified Health Center, Native American tribe or tribal association, hospital or health system, academic medical institution, currently practicing licensed provider, or other local Oklahoma provider organization as approved by the Authority;

14. "Medical necessity" has the same meaning as provided by rules ~~of~~ promulgated by the Oklahoma Health Care Authority Board;

~~9.~~ 15. "Participating provider" means a provider who has a contract with or is employed by a ~~managed care organization or dental benefit manager~~ contracted entity to provide services to ~~enrollees under the capitated managed care delivery model of the~~

~~state Medicaid program~~ Medicaid members as authorized by this act;

~~and~~

~~10.~~ 16. "Provider" means a health care or dental provider licensed or certified in this state or a provider that meets the Authority's provider enrollment criteria to contract with the Authority as a SoonerCare provider;

17. "Provider-led entity" means an organization or entity that meets the criteria of at least one of following two subparagraphs:

a. a majority of the entity's ownership is held by Medicaid providers in this state or is held by an entity that directly or indirectly owns or is under common ownership with Medicaid providers in this state, or

b. a majority of the entity's governing body is composed of individuals who:

(1) have experience serving Medicaid members and:

(a) are licensed in this state as physicians, physician assistants, nurse practitioners, certified nurse-midwives, or certified registered nurse anesthetists,

(b) at least one board member is a licensed behavioral health provider, or

(c) are employed by:

i. a hospital or other medical facility licensed by this state and operating in this state, or

ii. an inpatient or outpatient mental health or substance abuse treatment facility or program licensed or certified by this state and operating in this state,

(2) represent the providers or facilities described in division (1) of this subparagraph including, but not limited to, individuals who are employed by a statewide provider association, or

(3) are nonclinical administrators of clinical practices serving Medicaid members;

18. "Statewide" means all counties of this state including the urban region; and

19. "Urban region" means:

a. all counties of this state with a county population of not less than five hundred thousand (500,000) according to the latest Federal Decennial Census, and

b. all counties that are contiguous to the counties described in subparagraph a of this paragraph,

combined into one region.

SECTION 3. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 4002.3a of Title 56, unless there is created a duplication in numbering, reads as follows:

A. 1. The Oklahoma Health Care Authority (OHCA) shall enter into capitated contracts with contracted entities for the delivery of Medicaid services as specified in this act to transform the delivery system of the state Medicaid program for the Medicaid populations listed in this section.

2. Unless expressly authorized by the Legislature, the Authority shall not issue any request for proposals or enter into any contract to transform the delivery system for the aged, blind, and disabled populations eligible for SoonerCare.

B. 1. The Oklahoma Health Care Authority shall issue a request for proposals to enter into public-private partnerships with contracted entities other than dental benefit managers to cover all Medicaid services other than dental services for the following Medicaid populations:

a. pregnant women,

b. children,

c. deemed newborns under 42 C.F.R., Section 435.117,

d. parents and caretaker relatives, and

e. the expansion population.

2. The Authority shall specify the services to be covered in the request for proposals referenced in paragraph 1 of this

subsection. Capitated contracts referenced in this subsection shall cover all Medicaid services other than dental services including:

a. physical health services including, but not limited to:

(1) primary care,

(2) inpatient and outpatient services, and

(3) emergency room services,

b. behavioral health services, and

c. prescription drug services.

3. The Authority shall specify the services not covered in the request for proposals referenced in paragraph 1 of this subsection.

4. Subject to the requirements and approval of the Centers for Medicare and Medicaid Services, the implementation of the program shall be no later than October 1, 2023.

C. 1. The Authority shall issue a request for proposals to enter into public-private partnerships with dental benefit managers to cover dental services for the following Medicaid populations:

a. pregnant women,

b. children,

c. parents and caretaker relatives,

d. the expansion population, and

e. members of the Children's Specialty Plan as provided by subsection D of this section.

2. The Authority shall specify the services to be covered in the request for proposals referenced in paragraph 1 of this subsection.

3. Subject to the requirements and approval of the Centers for Medicare and Medicaid Services, the implementation of the program shall be no later than October 1, 2023.

D. 1. Either as part of the request for proposals referenced in subsection B of this section or as a separate request for proposals, the Authority shall issue a request for proposals to enter into public-private partnerships with one contracted entity to administer a Children's Specialty Plan.

2. The Authority shall specify the services to be covered in the request for proposals referenced in paragraph 1 of this subsection.

3. The contracted entity for the Children's Specialty Plan shall coordinate with the dental benefit managers who cover dental services for its members as provided by subsection C of this section.

4. Subject to the requirements and approval of the Centers for Medicare and Medicaid Services, the implementation of the program shall be no later than October 1, 2023.

E. The Authority shall not implement the transformation of the Medicaid delivery system until it receives written confirmation from the Centers for Medicare and Medicaid Services that a managed care

directed payment program utilizing average commercial rate methodology for hospital services under the Supplemental Hospital Offset Payment Program has been approved for Year 1 of the transformation and will be included in the budget neutrality cap baseline spending level for purposes of Oklahoma's 1115 waiver renewal; provided, however, nothing in this section shall prohibit the Authority from exploring alternative opportunities with the Centers for Medicare and Medicaid Services to maximize the average commercial rate benefit.

SECTION 4. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 4002.3b of Title 56, unless there is created a duplication in numbering, reads as follows:

A. All capitated contracts shall be the result of requests for proposals issued by the Oklahoma Health Care Authority and submission of competitive bids by contracted entities pursuant to the Oklahoma Central Purchasing Act.

B. Statewide capitated contracts may be awarded to any contracted entity including, but not limited to, a provider-led entity.

C. The Authority shall award no less than three statewide capitated contracts to provide comprehensive integrated health services including, but not limited to, medical, behavioral health, and pharmacy services and no less than two statewide capitated

contracts to provide dental coverage to Medicaid members as specified in Section 3 of this act.

D. 1. Except as specified in paragraph 2 of this subsection, at least one capitated contract to provide statewide coverage to Medicaid members shall be awarded to a provider-led entity, as long as the provider-led entity submits a responsive reply to the Authority's request for proposals demonstrating ability to fulfill the contract requirements.

2. If no provider-led entity submits a responsive reply to the Authority's request for proposals demonstrating ability to fulfill the contract requirements, the Authority shall not be required to contract for statewide coverage with a provider-led entity.

3. The Authority shall develop a scoring methodology for the request for proposals that affords preferential scoring to provider-led entities, as long as the provider-led entity otherwise demonstrates ability to fulfill the contract requirements. The preferential scoring methodology shall include opportunities to award additional points to provider-led entities based on certain factors including, but not limited to:

a. broad provider participation in ownership and governance structure,

b. demonstrated experience in care coordination and care management for Medicaid members across a variety of

service types including, but not limited to, primary care and behavioral health,

c. demonstrated experience in Medicare or Medicaid accountable care organizations or other Medicare or Medicaid alternative payment models, Medicare or Medicaid value-based payment arrangements, or Medicare or Medicaid risk-sharing arrangements including, but not limited to, innovation models of the Center for Medicare and Medicaid Innovation of the Centers for Medicare and Medicaid Services, or value-based payment arrangements or risk-sharing arrangements in the commercial health care market, and

d. other relevant factors identified by the Authority.

E. The Authority may select at least one provider-led entity for the urban region if:

1. The provider-led entity submits a responsive reply to the Authority's request for proposals demonstrating ability to fulfill the contract requirements; and

2. The provider-led entity demonstrates the ability, and agrees continually, to expand its coverage area throughout the contract term and to develop statewide operational readiness within a time frame set by the Authority but not mandated before five (5) years.

F. At the discretion of the Authority, capitated contracts may be extended to ensure there are no gaps in coverage that may result

from termination of a capitated contract; provided, the total contracting period for a capitated contract shall not exceed seven (7) years.

G. At the end of the contracting period, the Authority shall solicit and award new contracts as provided by this section and Section 3 of this act.

H. At the discretion of the Authority, subject to appropriate notice to the Legislature and the Centers for Medicare and Medicaid Services, the Authority may approve a delay in the implementation of one or more capitated contracts to ensure financial and operational readiness.

SECTION 5. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 4002.3c of Title 56, unless there is created a duplication in numbering, reads as follows:

A. The Authority shall develop and implement a process for assignment of Medicaid members to contracted entities.

B. The Authority may only utilize an opt-in enrollment process for the voluntary enrollment of American Indians and Alaska Natives. Notwithstanding any other provision of this act, the Authority shall comply with all Indian provisions associated with Medicaid managed care including, but not limited to, the Social Security Act, 1932(a)(2)(C), the American Recovery and Reinvestment Act of 2009, P.L. 111-5 (Feb. 17, 2009), Section 5006, the Children's Health Insurance Program Reauthorization Act of 2009, P.L. 111-3 (Feb. 4,

2009), and the Centers for Medicare and Medicaid Services (CMS) managed care protections, 25 C.F.R., 438.14.

C. In the event of the termination of a capitated contract with a contracted entity during the contract duration, the Authority shall reassign members to a remaining contracted entity with demonstrated performance and capability. If no remaining contracted entity is able to assume management for such members, the Authority may select another contracted entity by application, as specified in rules promulgated by the Oklahoma Health Care Authority Board, if the financial, operation, and performance requirements can be met, at the discretion of the Authority.

SECTION 6. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 4002.3d of Title 56, unless there is created a duplication in numbering, reads as follows:

A. Every Medicaid member enrolled in a contracted entity shall have the right to select his or her primary care provider and to change his or her primary care provider at any time, as long as the selected primary care provider is a participating provider. Any parent or guardian of a Medicaid member who is a minor child enrolled in a contracted entity shall have the right to select the primary care provider for the member's minor child and to change the primary care provider at any time, as long as the selected primary care provider is a participating provider.

B. If a member, or parent or guardian of a member who is a minor child, does not select a primary care provider, the contracted entity shall notify the member, parent, or guardian that he or she needs to select a primary care provider and shall send the member, parent, or guardian the name, contact information, employer, and any other applicable information as determined by the Oklahoma Health Care Authority of the three primary care providers nearest to the member's home address that are contracted with the contracted entity.

C. 1. If, after the contracted entity sends the information described in subsection B of this section, the member, parent, or guardian does not select a primary care provider within a time determined by the Authority, the contracted entity shall assign the member to a primary care provider in accordance with the process described in paragraph 2 of this subsection.

2. The Authority shall develop and implement a process for the assignment by contracted entities of Medicaid members who do not select a primary care provider to a primary care provider. The process shall prioritize existing patient-provider relationships and geographic proximity of the patient to the provider, and shall assign families to the same primary care provider to the extent possible.

SECTION 7. AMENDATORY 56 O.S. 2021, Section 4002.4, is amended to read as follows:

Section 4002.4. A. The Oklahoma Health Care Authority shall develop network adequacy standards for all ~~managed care organizations and dental benefit managers~~ contracted entities that, at a minimum, meet the requirements of 42 C.F.R., Sections ~~438.14~~ 438.3 and 438.68. Network adequacy standards established under this subsection shall include distance and time standards and shall be designed to ensure ~~enrollees~~ members covered by the ~~managed care organizations and dental benefit managers~~ contracted entities who reside in health professional shortage areas (HPSAs) designated under Section 332(a)(1) of the Public Health Service Act (42 U.S.C., Section 254e(a)(1)) have access to in-person health care and telehealth services with providers, especially adult and pediatric primary care practitioners.

B. ~~All managed care organizations and dental benefit managers shall meet or exceed network adequacy standards established by the Authority under subsection A of this section to ensure sufficient access to providers for enrollees of the state Medicaid program.~~

~~C. All managed care organizations and dental benefit managers shall contract to the extent possible and practicable~~ The Authority shall require all contracted entities to offer or extend contracts with all essential community providers, all providers who receive directed payments in accordance with 42 C.F.R., Part 438 and such other providers as the Authority may specify. The Authority shall establish such requirements as may be necessary to prohibit

contracted entities from excluding essential community providers, providers who receive directed payments in accordance with 42 C.F.R., Part 438 and such other providers as the Authority may specify from contracts with contracted entities.

~~D.~~ C. To ensure models of care are developed to meet the needs of Medicaid members, each contracted entity must contract with at least one local Oklahoma provider organization for a model of care containing care coordination, care management, utilization management, disease management, network management, or another model of care as approved by the Authority. Such contractual arrangements must be in place within twelve (12) months of the effective date of the contracts awarded pursuant to the requests for proposals authorized by Section 3 of this act.

D. All ~~managed care organizations and dental benefit managers~~ contracted entities shall formally credential and recredential network providers at a frequency required by a single, consolidated provider enrollment and credentialing process established by the Authority in accordance with 42 C.F.R., Section 438.214.

E. All ~~managed care organizations and dental benefit managers~~ contracted entities shall be accredited in accordance with 45 C.F.R., Section 156.275 by an accrediting entity recognized by the United States Department of Health and Human Services.

F. 1. If the Authority awards a capitated contract to a provider-led entity for the urban region under Section 4 of this

act, the provider-led entity shall expand its coverage area to every county of this state within the time frame set by the Authority under subsection E of Section 4 of this act.

2. The expansion of the provider-led entity's coverage area beyond the urban region shall be subject to the approval of the Authority. The Authority shall approve expansion to counties for which the provider-led entity can demonstrate evidence of network adequacy as required under 42 C.F.R., Sections 438.3 and 438.68. When approved, the additional county or counties shall be added to the provider-led entity's region during the next open enrollment period.

SECTION 8. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 4002.4a of Title 56, unless there is created a duplication in numbering, reads as follows:

A. 1. The Oklahoma Health Care Authority shall develop standard contract terms for contracted entities to include, but not be limited to, all requirements stipulated by this act. The Authority shall oversee and monitor performance of contracted entities and shall enforce the terms of capitated contracts as required by paragraph 2 of this subsection.

2. The Authority shall require each contracted entity to meet all contractual and operational requirements as defined in the requests for proposals issued pursuant to Section 3 of this act. Such requirements shall include but not be limited to reimbursement

and capitation rates, insurance reserve requirements as specified by the Insurance Department, acceptance of risk as defined by the Authority, operational performance expectations including the assessment of penalties, member marketing guidelines, other applicable state and federal regulatory requirements, and all requirements of this act including, but not limited to, the requirements stipulated in this section.

B. The Authority shall develop methods to ensure program integrity against provider fraud, waste, and abuse.

C. The Authority shall develop processes for providers and Medicaid members to report violations by contracted entities of applicable administrative rules, state laws, or federal laws.

SECTION 9. AMENDATORY 56 O.S. 2021, Section 4002.5, is amended to read as follows:

Section 4002.5. A. A contracted entity shall be responsible for all administrative functions for members enrolled in its plan including, but not limited to, claims processing, authorization of health services, care and case management, grievances and appeals, and other necessary administrative services.

B. A contracted entity selected by the Oklahoma Health Care Authority under Section 4 of this act shall obtain a certificate of authority as a health maintenance organization issued by the Insurance Department prior to the execution of the contract between the contracted entity and the Authority.

C. 1. To ensure providers have a voice in the direction and operation of the contracted entities selected by the Oklahoma Health Care Authority under Section 4 of this act, each contracted entity shall have a shared governance structure that includes:

a. representatives of local Oklahoma provider organizations who are Medicaid providers,

b. essential community providers, and

c. a representative from a teaching hospital owned, jointly owned, or affiliated with and designated by the University Hospitals Authority, University Hospitals Trust, Oklahoma State University Medical Authority, or Oklahoma State University Medical Trust.

2. No less than one-third (1/3) of the contracted entity's local governing body shall be comprised of representatives of local Oklahoma provider organizations.

3. No less than two members of the contracted entity's clinical and quality committees shall be representatives of local Oklahoma provider organizations, and the committees shall be chaired or co-chaired by a representative of a local Oklahoma provider organization.

D. A ~~managed care organization or dental benefit manager~~ contracted entity shall promptly notify the Authority of all ~~changes materially~~ material changes affecting the delivery of care or the administration of its program.

~~B.~~ E. A ~~managed care organization or dental benefit manager~~ contracted entity shall have a medical loss ratio that meets the standards provided by 42 C.F.R., Section 438.8.

~~C.~~ F. A ~~managed care organization or dental benefit manager~~ contracted entity shall provide patient data to a provider upon request to the extent allowed under federal or state laws, rules or regulations including, but not limited to, the Health Insurance Portability and Accountability Act of 1996.

~~D.~~ G. A ~~managed care organization or dental benefit manager~~ contracted entity or a subcontractor of ~~such managed care organization or dental benefit manager~~ a contracted entity shall not enforce a policy or contract term with a provider that requires the provider to contract for all products that are currently offered or that may be offered in the future by the ~~managed care organization or dental benefit manager~~ contracted entity or subcontractor.

~~E.~~ H. Nothing in this act or in a contract between the Authority and a ~~managed care organization or dental benefit manager~~ contracted entity shall prohibit the ~~managed care organization or dental benefit manager~~ contracted entity from contracting with a statewide or regional accountable care organization ~~to implement the capitated managed care delivery model of the state Medicaid program~~.

I. Nothing in this act, in a contract between the Authority and a contracted entity, or in a contract between a contracted entity

and a provider shall prohibit any provider from contracting with more than one contracted entity.

J. A contracted entity shall not withhold, fail to offer, or make impracticable a contract with a provider on the basis of independent practice or lack of hospital system affiliation.

K. All contracted entities shall:

1. Use the same drug formulary, which shall be established by the Authority; and

2. Ensure broad access to pharmacies including, but not limited to, pharmacies contracted with covered entities under Section 340B of the Public Health Service Act. Such access shall, at a minimum, meet the requirements of the Patient's Right to Pharmacy Choice Act, Section 6958 et seq. of Title 36 of the Oklahoma Statutes.

L. Each contracted entity and each participating provider shall submit data through the state-designated entity for health information exchange to ensure effective systems and connectivity to support clinical coordination of care, the exchange of information, and the availability of data to the Authority to manage the state Medicaid program.

SECTION 10. AMENDATORY 56 O.S. 2021, Section 4002.6, is amended to read as follows:

Section 4002.6. A. A ~~managed care organization~~ contracted entity shall meet all requirements established by the Oklahoma Health Care Authority pertaining to prior authorizations. The

Authority shall establish requirements that ensure timely determinations by contracted entities when prior authorizations are required including expedited review in urgent and emergent cases that at a minimum meet the criteria of this section.

B. A contracted entity shall make a determination on a request for an authorization of the transfer of a hospital inpatient to a post-acute care or long-term acute care facility within twenty-four (24) hours of receipt of the request.

~~B. Review and issue determinations made by a managed care organization or, as appropriate, by a dental benefit manager for prior authorization for care ordered by primary care or specialist providers shall be timely and shall occur in accordance with the following:~~

~~1. Within seventy-two (72) hours of receipt of the~~

C. A contracted entity shall make a determination on a request for any ~~patient~~ member who is not hospitalized at the time of the request within seventy-two (72) hours of receipt of the request; provided, that if the request does not include sufficient or adequate documentation, the review and ~~issue~~ determination shall occur within a time frame and in accordance with a process established by the Authority. The process established by the Authority pursuant to this ~~paragraph~~ subsection shall include a time frame of at least forty-eight (48) hours within which a provider may submit the necessary documentation~~;~~

~~2. Within one (1) business day of receipt of the~~.

D. A contracted entity shall make a determination on a request for services for a hospitalized ~~patient~~ member including, but not limited to, acute care inpatient services or equipment necessary to discharge the ~~patient~~ member from an inpatient facility~~;~~ within one (1) business day of receipt of the request.

~~3.~~ E. Notwithstanding the provisions of ~~paragraphs 1 or 2 of this~~ subsection C of this section, a contracted entity shall make a determination on a request as expeditiously as necessary and, in any event, within twenty-four (24) hours of receipt of the request for service if adhering to the provisions of ~~paragraphs 1 or 2 of this~~ subsection C or D of this section could jeopardize the ~~enrollee's~~ member's life, health or ability to attain, maintain or regain maximum function. In the event of a medically emergent matter, the ~~managed care organization or dental benefit manager~~ contracted entity shall not impose limitations on providers in coordination of post-emergent stabilization health care including pre-certification or prior authorization~~;~~.

~~4.~~ F. Notwithstanding any other provision of this ~~subsection~~ section, a contracted entity shall make a determination on a request for inpatient behavioral health services within twenty-four (24) hours of receipt of the request ~~for inpatient behavioral health services; and~~

~~5. Within twenty-four (24) hours of receipt of the~~.

G. A contracted entity shall make a determination on a request for covered prescription drugs that are required to be prior authorized by the Authority within twenty-four (24) hours of receipt of the request. The ~~managed care organization~~ contracted entity shall not require prior authorization on any covered prescription drug for which the Authority does not require prior authorization.

~~C.~~ H. Upon issuance of an adverse determination on a prior authorization request under subsection B of this section, the ~~managed care organization or dental benefit manager~~ contracted entity shall provide the requesting provider, within seventy-two (72) hours of receipt of such issuance, with reasonable opportunity to participate in a peer-to-peer review process with a provider who practices in the same specialty, but not necessarily the same sub-specialty, and who has experience treating the same population as the patient on whose behalf the request is submitted; provided, however, if the requesting provider determines the services to be clinically urgent, the ~~managed care organization or dental benefit manager~~ contracted entity shall provide such opportunity within twenty-four (24) hours of receipt of such issuance. Services not covered under the state Medicaid program for the particular patient shall not be subject to peer-to-peer review.

~~D.~~ I. The Authority shall ensure that a provider offers to provide to an enrollee in a timely manner services authorized by a

~~managed care organization or dental benefit manager~~ contracted entity.

J. The Authority shall establish requirements for both internal and external reviews and appeals of adverse determinations on prior authorization requests or claims that, at a minimum:

1. Require contracted entities to provide a detailed explanation of denials to Medicaid providers and members;

2. Require contracted entities to provide a prompt opportunity for peer-to-peer conversations with licensed clinical staff of the same or similar specialty which shall include, but not be limited to, Oklahoma-licensed clinical staff upon adverse determination; and

3. Establish uniform rules for Medicaid provider or member appeals across all contracted entities.

SECTION 11. AMENDATORY 56 O.S. 2021, Section 4002.7, is amended to read as follows:

Section 4002.7. ~~A managed care organization or dental benefit manager shall~~

A. The Oklahoma Health Care Authority shall establish requirements for fair processing and adjudication of claims that ensure prompt reimbursement of providers by contracted entities. A contracted entity shall comply with ~~the following requirements with respect to processing and adjudication of claims for payment submitted in good faith by providers for health care items and~~

~~services furnished by such providers to enrollees of the state Medicaid program:~~ all such requirements.

~~1.~~ B. A ~~managed care organization or dental benefit manager~~ contracted entity shall process a clean claim in the time frame provided by Section 1219 of Title 36 of the Oklahoma Statutes and no less than ninety percent (90%) of all clean claims shall be paid within fourteen (14) days of submission to the ~~managed care organization or dental benefit manager~~ contracted entity. A clean claim that is not processed within the time frame provided by Section 1219 of Title 36 of the Oklahoma Statutes shall bear simple interest at the monthly rate of one and one-half percent (1.5%) payable to the provider. A claim filed by a provider within six (6) months of the date the item or service was furnished to ~~an enrollee~~ a member shall be considered timely. If a claim meets the definition of a clean claim, the ~~managed care organization or dental benefit manager~~ contracted entity shall not request medical records of the ~~enrollee~~ member prior to paying the claim. Once a claim has been paid, the ~~managed care organization or dental benefit manager~~ contracted entity may request medical records if additional documentation is needed to review the claim for medical necessity~~;~~.

~~2.~~ C. In the case of a denial of a claim including, but not limited to, a denial on the basis of the level of emergency care indicated on the claim, the ~~managed care organization or dental benefit manager~~ contracted entity shall establish a process by which

the provider may identify and provide such additional information as may be necessary to substantiate the claim. Any such claim denial shall include the following:

~~a.~~ ~~a~~

1. A detailed explanation of the basis for the denial~~,~~; and

~~b.~~ ~~a~~

2. A detailed description of the additional information necessary to substantiate the claim~~;~~.

~~3.~~ D. Postpayment audits by a ~~managed care organization or dental benefit manager~~ contracted entity shall be subject to the following requirements:

~~a.~~ ~~subject~~

1. Subject to ~~subparagraph b~~ paragraph 2 of this ~~paragraph~~ subsection, insofar as a ~~managed care organization or dental benefit manager~~ contracted entity conducts postpayment audits, the ~~managed care organization or dental benefit manager~~ contracted entity shall employ the postpayment audit process determined by the Authority~~,~~;

~~b.~~ ~~the~~

2. The Authority shall establish a limit on the percentage of claims with respect to which postpayment audits may be conducted by a ~~managed care organization or dental benefit manager~~ contracted entity for health care items and services furnished by a provider in a plan year~~,~~; and

~~c.~~ ~~the~~

3. The Authority shall provide for the imposition of financial penalties under such contract in the case of any ~~managed care organization or dental benefit manager~~ contracted entity with respect to which the Authority determines has a claims denial error rate of greater than five percent (5%). The Authority shall establish the amount of financial penalties and the time frame under which such penalties shall be imposed on ~~managed care organizations and dental benefit managers~~ contracted entities under this ~~subparagraph~~ paragraph, in no case less than annually~~; and~~.

~~4.~~ E. A ~~managed care organization~~ contracted entity may only apply readmission penalties pursuant to rules promulgated by the Oklahoma Health Care Authority Board. The Board shall promulgate rules establishing a program to reduce potentially preventable readmissions. The program shall use a nationally recognized tool, establish a base measurement year and a performance year, and provide for risk-adjustment based on the population of the state Medicaid program covered by the ~~managed care organizations and dental benefit managers~~ contracted entities.

SECTION 12. AMENDATORY 56 O.S. 2021, Section 4002.8, is amended to read as follows:

Section 4002.8. A. A ~~managed care organization or dental benefit manager~~ contracted entity shall utilize uniform procedures established by the Authority under subsection B of this section for the review and appeal of any adverse determination by the ~~managed~~

~~care organization or dental benefit manager~~ contracted entity sought by any enrollee or provider adversely affected by such determination.

B. The Authority shall develop procedures for ~~enrollee~~ enrollees or providers to seek review by the ~~managed care organization or dental benefit manager~~ contracted entity of any adverse determination made by the ~~managed care organization or dental benefit manager~~ contracted entity. A provider shall have six (6) months from the receipt of a claim denial to file an appeal. With respect to appeals of adverse determinations made by a ~~managed care organization or dental benefit manager~~ contracted entity on the basis of medical necessity, the following requirements shall apply:

1. Medical review staff of the ~~managed care organization or dental benefit manager~~ contracted entity shall be licensed or credentialed health care clinicians with relevant clinical training or experience; and

2. All ~~managed care organizations and dental benefit managers~~ contracted entities shall use medical review staff for such appeals and shall not use any automated claim review software or other automated functionality for such appeals.

C. Upon receipt of notice from the ~~managed care organization or dental benefit manager~~ contracted entity that the adverse determination has been upheld on appeal, the enrollee or provider may request a fair hearing from the Authority. The Authority shall

develop procedures for fair hearings in accordance with 42 C.F.R., Part 431.

SECTION 13. AMENDATORY 56 O.S. 2021, Section 4002.10, is amended to read as follows:

Section 4002.10. ~~A.~~ The Oklahoma Health Care Authority shall require ~~a managed care organization or dental benefit manager~~ all contracted entities to participate in a readiness review in accordance with 42 C.F.R., Section 438.66. The readiness review shall assess the ability and capacity of the ~~managed care organization or dental benefit manager~~ contracted entity to perform satisfactorily in such areas as may be specified in 42 C.F.R., Section 438.66~~. In addition, the readiness review shall assess whether:~~

~~1. The managed care organization or dental benefit manager has entered into contracts with providers to the extent necessary to meet network adequacy standards prescribed by Section 4 of this act;~~

~~2. The contracts described in paragraph 1 of this subsection offer, but do not require, value-based payment arrangements as provided by Section 12 of this act; and~~

~~3. The managed care organization or dental benefit manager and the providers described in paragraph 1 of this subsection have established and tested data infrastructure such that exchange of patient data can reasonably be expected to occur within one hundred twenty (120) calendar days of execution of the transition of the~~

~~delivery system described in subsection B of this section. The Authority shall assess its ability to facilitate the exchange of patient data, claims, coordination of benefits and other components of a managed care delivery model.~~

~~B. The Oklahoma Health Care Authority may only execute the transition of the delivery system of the state Medicaid program to the capitated managed care delivery model of the state Medicaid program ninety (90) days after the Centers for Medicare and Medicaid Services has approved all contracts entered into between the Authority and all managed care organizations and dental benefit managers following submission of the readiness reviews to the Centers for Medicare and Medicaid Services~~.

SECTION 14. AMENDATORY 56 O.S. 2021, Section 4002.11, is amended to read as follows:

Section 4002.11. No later than one (1) year following the execution of the delivery model transition described in ~~Section 10 of this act~~ the Ensuring Access to Medicaid Act, the Oklahoma Health Care Authority shall create a scorecard that compares ~~managed care organizations~~ each contracted entity and separately compares each dental benefit ~~managers~~ manager. The scorecard shall report the average speed of authorizations of services, rates of denials of Medicaid reimbursable services when a complete authorization request is submitted in a timely manner, ~~enrollee~~ member satisfaction survey results, provider satisfaction survey results, and such other

criteria as the Authority may require. The scorecard shall be compiled quarterly and shall consist of the information specified in this section from the prior ~~year~~ quarter. The Authority shall provide the most recent quarterly scorecard to all initial ~~enrollees~~ members during enrollment choice counseling following the eligibility determination and prior to initial enrollment. The Authority shall provide the most recent quarterly scorecard to all ~~enrollees~~ members at the beginning of each enrollment period. The Authority shall publish each quarterly scorecard on its public Internet website.

SECTION 15. AMENDATORY 56 O.S. 2021, Section 4002.12, is amended to read as follows:

Section 4002.12. A. ~~The~~ Until July 1, 2026, the Oklahoma Health Care Authority shall establish minimum rates of reimbursement from ~~managed care organizations and dental benefit managers~~ contracted entities to providers who elect not to enter into value-based payment arrangements under subsection B of this section or other alternative payment agreements for health care items and services furnished by such providers to enrollees of the state Medicaid program. ~~Until~~ Except as provided by subsection I of this section, until July 1, 2026, such reimbursement rates shall be equal to or greater than:

1. For an item or service provided by a participating provider who is in the network of the ~~managed care organization or dental~~

~~benefit manager~~ contracted entity, one hundred percent (100%) of the reimbursement rate for the applicable service in the applicable fee schedule of the Authority; or

2. For an item or service provided by a non-participating provider or a provider who is not in the network of the ~~managed care organization or dental benefit manager~~ contracted entity, ninety percent (90%) of the reimbursement rate for the applicable service in the applicable fee schedule of the Authority as of January 1, 2021.

B. A ~~managed care organization or dental benefit manager~~ contracted entity shall offer value-based payment arrangements to all providers in its network capable of entering into value-based payment arrangements. Such arrangements shall be optional for the provider but shall be tied to reimbursement incentives when quality metrics are met. The quality measures used by a ~~managed care organization or dental benefit manager~~ contracted entity to determine reimbursement amounts to providers in value-based payment arrangements shall align with the quality measures of the Authority for ~~managed care organizations or dental benefit managers~~ contracted entities.

C. Notwithstanding any other provision of this section, the Authority shall comply with payment methodologies required by federal law or regulation for specific types of providers including, but not limited to, Federally Qualified Health Centers, rural health

clinics, pharmacies, Indian Health Care Providers and emergency services.

D. A contracted entity shall offer all rural health clinics (RHCs) contracts that reimburse RHCs using the methodology in place for each specific RHC prior to January 1, 2023, including any and all annual rate updates. The contracted entity shall comply with all federal program rules and requirements, and the transformed Medicaid delivery system shall not interfere with the program as designed.

E. The Oklahoma Health Care Authority shall establish minimum rates of reimbursement from contracted entities to Certified Community Behavioral Health Clinic (CCBHC) providers who elect alternative payment arrangements equal to the prospective payment system rate under the Medicaid State Plan.

F. The Authority shall establish an incentive payment under the Supplemental Hospital Offset Payment Program that is determined by value-based outcomes for providers other than hospitals.

G. Psychologist reimbursement shall reflect outcomes. Reimbursement shall not be limited to therapy and shall include but not be limited to testing and assessment.

H. Coverage for Medicaid ground transportation services by licensed Oklahoma emergency medical services shall be reimbursed at no less than the published Medicaid rates as set by the Authority. All currently published Medicaid Healthcare Common Procedure Coding

System (HCPCS) codes paid by the Authority shall continue to be paid by the contracted entity. The contracted entity shall comply with all reimbursement policies established by the Authority for the ambulance providers. Contracted entities shall accept the modifiers established by the Centers for Medicare and Medicaid Services currently in use by Medicare at the time of the transport of a member that is dually eligible for Medicare and Medicaid.

I. The rate paid to participating pharmacy providers is independent of subsection A of this section and shall be the same as the fee-for-service rate employed by the Authority for the Medicaid program as stated in the payment methodology at OAC 317:30-5-78, unless the participating pharmacy provider elects to enter into other alternative payment agreements.

J. The Authority shall specify in the requests for proposals a reasonable time frame in which a contracted entity shall have entered into a certain percentage, as determined by the Authority, of value-based contracts with providers.

K. Capitation rates established by the Oklahoma Health Care Authority and paid to contracted entities under capitated contracts shall be updated annually and in accordance with 42 C.F.R., Section 438.3. Capitation rates shall be approved as actuarially sound as determined by the Centers for Medicare and Medicaid Services in accordance with 42 C.F.R., Section 438.4 and the following:

1. Actuarial calculations must include utilization and expenditure assumptions consistent with industry and local standards; and

2. Capitation rates shall be risk-adjusted and shall include a portion that is at risk for achievement of quality and outcomes measures.

L. The Authority may establish a symmetric risk corridor for contracted entities.

M. The Authority shall establish a process for annual recovery of funds from, or assessment of penalties on, contracted entities that do not meet the medical loss ratio standards stipulated in Section 4002.5 of this title.

N. 1. The Authority shall, through the financial reporting required under subsection G of Section 17 of this act, determine the percentage of health care expenses by each contracted entity on primary care services.

2. Not later than the end of the fourth year of the initial contracting period, each contracted entity shall be currently spending not less than eleven percent (11%) of its total health care expenses on primary care services.

3. The Authority shall monitor the primary care spending of each contracted entity and require each contracted entity to maintain the level of spending on primary care services stipulated in paragraph 2 of this subsection.

SECTION 16. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 4002.12a of Title 56, unless there is created a duplication in numbering, reads as follows:

A. All dental benefit managers shall maintain a Medicaid Dental Advisory Committee, comprised exclusively of Oklahoma-licensed dentists and specialists, to advise dental benefit managers regarding quality measures.

B. Dental providers shall not be required to enter into capitated contracts with a dental benefit manager.

SECTION 17. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 4002.12b of Title 56, unless there is created a duplication in numbering, reads as follows:

A. The Oklahoma Health Care Authority shall ensure the sustainability of the transformed Medicaid delivery system.

B. The Authority shall ensure that existing revenue sources designated for the state share of Medicaid expenses are designed to maximize federal matching funds for the benefit of providers and the state.

C. The Authority shall develop a plan, utilizing waivers or Medicaid state plan amendments as necessary, to preserve or increase supplemental payments available to providers with existing revenue sources as provided in the Oklahoma Statutes including, but not limited to:

1. Hospitals that participate in the supplemental hospital offset payment program as provided by Section 3241.3 of Title 63 of the Oklahoma Statutes;

2. Hospitals in this state that have Level I trauma centers, as defined by the American College of Surgeons, that provide inpatient and outpatient services and are owned or operated by the University Hospitals Trust, or affiliates or locations of those hospitals designated by the Trust as part of the hospital trauma system; and

3. Providers employed by or contracted with, or otherwise a member of the faculty practice plan of:

a. a public, accredited Oklahoma medical school, or

b. a hospital or health care entity directly or indirectly owned or operated by the University Hospitals Trust or the Oklahoma State University Medical Trust.

D. Subject to approval by the Centers for Medicare and Medicaid Services, the Authority shall preserve and, to the maximum extent permissible under federal law, improve existing levels of funding through directed payments or other mechanisms outside the capitated rate to contracted entities, including, where applicable, the use of a directed payment program with an average commercial rate methodology under the Supplemental Hospital Payment Program Act.

E. On or before January 31, 2023, the Authority shall submit a report to the Oklahoma Health Care Authority Board, the Chair of the

Appropriations Committee of the Oklahoma State Senate, and the Chair of the Appropriations and Budget Committee of the Oklahoma House of Representatives that includes the Authority's plans to continue supplemental payment programs and implement a managed care directed payment program for hospital services that complies with the reforms required by this act. If Medicaid-specific funding cannot be maintained as currently implemented and authorized by state law, the Authority shall propose to the Legislature any modifications necessary to preserve supplemental payments and managed care directed payments to prevent budgetary disruptions to providers.

F. The Authority shall submit a report to the Governor, the President Pro Tempore of the Oklahoma State Senate and the Speaker of the Oklahoma House of Representatives that includes at a minimum:

1. A description of the selection process of the contracted entities;

2. Plans for enrollment of Medicaid members in health plans of contracted entities;

3. Medicaid member network access standards;

4. Performance and quality metrics;

5. Maintenance of existing funding mechanisms described in this section;

6. A description of the requirements and other provisions included in capitated contracts; and

7. A full and complete copy of each executed capitated contract.

G. 1. Each contracted entity shall report to the Authority in time intervals determined by the Authority and through a process determined by the Authority all claims data, expenditures, and such other financial reporting information as may be required by the Authority.

2. The Authority shall compile and analyze the information described in paragraph 1 of this subsection and annually submit a report summarizing such information, devoid of any personally identifying information, to the President Pro Tempore of the Senate, the Speaker of the House of Representatives, and the Oklahoma Health Care Authority Board.

SECTION 18. AMENDATORY 56 O.S. 2021, Section 4002.13, is amended to read as follows:

Section 4002.13. A. ~~There is hereby created the MC~~ The Oklahoma Health Care Authority shall establish a Medicaid Delivery System Quality Advisory Committee for the purpose of performing the duties specified in subsection B of this section.

B. The ~~primary power and duty of the~~ Committee shall ~~be~~ have the power and duty to make recommendations to the Administrator of the Oklahoma Health Care Authority and the Oklahoma Health Care Authority Board on quality measures used by ~~managed care~~

~~organizations and dental benefit managers~~ contracted entities in the capitated ~~managed~~ care delivery model of the state Medicaid program.

C. 1. The Committee shall be comprised of members appointed by the Administrator of the Oklahoma Health Care Authority. Members shall serve at the pleasure of the Administrator.

2. A majority of the members shall be providers participating in the capitated ~~managed~~ care delivery model of the state Medicaid program, and such providers may include members of the Advisory Committee on Medical Care for Public Assistance Recipients. Other members shall include, but not be limited to, representatives of hospitals and integrated health systems, other members of the health care community, and members of the academic community having subject-matter expertise in the field of health care or subfields of health care, or other applicable fields including, but not limited to, statistics, economics or public policy.

3. The Committee shall select from among its membership a chair and vice chair.

~~E.~~ D. 1. The Committee may meet as often as may be required in order to perform the duties imposed on it.

2. A quorum of the Committee shall be required to approve any final ~~action~~ recommendations of the Committee. A majority of the members of the Committee shall constitute a quorum.

3. Meetings of the Committee shall be subject to the Oklahoma Open Meeting Act.

~~F.~~ E. Members of the Committee shall receive no compensation or travel reimbursement.

~~G.~~ F. The Oklahoma Health Care Authority shall provide staff support to the Committee. To the extent allowed under federal or state law, rules or regulations, the Authority, the State Department of Health, the Department of Mental Health and Substance Abuse Services and the Department of Human Services shall as requested provide technical expertise, statistical information, and any other information deemed necessary by the chair of the Committee to perform the duties imposed on it.

SECTION 19. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 4002.14 of Title 56, unless there is created a duplication in numbering, reads as follows:

A. The transformed delivery system of the state Medicaid program and capitated contracts awarded under the transformed delivery system shall be designed with uniform defined measures and goals that are consistent across contracted entities including, but not limited to, adjusted health outcomes, social determinants of health, quality of care, member satisfaction, provider satisfaction, access to care, network adequacy, and cost.

B. Prior to implementation of the transformed Medicaid delivery system, each contracted entity shall use nationally recognized, standardized provider quality metrics as established by the Oklahoma Health Care Authority and, where applicable, may use additional

quality metrics if the measures are mutually agreed upon by the Authority, the contracted entity, and participating providers. The Authority shall develop processes for determining quality metrics and cascading quality metrics from contracted entities to subcontractors and providers.

C. The Authority may use consultants, organizations, or measures used by health plans, the federal government, or other states to develop effective measures for outcomes and quality including, but not limited to, the National Committee for Quality Assurance (NCQA) or the Healthcare Effectiveness Data and Information Set (HEDIS) established by NCQA, the Physician Consortium for Performance Improvement (PCPI) or any measures developed by PCPI.

D. Each component of the quality metrics established by the Authority shall be subject to specific accountability measures including, but not limited to, penalties for noncompliance.

SECTION 20. AMENDATORY 56 O.S. 2021, Section 4004, is amended to read as follows:

Section 4004. A. 1. The Oklahoma Health Care Authority shall seek any federal approval necessary to implement ~~this act~~ the Ensuring Access to Medicaid Act. This shall include, but not be limited to, submission to the Centers for Medicare and Medicaid Services of any appropriate demonstration waiver application or

Medicaid State Plan amendment necessary to accomplish the requirements of this act within the required time frames.

2. Prior to implementation of contracts with any contracted entities except dental benefit managers, the Authority shall obtain federal approval of a managed care directed payment program with an average commercial rate methodology under the Supplemental Hospital Offset Payment Program Act. Contracts with dental benefit managers shall be exempt from the requirement stipulated by this paragraph.

B. The Oklahoma Health Care Authority Board shall promulgate rules to implement ~~this act~~ the Ensuring Access to Medicaid Act.

SECTION 21. AMENDATORY 63 O.S. 2021, Section 5009, is amended to read as follows:

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

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

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

~~3. Preventative care.~~

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

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

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

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

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

~~C.~~ B. In order to provide adequate funding for the unique training and research purposes associated with the demonstration

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

SECTION 22. AMENDATORY 36 O.S. 2021, Section 624, is amended to read as follows:

Section 624. A. Every insurance company, copartnership, insurance association, interinsurance exchange, person, insurer, nonprofit hospital service and medical indemnity corporation, or health maintenance organization doing business in this state in the execution or exchange of contracts of insurance, indemnity or health maintenance services, or as an insurance company of any nature or character whatsoever, hereinafter referred to in this article as an insurance company or company, shall annually, on or before the first day of March, report under oath of the president or secretary or other chief officer of such company to the Insurance Commissioner the total amount of direct written premiums, membership,

application, policy and/or registration fees charged during the preceding calendar year, or since the last return of such direct written premiums, membership, application, policy and/or registration fees was made by such company, from insurance of every kind upon persons or on the lives of persons resident in this state, or upon real and personal property located within this state, and/or upon any other risks insured within this state, provided, that with respect to the tax payable annually, considerations received for annuity contracts and payments received by a health maintenance organization from the Secretary of Health and Human Services pursuant to a contract issued under the provisions of 42 U.S.C., Section 1395mm(g) shall no longer be deemed to be premiums for insurance and shall no longer be subject to the tax imposed by this section. Every such company shall, at the same time, pay to the Insurance Commissioner:

1. An annual license fee as prescribed by Section 321 of this title; and

2. An annual tax on all of the direct written premiums after all returned premiums are deducted, and on all membership, application, policy and/or registration fees, installment and/or finance fees or charges collected thereby, for the privileges of having written, continued and/or serviced insurance on lives, property and/or other risks in this state and of having made and serviced investments therein during the then expiring license year

except premiums or fees paid by any county, city, town or school district funds or by their duly constituted authorities performing a public service organized pursuant to Sections 1001 through 1008 of Title 74 of the Oklahoma Statutes, or Sections 176 through 180.4 of Title 60 of the Oklahoma Statutes. Provided, no deduction shall be made from premiums for dividends paid to policyholders. Except as set forth in this paragraph, the rate of taxation for all entities subject to the tax shall be two and twenty-five one-hundredths percent (2.25%). If any insurance company or other entity liable for the taxes levied pursuant to the provisions of this section fails to remit such taxes in a timely manner, it shall remain liable therefor together with interest thereon at an annual rate equal to the average United States Treasury Bill rate of the preceding calendar year as certified by the State Treasurer on the first regular business day in January of each year, plus four percentage points.

a. The rate of taxation for all life insurance policies insuring the life of an employee or director for the benefit of the employer or a trust sponsored by the employer, which is purchased by the employer or trust sponsored by the employer for the benefit of its employees, shall be computed for each policy at the rate of:

(1) two and twenty-five one-hundredths percent (2.25%) of policy year premium up to One Hundred Thousand Dollars ($100,000.00), and

(2) one-tenth of one percent (1/10 of 1%) of policy year premium exceeding One Hundred Thousand Dollars ($100,000.00).

b. Premiums on which taxes are paid under division (2) of subparagraph a of this paragraph are not subject to Section 628 of this title. The Commissioner shall promulgate rules regarding the sale of life insurance policies subject to division (2) of subparagraph a of this paragraph.

c. Proceeds from the premium tax collected under this paragraph from contracted entities under the Ensuring Access to Medicaid Act shall be deposited in the Medicaid Health Improvement Revolving Fund created in Section 23 of this act. The provisions of this subparagraph shall not be construed to affect or modify the apportionments provided in Section 312.1 of this title.

B. For all insurance companies or other entities taxed pursuant to this section, the annual license fee and tax and all required membership, application, policy, registration, and agent appointment fees shall be in lieu of all other state taxes or fees, except those

taxes and fees provided for in the Insurance Code, and the taxes and fees of any subdivision or municipality of the state, except ad valorem taxes and the tax required to be paid pursuant to Section 50001 of Title 68 of the Oklahoma Statutes. Provided, such license fee, tax and membership, application, policy, registration, and appointment fees shall be in lieu of any and all ad valorem taxes levied on intangible personal property. Any company, except health maintenance organizations, failing to make such returns and payments promptly and correctly shall forfeit and pay to the Insurance Commissioner, in addition to the amount of the taxes and fees and interest, the sum of Five Hundred Dollars ($500.00) or an amount equal to one percent (1%) of the unpaid amount, whichever is greater; and the company so failing or neglecting for sixty (60) days shall thereafter be debarred from transacting any business of insurance in this state until the taxes, fees and penalties are fully paid, and the Insurance Commissioner shall revoke the license or certificate of authority granted to the agent or agents of that company to transact business in this state. Provided, that when any such insurance company, copartnership, insurance association, interinsurance exchange, person, insurer, or nonprofit hospital service and indemnity corporation, applies for the first time for a license to do business in Oklahoma, it shall, at the time of making such application, pay a license fee as prescribed by Section 1425 of this title, and, on or before the first day of March, following, pay

the premium tax, membership, application, policy, registration, and agent appointment fees, as hereinbefore provided. Such license fee, tax and membership, application, policy, registration, and appointment fees shall be in lieu of all other state taxes or fees, except those taxes and fees provided for in the Insurance Code, and the taxes and fees of any subdivision or municipality of the state, except ad valorem taxes and the tax required to be paid pursuant to Section 50001 of Title 68 of the Oklahoma Statutes.

C. Any health maintenance organization failing to file premium tax returns and payments promptly and correctly shall forfeit and pay to the Insurance Commissioner, in addition to the amount of the taxes, the sum of Five Hundred Dollars ($500.00) or an amount equal to one percent (1%) of the unpaid amount, whichever is greater. Any health maintenance organization failing or neglecting to pay the tax and penalty shall be debarred from operating in this state and the Insurance Commissioner shall revoke the license of the health maintenance organization, until such taxes and penalties are fully paid.

SECTION 23. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1010.8A of Title 56, unless there is created a duplication in numbering, reads as follows:

There is hereby created in the State Treasury a revolving fund for the Oklahoma Health Care Authority to be designated the "Medicaid Health Improvement Revolving Fund". The fund shall be a

continuing fund, not subject to fiscal year limitations, and shall consist of all monies received from the premium tax levied on contracted entities under paragraph 2 of subsection A of Section 624 of Title 36 of the Oklahoma Statutes and such other funds as may be provided by law. All monies accruing to the credit of the fund are hereby appropriated and may be budgeted and expended by the Authority for the following purposes:

1. To supplement the state Medicaid program;

2. To supplement the Supplemental Hospital Offset Payment Program; and

3. To supplement the Rate Preservation Fund created in Section 5020A of Title 63 of the Oklahoma Statutes.

Expenditures from the fund shall be made upon warrants issued by the State Treasurer against claims filed as prescribed by law with the Director of the Office of Management and Enterprise Services for approval and payment.

SECTION 24. RECODIFICATION 56 O.S. 2021, Section 4004, as amended by Section 20 of this act, shall be recodified as Section 4002.15 of Title 56 of the Oklahoma Statutes, unless there is created a duplication in numbering.

SECTION 25. REPEALER 56 O.S. 2021, Sections 1010.2, 1010.3, 1010.4, 1010.5, and 1010.8, are hereby repealed.

SECTION 26. REPEALER 56 O.S. 2021, Sections 4002.3 and 4002.9, are hereby repealed.

SECTION 27. REPEALER 63 O.S. 2021, Sections 5009.5, 5011, and 5028, are hereby repealed.

SECTION 28. The provisions of this act shall not become effective as law unless Enrolled Senate Bill No. 1396 of the 2nd Session of the 58th Oklahoma Legislature becomes effective as law.

SECTION 29. This act shall become effective July 1, 2022.

SECTION 30. It being immediately necessary for the preservation of the public peace, health or safety, an emergency is hereby declared to exist, by reason whereof this act shall take effect and be in full force from and after its passage and approval.

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