ENGROSSED SENATE
BILL NO. 1337

By: McCortney of the Senate

and

McEntire of the House

[state Medicaid program - legislative intent - definitions - capitated contracts - requests for proposals - award of contracts to provider-led entities – enrollment and assignment of Medicaid members - network adequacy standards - essential community providers – Oklahoma Health Care Authority monitoring, oversight, and enforcement – duties of contracted entities - determination and review requirements - processing and adjudication of claims - readiness review - scorecard – provider reimbursement - capitation rates - supplemental payments – reports – advisory committee - measures and goals - federal approval - recodification – repealers - codification - effective date]

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. ~~"Claims denial error rate" means the rate of claims denials that are overturned on appeal;~~ "Accountable care organization" means a network of physicians, hospitals, and other health care providers that provides coordinated care to Medicaid members;

2. "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 as provided by Section 4002.12 of this title;

3. "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;

4. "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;

5. "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, or a dental benefit manager, or any other entity as determined by the Authority;

6. "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.~~ 7. "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, district department of health, cooperative department of health, or city-county health department,

j. a comprehensive community addiction recovery center,

k. 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

l. 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. "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;~~

8. "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, licensed provider currently practicing, foster child or parent associations, or other local Oklahoma provider organization as approved by Authority;

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

~~9.~~ 10. "Participating provider" means a provider who has a contract with or is employed by a ~~managed care organization~~ contracted entity or dental benefit manager 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.~~ 11. "Provider" means a health care or dental provider licensed or certified in this state;

12. "Provider-led entity" means an organization or entity that meets the following criteria:

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, and

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, or licensed behavioral health providers, or

(b) are employed by:

i. a hospital, long-term care facility or other medical facility licensed 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;

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

14. "Urban region" means all counties of this state with a county population of not less than five hundred thousand (500,000), 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 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. The Authority shall not issue any request for proposals or enter into any contract to transform the delivery system of the state Medicaid program for any Medicaid population that is not expressly included in this section.

B. 1. No later than January 1, 2023, 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,

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 primary care,

b. behavioral health services, and

c. prescription drug services.

C. 1. No later than January 1, 2023, 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.

D. 1. No later than January 1, 2023, 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 that covers all Medicaid services other than dental services and is designed to provide care to:

a. children in foster care and former foster care children up to age twenty-five (25),

b. juvenile justice involved children, and

c. children receiving adoption assistance.

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.

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 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 to 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 accountable care organizations or other Medicare alternative payment models, Medicare value-based payment arrangements, or Medicare 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,

d. demonstrated experience in improving health outcomes for Medicaid members, and

e. 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, to expand its coverage area to the entire state within a time frame specified in the request for proposals.

F. At the discretion of the Authority, capitated contracts may be extended to ensure against 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 Oklahoma Health Care Authority shall require each contracted entity to ensure that Medicaid members who do not elect a primary care provider are assigned to a provider, prioritizing existing patient-provider relationships.

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

C. The Authority may only utilize an opt-in enrollment process for the voluntary enrollment of American Indians and Alaska Natives.

D. 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. 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 be designed to ensure enrollees covered by the managed care organizations and dental benefit managers 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~~ The Authority shall require all contracted entities to contract to the extent possible ~~and practicable~~ 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 essential community provider for a model of care containing care coordination, care management, utilization management, disease management, network management, or another model of care as approved by Authority. Such contractual arrangements must be in place within eighteen (18) 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 Oklahoma Health Care 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, as provided by the contract with the Authority, expand its coverage area beyond the urban region 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 and as approved by Authority. If

approved, the additional county or counties shall be added to the urban region during the next open enrollment period.

2. As provided by Section 4 of this act and by the contract with the Authority, the provider-led entity shall expand its coverage area to every county of this state within the time frame specified by such contract.

3. 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 must include in its network all providers in the coverage area that are designated as essential community providers by the Authority, unless the Authority approves an alternative arrangement for securing the types of services offered by the essential community providers.

SECTION 7. 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 law or federal law.

SECTION 8. 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 shall hold a certificate of authority as a health maintenance organization issued by the Insurance Department.

C. 1. To ensure providers have a voice in the direction and operation of the contracted entities selected by the 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 board of directors 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 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. All contracted entities shall:

1. Use the same open 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.

J. 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 9. 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. 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 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 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. 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.~~

H. 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 upon adverse determination; and

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

SECTION 10. 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 of this paragraph, 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, 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 11. 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 12. AMENDATORY 56 O.S. 2021, Section 4002.11, is amended to read as follows:

Section 4002.11. No later than one 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, 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 13. AMENDATORY 56 O.S. 2021, Section 4002.12, is amended to read as follows:

Section 4002.12. A. The Oklahoma Health Care Authority ~~shall~~ may 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~~

~~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, 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, 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 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. The quality measures used by a managed care organization or dental benefit manager 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.~~

~~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~~ Medicaid members.

B. 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.

C. Capitation rates established by the Oklahoma Health Care Authority and paid to contracted entities under capitated contracts shall be:

1. Actuarily sound. Actuarial calculations must include assumptions consistent with industry and local standards; and

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

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

SECTION 14. 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. 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 an average commercial rate methodology.

E. On or before January 31, 2023, the Authority shall submit a report to the Oklahoma Health Care Authority Board, the Chair of the Senate Appropriations Committee, and the Chair of the House Appropriation and Budget Committee that includes the Authority's plans to continue or enhance all supplemental payment programs under the reforms provided for in 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 minimize budgetary disruptions to providers.

F. On or before July 1, 2023, the Authority shall submit a report to the Governor, the President Pro Tempore of the Senate and the Speaker of the 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.

SECTION 15. 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 and to monitor the implementation of and adherence to such quality measures.

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 not 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 16. 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, quality of care, member satisfaction, access to care, network adequacy, and cost.

B. 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 organizations, 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 17. AMENDATORY 56 O.S. 2021, Section 4004, is amended to read as follows:

Section 4004. A. 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 timeframes.

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

SECTION 18. 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 19. AMENDATORY 25 O.S. 2021, Section 304, is amended to read as follows:

Section 304. As used in the Oklahoma Open Meeting Act:

1. "Public body" means the governing bodies of all municipalities located within this state, boards of county commissioners of the counties in this state, boards of public and higher education in this state and all boards, bureaus, commissions, agencies, trusteeships, authorities, councils, committees, public trusts or any entity created by a public trust, including any committee or subcommittee composed of any of the members of a public trust or other legal entity receiving funds from the Rural Economic Action Plan Fund as authorized by Section 2007 of Title 62 of the Oklahoma Statutes, task forces or study groups in this state supported in whole or in part by public funds or entrusted with the expending of public funds, or administering public property, and shall include all committees or subcommittees of any public body. Public body shall not include the state judiciary, the Council on Judicial Complaints when conducting, discussing, or deliberating any matter relating to a complaint received or filed with the Council, the Legislature, or administrative staffs of public bodies, including, but not limited to, faculty meetings and athletic staff meetings of institutions of higher education when those staffs are not meeting with the public body, or entry-year assistance committees. Furthermore, public body shall not include the multidisciplinary teams provided for in Section 1-9-102 of Title 10A of the Oklahoma Statutes and subsection C of Section 1-502.2 of

Title 63 of the Oklahoma Statutes or any school board meeting for the sole purpose of considering recommendations of a multidisciplinary team and deciding the placement of any child who is the subject of the recommendations. Furthermore, public body shall not include meetings conducted by stewards designated by the Oklahoma Horse Racing Commission pursuant to Section 203.4 of Title 3A of the Oklahoma Statutes when the stewards are officiating at races or otherwise enforcing rules of the Commission. Furthermore, public body shall not include the board of directors of a Federally Qualified Health Center. Furthermore, public body shall not include the Medicaid Delivery System Quality Advisory Committee of the Oklahoma Health Care Authority created in Section 4002.13 of Title 56 of the Oklahoma Statutes;

2. "Meeting" means the conduct of business of a public body by a majority of its members being personally together or, as authorized by Section 307.1 of this title, together pursuant to a videoconference. Meeting shall not include informal gatherings of a majority of the members of the public body when no business of the public body is discussed;

3. "Regularly scheduled meeting" means a meeting at which the regular business of the public body is conducted;

4. "Special meeting" means any meeting of a public body other than a regularly scheduled meeting or emergency meeting;

5. "Emergency meeting" means any meeting called for the purpose of dealing with an emergency. For purposes of the Oklahoma Open Meeting Act, an emergency is defined as a situation involving injury to persons or injury and damage to public or personal property or immediate financial loss when the time requirements for public notice of a special meeting would make such procedure impractical and increase the likelihood of injury or damage or immediate financial loss;

6. "Continued or reconvened meeting" means a meeting which is assembled for the purpose of finishing business appearing on an agenda of a previous meeting. For the purposes of the Oklahoma Open Meeting Act, only matters on the agenda of the previous meeting at which the announcement of the continuance is made may be discussed at a continued or reconvened meeting;

7. "Videoconference" means a conference among members of a public body remote from one another who are linked by interactive telecommunication devices or technology and/or technology permitting both visual and auditory communication between and among members of the public body and/or between and among members of the public body and members of the public. During any videoconference, both the visual and auditory communications functions shall attempt to be utilized; and

8. "Teleconference" means a conference among members of a public body remote from one another who are linked by

telecommunication devices and/or technology permitting auditory communication between and among members of the public body and/or between and among members of the public body and members of the public.

SECTION 20. RECODIFICATION 56 O.S. 2021, Section 4004, as amended by Section 17 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 21. REPEALER 56 O.S. 2021, Sections 1010.2 1010.3, 1010.4, and 1010.5, are hereby repealed.

SECTION 22. REPEALER 56 O.S. 2021, Sections 4002.3, 4002.8, and 4002.9, are hereby repealed.

SECTION 23. REPEALER 63 O.S. 2021, Sections 5009.5, 5011, and 5028, are hereby repealed.

SECTION 24. This act shall become effective November 1, 2022.

Passed the Senate the 23rd day of March, 2022.

_____
Presiding Officer of the Senate

Passed the House of Representatives the ____ day of _____, 2022.

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Presiding Officer of the House of Representatives