HB1091 FA2 BushCa-AB(Untimely Filed)
3/3/2021 9:17:40 am

FLOOR AMENDMENT

HOUSE OF REPRESENTATIVES
State of Oklahoma

SPEAKER:

CHAIR:

I move to amend HB1091
Of the printed Bill

Page _____ Section _____ Lines _____
Of the Engrossed Bill

By striking the Title, the Enacting Clause, the entire bill, and by inserting in lieu thereof the following language:

AMEND TITLE TO CONFORM TO AMENDMENTS

Amendment submitted by: Carol Bush

Adopted: _____

_____
Reading Clerk

STATE OF OKLAHOMA

1st Session of the 58th Legislature (2021)

FLOOR SUBSTITUTE
FOR
HOUSE BILL NO. 1091 By: Bush of the House

and

Kidd of the Senate

FLOOR SUBSTITUTE

An Act relating to Medicaid; creating the Ensuring Access to Medicaid Act; recognizing certain statements; establishing conditions for Medicaid providers; requiring certain provisions for provider contracts entered into by the Oklahoma Health Care Authority; requiring certain time frames for claim processing; defining term; requiring timely authorizations for certain patients; requiring network contracts to be offered to certain providers; requiring certain provider payment rates; providing for credentialing and recredentialing; requiring certain fund disposition; providing for authorization requirements and time frames; requiring compliance with certain claim processing and adjudication procedures; prohibiting plans from making certain changes; requiring plans to meet certain provider network requirements; requiring plans to provide certain data; requiring the Oklahoma Health Care Authority to establish certain rates, develop certain procedures and develop certain policies and standards; allowing the Oklahoma Health Care Authority to enter certain contracts and establish and administer certain programs; repealing 56 O.S. 2011, Section 1010.2, which relates to definitions; repealing 56 O.S. 2011, Section 1010.3, which relates to establishment of the Oklahoma Medicaid Healthcare Options System; repealing 56 O.S. 2011, Section 1010.4, which relates to implementation of system; repealing 56 O.S. 2011, Section 1010.5, which relates

to contract provisions; providing for codification; and providing an 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 4002.1 of Title 56, unless there is created a duplication in numbering, reads as follows:

This act shall be known and may be cited as the "Ensuring Access to Medicaid Act".

SECTION 2. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 4002.2 of Title 56, unless there is created a duplication in numbering, reads as follows:

Recognizing that many Oklahomans do not have health care benefits or health care coverage, that the Oklahoma Health Care Authority is changing payment delivery models to capitated managed care, and that certain provisions must be statutory in order to preserve the rights and access of Oklahomans to quality health care, the Oklahoma Legislature hereby establishes the conditions for which providers and plans will participate in Medicaid.

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

A. As a condition of any proposed or potential plan participating in capitated managed care, the Oklahoma Health Care Authority (OHCA) shall require the following contract provisions:

1. Claims shall be processed in the time frame provided by Section 1219 of Title 36 of the Oklahoma Statutes and no less than ninety percent (90%) of all claims shall be paid within fourteen (14) days of submission to the plan. An overdue payment shall bear simple interest at the rate of ten percent (10%) per year. For purposes of this subsection, the term "clean claim" means a properly completed billing form with CPT-4, ICD-10 coding or HCPCS coding where applicable that contains information specifically required in the OHCA Provider Billing and Procedures Manual;

2. 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 shall be made within twenty-four (24) hours of receipt of the request;

3. All plans shall offer network contracts to all essential community providers as defined by Section 156.325(c) of Title 45 of the Code of Federal Regulations and such other health care providers as OHCA may specify;

4. All plans shall offer payment rates to contracted providers that are no lower than payment rates under the OHCA fee schedule established pursuant to subsection A of Section 4 of this act for the year involved. Nothing in this act shall be construed to

preclude health care providers and plans from negotiating payment rates in excess of the payment rates established in the OHCA fee schedule; and

5. All plans shall formally credential and recredential physicians or other providers at a frequency required by a single, consolidated Medicaid provider enrollment and credentialing process established by OHCA. The required frequency of recredentialing may be less than once in three (3) years.

B. When the state appropriates funds to OHCA for specific purposes, including, but not limited to, increases in reimbursement rates, participating plans and subcontractors shall apportion such funds in accordance with legislative directive.

C. Plan review and issue determinations for prior authorization for care ordered by primary care or specialist providers shall be timely and must occur in accordance with the following:

1. Within twenty-four (24) hours of receipt of the request for any patient who is not hospitalized at the time of the request, provided that if the request does not include sufficient or adequate documentation, the plan review and issue determination shall occur within a time frame and in accordance with a process established by OHCA. The process established by OHCA pursuant to this paragraph 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 request for services for a hospitalized patient, including, but not limited to, acute care inpatient services or equipment necessary to discharge the patient from an inpatient facility;

3. Within one (1) hour of receipt of the request for a hospitalized patient if the request is related to post-stabilization care or a life-threatening condition; or

4. Before issuing an adverse determination on a prior authorization request and within forty-eight (48) hours of receiving the request, the plan shall provide the requesting physician with reasonable opportunity to discuss the request with another physician who practices in the same or similar 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.

D. All plans must comply with the following requirements with respect to processing and adjudication of claims for payment submitted in good faith by health care providers for health care items and services furnished by such providers to individuals under the State Medicaid Program:

1. In the case of a denial of a claim for the health care items and services, including, but not limited to, such a denial on the basis of the level of emergency care indicated on a claim, the plan shall establish a process by which the health care 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 detailed explanation of the basis for the denial,

b. a detailed description of the additional information necessary to substantiate the claim, and

c. a description of the process by which such additional information may be submitted to the plan;

2. No plan may deny a claim for the health care items and services furnished by a health care provider to an individual on the basis of medical necessity where the furnishing of such health care items and services to such individual was approved by the plan in a prior authorization determination;

3. Postpayment audits by plans shall be subject to the following requirements:

a. subject to subparagraph b of this paragraph, insofar as a plan conducts postpayment audits, the plan shall employ the postpayment audit process utilized by OHCA as in effect on the date of the enactment of this act,

b. OHCA shall establish a limit on the percentage of claims with respect to which postpayment audits may be conducted by plans for health care items and services furnished by a health care provider in a plan year. The percentage limit established under this

subparagraph may not exceed five of total claims based on volume percent, and

c. OHCA shall provide for the imposition of financial penalties under such contract in the case of any plan with respect to which OHCA determines the plan has a claims denial error rate of greater than five percent (5%). OHCA shall establish the amount of financial penalties and the time frame under which such penalties shall be imposed on plans under this subparagraph, in no case less than annually. In this subparagraph, the term "claims denial error rate" means the rate of claims denials that are overturned on appeal;

4. No plan may deny a claim for the health care items and services furnished by a health care provider to an individual solely on the basis of typographical errors, a missed notification to the plan that a patient was admitted, or other purely administrative errors or omissions as specified by OHCA; and

5. Plans may only apply readmission penalties pursuant to rules promulgated by OHCA. OHCA 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 Medicaid population covered by the plans.

E. All plans shall utilize uniform procedures established by OHCA under subsection B of Section 4 of this act for the review and appeal of any plan adverse determination, as defined in paragraph 1 of Section 6475.3 of Title 36 of the Oklahoma Statutes, sought by any individual or health care provider adversely affected by such determination;

F. Insofar as a plan requires the use of arbitration for disputes between health care providers and the plan with respect to health care items and services furnished to individuals under the State Medicaid Program, the plan shall utilize uniform procedures established by OHCA under subsection C of Section 4 of this act for arbitration proceedings;

G. No plan may make material changes during a plan year to the benefit, payment or coverage policies established by the plan and in effect on the first day of the plan year involved, except where OHCA has approved the material change or where the material change is required by federal or state law or regulation. Absent exigent circumstances as determined by OHCA, no material change may take effect until the expiration of ninety (90) days following the date of notice to health care providers of such material change. In this section, the term "material change" means a change that has a significant financial impact on the ability to provide, or the payment rate for, health care items and services;

H. All plans shall meet the following requirements with respect to health care provider networks:

1. All plans shall meet or exceed network adequacy standards established by OHCA under subsection D of Section 4 of this act to ensure sufficient access to health care providers for individuals under the State Medicaid Plan;

2. All plans shall permit the participation in their plan networks of any health care provider that meets the terms and conditions under the plan involve; and

3. All plans shall be accredited by the National Committee for Quality Assurance.

I. All plans must have a medical loss ratio of not less than 85 percent (85%) for each medical loss ratio reporting year.

J. Plans shall provide patient data as requested by health care providers at no charge to the provider.

SECTION 4. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 4002.4 of Title 56, unless there is created a duplication in numbering, reads as follows:

A. OHCA shall continue to establish payment rates for health care items and services furnished to individuals under the State Medicaid Program by health care providers.

1. Subject to paragraph 2 of this subsection, the payment rates established pursuant to this subsection for the year 2022 and each subsequent year shall be determined in the same manner as OHCA

determined such payment rates for health care items and services furnished for the year 2021.

2. The payment rates established pursuant to this subsection for the year involved may not be less than the payment rates for such health care items and services established for the previous year subject to an increase equal to the percentage increase in the medical care component of the Consumer Price Index (U.S. city average) published by the Bureau of Labor Statistics of the U.S. Department of Labor over the previous year.

B. OHCA shall develop procedures for individuals or health care providers to seek review by the plan of any adverse determination as defined in paragraph 1 of Section 6475.3 of Title 36 of the Oklahoma Statutes made by such plan, hereinafter referred to as internal appeals. The procedures shall include the following:

1. OHCA shall require the use of two levels of internal appeals;

2. Medical review staff of the plan, who are involved in the first level of internal appeals with respect to an adverse determination, may not participate in the review conducted at the second level of internal review for such adverse determination; and

3. With respect to internal appeals of adverse determinations made by a plan on the basis of medical necessity, the following requirements shall apply:

a. medical review staff of the plan shall be licensed or credentialed health care clinicians with relevant clinical training or experience,

b. all plans shall use medical review staff for such internal appeals and may not use any automated claim review software or other automated functionality for such internal appeals, and

c. for purposes of internal appeals, the term "medical necessity" shall have the meaning given such term by OHCA in rulemaking.

C. OHCA shall develop for use by all plans a standard, uniform set of policies, procedures and requirements for arbitration of disputes between plans and health care providers with respect to health care items and services furnished to individuals under the State Medicaid Program. The standard, uniform set of policies, procedures and requirements established under this subsection may be based on the procedures of the American Arbitration Association.

D. OHCA shall develop network adequacy standards for all plans. OHCA network adequacy standards shall include provider-specific network adequacy standards under Section 438.68(b)(1) of Title 42, Code of Federal Regulations as in effect on November 1, 2020. Network adequacy standards established under this subsection shall be designed to ensure individuals under the State Medicaid Program who reside in health professional shortage areas 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 with health care providers, especially adult and pediatric primary care practitioners.

E. OHCA may enter into a contract with an organization that offers a regional plan to participate in capitated managed care under the State Medicaid Program.

F. OHCA may establish and administer a program of risk corridors for plans participating in capitated managed care under the State Medicaid Program, under which a plan shall participate in a payment adjustment system based on the ratio of the allowable costs of the plan to the aggregate premium payments made to the plan. In establishing a risk corridor program designed to limit plan gains and losses, OHCA shall establish corridors that are symmetrical

SECTION 5. REPEALER 56 O.S. 2011, Sections 1010.2, 1010.3, 1010.4 and 1010.5, are hereby repealed.

SECTION 6. This act shall become effective September 1, 2021.

58-1-7865 AB 03/02/21