<DateSubmitted>

HOUSE OF REPRESENTATIVES
CONFERENCE COMMITTEE REPORT

Mr. President:
Mr. Speaker:

The Conference Committee, to which was referred

HB2322

By: Frix of the House and Taylor of the Senate

Title: Health insurance; Health Care Freedom of Choice Act; assigned benefits; compensation; insurers; effective date.

Together with Engrossed Senate Amendments thereto, beg leave to report that we have had the same under consideration and herewith return the same with the following recommendations:

1. That the Senate recede from its amendment; and
2. That the attached Conference Committee Substitute be adopted.

Respectfully submitted,

House Action _____ Date _____ Senate Action _____ Date _____

SENATE CONFEREES

Bullard _____

Montgomery _____

Garvin _____

Quinn _____

Taylor _____

Matthews _____

Brooks _____

House Action _____ Date _____ Senate Action _____ Date _____

STATE OF OKLAHOMA

2nd Session of the 58th Legislature (2022)

CONFERENCE COMMITTEE
SUBSTITUTE
FOR ENGROSSED
HOUSE BILL NO. 2322

By: Frix, Sims, Sneed, and Roberts (Eric) of the House

and

Bullard and Pemberton of the Senate

CONFERENCE COMMITTEE SUBSTITUTE

An Act relating to the state Medicaid program; amending 56 O.S. 2021, Section 4002.2, as amended by Section 2 of Enrolled Senate Bill No. 1337 of the 2nd Session of the 58th Oklahoma Legislature, which relates to definitions used in the Ensuring Access to Medicaid Act; broadening certain definition; amending 56 O.S. 2021, Section 4002.12, as amended by Section 15 of Enrolled Senate Bill No. 1337 of the 2nd Session of the 58th Oklahoma Legislature, which relates to reimbursement of providers; requiring certain reimbursement for pharmacist; providing an effective date; declaring an emergency; and creating contingent effectiveness.

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

SECTION 1. AMENDATORY 56 O.S. 2021, Section 4002.2, as amended by Section 2 of Enrolled Senate Bill No. 1337 of the 2nd Session of the 58th Oklahoma Legislature, is amended to read as follows:

Section 4002.2. As used in 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;

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);

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~~ the Ensuring Access to Medicaid Act that will assume financial risk, operational accountability, and statewide or regional functionality as defined in ~~this act~~ the Ensuring Access to Medicaid Act in managing comprehensive health outcomes of Medicaid members. For purposes of ~~this act~~ the Ensuring Access to Medicaid 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 that handles claims payment and prior authorizations and coordinates dental care with participating providers and Medicaid members;

10. "Essential community provider" 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. a pharmacy or pharmacist, or

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

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 contracted entity;

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 promulgated by the Oklahoma Health Care Authority Board;

15. "Participating provider" means a provider who has a contract with or is employed by a contracted entity to provide services to Medicaid members as authorized by ~~this act~~ the Ensuring Access to Medicaid Act;

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 2. AMENDATORY 56 O.S. 2021, Section 4002.12, as amended by Section 15 of Enrolled Senate Bill No. 1337 of the 2nd Session of the 58th Oklahoma Legislature, is amended to read as follows:

Section 4002.12. A. Until July 1, 2026, the Oklahoma Health Care Authority shall establish minimum rates of reimbursement from 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. 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 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 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 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 contracted entity to determine reimbursement amounts to providers in value-based payment arrangements shall align with the quality measures of the Authority for 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. 1. 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.

2. A pharmacy or pharmacist shall receive direct payment or reimbursement from the Authority or contracted entity when providing a healthcare service to the Medicaid member at a rate no less than that of other healthcare providers for providing the same service.

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~~ 4002.13 of this title, 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 3. This act shall become effective July 1, 2022.

SECTION 4. 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.

SECTION 5. The provisions of this act shall be contingent upon the enactment of Enrolled Senate Bill No. 1337 of the 2nd Session of the 58th Oklahoma Legislature and shall not become effective as law otherwise.

58-2-11604 KN 05/18/22