

1 ENGROSSED HOUSE AMENDMENT
TO
2 ENGROSSED SENATE BILL NO. 1675 By: McCortney of the Senate
3 and
4 McEntire of the House
5
6

7 An Act relating to the state Medicaid program;
8 amending Section 3, Chapter 395, O.S.L. 2022 (56 O.S.
9 Supp. 2023, Section 4002.3a), which relates to
10 capitated contracts for delivery of Medicaid
11 services; extending certain deadlines; amending 56
12 O.S. 2021, Section 4002.4, as amended by Section 7,
13 Chapter 395, O.S.L. 2022 (56 O.S. Supp. 2023, Section
14 4002.4), which relates to network adequacy standards
15 for contracted entities; imposing certain deadline on
16 credentialing or recredentialing by contracted
17 entities; amending 56 O.S. 2021, Section 4002.6, as
18 last amended by Section 2, Chapter 331, O.S.L. 2023
19 (56 O.S. Supp. 2023, Section 4002.6), which relates
20 to requirements for prior authorizations; modifying
21 and adding deadlines for certain determinations and
22 reviews; requiring certain reviews to be conducted by
23 Oklahoma-licensed clinical staff; amending 56 O.S.
24 2021, Section 4002.7, as amended by Section 11,
Chapter 395, O.S.L. 2022 (56 O.S. Supp. 2023, Section
4002.7), which relates to requirements for processing
and adjudicating claims; expanding certain provisions
to include downgraded claims; specifying certain
limit on claims subject to postpayment audits;
amending 56 O.S. 2021, Section 4002.12, as last
amended by Section 1, Chapter 308, O.S.L. 2023 (56
O.S. Supp. 2023, Section 4002.12), which relates to
minimum rates of reimbursement; extending certain
deadline; updating statutory references; updating
statutory language; and declaring an emergency.

1 AMENDMENT NO. 1. Strike the title, enacting clause, and entire bill
2 and insert:

3
4 "[Medicaid program - capitated contracts - entity -
5 deadlines - contracted entities - credentialing -
6 recredentialing - authorizations - deadlines -
7 clinical staff - claims - audits - reimbursement -
8 deadlines -
9 emergency]

10
11
12 ~~BE IT ENACTED BY THE PEOPLE OF THE STATE OF OKLAHOMA:~~

13 SECTION 1. AMENDATORY 56 O.S. 2021, Section 4002.2, as
14 last amended by Section 1, Chapter 334, O.S.L. 2022 (56 O.S. Supp.
15 2023, Section 4002.2), is amended to read as follows:

16 Section 4002.2 As used in the Ensuring Access to Medicaid Act:

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

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

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

24

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

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

- 8 a. children in foster care,
- 9 b. former foster care children up to twenty-five (25)
10 years of age,
- 11 c. ~~juvenile justice involved~~ juvenile-justice-involved
12 children, and
- 13 d. children receiving adoption assistance;

14 6. "Clean claim" means a properly completed billing form with
15 Current Procedural Terminology, 4th Edition or a more recent
16 edition, the Tenth Revision of the International Classification of
17 Diseases coding or a more recent revision, or Healthcare Common
18 Procedure Coding System coding where applicable that contains
19 information specifically required in the Provider Billing and
20 Procedure Manual of the Oklahoma Health Care Authority, as defined
21 in 42 C.F.R., Section 447.45(b);

22 7. "Commercial plan" means an organization or entity that
23 undertakes to provide or arrange for the delivery of health care
24

1 services to Medicaid members on a prepaid basis and is subject to
2 all applicable federal and state laws and regulations;

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

14 9. "Dental benefit manager" means an entity that handles claims
15 payment and prior authorizations and coordinates dental care with
16 participating providers and Medicaid members;

17 10. "Essential community provider" means:

- 18 a. a Federally Qualified Health Center,
- 19 b. a community mental health center,
- 20 c. an Indian Health Care Provider,
- 21 d. a rural health clinic,
- 22 e. a state-operated mental health hospital,
- 23 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,

- 1 n. any additional Medicaid provider as approved by the
2 Authority if the provider either offers services that
3 are not available from any other provider within a
4 reasonable access standard or provides a substantial
5 share of the total units of a particular service
6 utilized by Medicaid members within the region during
7 the last three (3) years, and the combined capacity of
8 other service providers in the region is insufficient
9 to meet the total needs of the Medicaid members,
10 o. a pharmacy or pharmacist, or
11 p. any provider not otherwise mentioned in this paragraph
12 that meets the definition of "essential community
13 provider" under 45 C.F.R., Section 156.235;

14 11. "Material change" includes, but is not limited to, any
15 change in overall business operations such as policy, process or
16 protocol which affects, or can reasonably be expected to affect,
17 more than five percent (5%) of enrollees or participating providers
18 of the contracted entity;

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

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

8 14. "Medical necessity" has the same meaning as ~~provided by~~
9 ~~rules promulgated by the Oklahoma Health Care Authority Board~~
10 "medically necessary" in Section 6592 of Title 36 of the Oklahoma
11 Statutes;

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

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

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

- 22 a. ~~a majority of the entity's ownership is held by~~
23 ~~Medicaid providers in this state or is held by an~~
24 ~~entity that directly or indirectly owns or is under~~

~~common ownership with Medicaid providers in this~~
~~state, or~~
~~b.~~ wherein a majority of the entity's governing body is
composed of individuals who:
~~(1)~~
a. have experience serving Medicaid members and:
~~(a)~~
(1) are licensed in this state as physicians,
physician assistants, nurse practitioners,
certified nurse-midwives, or certified registered
nurse anesthetists,
~~(b)~~
(2) at least one board member is a licensed
behavioral health provider, or
~~(c)~~
(3) are employed by:
~~i.~~
(a) a hospital or other medical facility
licensed by this state and operating in this
state, or
~~ii.~~
(b) 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)~~

b. represent the providers or facilities described in
~~division (1) of this subparagraph~~ a of this paragraph
including, but not limited to, individuals who are
employed by a statewide provider association, or
~~(3)~~

c. are nonclinical administrators of clinical practices
serving Medicaid members;

18. "Provider-owned entity" means an organization or entity
that 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;

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

~~19.~~ 20. "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.

1 SECTION 2. AMENDATORY Section 3, Chapter 395, O.S.L.
2 2022 (56 O.S. Supp. 2023, Section 4002.3a), is amended to read as
3 follows:

4 Section 4002.3a A. 1. The Oklahoma Health Care Authority
5 (OHCA) shall enter into capitated contracts with contracted entities
6 for the delivery of Medicaid services as specified in ~~this act~~ the
7 Ensuring Access to Medicaid Act to transform the delivery system of
8 the state Medicaid program for the Medicaid populations listed in
9 this section.

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

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

- 19 a. pregnant women,
- 20 b. children,
- 21 c. deemed newborns under 42 C.F.R., Section 435.117,
- 22 d. parents and caretaker relatives, and
- 23 e. the expansion population.

1 2. The Authority shall specify the services to be covered in
2 the request for proposals referenced in paragraph 1 of this
3 subsection. Capitated contracts referenced in this subsection shall
4 cover all Medicaid services other than dental services including:

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

7 (1) primary care,

8 (2) inpatient and outpatient services, and

9 (3) emergency room services,

10 b. behavioral health services, and

11 c. prescription drug services.

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

14 4. Subject to the requirements and approval of the Centers for
15 Medicare and Medicaid Services, the implementation of the program
16 shall be no later than ~~October 1, 2023~~ April 1, 2024.

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

20 a. pregnant women,

21 b. children,

22 c. parents and caretaker relatives,

23 d. the expansion population, and
24

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

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

3. Subject to the requirements and approval of the Centers for
Medicare and Medicaid Services, the implementation of the program
shall be no later than ~~October 1, 2023~~ April 1, 2024.

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

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

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

4. Subject to the requirements and approval of the Centers for
Medicare and Medicaid Services, the implementation of the program
shall be no later than ~~October 1, 2023~~ April 1, 2024.

1 E. The Authority shall not implement the transformation of the
2 Medicaid delivery system until it receives written confirmation from
3 the Centers for Medicare and Medicaid Services that a managed care
4 directed payment program utilizing average commercial rate
5 methodology for hospital services under the Supplemental Hospital
6 Offset Payment Program has been approved for Year 1 of the
7 transformation and will be included in the budget neutrality cap
8 baseline spending level for purposes of Oklahoma's 1115 waiver
9 renewal; provided, however, nothing in this section shall prohibit
10 the Authority from exploring alternative opportunities with the
11 Centers for Medicare and Medicaid Services to maximize the average
12 commercial rate benefit.

13 SECTION 3. AMENDATORY Section 4, Chapter 395, O.S.L.
14 2022 (56 O.S. Supp. 2023, Section 4002.3b), is amended to read as
15 follows:

16 Section 4002.3b A. All capitated contracts shall be the result
17 of requests for proposals issued by the Oklahoma Health Care
18 Authority and submission of competitive bids by contracted entities
19 pursuant to the Oklahoma Central Purchasing Act.

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

23 C. The Authority shall award no less than ~~three~~ four statewide
24 capitated contracts to provide comprehensive integrated health

1 services including, but not limited to, medical, behavioral health,
2 and pharmacy services and no less than two statewide capitated
3 contracts to provide dental coverage to Medicaid members as
4 specified in Section ~~3~~ 4002.3a of this ~~act~~ title. At least one
5 statewide capitated contract shall be a provider-owned entity.

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

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

19 3. The Authority shall develop a scoring methodology for the
20 request for proposals that affords preferential scoring to provider-
21 led entities and provider-owned entities, as long as the provider-
22 led entity and provider-owned entity otherwise ~~demonstrates~~
23 demonstrate an ability to fulfill the contract requirements. The
24 preferential scoring methodology shall include opportunities to

award additional points to provider-led entities and provider-owned entities based on certain factors including, but not limited to:

- a. broad provider participation in ownership and governance structure,
- b. demonstrated experience in care coordination and care management for Medicaid members across a variety of service types including, but not limited to, primary care and behavioral health,
- c. demonstrated experience in Medicare or Medicaid accountable care organizations or other Medicare or Medicaid alternative payment models, Medicare or Medicaid value-based payment arrangements, or Medicare or Medicaid risk-sharing arrangements including, but not limited to, innovation models of the Center for Medicare and Medicaid Innovation of the Centers for Medicare and Medicaid Services, or value-based payment arrangements or risk-sharing arrangements in the commercial health care market, and
- d. other relevant factors identified by the Authority.

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

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

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

6 F. At the discretion of the Authority, capitated contracts may
7 be extended to ensure there are no gaps in coverage that may result
8 from termination of a capitated contract; provided, the total
9 contracting period for a capitated contract shall not exceed seven
10 (7) years.

11 G. At the end of the contracting period, the Authority shall
12 solicit and award new contracts as provided by this section and
13 ~~Section 3 of this act~~ Section 4002.3a of this title.

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

19 SECTION 4. AMENDATORY 56 O.S. 2021, Section 4002.4, as
20 amended by Section 7, Chapter 395, O.S.L. 2022 (56 O.S. Supp. 2023,
21 Section 4002.4), is amended to read as follows:

22 Section 4002.4 A. The Oklahoma Health Care Authority shall
23 develop network adequacy standards for all contracted entities that,
24 at a minimum, meet the requirements of 42 C.F.R., Sections 438.3 and

1 438.68. Network adequacy standards established under this
2 subsection shall include distance and time standards and shall be
3 designed to ensure members covered by the contracted entities who
4 reside in health professional shortage areas (HPSAs) designated
5 under Section 332(a)(1) of the Public Health Service Act (42 U.S.C.,
6 Section 254e(a)(1)) have access to in-person health care and
7 telehealth services with providers, especially adult and pediatric
8 primary care practitioners.

9 B. The Authority shall require all contracted entities to offer
10 or extend contracts with all essential community providers, all
11 providers who receive directed payments in accordance with 42
12 C.F.R., Part 438 and such other providers as the Authority may
13 specify. The Authority shall establish such requirements as may be
14 necessary to prohibit contracted entities from excluding essential
15 community providers, providers who receive directed payments in
16 accordance with 42 C.F.R., Part 438 and such other providers as the
17 Authority may specify from contracts with contracted entities.

18 C. To ensure models of care are developed to meet the needs of
19 Medicaid members, each contracted entity must contract with at least
20 one local Oklahoma provider organization for a model of care
21 containing care coordination, care management, utilization
22 management, disease management, network management, or another model
23 of care as approved by the Authority. Such contractual arrangements
24 must be in place within twelve (12) months of the effective date of

1 the contracts awarded pursuant to the requests for proposals
2 authorized by ~~Section 3 of this act~~ Section 4002.3a of this title.

3 D. All contracted entities shall formally credential and
4 recredential network providers at a frequency required by a single,
5 consolidated provider enrollment and credentialing process
6 established by the Authority in accordance with 42 C.F.R., Section
7 438.214. A contracted entity shall complete credentialing or
8 recredentialing of a provider within sixty (60) calendar days of
9 receipt of a completed application.

10 E. All contracted entities shall be accredited in accordance
11 with 45 C.F.R., Section 156.275 by an accrediting entity recognized
12 by the United States Department of Health and Human Services.

13 F. 1. If the Authority awards a capitated contract to a
14 provider-led entity for the urban region under ~~Section 4 of this act~~
15 Section 4002.3b of this title, the provider-led entity shall expand
16 its coverage area to every county of this state within the time
17 frame set by the Authority under subsection E of ~~Section 4 of this~~
18 ~~act~~ Section 4002.3b of this title.

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

1 the provider-led entity's region during the next open enrollment
2 period.

3 SECTION 5. AMENDATORY 56 O.S. 2021, Section 4002.6, as
4 last amended by Section 2, Chapter 331, O.S.L. 2023 (56 O.S. Supp.
5 2023, Section 4002.6), is amended to read as follows:

6 Section 4002.6 A. A contracted entity shall meet all
7 requirements established by the Oklahoma Health Care Authority
8 pertaining to prior authorizations. The Authority shall establish
9 requirements that ensure timely determinations by contracted
10 entities when prior authorizations are required including expedited
11 review in urgent and emergent cases that at a minimum meet the
12 criteria of this section.

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

17 C. A contracted entity shall make a determination on a request
18 for any member who is not hospitalized at the time of the request
19 within seventy-two (72) hours of receipt of the request; provided,
20 that if the request does not include sufficient or adequate
21 documentation, the review and determination shall occur within a
22 time frame and in accordance with a process established by the
23 Authority. The process established by the Authority pursuant to
24 this subsection shall include a time frame of at least forty-eight

1 (48) hours within which a provider may submit the necessary
2 documentation.

3 D. A contracted entity shall make a determination on a request
4 for services for a hospitalized member including, but not limited
5 to, acute care inpatient services or equipment necessary to
6 discharge the member from an inpatient facility within ~~one (1)~~
7 ~~business day~~ twenty-four (24) hours of receipt of the request.

8 E. Notwithstanding the provisions of subsection C of this
9 section, a contracted entity shall make a determination on a request
10 as expeditiously as necessary and, in any event, within twenty-four
11 (24) hours of receipt of the request for service if adhering to the
12 provisions of subsection C or D of this section could jeopardize the
13 member's life, health or ability to attain, maintain or regain
14 maximum function. In the event of a medically emergent matter, the
15 contracted entity shall not impose limitations on providers in
16 coordination of post-emergent stabilization health care including
17 pre-certification or prior authorization.

18 F. Notwithstanding any other provision of this section, a
19 contracted entity shall make a determination on a request for
20 inpatient behavioral health services within twenty-four (24) hours
21 of receipt of the request.

22 G. A contracted entity shall make a determination on a request
23 for covered prescription drugs that are required to be prior
24 authorized by the Authority within twenty-four (24) hours of receipt

1 of the request. The contracted entity shall not require prior
2 authorization on any covered prescription drug for which the
3 Authority does not require prior authorization.

4 H. A contracted entity shall make a determination on a request
5 for coverage of biomarker testing in accordance with ~~Section 3 of~~
6 ~~this act~~ Section 4003 of this title.

7 I. Upon issuance of an adverse determination on a prior
8 authorization request under subsection B of this section, the
9 contracted entity shall provide the requesting provider, within
10 seventy-two (72) hours of receipt of such issuance, with reasonable
11 opportunity to participate in a peer-to-peer review process with a
12 provider who practices in the same specialty, but not necessarily
13 the same sub-specialty, and who has experience treating the same
14 population as the patient on whose behalf the request is submitted;
15 provided, however, if the requesting provider determines the
16 services to be clinically urgent, the contracted entity shall
17 provide such opportunity within twenty-four (24) hours of receipt of
18 such issuance. Services not covered under the state Medicaid
19 program for the particular patient shall not be subject to peer-to-
20 peer review.

21 J. The Authority shall ensure that a provider offers to provide
22 to a member in a timely manner services authorized by a contracted
23 entity.

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

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

6 2. Require contracted entities to provide ~~a prompt~~ an
7 opportunity for peer-to-peer conversations with ~~licensed~~ Oklahoma-
8 licensed clinical staff of the same or similar specialty ~~which shall~~
9 ~~include, but not be limited to, Oklahoma-licensed clinical staff~~
10 ~~upon~~ within twenty-four (24) hours of the adverse determination; and

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

13 SECTION 6. AMENDATORY 56 O.S. 2021, Section 4002.7, as
14 amended by Section 11, Chapter 395, O.S.L. 2022 (56 O.S. Supp. 2023,
15 Section 4002.7), is amended to read as follows:

16 Section 4002.7 A. The Oklahoma Health Care Authority shall
17 establish requirements for fair processing and adjudication of
18 claims that ensure prompt reimbursement of providers by contracted
19 entities. A contracted entity shall comply with all such
20 requirements.

21 B. A contracted entity shall process a clean claim in the time
22 frame provided by Section 1219 of Title 36 of the Oklahoma Statutes
23 and no less than ninety percent (90%) of all clean claims shall be
24 paid within fourteen (14) days of submission to the contracted

1 entity. A clean claim that is not processed within the time frame
2 provided by Section 1219 of Title 36 of the Oklahoma Statutes shall
3 bear simple interest at the monthly rate of one and one-half percent
4 (1.5%) payable to the provider. A claim filed by a provider within
5 six (6) months of the date the item or service was furnished to a
6 member shall be considered timely. If a claim meets the definition
7 of a clean claim, the contracted entity shall not request medical
8 records of the member prior to paying the claim. Once a claim has
9 been paid, the contracted entity may request medical records if
10 additional documentation is needed to review the claim for medical
11 necessity.

12 C. In the case of a denial of a claim including, but not
13 limited to, a denial on the basis of the level of emergency care
14 indicated on the claim, or in the case of a downcoded claim, the
15 contracted entity shall establish a process by which the provider
16 may identify and provide such additional information as may be
17 necessary to substantiate the claim. Any such claim denial or
18 downcode shall include the following:

- 19 1. A detailed explanation of the basis for the denial; and
20 2. A detailed description of the additional information
21 necessary to substantiate the claim.

22 D. Postpayment audits by a contracted entity shall be subject
23 to the following requirements:

24

1 1. Subject to paragraph 2 of this subsection, insofar as a
2 contracted entity conducts postpayment audits, the contracted entity
3 shall employ the postpayment audit process determined by the
4 Authority;

5 2. The Authority shall establish a limit, not to exceed three
6 percent (3%), on the percentage of claims with respect to which
7 postpayment audits may be conducted by a contracted entity for
8 health care items and services furnished by a provider in a plan
9 year; and

10 3. The Authority shall provide for the imposition of financial
11 penalties under such contract in the case of any contracted entity
12 with respect to which the Authority determines has a claims denial
13 error rate of greater than five percent (5%). The Authority shall
14 establish the amount of financial penalties and the time frame under
15 which such penalties shall be imposed on contracted entities under
16 this paragraph, in no case less than annually.

17 E. A contracted entity may only apply readmission penalties
18 pursuant to rules promulgated by the Oklahoma Health Care Authority
19 Board. The Board shall promulgate rules establishing a program to
20 reduce potentially preventable readmissions. The program shall use
21 a nationally recognized tool, establish a base measurement year and
22 a performance year, and provide for risk-adjustment based on the
23 population of the state Medicaid program covered by the contracted
24 entities.

1 SECTION 7. AMENDATORY 56 O.S. 2021, Section 4002.12, as
2 last amended by Section 1, Chapter 308, O.S.L. 2023 (56 O.S. Supp.
3 2023, Section 4002.12), is amended to read as follows:

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

13 1. For an item or service provided by a participating provider
14 who is in the network of the contracted entity, one hundred percent
15 (100%) of the reimbursement rate for the applicable service in the
16 applicable fee schedule of the Authority; or

17 2. For an item or service provided by a non-participating
18 provider or a provider who is not in the network of the contracted
19 entity, ninety percent (90%) of the reimbursement rate for the
20 applicable service in the applicable fee schedule of the Authority
21 as of January 1, 2021.

22 B. A contracted entity shall offer value-based payment
23 arrangements to all providers in its network capable of entering
24 into value-based payment arrangements. Such arrangements shall be

1 optional for the provider but shall be tied to reimbursement
2 incentives when quality metrics are met. The quality measures used
3 by a contracted entity to determine reimbursement amounts to
4 providers in value-based payment arrangements shall align with the
5 quality measures of the Authority for contracted entities.
6 Reimbursement under a value-based arrangement shall be in addition
7 to the minimum rate established in Section 4002.3a of this title or
8 one hundred percent (100%) of the minimum rate floor, whichever is
9 greater.

10 C. Notwithstanding any other provision of this section, the
11 Authority shall comply with payment methodologies required by
12 federal law or regulation for specific types of providers including,
13 but not limited to, Federally Qualified Health Centers, rural health
14 clinics, pharmacies, Indian Health Care Providers and emergency
15 services.

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

23 E. The Oklahoma Health Care Authority shall establish minimum
24 rates of reimbursement from contracted entities to Certified

1 Community Behavioral Health Clinic (CCBHC) providers who elect
2 alternative payment arrangements equal to the prospective payment
3 system rate under the Medicaid State Plan.

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

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

10 H. Coverage for Medicaid ground transportation services by
11 licensed Oklahoma emergency medical services shall be reimbursed at
12 no less than the published Medicaid rates as set by the Authority.
13 All currently published Medicaid Healthcare Common Procedure Coding
14 System (HCPCS) codes paid by the Authority shall continue to be paid
15 by the contracted entity. The contracted entity shall comply with
16 all reimbursement policies established by the Authority for the
17 ambulance providers. Contracted entities shall accept the modifiers
18 established by the Centers for Medicare and Medicaid Services
19 currently in use by Medicare at the time of the transport of a
20 member that is dually eligible for Medicare and Medicaid.

21 I. 1. The rate paid to participating pharmacy providers is
22 independent of subsection A of this section and shall be the same as
23 the fee-for-service rate employed by the Authority for the Medicaid
24 program as stated in the payment methodology ~~at~~ in OAC 317:30-5-78,

1 unless the participating pharmacy provider elects to enter into
2 other alternative payment agreements.

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

7 J. Notwithstanding any other provision of this section,
8 anesthesia shall continue to be reimbursed equal to or greater than
9 the ~~Anesthesia Fee Schedule~~ anesthesia fee schedule established by
10 the Authority as of January 1, 2021. Anesthesia providers may also
11 enter into value-based payment arrangements under this section or
12 alternative payment arrangements for services furnished to Medicaid
13 members.

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

18 L. Capitation rates established by the Oklahoma Health Care
19 Authority and paid to contracted entities under capitated contracts
20 shall be updated annually and in accordance with 42 C.F.R., Section
21 438.3. Capitation rates shall be approved as actuarially sound as
22 determined by the Centers for Medicare and Medicaid Services in
23 accordance with 42 C.F.R., Section 438.4 and the following:
24

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

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

7 M. The Authority may establish a symmetric risk corridor for
8 contracted entities.

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

13 O. 1. The Authority shall, through the financial reporting
14 required under subsection G of Section 4002.12b of this title,
15 determine the percentage of health care expenses by each contracted
16 entity on primary care services.

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

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

SECTION 8. 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."

Passed the House of Representatives the 25th day of April, 2024.

Presiding Officer of the House of
Representatives

Passed the Senate the day of , 2024.

Presiding Officer of the Senate

1 ENGROSSED SENATE
2 BILL NO. 1675

By: McCortney of the Senate

3 and

4 McEntire of the House
5

6 An Act relating to the state Medicaid program;
7 amending Section 3, Chapter 395, O.S.L. 2022 (56 O.S.
8 Supp. 2023, Section 4002.3a), which relates to
9 capitated contracts for delivery of Medicaid
10 services; extending certain deadlines; amending 56
11 O.S. 2021, Section 4002.4, as amended by Section 7,
12 Chapter 395, O.S.L. 2022 (56 O.S. Supp. 2023, Section
13 4002.4), which relates to network adequacy standards
14 for contracted entities; imposing certain deadline on
15 credentialing or recredentialing by contracted
16 entities; amending 56 O.S. 2021, Section 4002.6, as
17 last amended by Section 2, Chapter 331, O.S.L. 2023
18 (56 O.S. Supp. 2023, Section 4002.6), which relates
19 to requirements for prior authorizations; modifying
20 and adding deadlines for certain determinations and
21 reviews; requiring certain reviews to be conducted by
22 Oklahoma-licensed clinical staff; amending 56 O.S.
23 2021, Section 4002.7, as amended by Section 11,
24 Chapter 395, O.S.L. 2022 (56 O.S. Supp. 2023, Section
4002.7), which relates to requirements for processing
and adjudicating claims; expanding certain provisions
to include downgraded claims; specifying certain
limit on claims subject to postpayment audits;
amending 56 O.S. 2021, Section 4002.12, as last
amended by Section 1, Chapter 308, O.S.L. 2023 (56
O.S. Supp. 2023, Section 4002.12), which relates to
minimum rates of reimbursement; extending certain
deadline; updating statutory references; updating
statutory language; and declaring an emergency.

23 BE IT ENACTED BY THE PEOPLE OF THE STATE OF OKLAHOMA:
24

SECTION 9. AMENDATORY Section 3, Chapter 395, O.S.L.

2022 (56 O.S. Supp. 2023, Section 4002.3a), is amended to read as follows:

Section 4002.3a. A. 1. The Oklahoma Health Care Authority (OHCA) shall enter into capitated contracts with contracted entities for the delivery of Medicaid services as specified in ~~this act~~ the Ensuring Access to Medicaid Act to transform the delivery system of the state Medicaid program for the Medicaid populations listed in this section.

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

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

- a. pregnant women,
- b. children,
- c. deemed newborns under 42 C.F.R., Section 435.117,
- d. parents and caretaker relatives, and
- e. the expansion population.

1 2. The Authority shall specify the services to be covered in
2 the request for proposals referenced in paragraph 1 of this
3 subsection. Capitated contracts referenced in this subsection shall
4 cover all Medicaid services other than dental services including:

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

7 (1) primary care,

8 (2) inpatient and outpatient services, and

9 (3) emergency room services,

10 b. behavioral health services, and

11 c. prescription drug services.

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

14 4. Subject to the requirements and approval of the Centers for
15 Medicare and Medicaid Services, the implementation of the program
16 shall be no later than ~~October 1, 2023~~ April 1, 2024.

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

20 a. pregnant women,

21 b. children,

22 c. parents and caretaker relatives,

23 d. the expansion population, and

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

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

3. Subject to the requirements and approval of the Centers for
Medicare and Medicaid Services, the implementation of the program
shall be no later than ~~October 1, 2023~~ April 1, 2024.

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

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

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

4. Subject to the requirements and approval of the Centers for
Medicare and Medicaid Services, the implementation of the program
shall be no later than ~~October 1, 2023~~ April 1, 2024.

1 E. The Authority shall not implement the transformation of the
2 Medicaid delivery system until it receives written confirmation from
3 the Centers for Medicare and Medicaid Services that a managed care
4 directed payment program utilizing average commercial rate
5 methodology for hospital services under the Supplemental Hospital
6 Offset Payment Program has been approved for Year 1 of the
7 transformation and will be included in the budget neutrality cap
8 baseline spending level for purposes of Oklahoma's 1115 waiver
9 renewal; provided, however, nothing in this section shall prohibit
10 the Authority from exploring alternative opportunities with the
11 Centers for Medicare and Medicaid Services to maximize the average
12 commercial rate benefit.

13 SECTION 10. AMENDATORY 56 O.S. 2021, Section 4002.4, as
14 amended by Section 7, Chapter 395, O.S.L. 2022 (56 O.S. Supp. 2023,
15 Section 4002.4), is amended to read as follows:

16 Section 4002.4. A. The Oklahoma Health Care Authority shall
17 develop network adequacy standards for all contracted entities that,
18 at a minimum, meet the requirements of 42 C.F.R., Sections 438.3 and
19 438.68. Network adequacy standards established under this
20 subsection shall include distance and time standards and shall be
21 designed to ensure members covered by the contracted entities who
22 reside in health professional shortage areas (HPSAs) designated
23 under Section 332(a)(1) of the Public Health Service Act (42 U.S.C.,
24 Section 254e(a)(1)) have access to in-person health care and

1 telehealth services with providers, especially adult and pediatric
2 primary care practitioners.

3 B. The Authority shall require all contracted entities to offer
4 or extend contracts with all essential community providers, all
5 providers who receive directed payments in accordance with 42
6 C.F.R., Part 438 and such other providers as the Authority may
7 specify. The Authority shall establish such requirements as may be
8 necessary to prohibit contracted entities from excluding essential
9 community providers, providers who receive directed payments in
10 accordance with 42 C.F.R., Part 438 and such other providers as the
11 Authority may specify from contracts with contracted entities.

12 C. To ensure models of care are developed to meet the needs of
13 Medicaid members, each contracted entity must contract with at least
14 one local Oklahoma provider organization for a model of care
15 containing care coordination, care management, utilization
16 management, disease management, network management, or another model
17 of care as approved by the Authority. Such contractual arrangements
18 must be in place within twelve (12) months of the effective date of
19 the contracts awarded pursuant to the requests for proposals
20 authorized by ~~Section 3 of this act~~ Section 4002.3a of this title.

21 D. All contracted entities shall formally credential and
22 recredential network providers at a frequency required by a single,
23 consolidated provider enrollment and credentialing process
24 established by the Authority in accordance with 42 C.F.R., Section

1 438.214. A contracted entity shall complete credentialing or
2 recredentialing of a provider within sixty (60) calendar days of
3 receipt of a completed application.

4 E. All contracted entities shall be accredited in accordance
5 with 45 C.F.R., Section 156.275 by an accrediting entity recognized
6 by the United States Department of Health and Human Services.

7 F. 1. If the Authority awards a capitated contract to a
8 provider-led entity for the urban region under ~~Section 4 of this act~~
9 Section 4002.3b of this title, the provider-led entity shall expand
10 its coverage area to every county of this state within the time
11 frame set by the Authority under subsection E of ~~Section 4 of this~~
12 ~~act~~ Section 4002.3b of this title.

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

21 SECTION 11. AMENDATORY 56 O.S. 2021, Section 4002.6, as
22 last amended by Section 2, Chapter 331, O.S.L. 2023 (56 O.S. Supp.
23 2023, Section 4002.6), is amended to read as follows:
24

1 Section 4002.6. A. A contracted entity shall meet all
2 requirements established by the Oklahoma Health Care Authority
3 pertaining to prior authorizations. The Authority shall establish
4 requirements that ensure timely determinations by contracted
5 entities when prior authorizations are required including expedited
6 review in urgent and emergent cases that at a minimum meet the
7 criteria of this section.

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

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

22 D. A contracted entity shall make a determination on a request
23 for services for a hospitalized member including, but not limited
24 to, acute care inpatient services or equipment necessary to

1 discharge the member from an inpatient facility within ~~one (1)~~
2 ~~business day~~ twenty-four (24) hours of receipt of the request.

3 E. Notwithstanding the provisions of subsection C of this
4 section, a contracted entity shall make a determination on a request
5 as expeditiously as necessary and, in any event, within twenty-four
6 (24) hours of receipt of the request for service if adhering to the
7 provisions of subsection C or D of this section could jeopardize the
8 member's life, health or ability to attain, maintain or regain
9 maximum function. In the event of a medically emergent matter, the
10 contracted entity shall not impose limitations on providers in
11 coordination of post-emergent stabilization health care including
12 pre-certification or prior authorization.

13 F. Notwithstanding any other provision of this section, a
14 contracted entity shall make a determination on a request for
15 inpatient behavioral health services within twenty-four (24) hours
16 of receipt of the request.

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

1 H. A contracted entity shall make a determination on a request
2 for coverage of biomarker testing in accordance with ~~Section 3 of~~
3 ~~this act~~ Section 4003 of this title.

4 I. Upon issuance of an adverse determination on a prior
5 authorization request under subsection B of this section, the
6 contracted entity shall provide the requesting provider, within
7 seventy-two (72) hours of receipt of such issuance, with reasonable
8 opportunity to participate in a peer-to-peer review process with a
9 provider who practices in the same specialty, but not necessarily
10 the same sub-specialty, and who has experience treating the same
11 population as the patient on whose behalf the request is submitted;
12 provided, however, if the requesting provider determines the
13 services to be clinically urgent, the contracted entity shall
14 provide such opportunity within twenty-four (24) hours of receipt of
15 such issuance. Services not covered under the state Medicaid
16 program for the particular patient shall not be subject to peer-to-
17 peer review.

18 J. The Authority shall ensure that a provider offers to provide
19 to a member in a timely manner services authorized by a contracted
20 entity.

21 K. The Authority shall establish requirements for both internal
22 and external reviews and appeals of adverse determinations on prior
23 authorization requests or claims that, at a minimum:
24

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

3 2. Require contracted entities to provide ~~a prompt~~ an
4 opportunity for peer-to-peer conversations with ~~licensed~~ Oklahoma-
5 licensed clinical staff of the same or similar specialty ~~which shall~~
6 ~~include, but not be limited to, Oklahoma-licensed clinical staff~~
7 upon within twenty-four (24) hours of the adverse determination; and

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

10 SECTION 12. AMENDATORY 56 O.S. 2021, Section 4002.7, as
11 amended by Section 11, Chapter 395, O.S.L. 2022 (56 O.S. Supp. 2023,
12 Section 4002.7), is amended to read as follows:

13 Section 4002.7. A. The Oklahoma Health Care Authority shall
14 establish requirements for fair processing and adjudication of
15 claims that ensure prompt reimbursement of providers by contracted
16 entities. A contracted entity shall comply with all such
17 requirements.

18 B. A contracted entity shall process a clean claim in the time
19 frame provided by Section 1219 of Title 36 of the Oklahoma Statutes
20 and no less than ninety percent (90%) of all clean claims shall be
21 paid within fourteen (14) days of submission to the contracted
22 entity. A clean claim that is not processed within the time frame
23 provided by Section 1219 of Title 36 of the Oklahoma Statutes shall
24 bear simple interest at the monthly rate of one and one-half percent

1 (1.5%) payable to the provider. A claim filed by a provider within
2 six (6) months of the date the item or service was furnished to a
3 member shall be considered timely. If a claim meets the definition
4 of a clean claim, the contracted entity shall not request medical
5 records of the member prior to paying the claim. Once a claim has
6 been paid, the contracted entity may request medical records if
7 additional documentation is needed to review the claim for medical
8 necessity.

9 C. In the case of a denial of a claim including, but not
10 limited to, a denial on the basis of the level of emergency care
11 indicated on the claim, or in the case of a downgraded claim, the
12 contracted entity shall establish a process by which the provider
13 may identify and provide such additional information as may be
14 necessary to substantiate the claim. Any such claim denial or
15 downgrade shall include the following:

- 16 1. A detailed explanation of the basis for the denial; and
17 2. A detailed description of the additional information
18 necessary to substantiate the claim.

19 D. Postpayment audits by a contracted entity shall be subject
20 to the following requirements:

- 21 1. Subject to paragraph 2 of this subsection, insofar as a
22 contracted entity conducts postpayment audits, the contracted entity
23 shall employ the postpayment audit process determined by the
24 Authority;

1 2. The Authority shall establish a limit, not to exceed three
2 percent (3%), on the percentage of claims with respect to which
3 postpayment audits may be conducted by a contracted entity for
4 health care items and services furnished by a provider in a plan
5 year; and

6 3. The Authority shall provide for the imposition of financial
7 penalties under such contract in the case of any contracted entity
8 with respect to which the Authority determines has a claims denial
9 error rate of greater than five percent (5%). The Authority shall
10 establish the amount of financial penalties and the time frame under
11 which such penalties shall be imposed on contracted entities under
12 this paragraph, in no case less than annually.

13 E. A contracted entity may only apply readmission penalties
14 pursuant to rules promulgated by the Oklahoma Health Care Authority
15 Board. The Board shall promulgate rules establishing a program to
16 reduce potentially preventable readmissions. The program shall use
17 a nationally recognized tool, establish a base measurement year and
18 a performance year, and provide for risk-adjustment based on the
19 population of the state Medicaid program covered by the contracted
20 entities.

21 SECTION 13. AMENDATORY 56 O.S. 2021, Section 4002.12, as
22 last amended by Section 1, Chapter 308, O.S.L. 2023 (56 O.S. Supp.
23 2023, Section 4002.12), is amended to read as follows:
24

1 Section 4002.12. A. Until July 1, ~~2026~~ 2027, the Oklahoma
2 Health Care Authority shall establish minimum rates of reimbursement
3 from contracted entities to providers who elect not to enter into
4 value-based payment arrangements under subsection B of this section
5 or other alternative payment agreements for health care items and
6 services furnished by such providers to enrollees of the state
7 Medicaid program. Except as provided by subsection I of this
8 section, until July 1, ~~2026~~ 2027, such reimbursement rates shall be
9 equal to or greater than:

10 1. For an item or service provided by a participating provider
11 who is in the network of the contracted entity, one hundred percent
12 (100%) of the reimbursement rate for the applicable service in the
13 applicable fee schedule of the Authority; or

14 2. For an item or service provided by a non-participating
15 provider or a provider who is not in the network of the contracted
16 entity, ninety percent (90%) of the reimbursement rate for the
17 applicable service in the applicable fee schedule of the Authority
18 as of January 1, 2021.

19 B. A contracted entity shall offer value-based payment
20 arrangements to all providers in its network capable of entering
21 into value-based payment arrangements. Such arrangements shall be
22 optional for the provider but shall be tied to reimbursement
23 incentives when quality metrics are met. The quality measures used
24 by a contracted entity to determine reimbursement amounts to

1 providers in value-based payment arrangements shall align with the
2 quality measures of the Authority for contracted entities.

3 C. Notwithstanding any other provision of this section, the
4 Authority shall comply with payment methodologies required by
5 federal law or regulation for specific types of providers including,
6 but not limited to, Federally Qualified Health Centers, rural health
7 clinics, pharmacies, Indian Health Care Providers and emergency
8 services.

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

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

21 F. The Authority shall establish an incentive payment under the
22 Supplemental Hospital Offset Payment Program that is determined by
23 value-based outcomes for providers other than hospitals.
24

1 G. Psychologist reimbursement shall reflect outcomes.

2 Reimbursement shall not be limited to therapy and shall include but
3 not be limited to testing and assessment.

4 H. Coverage for Medicaid ground transportation services by
5 licensed Oklahoma emergency medical services shall be reimbursed at
6 no less than the published Medicaid rates as set by the Authority.
7 All currently published Medicaid Healthcare Common Procedure Coding
8 System (HCPCS) codes paid by the Authority shall continue to be paid
9 by the contracted entity. The contracted entity shall comply with
10 all reimbursement policies established by the Authority for the
11 ambulance providers. Contracted entities shall accept the modifiers
12 established by the Centers for Medicare and Medicaid Services
13 currently in use by Medicare at the time of the transport of a
14 member that is dually eligible for Medicare and Medicaid.

15 I. 1. The rate paid to participating pharmacy providers is
16 independent of subsection A of this section and shall be the same as
17 the fee-for-service rate employed by the Authority for the Medicaid
18 program as stated in the payment methodology ~~at~~ in OAC 317:30-5-78,
19 unless the participating pharmacy provider elects to enter into
20 other alternative payment agreements.

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

1 J. Notwithstanding any other provision of this section,
2 anesthesia shall continue to be reimbursed equal to or greater than
3 the ~~Anesthesia Fee Schedule~~ anesthesia fee schedule established by
4 the Authority as of January 1, 2021. Anesthesia providers may also
5 enter into value-based payment arrangements under this section or
6 alternative payment arrangements for services furnished to Medicaid
7 members.

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

12 L. Capitation rates established by the Oklahoma Health Care
13 Authority and paid to contracted entities under capitated contracts
14 shall be updated annually and in accordance with 42 C.F.R., Section
15 438.3. Capitation rates shall be approved as actuarially sound as
16 determined by the Centers for Medicare and Medicaid Services in
17 accordance with 42 C.F.R., Section 438.4 and the following:

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

21 2. Capitation rates shall be risk-adjusted and shall include a
22 portion that is at risk for achievement of quality and outcomes
23 measures.
24

1 M. The Authority may establish a symmetric risk corridor for
2 contracted entities.

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

7 O. 1. The Authority shall, through the financial reporting
8 required under subsection G of Section 4002.12b of this title,
9 determine the percentage of health care expenses by each contracted
10 entity on primary care services.

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

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

19 SECTION 14. It being immediately necessary for the preservation
20 of the public peace, health or safety, an emergency is hereby
21 declared to exist, by reason whereof this act shall take effect and
22 be in full force from and after its passage and approval.

1 Passed the Senate the 7th day of March, 2024.

2
3 _____
4 Presiding Officer of the Senate

5 Passed the House of Representatives the ____ day of _____,
6 2024.

7
8 _____
9 Presiding Officer of the House
10 of Representatives