

COMMITTEE AMENDMENT

HOUSE OF REPRESENTATIVES
State of Oklahoma

SPEAKER:

CHAIR:

I move to amend SB1675 _____
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

Adopted: _____

Amendment submitted by: Marcus McEntire _____

Reading Clerk

1 STATE OF OKLAHOMA

2 2nd Session of the 59th Legislature (2024)

3 PROPOSED SUBCOMMITTEE
4 SUBSTITUTE
5 FOR ENGROSSED
6 SENATE BILL NO. 1675

By: McCortney of the Senate

and

McEntire of the House

7
8
9 PROPOSED SUBCOMMITTEE SUBSTITUTE

10 An Act relating to the state Medicaid program;
11 amending 56 O.S. 2021, Section 4002.2, as last
12 amended by Section 1, Chapter 334, O.S.L. 2022 (56
13 O.S. Supp. 2023, Section 4002.2), which relates to
14 definitions in the Ensuring Access to Medicaid Act;
15 adding a definition; amending Section 3, Chapter 395,
16 O.S.L. 2022 (56 O.S. Supp. 2023, Section 4002.3a),
17 which relates to capitated contracts for delivery of
18 Medicaid services; amending Section 4, Chapter 395,
19 O.S.L. 2022 (56 O.S. Supp. 2023, Section 4002.3b),
20 which relates to capitated contracts; including a
21 certain entity; extending certain deadlines; amending
22 56 O.S. 2021, Section 4002.4, as amended by Section
23 7, Chapter 395, O.S.L. 2022 (56 O.S. Supp. 2023,
24 Section 4002.4), which relates to network adequacy
standards for contracted entities; imposing certain
deadline on credentialing or recredentialing by
contracted entities; amending 56 O.S. 2021, Section
4002.6, as last amended by Section 2, Chapter 331,
O.S.L. 2023 (56 O.S. Supp. 2023, Section 4002.6),
which relates to requirements for prior
authorizations; modifying and adding deadlines for
certain determinations and reviews; requiring certain
reviews to be conducted by Oklahoma-licensed clinical
staff; amending 56 O.S. 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 downcoded

1 claims; specifying certain limit on claims subject to
2 postpayment audits; amending 56 O.S. 2021, Section
3 4002.12, as last amended by Section 1, Chapter 308,
4 O.S.L. 2023 (56 O.S. Supp. 2023, Section 4002.12),
5 which relates to minimum rates of reimbursement;
6 extending certain deadline; updating statutory
7 references; updating statutory language; and
8 declaring an emergency.

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

10 SECTION 1. AMENDATORY 56 O.S. 2021, Section 4002.2, as
11 last amended by Section 1, Chapter 334, O.S.L. 2022 (56 O.S. Supp.
12 2023, Section 4002.2), is amended to read as follows:

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

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

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

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

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

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

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

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

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

22 8. "Contracted entity" means an organization or entity that
23 enters into or will enter into a capitated contract with the
24 Oklahoma Health Care Authority for the delivery of services

1 specified in the Ensuring Access to Medicaid Act that will assume
2 financial risk, operational accountability, and statewide or
3 regional functionality as defined in the Ensuring Access to Medicaid
4 Act in managing comprehensive health outcomes of Medicaid members.
5 For purposes of the Ensuring Access to Medicaid Act, the term
6 contracted entity includes an accountable care organization, a
7 provider-led entity, a commercial plan, a dental benefit manager, or
8 any other entity as determined by the Authority;

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

12 10. "Essential community provider" means:

- 13 a. a Federally Qualified Health Center,
- 14 b. a community mental health center,
- 15 c. an Indian Health Care Provider,
- 16 d. a rural health clinic,
- 17 e. a state-operated mental health hospital,
- 18 f. a long-term care hospital serving children (LTCH-C),
- 19 g. a teaching hospital owned, jointly owned, or
20 affiliated with and designated by the University
21 Hospitals Authority, University Hospitals Trust,
22 Oklahoma State University Medical Authority, or
23 Oklahoma State University Medical Trust,

24

- 1 h. a provider employed by or contracted with, or
2 otherwise a member of the faculty practice plan of:
3 (1) a public, accredited medical school in this
4 state, or
5 (2) a hospital or health care entity directly or
6 indirectly owned or operated by the University
7 Hospitals Trust or the Oklahoma State University
8 Medical Trust,
- 9 i. a county department of health or city-county health
10 department,
- 11 j. a comprehensive community addiction recovery center,
- 12 k. a hospital licensed by the State of Oklahoma including
13 all hospitals participating in the Supplemental
14 Hospital Offset Payment Program,
- 15 l. a Certified Community Behavioral Health Clinic
16 (CCBHC),
- 17 m. a provider employed by or contracted with a primary
18 care residency program accredited by the Accreditation
19 Council for Graduate Medical Education,
- 20 n. any additional Medicaid provider as approved by the
21 Authority if the provider either offers services that
22 are not available from any other provider within a
23 reasonable access standard or provides a substantial
24 share of the total units of a particular service

1 utilized by Medicaid members within the region during
2 the last three (3) years, and the combined capacity of
3 other service providers in the region is insufficient
4 to meet the total needs of the Medicaid members,

5 o. a pharmacy or pharmacist, or

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

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

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

19 13. "Local Oklahoma provider organization" means any state
20 provider association, accountable care organization, Certified
21 Community Behavioral Health Clinic, Federally Qualified Health
22 Center, Native American tribe or tribal association, hospital or
23 health system, academic medical institution, currently practicing
24

1 licensed provider, or other local Oklahoma provider organization as
2 approved by the Authority;

3 14. "Medical necessity" has the same meaning as ~~provided by~~
4 ~~rules promulgated by the Oklahoma Health Care Authority Board~~
5 "medically necessary" in Section 6592 of Title 36 of the Oklahoma
6 Statutes;

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

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

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

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

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

24 ~~(1)~~ A. have experience serving Medicaid members and:

1 ~~(a)~~ 1. are licensed in this state as
2 physicians, physician assistants, nurse
3 practitioners, certified nurse-midwives, or
4 certified registered nurse anesthetists,

5 ~~(b)~~ 2. at least one board member is a licensed
6 behavioral health provider, or

7 ~~(e)~~ 3. are employed by:

8 ~~i.~~ (a) a hospital or other medical
9 facility licensed by this state and
10 operating in this state, or

11 ~~ii.~~ (b) an inpatient or outpatient mental
12 health or substance abuse treatment
13 facility or program licensed or
14 certified by this state and operating
15 in this state,

16 ~~(2)~~ B. represent the providers or facilities
17 described in division (1) of this subparagraph
18 including, but not limited to, individuals who
19 are employed by a statewide provider association,
20 or

21 ~~(3)~~ C. are nonclinical administrators of clinical
22 practices serving Medicaid members;

23 18. "Provider-owned entity" means an organization or entity
24 that a majority of the entity's ownership is held by Medicaid

1 providers in this state or is held by an entity that directly or
2 indirectly owns or is under common ownership with Medicaid providers
3 in this state;

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

6 ~~19.~~ 20. "Urban region" means:

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

10 b. all counties that are contiguous to the counties
11 described in subparagraph a of this paragraph,
12 combined into one region.

13 SECTION 2. AMENDATORY Section 3, Chapter 395, O.S.L.
14 2022 (56 O.S. Supp. 2023, Section 4002.3a), is amended to read as
15 follows:

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

22 2. Unless expressly authorized by the Legislature, the
23 Authority shall not issue any request for proposals or enter into
24

1 any contract to transform the delivery system for the aged, blind,
2 and disabled populations eligible for SoonerCare.

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

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

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

- 17 a. physical health services including, but not limited
18 to:
 - 19 (1) primary care,
 - 20 (2) inpatient and outpatient services, and
 - 21 (3) emergency room services,
- 22 b. behavioral health services, and
- 23 c. prescription drug services.

24

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

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

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

- 9 a. pregnant women,
- 10 b. children,
- 11 c. parents and caretaker relatives,
- 12 d. the expansion population, and
- 13 e. members of the Children's Specialty Plan as provided
14 by subsection D of this section.

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

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

21 D. 1. Either as part of the request for proposals referenced
22 in subsection B of this section or as a separate request for
23 proposals, the Authority shall issue a request for proposals to
24

1 enter into public-private partnerships with one contracted entity to
2 administer a Children's Specialty Plan.

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

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

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

13 E. The Authority shall not implement the transformation of the
14 Medicaid delivery system until it receives written confirmation from
15 the Centers for Medicare and Medicaid Services that a managed care
16 directed payment program utilizing average commercial rate
17 methodology for hospital services under the Supplemental Hospital
18 Offset Payment Program has been approved for Year 1 of the
19 transformation and will be included in the budget neutrality cap
20 baseline spending level for purposes of Oklahoma's 1115 waiver
21 renewal; provided, however, nothing in this section shall prohibit
22 the Authority from exploring alternative opportunities with the
23 Centers for Medicare and Medicaid Services to maximize the average
24 commercial rate benefit.

1 SECTION 3. AMENDATORY Section 4, Chapter 395, O.S.L.
2 2022 (56 O.S. Supp. 2023, Section 4002.3b), is amended to read as
3 follows:

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

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

11 C. The Authority shall award no less than ~~three~~ four statewide
12 capitated contracts to provide comprehensive integrated health
13 services including, but not limited to, medical, behavioral health,
14 and pharmacy services and no less than two statewide capitated
15 contracts to provide dental coverage to Medicaid members as
16 specified in Section ~~3~~ 4002.3a of this ~~act~~ title. At least one
17 statewide capitated contract must be a provider-owned entity.

18 D. 1. Except as specified in paragraph 2 of this subsection,
19 at least one capitated contract to provide statewide coverage to
20 Medicaid members shall be awarded to a provider-owned entity and at
21 least one capitated contract to provide statewide coverage to
22 Medicaid members shall be awarded to a provider-led entity, as long
23 as the provider-led entity submits a responsive reply to the
24

1 Authority's request for proposals demonstrating ability to fulfill
2 the contract requirements.

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

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

- 16 a. broad provider participation in ownership and
17 governance structure,
- 18 b. demonstrated experience in care coordination and care
19 management for Medicaid members across a variety of
20 service types including, but not limited to, primary
21 care and behavioral health,
- 22 c. demonstrated experience in Medicare or Medicaid
23 accountable care organizations or other Medicare or
24 Medicaid alternative payment models, Medicare or

1 Medicaid value-based payment arrangements, or Medicare
2 or Medicaid risk-sharing arrangements including, but
3 not limited to, innovation models of the Center for
4 Medicare and Medicaid Innovation of the Centers for
5 Medicare and Medicaid Services, or value-based payment
6 arrangements or risk-sharing arrangements in the
7 commercial health care market, and

8 d. other relevant factors identified by the Authority.

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

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

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

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

1 G. At the end of the contracting period, the Authority shall
2 solicit and award new contracts as provided by this section and
3 Section ~~3~~ 2 of this act.

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

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

12 Section 4002.4 A. The Oklahoma Health Care Authority shall
13 develop network adequacy standards for all contracted entities that,
14 at a minimum, meet the requirements of 42 C.F.R., Sections 438.3 and
15 438.68. Network adequacy standards established under this
16 subsection shall include distance and time standards and shall be
17 designed to ensure members covered by the contracted entities who
18 reside in health professional shortage areas (HPSAs) designated
19 under Section 332(a)(1) of the Public Health Service Act (42 U.S.C.,
20 Section 254e(a)(1)) have access to in-person health care and
21 telehealth services with providers, especially adult and pediatric
22 primary care practitioners.

23 B. The Authority shall require all contracted entities to offer
24 or extend contracts with all essential community providers, all

1 providers who receive directed payments in accordance with 42
2 C.F.R., Part 438 and such other providers as the Authority may
3 specify. The Authority shall establish such requirements as may be
4 necessary to prohibit contracted entities from excluding essential
5 community providers, providers who receive directed payments in
6 accordance with 42 C.F.R., Part 438 and such other providers as the
7 Authority may specify from contracts with contracted entities.

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

17 D. All contracted entities shall formally credential and
18 recredential network providers at a frequency required by a single,
19 consolidated provider enrollment and credentialing process
20 established by the Authority in accordance with 42 C.F.R., Section
21 438.214. A contracted entity shall complete credentialing or
22 recredentialing of a provider within sixty (60) calendar days of
23 receipt of a completed application.

24

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

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

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

18 SECTION 5. AMENDATORY 56 O.S. 2021, Section 4002.6, as
19 last amended by Section 2, Chapter 331, O.S.L. 2023 (56 O.S. Supp.
20 2023, Section 4002.6), is amended to read as follows:

21 Section 4002.6 A. A contracted entity shall meet all
22 requirements established by the Oklahoma Health Care Authority
23 pertaining to prior authorizations. The Authority shall establish
24 requirements that ensure timely determinations by contracted

1 entities when prior authorizations are required including expedited
2 review in urgent and emergent cases that at a minimum meet the
3 criteria of this section.

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

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

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

23 E. Notwithstanding the provisions of subsection C of this
24 section, a contracted entity shall make a determination on a request

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

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

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

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

22 I. Upon issuance of an adverse determination on a prior
23 authorization request under subsection B of this section, the
24 contracted entity shall provide the requesting provider, within

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

12 J. The Authority shall ensure that a provider offers to provide
13 to a member in a timely manner services authorized by a contracted
14 entity.

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

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

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

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

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

6 Section 4002.7 A. The Oklahoma Health Care Authority shall
7 establish requirements for fair processing and adjudication of
8 claims that ensure prompt reimbursement of providers by contracted
9 entities. A contracted entity shall comply with all such
10 requirements.

11 B. A contracted entity shall process a clean claim in the time
12 frame provided by Section 1219 of Title 36 of the Oklahoma Statutes
13 and no less than ninety percent (90%) of all clean claims shall be
14 paid within fourteen (14) days of submission to the contracted
15 entity. A clean claim that is not processed within the time frame
16 provided by Section 1219 of Title 36 of the Oklahoma Statutes shall
17 bear simple interest at the monthly rate of one and one-half percent
18 (1.5%) payable to the provider. A claim filed by a provider within
19 six (6) months of the date the item or service was furnished to a
20 member shall be considered timely. If a claim meets the definition
21 of a clean claim, the contracted entity shall not request medical
22 records of the member prior to paying the claim. Once a claim has
23 been paid, the contracted entity may request medical records if
24

1 additional documentation is needed to review the claim for medical
2 necessity.

3 C. In the case of a denial of a claim including, but not
4 limited to, a denial on the basis of the level of emergency care
5 indicated on the claim, or in the case of a downcoded claim, the
6 contracted entity shall establish a process by which the provider
7 may identify and provide such additional information as may be
8 necessary to substantiate the claim. Any such claim denial or
9 downcode shall include the following:

- 10 1. A detailed explanation of the basis for the denial; and
- 11 2. A detailed description of the additional information
12 necessary to substantiate the claim.

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

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

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

24

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

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

16 SECTION 7. AMENDATORY 56 O.S. 2021, Section 4002.12, as
17 last amended by Section 1, Chapter 308, O.S.L. 2023 (56 O.S. Supp.
18 2023, Section 4002.12), is amended to read as follows:

19 Section 4002.12 A. ~~Until July 1, 2026, the~~ The Oklahoma Health
20 Care Authority shall establish minimum rates of reimbursement from
21 contracted entities to providers who elect not to enter into value-
22 based payment arrangements under subsection B of this section or
23 other alternative payment agreements for health care items and
24 services furnished by such providers to enrollees of the state

1 Medicaid program. Except as provided by subsection I of this
2 section ~~until July 1, 2026,~~ such reimbursement rates shall be equal
3 to or greater than:

4 1. For an item or service provided by a participating provider
5 who is in the network of the contracted entity, one hundred percent
6 (100%) of the reimbursement rate for the applicable service in the
7 applicable fee schedule of the Authority; or

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

13 B. A contracted entity shall offer value-based payment
14 arrangements to all providers in its network capable of entering
15 into value-based payment arrangements. Such arrangements shall be
16 optional for the provider but shall be tied to reimbursement
17 incentives when quality metrics are met. The quality measures used
18 by a contracted entity to determine reimbursement amounts to
19 providers in value-based payment arrangements shall align with the
20 quality measures of the Authority for contracted entities.

21 Reimbursement under a value-based arrangement will be in addition to
22 the minimum rate established in Section 4002.3a of this title or one
23 hundred percent (100%) of minimum rate floor, whichever is greater.

24

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

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

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

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

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

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

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

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

22 J. Notwithstanding any other provision of this section,
23 anesthesia shall continue to be reimbursed equal to or greater than
24 the ~~Anesthesia Fee Schedule~~ anesthesia fee schedule established by

1 the Authority as of January 1, 2021. Anesthesia providers may also
2 enter into value-based payment arrangements under this section or
3 alternative payment arrangements for services furnished to Medicaid
4 members.

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

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

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

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

21 M. The Authority may establish a symmetric risk corridor for
22 contracted entities.

23 N. The Authority shall establish a process for annual recovery
24 of funds from, or assessment of penalties on, contracted entities

1 that do not meet the medical loss ratio standards stipulated in
2 Section 4002.5 of this title.

3 0. 1. The Authority shall, through the financial reporting
4 required under subsection G of Section 4002.12b of this title,
5 determine the percentage of health care expenses by each contracted
6 entity on primary care services.

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

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

15 SECTION 8. It being immediately necessary for the preservation
16 of the public peace, health or safety, an emergency is hereby
17 declared to exist, by reason whereof this act shall take effect and
18 be in full force from and after its passage and approval.

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