

STATE OF OKLAHOMA

2nd Session of the 60th Legislature (2026)

COMMITTEE SUBSTITUTE
FOR

HOUSE BILL NO. 3650

By: Stinson

COMMITTEE SUBSTITUTE

An Act relating to poor persons; amending 56 O.S. 2021, Section 4002.12, as last amended by Section 7, Chapter 448, O.S.L. 2024 (56 O.S. Supp. 2025, Section 4002.12), which relates to minimum rates of reimbursement; extending deadlines; and providing an effective date.

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

SECTION 1. AMENDATORY 56 O.S. 2021, Section 4002.12, as last amended by Section 7, Chapter 448, O.S.L. 2024 (56 O.S. Supp. 2025, Section 4002.12), is amended to read as follows:

Section 4002.12. A. Until July 1, ~~2027~~ 2028, the Oklahoma Health Care Authority shall establish minimum rates of reimbursement from contracted entities to providers who elect not to enter into value-based payment arrangements under subsection B of this section or other alternative payment agreements for health care items and services furnished by such providers to enrollees of the state Medicaid program. Except as provided by subsection I of this

1 section, until July 1, ~~2027~~ 2028, such reimbursement rates shall be
2 equal to or greater than:

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

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

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

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

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

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

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

18 G. Psychologist reimbursement shall reflect outcomes.
19 Reimbursement shall not be limited to therapy and shall include but
20 not be limited to testing and assessment.

21 H. Coverage for Medicaid ground transportation services by
22 licensed Oklahoma emergency medical services shall be reimbursed at
23 no less than the published Medicaid rates as set by the Authority.
24 All currently published Medicaid Healthcare Common Procedure Coding

1 System (HCPCS) codes paid by the Authority shall continue to be paid
2 by the contracted entity. The contracted entity shall comply with
3 all reimbursement policies established by the Authority for the
4 ambulance providers. Contracted entities shall accept the modifiers
5 established by the Centers for Medicare and Medicaid Services
6 currently in use by Medicare at the time of the transport of a
7 member that is dually eligible for Medicare and Medicaid.

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

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

18 J. Notwithstanding any other provision of this section,
19 anesthesia shall continue to be reimbursed equal to or greater than
20 the anesthesia fee schedule established by the Authority as of
21 January 1, 2021. Anesthesia providers may also enter into value-
22 based payment arrangements under this section or alternative payment
23 arrangements for services furnished to Medicaid members.

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

5 L. Capitation rates established by the Oklahoma Health Care
6 Authority and paid to contracted entities under capitated contracts
7 shall be updated annually and in accordance with 42 C.F.R., Section
8 438.3. Capitation rates shall be approved as actuarially sound as
9 determined by the Centers for Medicare and Medicaid Services in
10 accordance with 42 C.F.R., Section 438.4 and the following:

11 1. Actuarial calculations must include utilization and
12 expenditure assumptions consistent with industry and local
13 standards; and

14 2. Capitation rates shall be risk-adjusted and shall include a
15 portion that is at risk for achievement of quality and outcomes
16 measures.

17 M. The Authority may establish a symmetric risk corridor for
18 contracted entities.

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

23 O. 1. The Authority shall, through the financial reporting
24 required under subsection G of Section 4002.12b of this title,

1 determine the percentage of health care expenses by each contracted
2 entity on primary care services.

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

7 3. The Authority shall monitor the primary care spending of
8 each contracted entity and require each contracted entity to
9 maintain the level of spending on primary care services stipulated
10 in paragraph 2 of this subsection.

11 SECTION 2. This act shall become effective November 1, 2026.

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