HOUSE OF REPRESENTATIVES - FLOOR VERSION

STATE OF OKLAHOMA

1st Session of the 57th Legislature (2019)

HOUSE BILL 1278 By: Lawson

AS INTRODUCED

An Act relating to community-based service providers; amending 56 O.S. 2011, Section 2004, as amended by Section 242, Chapter 304, O.S.L. 2012 (56 O.S. Supp. 2018, Section 2004), which relates to funding for community-based service providers; establishing requirements for reductions in planned services; mandating prospective application of reductions; exempting prior authorized services; requiring minimum amount of services for new members; and providing an effective date.

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

SECTION 1. AMENDATORY 56 O.S. 2011, Section 2004, as amended by Section 242, Chapter 304, O.S.L. 2012 (56 O.S. Supp. 2018, Section 2004), is amended to read as follows:

Section 2004. A. As used in this section:

1. "Additional costs reimbursed to the contracted community-based service provider" means both state and federal Medicaid expenditures in excess of the aggregate amounts that would otherwise have been paid to a contracted community-based service provider

including, but not limited to, costs related to an audit required by the Department of Human Services, the Oklahoma Health Care Authority, or the State Auditor and Inspector;

2. "Contracted community-based service provider" means any entity contracted by the Department of Human Services, the Oklahoma Health Care Authority, or any private person providing the support, or promotion of support, for a service recipient to remain in such person's home or residence and shall include, but not be limited to, entities and persons providing personal support, professional support, case management, transportation services, and services through a Home and Community-Based Waiver or ~~Advantage~~ ADvantage Waiver as defined by Title XIX of the Social Security Act, Section 1915 (C);

3. "Gross receipts" means annual gross revenues received in compensation for services rendered by a contracted community-based service provider, but shall not include any amount received by a contracted service provider as a charitable contribution or any amount received by a provider as compensation for services rendered that is not reimbursed; and

4. "Medicaid" means the medical assistance program established in Title XIX of the federal Social Security Act and administered in the state by the Oklahoma Health Care Authority.

B. Information required to calculate the Home-Based Support Quality Assurance Assessment provided in Section 4002 of Title 68 of

the Oklahoma Statutes for a contracted community-based service provider shall be reported to the Oklahoma Health Care Authority using forms supplied by the Oklahoma Health Care Authority.

C. The payment of the Home-Based Quality Assurance Assessment by contracted community-based service providers shall be an allowable cost for Medicaid reimbursement purposes.

D. 1. There is hereby created in the State Treasury a revolving fund for the Oklahoma Health Care Authority to be designated the "Home-Based Quality Assurance Fund".

2. The fund shall be a continuing fund, not subject to fiscal year limitations, and shall consist of:

a. all monies received by the Oklahoma Health Care Authority pursuant to Section 4002 of Title 68 of the Oklahoma Statutes and otherwise specified or authorized by law,

b. monies received by the Oklahoma Health Care Authority due to federal financial participation pursuant to Title XIX of the Social Security Act, and

c. interest attributable to investment of money in the Home-Based Quality Assurance Fund.

3. All monies accruing to the credit of the fund are appropriated and may be budgeted and expended by the Oklahoma Health Care Authority for Medicaid services provided by contracted community-based service providers.

4. Expenditures from the fund shall be made upon warrants issued by the State Treasurer against claims filed as prescribed by law with the Director of the Office of Management and Enterprise Services for approval and payment.

5. The Home-Based Quality Assurance Fund and the programs specified in this section that are funded by revenues collected from the Home-Based Quality Assurance Assessment pursuant to this section are exempt from budgetary cuts, reductions, or eliminations.

6. The reimbursement rate for contracted community-based service providers shall be made in accordance with Oklahoma's Medicaid reimbursement rate methodology and the provisions of this section.

7. No contracted community-based service provider shall be guaranteed, expressly or otherwise, that any additional costs reimbursed to the contracted community-based service provider shall equal or exceed the amount of the Home-Based Quality Assurance Assessment paid by the contracted community-based service provider.

E. 1. If federal financial participation pursuant to Title XIX of the Social Security Act is not available to the Oklahoma Medicaid program, for purposes of matching expenditures from the Home-Based Quality Assurance Fund at the approved federal medical assistance percentage for the applicable fiscal year, the Home-Based Quality Assurance Assessment shall be null and void as of the date of the

nonavailability of such federal funding, through and during any period of nonavailability.

2. If this section is invalidated by any court of last resort under circumstances not covered in subsection F of this section, the Home-Based Quality Assurance Assessment shall be void as of the effective date of that invalidation.

3. If the Home-Based Quality Assurance Assessment is determined to be void for any of the reasons enumerated in this section, any Home-Based Quality Assurance Assessment assessed and collected for any periods after such invalidation shall be returned in full within sixty (60) days by the Oklahoma Health Care Authority to the contracted community-based service provider from which it was collected.

4. If any provision of this section, or the application thereof, is determined by any court of last resort to prevent the state from obtaining federal financial participation in the state Medicaid program, such provision shall be deemed void as of the date of the nonavailability of such federal funding and through and during any period of nonavailability.

F. 1. If any provision of this section or the application thereof shall be adjudged to be invalid by any court of last resort, such judgment shall not affect, impair or invalidate the remaining provisions of the section, but shall be confined in its operation to the provision thereof directly involved in the controversy in which

such judgment was rendered. The applicability of such provision to other persons or circumstances shall not be affected thereby.

2. This subsection shall not apply to any judgment that affects the rate of the Home-Based Quality Assurance Assessment, its applicability to all contracted community-based service providers in the state, the usage of the fee for the purposes prescribed in this section, or the ability of the Oklahoma Health Care Authority to obtain full federal participation to match its expenditures of the proceeds of the assessment.

G. The Oklahoma Health Care Authority shall:

1. Promulgate rules for the implementation and enforcement of the Home-Based Quality Assurance Assessment established by this section; and

2. Provide for administrative penalties in the event a contracted community-based service provider fails to:

a. submit the Home-Based Quality Assurance Assessment,

b. submit the Home-Based Quality Assurance Assessment in a timely manner, or

c. submit reports as required by this section or by the Oklahoma Health Care Authority.

H. Beginning November 1, 2019, any reductions in planned services shall comply with the following:

1. All reductions in planned services shall be applied prospectively with the new plan year and not changed retroactively;

2. The updated algorithms shall not affect any prior authorized service; and

3. Any new participant through the ADvantage Waiver program shall receive a minimum of Two Hundred (200) units of case management services to allow for the development of two plans within the same year.

SECTION 2. This act shall become effective November 1, 2019.

COMMITTEE REPORT BY: COMMITTEE ON HEALTH SERVICES AND LONG-TERM CARE, dated 02/13/2019 - DO PASS.