

1 ENGROSSED HOUSE AMENDMENT
TO
2 ENGROSSED SENATE BILL NO. 1337 By: McCortney of the Senate
3 and
4 McEntire of the House
5
6

7 [state Medicaid program - legislative intent -
8 definitions - capitated contracts - requests for
9 proposals - award of contracts to provider-led
10 entities - enrollment and assignment of Medicaid
11 members - network adequacy standards - essential
12 community providers - Oklahoma Health Care Authority
13 monitoring, oversight, and enforcement - duties of
14 contracted entities - determination and review
15 requirements - processing and adjudication of claims
16 - readiness review - scorecard - provider
17 reimbursement - capitation rates - supplemental
18 payments - reports - advisory committee - measures
19 and goals - federal approval - recodification -
20 repealers - codification - effective date]
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24

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

19 "An Act relating to the state Medicaid program;
20 providing legislative intent; amending 56 O.S. 2021,
21 Section 4002.2, which relates to the Ensuring Access
22 to Medicaid Act; defining terms; modifying terms;
23 requiring the Oklahoma Health Care Authority to
24 enter into certain contracts; requiring legislative
authorization for certain contracts; requiring the
Oklahoma Health Care Authority to request certain
partnerships; allowing agency specifications on
covered services; creating compliance deadline;
requiring the Oklahoma Health Care Authority to

1 receive certain confirmation from certain federal
2 agency; requiring certain payment programs;
3 requiring certain bids; allowing certain entities to
4 be awarded contracts; requiring a certain number of
5 contracts to be awarded; requiring certain
6 qualifications on certain contracts; creating
7 exemption to qualifications requirement; requiring
8 the Oklahoma Health Care Authority to develop
9 certain methodologies; providing factors for
10 developed methodologies; allowing extension of
11 contracts in certain situations; requiring new
12 contracts to be made after the end of the contract
13 term; requiring the agency to provide members
14 certain assistance; amending 56 O.S. 2021, Section
15 4002.4, which relates to network adequacy standards;
16 requiring network adequacy standards; removing
17 certain requirements; modifying terminology; setting
18 certain timelines; requiring Oklahoma Health Care
19 Authority to develop certain contract terms;
20 requiring contracted entities to meet all
21 requirements; requiring Oklahoma Health Care
22 Authority to develop certain methods; amending 56
23 O.S. 2021, Section 4002.5, which relates to
24 administrative responsibilities; requiring
contracted entities to hold certain administrative
responsibilities; requiring contracted entities to
hold certificates of authority; requiring certain
governance structures; requiring certain
notifications; requiring the use of certain drug
formulary; ensuring broad access to pharmacies;
requiring the submission of data; amending 56 O.S.
2021, Section 4002.6, which relates to
authorizations; making certain authorization
requirements; implementing certain deadlines for
certain requests; requiring agency implementation of
requirements for internal and external reviews;
amending 56 O.S. 2021, Section 4002.7, which relates
to requirements; creating claims adjudication
standards; modifying terms; amending 56 O.S. 2021,
Section 4002.8, which relates to procedures;
modifying terms; amending 56 O.S. 2021, Section
4002.10, which relates to readiness reviews;
updating terms; removing certain requirements;
amending 56 O.S. 2021, Section 4002.11, which
relates to delivery model transition scorecards;
updating timelines; modifying terms; amending 56
O.S. 2021, Section 4002.12, which relates to minimum

1 rates; providing deadline for compliance; modifying
2 terms; removing certain requirements; setting
3 certain requirements for certain services; setting
4 reimbursement standards; setting dental contracted
5 entity standards; requiring agency to ensure
6 sustainability of system; requiring agency to
7 preserve funding of certain programs; requiring
8 agency reporting; amending 56 O.S. 2021, Section
9 4002.13, which relates to the Quality Advisory
10 Committee; renaming committee; granting duties and
11 powers; requesting recommendations from committee;
12 creating defined measures for program and capitated
13 contracts; amending 56 O.S. 2021, Section 4004,
14 which relates to federal approval; requiring the
15 seeking of approval for implementation of the
16 Ensuring Access to Medicaid Act; amending 63 O.S.
17 2021, Section 5009, which relates to the Oklahoma
18 Medicaid program; removing certain requirements;
19 updating entity designation; amending 63 O.S. 2021,
20 Section 5009.2, which relates to the Advisory
21 Committee on Medical Care for Public Assistance
22 Recipients; updating membership requirements;
23 amending 36 O.S. 2021, Section 312.1, which relates
24 to the revolving funds; updating fiscal
apportionment; providing for recodification;
repealing 56 O.S. 2021, Sections 1010.2, 1010.3,
1010.4, and 1010.5, which relate to the Oklahoma
Medicaid Program Reform Act of 2003; repealing 56
O.S. 2021, Sections 4002.3 and 4002.9, which relate
to the Ensuring Access to Medicaid Act; repealing 63
O.S. 2021, Sections 5009.5, 5011, and 5028, which
relate to the Oklahoma Health Care Authority Act;
providing for codification; providing an effective
date; declaring an emergency; and providing
contingency effective date.

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

20 SECTION 1. NEW LAW A new section of law to be codified
21 in the Oklahoma Statutes as Section 4002.1a of Title 56, unless
22 there is created a duplication in numbering, reads as follows:

23 It is the intent of the Legislature to transform the state's
24 current Medicaid program to provide budget predictability for the

1 taxpayers of this state while ensuring quality care to those in
2 need. The state Medicaid program shall be designed to achieve the
3 following goals:

4 1. Improve health outcomes for Medicaid members and the state
5 as a whole;

6 2. Ensure budget predictability through shared risk and
7 accountability;

8 3. Ensure access to care, quality measures, and member
9 satisfaction;

10 4. Ensure efficient and cost-effective administrative systems
11 and structures; and

12 5. Ensure a sustainable delivery system that is a provider-led
13 effort and that is operated and managed by providers to the maximum
14 extent possible.

15 SECTION 2. AMENDATORY 56 O.S. 2021, Section 4002.2, is
16 amended to read as follows:

17 Section 4002.2 As used in ~~this act~~ the Ensuring Access to
18 Medicaid Act:

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

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

24

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

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

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

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

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

23 ~~4.~~ 7. "Commercial plan" means an organization or entity that
24 undertakes to provide or arrange for the delivery of health care

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 this act that will assume financial risk, operational
7 accountability, and statewide or regional functionality as defined
8 in this act in managing comprehensive health outcomes of Medicaid
9 members. For purposes of this act, the term contracted entity
10 includes an accountable care organization, a provider-led entity, a
11 commercial plan, a dental benefit manager, or any other entity as
12 determined by the Authority;

13 9. "Dental benefit manager" means an entity ~~under contract with~~
14 ~~the Oklahoma Health Care Authority to manage and deliver dental~~
15 ~~benefits and services to enrollees of the capitated managed care~~
16 ~~delivery model of the state Medicaid program~~ that handles claims
17 payment and prior authorizations and coordinates dental care with
18 participating providers and Medicaid members;

19 ~~5.~~ 10. "Essential community provider" ~~has the same meaning as~~
20 ~~provided by~~ means:

- 21 a. a Federally Qualified Health Center,
- 22 b. a community mental health center,
- 23 c. an Indian Health Care Provider,
- 24 d. a rural health clinic,

- 1 e. a state-operated mental health hospital,
- 2 f. a long-term care hospital serving children (LTCH-C),
- 3 g. a teaching hospital owned, jointly owned, or
- 4 affiliated with and designated by the University
- 5 Hospitals Authority, University Hospitals Trust,
- 6 Oklahoma State University Medical Authority, or
- 7 Oklahoma State University Medical Trust,
- 8 h. a provider employed by or contracted with, or
- 9 otherwise a member of the faculty practice plan of:
- 10 (1) a public, accredited medical school in this
- 11 state, or
- 12 (2) a hospital or health care entity directly or
- 13 indirectly owned or operated by the University
- 14 Hospitals Trust or the Oklahoma State University
- 15 Medical Trust,
- 16 i. a county department of health or city-county health
- 17 department,
- 18 j. a comprehensive community addiction recovery center,
- 19 k. any additional Medicaid provider as approved by the
- 20 Authority if the provider either offers services that
- 21 are not available from any other provider within a
- 22 reasonable access standard or provides a substantial
- 23 share of the total units of a particular service
- 24 utilized by Medicaid members within the region during

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

4 l. a hospital licensed by the State of Oklahoma,
5 including all hospitals participating in Section
6 3241.1 et. seq. of Title 63 of the Oklahoma Statutes,

7 m. Certified Community Behavioral Health Clinics
8 (CCBHCs), or

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

12 ~~6. "Managed care organization" means a health plan under~~
13 ~~contract with the Oklahoma Health Care Authority to participate in~~
14 ~~and deliver benefits and services to enrollees of the capitated~~
15 ~~managed care delivery model of the state Medicaid program;~~

16 ~~7.~~ 11. "Material change" includes, but is not limited to, any
17 change in overall business operations such as policy, process or
18 protocol which affects, or can reasonably be expected to affect,
19 more than five percent (5%) of enrollees or participating providers
20 of the contracted entity, managed care organization or dental
21 benefit manager;

22 ~~8.~~ 12. "Governing body" means a group of individuals appointed
23 by the contracted entity who approve policies, operations,
24 profit/loss ratios, executive employment decisions, and who have

1 overall responsibility for the operations of the contracted entity
2 of which they are appointed;

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

10 14. "Medical necessity" has the same meaning as provided by
11 rules of promulgated by the Oklahoma Health Care Authority Board;

12 ~~9.~~ 15. "Participating provider" means a provider who has a
13 contract with or is employed by a ~~managed care organization~~
14 ~~contracted entity~~ or dental benefit manager to provide services to
15 ~~enrollees under the capitated managed care delivery model of the~~
16 ~~state Medicaid program~~ Medicaid members as authorized by this act;
17 and

18 ~~10.~~ 16. "Provider" means a health care or dental provider
19 licensed or certified in this state or a provider that meets the
20 Authority's provider enrollment criteria to contract with the
21 Authority as a SoonerCare provider;

22 17. "Provider-led entity" means an organization or entity that
23 meets the following criteria:

24

1 a. a majority of the entity's ownership is held by
2 Medicaid providers in this state or is held by an
3 entity that directly or indirectly owns or is under
4 common ownership with Medicaid providers in this
5 state, or

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

8 (1) have experience serving Medicaid members and:

9 (a) are licensed in this state as physicians,
10 physician assistants, nurse practitioners,
11 certified nurse-midwives, or certified
12 registered nurse anesthetists,

13 (b) at least one board member is a licensed
14 behavioral health provider, or

15 (c) are employed by:

16 i. a hospital or other medical facility
17 licensed by this state and operating in
18 this state, or

19 ii. an inpatient or outpatient mental
20 health or substance abuse treatment
21 facility or program licensed or
22 certified by this state and operating
23 in this state,

1 (2) represent the providers or facilities described
2 in division (1) of this subparagraph including,
3 but not limited to, individuals who are employed
4 by a statewide provider association, or
5 (3) are nonclinical administrators of clinical
6 practices serving Medicaid members;

7 18. "Statewide" means all counties of this state including the
8 urban region; and

9 19. "Urban region" means all counties of this state with a
10 county population of not less than five hundred thousand (500,000)
11 according to the latest Federal Decennial Census, combined into one
12 region and the counties that are contiguous to the urban region.

13 SECTION 3. NEW LAW A new section of law to be codified
14 in the Oklahoma Statutes as Section 4002.3a of Title 56, unless
15 there is created a duplication in numbering, reads as follows:

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

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

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

- 6 a. pregnant women,
- 7 b. children,
- 8 c. deemed newborns,
- 9 d. parents and caretaker relatives, and
- 10 e. the expansion population.

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

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

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

1 4. The implementation of the program shall be no later than
2 October 1, 2023.

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

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

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

15 3. The implementation of the program shall be no later than
16 October 1, 2023.

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

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

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

5 4. The implementation of the program shall be no later than
6 October 1, 2023.

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

18 SECTION 4. NEW LAW A new section of law to be codified
19 in the Oklahoma Statutes as Section 4002.3b of Title 56, unless
20 there is created a duplication in numbering, reads as follows:

21 A. All capitated contracts shall be the result of requests for
22 proposals issued by the Oklahoma Health Care Authority and
23 submission of competitive bids by contracted entities pursuant to
24 the Oklahoma Central Purchasing Act.

1 B. Statewide capitated contracts may be awarded to any
2 contracted entity including, but not limited to, a provider-led
3 entity.

4 C. The Authority shall award no less than three statewide
5 capitated contracts to provide comprehensive integrated health
6 services including, but not limited to, medical, behavioral health,
7 and pharmacy services and no less than two capitated contracts to
8 provide dental coverage to Medicaid members as specified in Section
9 3 of this act.

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

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

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

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

- 3 a. broad provider participation in ownership and
4 governance structure,
- 5 b. demonstrated experience in care coordination and care
6 management for Medicaid members across a variety of
7 service types including, but not limited to, primary
8 care and behavioral health,
- 9 c. demonstrated experience in Medicare or Medicaid
10 accountable care organizations or other Medicare or
11 Medicaid alternative payment models, Medicare or
12 Medicaid value-based payment arrangements, or Medicare
13 or Medicaid risk-sharing arrangements including, but
14 not limited to, innovation models of the Center for
15 Medicare and Medicaid Innovation of the Centers for
16 Medicare and Medicaid Services, or value-based payment
17 arrangements or risk-sharing arrangements in the
18 commercial health care market, and
- 19 d. other relevant factors identified by the Authority.

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

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

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

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

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

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

18 SECTION 5. NEW LAW A new section of law to be codified
19 in the Oklahoma Statutes as Section 4002.3c of Title 56, unless
20 there is created a duplication in numbering, reads as follows:

21 A. The Oklahoma Health Care Authority shall require each
22 contracted entity to ensure that Medicaid members who do not elect a
23 primary care provider are assigned to a provider, prioritizing
24 existing patient-provider relationships.

1 B. The Authority shall develop and implement a process for
2 assignment of Medicaid members to contracted entities.

3 C. The Authority may only utilize an opt-in enrollment process
4 for the voluntary enrollment of American Indians and Alaska Natives.
5 Notwithstanding any other provision of this act, the Authority shall
6 comply with all Indian provisions associated with Medicaid managed
7 care, including, but not limited to, the Social Security Act,
8 1932(a)(2)(C), the American Recovery and Reinvestment Act of 2009,
9 P.L. 111-5 (Feb. 17, 2009), Section 5006, The Children's Health
10 Insurance Program Reauthorization Act of 2009, P.L. 111-3 (Feb. 4,
11 2009), and the Centers for Medicare and Medicaid Services (CMS)
12 managed care protections, 25 C.F.R., 438.14.

13 D. In the event of the termination of a capitated contract with
14 a contracted entity during the contract duration, the Authority
15 shall reassign members to a remaining contracted entity with
16 demonstrated performance and capability. If no remaining contracted
17 entity is able to assume management for such members, the Authority
18 may select another contracted entity by application, as specified in
19 rules promulgated by the Oklahoma Health Care Authority Board, if
20 the financial, operation, and performance requirements can be met,
21 at the discretion of the Authority.

22 SECTION 6. AMENDATORY 56 O.S. 2021, Section 4002.4, is
23 amended to read as follows:

1 Section 4002.4 A. The Oklahoma Health Care Authority shall
2 develop network adequacy standards for all ~~managed care~~
3 ~~organizations and dental benefit managers~~ contracted entities that,
4 at a minimum, meet the requirements of 42 C.F.R., Sections ~~438.14~~
5 438.3 and 438.68. ~~Network adequacy standards established under this~~
6 ~~subsection shall be designed to ensure enrollees covered by the~~
7 ~~managed care organizations and dental benefit managers who reside in~~
8 ~~health professional shortage areas (HPSAs) designated under Section~~
9 ~~332(a)(1) of the Public Health Service Act (42 U.S.C., Section~~
10 ~~254e(a)(1)) have access to in-person health care and telehealth~~
11 ~~services with providers, especially adult and pediatric primary care~~
12 ~~practitioners.~~

13 B. ~~All managed care organizations and dental benefit managers~~
14 ~~shall meet or exceed network adequacy standards established by the~~
15 ~~Authority under subsection A of this section to ensure sufficient~~
16 ~~access to providers for enrollees of the state Medicaid program.~~

17 C. ~~All managed care organizations and dental benefit managers~~
18 ~~shall contract to the extent possible and practicable~~ The Authority
19 shall require all contracted entities to offer or extend contracts
20 with all essential community providers, all providers who receive
21 directed payments in accordance with 42 C.F.R., Part 438 and such
22 other providers as the Authority may specify. The Authority shall
23 establish such requirements as may be necessary to prohibit
24 contracted entities from excluding essential community providers,

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 from contracts with contracted entities.

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

13 D. ~~All managed care organizations and dental benefit managers~~
14 contracted entities shall formally credential and recredential
15 network providers at a frequency required by a single, consolidated
16 provider enrollment and credentialing process established by the
17 Authority in accordance with 42 C.F.R., Section 438.214.

18 E. ~~All managed care organizations and dental benefit managers~~
19 contracted entities shall be accredited in accordance with 45
20 C.F.R., Section 156.275 by an accrediting entity recognized by the
21 United States Department of Health and Human Services.

22 F. 1. If the Oklahoma Health Care Authority awards a capitated
23 contract to a provider-led entity for the urban region under Section
24 4 of this act, the provider-led entity may, as provided by the

1 contract with the Authority, expand its coverage area beyond the
2 urban region to counties for which the provider-led entity can
3 demonstrate evidence of network adequacy as required under 42
4 C.F.R., Sections 438.3 and 438.68 and as approved by Authority. If
5 approved, the additional county or counties shall be added to the
6 urban region during the next open enrollment period.

7 2. As provided by Section 4 of this act and by the contract
8 with the Authority, the provider-led entity shall expand its
9 coverage area to every county of this state on a timeline set by the
10 Authority but no sooner than five (5) years from the date of initial
11 award of the capitated contract.

12 SECTION 7. NEW LAW A new section of law to be codified
13 in the Oklahoma Statutes as Section 4002.4a of Title 56, unless
14 there is created a duplication in numbering, reads as follows:

15 A. 1. The Oklahoma Health Care Authority shall develop
16 standard contract terms for contracted entities to include, but not
17 be limited to, all requirements stipulated by this act. The
18 Authority shall oversee and monitor performance of contracted
19 entities and shall enforce the terms of capitated contracts as
20 required by paragraph 2 of this subsection.

21 2. The Authority shall require each contracted entity to meet
22 all contractual and operational requirements as defined in the
23 requests for proposals issued pursuant to Section 3 of this act.
24 Such requirements shall include but not be limited to reimbursement

1 and capitation rates, insurance reserve requirements as specified by
2 the Insurance Department, acceptance of risk as defined by the
3 Authority, operational performance expectations including the
4 assessment of penalties, member marketing guidelines, other
5 applicable state and federal regulatory requirements, and all
6 requirements of this act including, but not limited to, the
7 requirements stipulated in this section.

8 B. The Authority shall develop methods to ensure program
9 integrity against provider fraud, waste, and abuse.

10 C. The Authority shall develop processes for providers and
11 Medicaid members to report violations by contracted entities of
12 applicable administrative rules, state laws, or federal laws.

13 SECTION 8. AMENDATORY 56 O.S. 2021, Section 4002.5, is
14 amended to read as follows:

15 Section 4002.5 A. A contracted entity shall be responsible for
16 all administrative functions for members enrolled in its plan
17 including, but not limited to, claims processing, authorization of
18 health services, care and case management, grievances and appeals,
19 and other necessary administrative services.

20 B. A contracted entity shall hold a certificate of authority as
21 a health maintenance organization issued by the Insurance
22 Department.

23 C. 1. To ensure providers have a voice in the direction and
24 operation of the contracted entities selected by the Oklahoma Health

1 Care Authority under Section 4 of this act, each contracted entity
2 shall have a shared governance structure that includes:

- 3 a. representatives of local Oklahoma provider
4 organizations who are Medicaid providers,
5 b. essential community providers, and
6 c. a representative from a teaching hospital owned,
7 jointly owned, or affiliated with and designated by
8 the University Hospitals Authority, University
9 Hospitals Trust, Oklahoma State University Medical
10 Authority, or Oklahoma State University Medical Trust.

11 2. No less than one-third (1/3) of the contracted entity's
12 board of directors shall be comprised of representatives of local
13 Oklahoma provider organizations.

14 3. No less than two members of the contracted entity's clinical
15 and quality committees shall be representatives of local Oklahoma
16 provider organizations, and the committees shall be chaired or co-
17 chaired by a representative of a local Oklahoma provider
18 organization.

19 D. A ~~managed care organization or dental benefit manager~~
20 contracted entity shall promptly notify the Authority of all ~~changes~~
21 ~~materially~~ material changes affecting the delivery of care or the
22 administration of its program.

1 ~~B. E.~~ A ~~managed care organization or dental benefit manager~~
2 contracted entity shall have a medical loss ratio that meets the
3 standards provided by 42 C.F.R., Section 438.8.

4 ~~C. F.~~ A ~~managed care organization or dental benefit manager~~
5 contracted entity shall provide patient data to a provider upon
6 request to the extent allowed under federal or state laws, rules or
7 regulations including, but not limited to, the Health Insurance
8 Portability and Accountability Act of 1996.

9 ~~D. G.~~ A ~~managed care organization or dental benefit manager~~
10 contracted entity or a subcontractor of ~~such managed care~~
11 ~~organization or dental benefit manager~~ a contracted entity shall not
12 enforce a policy or contract term with a provider that requires the
13 provider to contract for all products that are currently offered or
14 that may be offered in the future by the ~~managed care organization~~
15 ~~or dental benefit manager~~ contracted entity or subcontractor.

16 ~~E. H.~~ Nothing in this act or in a contract between the
17 Authority and a ~~managed care organization or dental benefit manager~~
18 contracted entity shall prohibit the ~~managed care organization or~~
19 ~~dental benefit manager~~ contracted entity from contracting with a
20 statewide or regional accountable care organization ~~to implement the~~
21 ~~capitated managed care delivery model of the state Medicaid program.~~

22 I. All contracted entities shall:

23 1. Use the same drug formulary, which shall be established by
24 the Authority; and

1 2. Ensure broad access to pharmacies including, but not limited
2 to, pharmacies contracted with covered entities under Section 340B
3 of the Public Health Service Act. Such access shall, at a minimum,
4 meet the requirements of the Patient's Right to Pharmacy Choice Act,
5 Section 6958 et seq. of Title 36 of the Oklahoma Statutes.

6 J. Each contracted entity and each participating provider shall
7 submit data through the state-designated entity for health
8 information exchange to ensure effective systems and connectivity to
9 support clinical coordination of care, the exchange of information,
10 and the availability of data to the Authority to manage the state
11 Medicaid program.

12 SECTION 9. AMENDATORY 56 O.S. 2021, Section 4002.6, is
13 amended to read as follows:

14 Section 4002.6 A. ~~A managed care organization~~ contracted
15 entity shall meet all requirements established by the Oklahoma
16 Health Care Authority pertaining to prior authorizations. The
17 Authority shall establish requirements that ensure timely
18 determinations by contracted entities when prior authorizations are
19 required including expedited review in urgent and emergent cases
20 that at a minimum meet the criteria of this section.

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

1 ~~B. Review and issue determinations made by a managed care~~
2 ~~organization or, as appropriate, by a dental benefit manager for~~
3 ~~prior authorization for care ordered by primary care or specialist~~
4 ~~providers shall be timely and shall occur in accordance with the~~
5 ~~following:~~

6 ~~1. Within seventy-two (72) hours of receipt of the~~

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

17 ~~2. Within one (1) business day of receipt of the.~~

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

23 ~~3. E. Notwithstanding the provisions of paragraphs 1 or 2 of~~
24 ~~this subsection C of this section, a contracted entity shall make a~~

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

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

16 ~~5. Within twenty-four (24) hours of receipt of the.~~

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 ~~managed care organization~~ contracted entity
21 shall not require prior authorization on any covered prescription
22 drug for which the Authority does not require prior authorization.

23 ~~C. H.~~ Upon issuance of an adverse determination on a prior
24 authorization request under subsection B of this section, the

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

14 ~~D.~~ I. The Authority shall ensure that a provider offers to
15 provide to an enrollee in a timely manner services authorized by a
16 managed care organization or dental benefit manager.

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

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

22 2. Require contracted entities to provide a prompt opportunity
23 for peer-to-peer conversations with licensed clinical staff of the
24

1 same or similar specialty which shall include, but not be limited
2 to, Oklahoma-licensed clinical staff upon adverse determination; and

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

5 SECTION 10. AMENDATORY 56 O.S. 2021, Section 4002.7, is
6 amended to read as follows:

7 Section 4002.7 ~~A managed care organization or dental benefit~~
8 ~~manager shall~~

9 A. The Oklahoma Health Care Authority shall establish
10 requirements for fair processing and adjudication of claims that
11 ensure prompt reimbursement of providers by contracted entities. A
12 contracted entity shall comply with the following requirements with
13 respect to processing and adjudication of claims for payment
14 submitted in good faith by providers for health care items and
15 services furnished by such providers to enrollees of the state
16 Medicaid program: all such requirements.

17 ~~1. B. A managed care organization or dental benefit manager~~
18 contracted entity shall process a clean claim in the time frame
19 provided by Section 1219 of Title 36 of the Oklahoma Statutes and no
20 less than ninety percent (90%) of all clean claims shall be paid
21 within fourteen (14) days of submission to the managed care
22 organization or dental benefit manager contracted entity. A clean
23 claim that is not processed within the time frame provided by
24 Section 1219 of Title 36 of the Oklahoma Statutes shall bear simple

1 interest at the monthly rate of one and one-half percent (1.5%)
2 payable to the provider. A claim filed by a provider within six (6)
3 months of the date the item or service was furnished to ~~an enrollee~~
4 a member shall be considered timely. If a claim meets the
5 definition of a clean claim, the ~~managed care organization or dental~~
6 ~~benefit manager~~ contracted entity shall not request medical records
7 of the ~~enrollee~~ member prior to paying the claim. Once a claim has
8 been paid, the ~~managed care organization or dental benefit manager~~
9 contracted entity may request medical records if additional
10 documentation is needed to review the claim for medical necessity~~7.~~

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

18 ~~a.~~ a

19 1. A detailed explanation of the basis for the denial~~7;~~ and

20 ~~b.~~ a

21 2. A detailed description of the additional information
22 necessary to substantiate the claim~~7.~~

23

24

1 3. D. Postpayment audits by a ~~managed care organization or~~
2 ~~dental benefit manager~~ contracted entity shall be subject to the
3 following requirements:

4 a. ~~subject~~

5 1. Subject to subparagraph b paragraph 2 of this ~~paragraph~~
6 subsection, insofar as a ~~managed care organization or dental benefit~~
7 ~~manager~~ contracted entity conducts postpayment audits, the ~~managed~~
8 ~~care organization or dental benefit manager~~ contracted entity shall
9 employ the postpayment audit process determined by the Authority~~;~~;

10 b. ~~the~~

11 2. The Authority shall establish a limit on the percentage of
12 claims with respect to which postpayment audits may be conducted by
13 a ~~managed care organization or dental benefit manager~~ contracted
14 entity for health care items and services furnished by a provider in
15 a plan year~~;~~ and

16 c. ~~the~~

17 3. The Authority shall provide for the imposition of financial
18 penalties under such contract in the case of any ~~managed care~~
19 ~~organization or dental benefit manager~~ contracted entity with
20 respect to which the Authority determines has a claims denial error
21 rate of greater than five percent (5%). The Authority shall
22 establish the amount of financial penalties and the time frame under
23 which such penalties shall be imposed on ~~managed care organizations~~

1 ~~and dental benefit managers~~ contracted entities under this
2 ~~subparagraph~~ paragraph, in no case less than annually; ~~and.~~

3 4. E. A ~~managed care organization~~ contracted entity may only
4 apply readmission penalties pursuant to rules promulgated by the
5 Oklahoma Health Care Authority Board. The Board shall promulgate
6 rules establishing a program to reduce potentially preventable
7 readmissions. The program shall use a nationally recognized tool,
8 establish a base measurement year and a performance year, and
9 provide for risk-adjustment based on the population of the state
10 Medicaid program covered by the ~~managed care organizations and~~
11 ~~dental benefit managers~~ contracted entities.

12 SECTION 11. AMENDATORY 56 O.S. 2021, Section 4002.8, is
13 amended to read as follows:

14 Section 4002.8 A. A ~~managed care organization or dental~~
15 ~~benefit manager~~ contracted entity shall utilize uniform procedures
16 established by the Authority under subsection B of this section for
17 the review and appeal of any adverse determination by the ~~managed~~
18 ~~care organization or dental benefit manager~~ contracted entity sought
19 by any enrollee or provider adversely affected by such
20 determination.

21 B. The Authority shall develop procedures for ~~enrollee~~
22 enrollees or providers to seek review by the ~~managed care~~
23 ~~organization or dental benefit manager~~ contracted entity of any
24 adverse determination made by the ~~managed care organization or~~

1 ~~dental benefit manager~~ contracted entity. A provider shall have six
2 (6) months from the receipt of a claim denial to file an appeal.

3 With respect to appeals of adverse determinations made by a ~~managed~~
4 ~~care organization or dental benefit manager~~ contracted entity on the
5 basis of medical necessity, the following requirements shall apply:

6 1. Medical review staff of the ~~managed care organization or~~
7 ~~dental benefit manager~~ contracted entity shall be licensed or
8 credentialed health care clinicians with relevant clinical training
9 or experience; and

10 2. All ~~managed care organizations and dental benefit managers~~
11 contracted entities shall use medical review staff for such appeals
12 and shall not use any automated claim review software or other
13 automated functionality for such appeals.

14 C. Upon receipt of notice from the ~~managed care organization or~~
15 ~~dental benefit manager~~ contracted entity that the adverse
16 determination has been upheld on appeal, the enrollee or provider
17 may request a fair hearing from the Authority. The Authority shall
18 develop procedures for fair hearings in accordance with 42 C.F.R.,
19 Part 431.

20 SECTION 12. AMENDATORY 56 O.S. 2021, Section 4002.10, is
21 amended to read as follows:

22 Section 4002.10 ~~A.~~ The Oklahoma Health Care Authority shall
23 require a ~~managed care organization or dental benefit manager~~ all
24 contracted entities to participate in a readiness review in

1 accordance with 42 C.F.R., Section 438.66. The readiness review
2 shall assess the ability and capacity of the ~~managed care~~
3 ~~organization or dental benefit manager~~ contracted entity to perform
4 satisfactorily in such areas as may be specified in 42 C.F.R.,
5 Section 438.66. ~~In addition, the readiness review shall assess~~
6 ~~whether:~~

7 1. ~~The managed care organization or dental benefit manager has~~
8 ~~entered into contracts with providers to the extent necessary to~~
9 ~~meet network adequacy standards prescribed by Section 4 of this act;~~

10 2. ~~The contracts described in paragraph 1 of this subsection~~
11 ~~offer, but do not require, value-based payment arrangements as~~
12 ~~provided by Section 12 of this act; and~~

13 3. ~~The managed care organization or dental benefit manager and~~
14 ~~the providers described in paragraph 1 of this subsection have~~
15 ~~established and tested data infrastructure such that exchange of~~
16 ~~patient data can reasonably be expected to occur within one hundred~~
17 ~~twenty (120) calendar days of execution of the transition of the~~
18 ~~delivery system described in subsection B of this section. The~~
19 ~~Authority shall assess its ability to facilitate the exchange of~~
20 ~~patient data, claims, coordination of benefits and other components~~
21 ~~of a managed care delivery model.~~

22 B. ~~The Oklahoma Health Care Authority may only execute the~~
23 ~~transition of the delivery system of the state Medicaid program to~~
24 ~~the capitated managed care delivery model of the state Medicaid~~

1 ~~program ninety (90) days after the Centers for Medicare and Medicaid~~
2 ~~Services has approved all contracts entered into between the~~
3 ~~Authority and all managed care organizations and dental benefit~~
4 ~~managers following submission of the readiness reviews to the~~
5 ~~Centers for Medicare and Medicaid Services.~~

6 SECTION 13. AMENDATORY 56 O.S. 2021, Section 4002.11, is
7 amended to read as follows:

8 Section 4002.11 No later than one (1) year following the
9 execution of the delivery model transition described in ~~Section 10~~
10 ~~of this act~~ the Ensuring Access to Medicaid Act, the Oklahoma Health
11 Care Authority shall create a scorecard that compares ~~managed care~~
12 ~~organizations~~ each contracted entity and separately compares each
13 dental benefit ~~managers~~ manager. The scorecard shall report the
14 average speed of authorizations of services, rates of denials of
15 Medicaid reimbursable services when a complete authorization request
16 is submitted in a timely manner, enrollee member satisfaction survey
17 results, provider satisfaction survey results, and such other
18 criteria as the Authority may require. The scorecard shall be
19 compiled quarterly and shall consist of the information specified in
20 this section from the prior ~~year~~ quarter. The Authority shall
21 provide the most recent quarterly scorecard to all initial ~~enrollees~~
22 members during enrollment choice counseling following the
23 eligibility determination and prior to initial enrollment. The
24 Authority shall provide the most recent quarterly scorecard to all

1 ~~enrollees~~ members at the beginning of each enrollment period. The
2 Authority shall publish each quarterly scorecard on its public
3 Internet website.

4 SECTION 14. AMENDATORY 56 O.S. 2021, Section 4002.12, is
5 amended to read as follows:

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

15 1. For an item or service provided by a participating provider
16 who is in the network of the managed care organization or dental
17 benefit manager, one hundred percent (100%) of the reimbursement
18 rate for the applicable service in the applicable fee schedule of
19 the Authority; or

20 2. For an item or service provided by a non-participating
21 provider or a provider who is not in the network of the managed care
22 organization or dental benefit manager, ninety percent (90%) of the
23 reimbursement rate for the applicable service in the applicable fee
24 schedule of the Authority as of January 1, 2021.

1 B. ~~A managed care organization or dental benefit manager~~
2 contracted entity shall offer value-based payment arrangements to
3 all providers in its network capable of entering into value-based
4 payment arrangements. Such arrangements shall be optional for the
5 provider but shall be tied to reimbursement incentives when quality
6 metrics are met. The quality measures used by a managed care
7 organization or dental benefit manager to determine reimbursement
8 amounts to providers in value-based payment arrangements shall align
9 with the quality measures of the Authority for ~~managed care~~
10 ~~organizations or dental benefit managers~~ contracted entities.

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

17 D. All rural health clinics (RHCs) shall be offered contracts
18 that will reimburse them using the methodology in place for each
19 specific RHC prior to January 1, 2023, including any and all annual
20 rate updates. Future RHC developments will be based on the federal
21 program rules and requirements, and this new commercially managed
22 Medicaid program will not interfere with the program as 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 is given flexibility to work with physicians
5 and other providers, not including hospitals, to design an incentive
6 payment in accordance with paragraph 1 of subsection C of Section
7 3241.3 of Title 63 of the Oklahoma Statutes that is determined by
8 value-based outcomes except for anesthesia which shall continue to
9 be paid at the Medicaid rate as of the passage of this act.

10 Physicians and providers may contract with multiple contracted
11 entities.

12 G. Psychologist reimbursement shall reflect outcomes and
13 include bill codes beyond reimbursement for therapy to be able to
14 obtain reimbursement for testing and assessment.

15 H. Coverage for Medicaid ground transportation services by
16 licensed Oklahoma emergency medical services should be reimbursed at
17 no less than the published Medicaid rates as set by the Authority.

18 All currently published Medicaid HCPC codes paid by OHCA will
19 continue to be paid by the contracted entity. The contracted entity
20 will continue to follow the reimbursement policies established by
21 the Authority for the ambulance providers. Such policies shall
22 include but are not limited to: emergency medical transportation not
23 being required for prior authorization; and the contracted entities

24

1 will accept the CMS modifiers currently in use by Medicare at the
2 time of the transport of a member that is a dual eligible.

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

7 J. Capitation rates established by the Oklahoma Health Care
8 Authority and paid to contracted entities under capitated contracts
9 shall be updated annually and in accordance with 42 C.F.R., Section
10 438.36(c) and approved as actuarially sound as determined by CMS in
11 accordance with 42 C.F.R., Section 438.4 and the following:

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

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

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

19 L. The Authority shall create a program for annual recovery by
20 the state a portion of funds from contracted entities when they
21 exceed their medical loss ratio.

22 SECTION 15. NEW LAW A new section of law to be codified
23 in the Oklahoma Statutes as Section 4002.12a of Title 56, unless
24 there is created a duplication in numbering, reads as follows:

1 Any dental managed care program shall include the following
2 components:

3 1. All contracted entities with a dental contract shall be
4 required to maintain a Medicaid Dental Advisory Committee, comprised
5 exclusively of Oklahoma-licensed dentists and specialists, to advise
6 contracted entities regarding quality measures in the dental managed
7 care program; and

8 2. Dental providers shall not be required to enter into
9 capitated contracts with a dental contracted entity.

10 SECTION 16. NEW LAW A new section of law to be codified
11 in the Oklahoma Statutes as Section 4002.12b of Title 56, unless
12 there is created a duplication in numbering, reads as follows:

13 A. The Oklahoma Health Care Authority shall ensure the
14 sustainability of the transformed Medicaid delivery system.

15 B. The Authority shall ensure that existing revenue sources
16 designated for the state share of Medicaid expenses are designed to
17 maximize federal matching funds for the benefit of providers and the
18 state.

19 C. The Authority shall develop a plan, utilizing waivers or
20 Medicaid state plan amendments as necessary, to preserve or increase
21 supplemental payments available to providers with existing revenue
22 sources as provided in the Oklahoma Statutes including, but not
23 limited to:

24

1 1. Hospitals that participate in the supplemental hospital
2 offset payment program as provided by Section 3241.3 of Title 63 of
3 the Oklahoma Statutes;

4 2. Hospitals in this state that have Level I trauma centers, as
5 defined by the American College of Surgeons, that provide inpatient
6 and outpatient services and are owned or operated by the University
7 Hospitals Trust, or affiliates or locations of those hospitals
8 designated by the Trust as part of the hospital trauma system; and

9 3. Providers employed by or contracted with, or otherwise a
10 member of the faculty practice plan of:

- 11 a. a public, accredited Oklahoma medical school, or
- 12 b. a hospital or health care entity directly or
13 indirectly owned or operated by the University
14 Hospitals Trust or the Oklahoma State University
15 Medical Trust.

16 D. Subject to approval by the Centers for Medicare and Medicaid
17 Services, the Authority shall preserve and, to the maximum extent
18 permissible under federal law, improve existing levels of funding
19 through directed payments or other mechanisms outside the capitated
20 rate to contracted entities, including, where applicable, the use of
21 a directed payment program with an average commercial rate
22 methodology, subject to approval by the Centers for Medicare and
23 Medicaid Services. The directed payment methodology shall be found
24

1 in Sections 3241.2 through 3241.4 of Title 63 of the Oklahoma
2 Statutes.

3 E. On or before January 31, 2023, the Authority shall submit a
4 report to the Oklahoma Health Care Authority Board, the Chair of the
5 Appropriations Committee of the Oklahoma State Senate, and the Chair
6 of the Appropriations and Budget Committee of the Oklahoma House of
7 Representatives that includes the Authority's plans to continue
8 supplemental payment programs and implement a managed care directed
9 payment program for hospital services that complies with the reforms
10 required by this act. If Medicaid-specific funding cannot be
11 maintained as currently implemented and authorized by state law, the
12 Authority shall propose to the Legislature any modifications
13 necessary to preserve supplemental payments and managed care
14 directed payments to prevent budgetary disruptions to providers.

15 F. The Authority shall submit a report to the Governor, the
16 President Pro Tempore of the Oklahoma State Senate and the Speaker
17 of the Oklahoma House of Representatives that includes at a minimum:

18 1. A description of the selection process of the contracted
19 entities;

20 2. Plans for enrollment of Medicaid members in health plans of
21 contracted entities;

22 3. Medicaid member network access standards;

23 4. Performance and quality metrics;

24

1 5. Maintenance of existing funding mechanisms described in this
2 section;

3 6. A description of the requirements and other provisions
4 included in capitated contracts; and

5 7. A full and complete copy of each executed capitated
6 contract.

7 SECTION 17. AMENDATORY 56 O.S. 2021, Section 4002.13, is
8 amended to read as follows:

9 Section 4002.13 A. ~~There is hereby created the MC~~ The Oklahoma
10 Health Care Authority shall establish a Medicaid Delivery System
11 Quality Advisory Committee for the purpose of performing the duties
12 specified in subsection B of this section.

13 B. The ~~primary power and duty of the~~ Committee shall ~~be~~ have
14 the power and duty to make recommendations to the Administrator of
15 the Oklahoma Health Care Authority and the Oklahoma Health Care
16 Authority Board on quality measures used by ~~managed care~~
17 ~~organizations and dental benefit managers~~ contracted entities in the
18 capitated ~~managed~~ care delivery model of the state Medicaid program.

19 C. 1. The Committee shall be comprised of members appointed by
20 the Administrator of the Oklahoma Health Care Authority. Members
21 shall serve at the pleasure of the Administrator.

22 2. A majority of the members shall be providers participating
23 in the capitated ~~managed~~ care delivery model of the state Medicaid
24 program, and such providers may include members of the Advisory

1 Committee on Medical Care for Public Assistance Recipients. Other
2 members shall include, but not be limited to, representatives of
3 hospitals and integrated health systems, other members of the health
4 care community, and members of the academic community having
5 subject-matter expertise in the field of health care or subfields of
6 health care, or other applicable fields including, but not limited
7 to, statistics, economics or public policy.

8 3. The Committee shall select from among its membership a chair
9 and vice chair.

10 ~~F.~~ D. 1. The Committee may meet as often as may be required in
11 order to perform the duties imposed on it.

12 2. A quorum of the Committee shall be required to approve any
13 final ~~action~~ recommendations of the Committee. A majority of the
14 members of the Committee shall constitute a quorum.

15 3. Meetings of the Committee shall be subject to the Oklahoma
16 Open Meeting Act.

17 ~~F.~~ E. Members of the Committee shall receive no compensation or
18 travel reimbursement.

19 ~~G.~~ F. The Oklahoma Health Care Authority shall provide staff
20 support to the Committee. To the extent allowed under federal or
21 state law, rules or regulations, the Authority, the State Department
22 of Health, the Department of Mental Health and Substance Abuse
23 Services and the Department of Human Services shall as requested
24 provide technical expertise, statistical information, and any other

1 information deemed necessary by the chair of the Committee to
2 perform the duties imposed on it.

3 SECTION 18. NEW LAW A new section of law to be codified
4 in the Oklahoma Statutes as Section 4002.14 of Title 56, unless
5 there is created a duplication in numbering, reads as follows:

6 A. The transformed delivery system of the state Medicaid
7 program and capitated contracts awarded under the transformed
8 delivery system shall be designed with uniform defined measures and
9 goals that are consistent across contracted entities including, but
10 not limited to, adjusted health outcomes, social determinants of
11 health, quality of care, member satisfaction, provider satisfaction,
12 access to care, network adequacy, and cost.

13 B. Prior to implementation of the transformed Medicaid delivery
14 system, each contracted entity shall use nationally recognized,
15 standardized provider quality metrics as established by the Oklahoma
16 Health Care Authority and, where applicable, may use additional
17 quality metrics if the measures are mutually agreed upon by the
18 Authority, the contracted entity, and participating providers. The
19 Authority shall develop processes for determining quality metrics
20 and cascading quality metrics from contracted entities to
21 subcontractors and providers.

22 C. The Authority may use consultants, organizations, or
23 measures used by health plans, the federal government, or other
24 states to develop effective measures for outcomes and quality

1 including, but not limited to, the National Committee for Quality
2 Assurance (NCQA) or the Healthcare Effectiveness Data and
3 Information Set (HEDIS) established by NCQA, the Physician
4 Consortium for Performance Improvement (PCPI) or any measures
5 developed by PCPI.

6 D. Each component of the quality metrics established by the
7 Authority shall be subject to specific accountability measures
8 including, but not limited to, penalties for noncompliance.

9 SECTION 19. AMENDATORY 56 O.S. 2021, Section 4004, is
10 amended to read as follows:

11 Section 4004. A. The Oklahoma Health Care Authority shall seek
12 any federal approval necessary to implement ~~this act~~ the Ensuring
13 Access to Medicaid Act. This shall include, but not be limited to,
14 submission to the Centers for Medicare and Medicaid Services of any
15 appropriate demonstration waiver application or Medicaid State Plan
16 amendment necessary to accomplish the requirements of this act
17 within the required time frames. Prior to implementation of the
18 managed care contracts, the Authority shall obtain federal approval
19 of a managed care directed payment program with an average
20 commercial rate methodology. The directed payment methodology shall
21 be found in Sections 3241.2 through 3241.4 of Title 63 of the
22 Oklahoma Statutes. Dental managed care shall be exempt from the
23 requirement of CMS approval of the directed payment program.
24

1 B. The Oklahoma Health Care Authority Board shall promulgate
2 rules to implement ~~this act~~ the Ensuring Access to Medicaid Act.

3 SECTION 20. AMENDATORY 63 O.S. 2021, Section 5009, is
4 amended to read as follows:

5 Section 5009. A. ~~On and after July 1, 1993, the Oklahoma~~
6 ~~Health Care Authority shall be the state entity designated by law to~~
7 ~~assume the responsibilities for the preparation and development for~~
8 ~~converting the present delivery of the Oklahoma Medicaid Program to~~
9 ~~a managed care system. The system shall emphasize:~~

10 1. ~~Managed care principles, including a capitated, prepaid~~
11 ~~system with either full or partial capitation, provided that highest~~
12 ~~priority shall be given to development of prepaid capitated health~~
13 ~~plans;~~

14 2. ~~Use of primary care physicians to establish the appropriate~~
15 ~~type of medical care a Medicaid recipient should receive; and~~

16 3. ~~Preventative care.~~

17 ~~The Authority shall also study the feasibility of allowing a~~
18 ~~private entity to administer all or part of the managed care system.~~

19 ~~B.~~ On and after January 1, 1995, the Oklahoma Health Care
20 Authority shall be the designated state agency for the
21 administration of the Oklahoma Medicaid Program.

22 1. The Authority shall contract with the Department of Human
23 Services for the determination of Medicaid eligibility and other
24

1 administrative or operational functions related to the Oklahoma
2 Medicaid Program as necessary and appropriate.

3 2. To the extent possible and appropriate, upon the transfer of
4 the administration of the Oklahoma Medicaid Program, the Authority
5 shall employ the personnel of the Medical Services Division of the
6 Department of Human Services.

7 3. The Department of Human Services and the Authority shall
8 jointly prepare a transition plan for the transfer of the
9 administration of the Oklahoma Medicaid Program to the Authority.
10 The transition plan shall include provisions for the retraining and
11 reassignment of employees of the Department of Human Services
12 affected by the transfer. The transition plan shall be submitted to
13 the Governor, the President Pro Tempore of the Senate and the
14 Speaker of the House of Representatives on or before January 1,
15 1995.

16 ~~C.~~ B. In order to provide adequate funding for the unique
17 training and research purposes associated with the demonstration
18 program conducted by the entity described in paragraph 7 of
19 subsection B of Section 6201 of Title 74 of the Oklahoma Statutes,
20 and to provide services to persons without regard to their ability
21 to pay, the Oklahoma Health Care Authority shall analyze the
22 feasibility of establishing a Medicaid reimbursement methodology for
23 nursing facilities to provide a separate Medicaid payment rate
24 sufficient to cover all costs allowable under Medicare principles of

1 reimbursement for the facility to be constructed or operated, or
2 constructed and operated, by the organization described in paragraph
3 7 of subsection B of Section 6201 of Title 74 of the Oklahoma
4 Statutes.

5 SECTION 21. AMENDATORY 63 O.S. 2021, Section 5009.2, is
6 amended to read as follows:

7 Section 5009.2 A. The Advisory Committee on Medical Care for
8 Public Assistance Recipients, created by the Oklahoma Health Care
9 Authority pursuant to 42 Code of Federal Regulations, Section
10 431.12, for the purpose of advising the Authority about health and
11 medical care services, shall include among its membership of no more
12 than fifteen (15) the following:

13 1. Board-certified physicians and other representatives of the
14 health professions who are familiar with the medical needs of low-
15 income population groups and with the resources available and
16 required for their care. The Advisory Committee shall, at all
17 times, include at least one physician from each of the six classes
18 of physicians listed in Section 725.2 of Title 59 of the Oklahoma
19 Statutes. The Advisory Committee shall at all times include at
20 least one pharmacist and one psychologist licensed in this state.

21 All such physicians and other representatives of the health
22 professions shall be participating providers in the State Medicaid
23 Plan;

24 2. Members of consumers' groups, including, but not limited to:

- a. Medicaid recipients, and
- b. representatives from consumer organizations including a member representing nursing homes, a member representing individuals with developmental disabilities and a member representing one or more behavioral health professions;

3. The Director of the Department of Human Services or designee;

4. The Commissioner of Mental Health and Substance Abuse Services or designee;

5. A member approved and appointed by a state organization or state chapter of a national organization of pediatricians dedicated to the health, safety and well-being of infants, children, adolescents and young adults, who shall:

- a. monitor provider relations with the Oklahoma Health Care Authority, and
- b. create a forum to address grievances; ~~and~~

6. Members who are representatives of a statewide association representing rural and urban hospitals; and

7. A member who is a member or citizen of a federally recognized American Indian tribe or nation whose primary tribal headquarters is located in this state.

1 Beginning on January 1, 2022, appointments made to the Advisory
2 Committee shall be for a duration not to exceed four (4) consecutive
3 calendar years.

4 B. The Advisory Committee shall meet bimonthly to review and
5 make recommendations related to:

6 1. Policy development and program administration;

7 2. Policy changes proposed by the Authority prior to
8 consideration of such changes by the Authority;

9 3. Financial concerns related to the Authority and the
10 administration of the programs under the Authority; and

11 4. Other pertinent information related to the management and
12 operation of the Authority and the delivery of health and medical
13 care services.

14 C. 1. The Administrator of the Authority shall provide such
15 staff support and independent technical assistance as needed by the
16 Advisory Committee to enable the Advisory Committee to make
17 effective recommendations.

18 2. The Advisory Committee shall elect from among its members a
19 chair and a vice-chair who shall serve one-year terms. A member may
20 serve more than one (1), but not more than four (4), consecutive
21 one-year terms as chair or vice-chair. A majority of the members of
22 the Advisory Committee shall constitute a quorum to transact
23 business, but no vacancy shall impair the right of the remaining
24 members to exercise all of the powers of the Advisory Committee.

1 3. Members shall not receive any compensation for their
2 services but shall be reimbursed pursuant to the provisions of the
3 State Travel Reimbursement Act, Section 500.1 et seq. of Title 74 of
4 the Oklahoma Statutes.

5 D. The Authority shall give due consideration to the comments
6 and recommendations of the Advisory Committee in the Authority's
7 deliberations on policies, administration, management and operation
8 of the Authority.

9 SECTION 22. AMENDATORY 36 O.S. 2021, Section 312.1, is
10 amended to read as follows:

11 Section 312.1 A. For the fiscal year ending June 30, 2004, the
12 Insurance Commissioner shall report and disburse one hundred percent
13 (100%) of the fees and taxes collected under Section 624 of this
14 title to the State Treasurer to be deposited to the credit of the
15 Education Reform Revolving Fund of the State Department of
16 Education. The Insurance Commissioner shall keep an accurate record
17 of all such funds and make an itemized statement and furnish same to
18 the State Auditor and Inspector, as to all other departments of this
19 state. The report shall be accompanied by an affidavit of the
20 Insurance Commissioner or the Chief Clerk of such office certifying
21 to the correctness thereof.

22 B. The Insurance Commissioner shall apportion an amount of the
23 taxes and fees received from Section 624 of this title, which shall
24 be at least One Million Two Hundred Fifty Thousand Dollars

1 (\$1,250,000.00) each year, but which shall also be computed on an
2 annual basis by the Commissioner as the amount of insurance premium
3 tax revenue loss attributable to the provisions of subsection H of
4 Section 625.1 of this title and increased if necessary to reflect
5 the annual computation, and which shall be apportioned before any
6 other amounts, as follows:

7 1. The following amounts shall be paid to the Oklahoma
8 Firefighters Pension and Retirement Fund in the manner provided for
9 in Sections 49-119, 49-120 and 49-123 of Title 11 of the Oklahoma
10 Statutes:

11 Fiscal Year	Amount
12 FY 2006 through FY 2020	65.0%
13 FY 2021 as follows:	
14 a. for the month beginning July 1,	
15 2020, through the month ending	
16 August 31, 2020	65.0%
17 b. for the month beginning September	
18 1, 2020, through the month ending	
19 June 30, 2021	45.5%
20 FY 2022 and each fiscal year thereafter	65.0%;

21 2. The following amounts shall be paid to the Oklahoma Police
22 Pension and Retirement System pursuant to the provisions of Sections
23 50-101 through 50-136 of Title 11 of the Oklahoma Statutes:

24 Fiscal Year	Amount
----------------	--------

1	FY 2006 through FY 2020	26.0%
2	FY 2021 as follows:	
3	a. for the month beginning July 1,	
4	2020, through the month ending	
5	August 31, 2020	26.0%
6	b. for the month beginning September	
7	1, 2020, through the month ending	
8	June 30, 2021	18.2%
9	FY 2022 and each fiscal year thereafter	26.0%;

10 3. The following amounts shall be paid to the Law Enforcement
11 Retirement Fund:

12	Fiscal Year	Amount
13	FY 2006 through FY 2020	9.0%
14	FY 2021 as follows:	
15	a. for the month beginning July 1,	
16	2020, through the month ending	
17	August 31, 2020	9.0%
18	b. for the month beginning September	
19	1, 2020, through the month ending	
20	June 30, 2021	6.3%
21	FY 2022 and each fiscal year thereafter	9.0%; and

22 4. The following amounts shall be paid to the Education Reform
23 Revolving Fund of the State Department of Education:

24	Fiscal Year	Amount
----	-------------	--------

1 FY 2021 as follows:

2 for the month beginning September 1,
3 2020, through the month ending June 30,
4 2021 30.0%.

5 C. After the apportionment required by subsection B of this
6 section, for the fiscal years beginning July 1, 2004, and ending
7 June 30, 2009, the Insurance Commissioner shall report and disburse
8 all of the fees and taxes collected under Section 624 of this title
9 and Section 2204 of this title, and the same are hereby apportioned
10 as follows:

11 1. Thirty-four percent (34%) of the taxes collected on premiums
12 shall be allocated and disbursed for the Oklahoma Firefighters
13 Pension and Retirement Fund, in the manner provided for in Sections
14 49-119, 49-120 and 49-123 of Title 11 of the Oklahoma Statutes;

15 2. Seventeen percent (17%) of the taxes collected on premiums
16 shall be allocated and disbursed to the Oklahoma Police Pension and
17 Retirement System pursuant to the provisions of Sections 50-101
18 through 50-136 of Title 11 of the Oklahoma Statutes;

19 3. Six and one-tenth percent (6.1%) of the taxes collected on
20 premiums shall be allocated and disbursed to the Law Enforcement
21 Retirement Fund; and

22 4. All the balance and remainder of the taxes and fees provided
23 in Section 624 of this title shall be paid to the State Treasurer to
24 the credit of the General Revenue Fund of the state to provide

1 revenue for general functions of state government. The Insurance
2 Commissioner shall keep an accurate record of all such funds and
3 make an itemized statement and furnish same to the State Auditor and
4 Inspector, as to all other departments of this state. The report
5 shall be accompanied by an affidavit of the Insurance Commissioner
6 or the Chief Clerk of such office certifying to the correctness
7 thereof.

8 D. After the apportionment required by subsection B of this
9 section, the Insurance Commissioner shall report and disburse all of
10 the fees and taxes collected under Section 624 of this title and
11 Section 2204 of this title, and the same are hereby apportioned as
12 follows:

13 1. Of the taxes collected on premiums the following shall be
14 allocated and disbursed for the Oklahoma Firefighters Pension and
15 Retirement Fund, in the manner provided for in Sections 49-119, 49-
16 120 and 49-123 of Title 11 of the Oklahoma Statutes:

17 Fiscal Year	Amount
18 FY 2006 through FY 2020	36.0%
19 FY 2021 as follows:	
20 a. for the month beginning July 1,	
21 2020, through the month ending	
22 August 31, 2020	36.0%
23	
24	

1	b.	for the month beginning September	
2		1, 2020, through the month ending	
3		June 30, 2021	25.2%
4	FY 2022		36.0%
5	FY 2023 through FY 2027		37.8%
6	FY 2028 and each fiscal year thereafter		36.0%;

7 2. Of the taxes collected on premiums the following shall be
8 allocated and disbursed to the Oklahoma Police Pension and
9 Retirement System pursuant to the provisions of Sections 50-101
10 through 50-136 of Title 11 of the Oklahoma Statutes:

11	Fiscal Year	Amount
12	FY 2006 through FY 2020	14.0%
13	FY 2021 as follows:	

14	a.	for the month beginning July 1,	
15		2020, through the month ending	
16		August 31, 2020	14.0%

17	b.	for the month beginning September	
18		1, 2020, through the month ending	
19		June 30, 2021	9.8%
20	FY 2022		14.0%
21	FY 2023 through FY 2027		14.7%
22	FY 2028 and each fiscal year thereafter		14.0%;

23 3. Of the taxes collected on premiums the following shall be
24 allocated and disbursed to the Law Enforcement Retirement Fund:

1	Fiscal Year	Amount
2	FY 2006 through FY 2020	5.0%
3	FY 2021 as follows:	
4	a. for the month beginning July 1,	
5	2020, through the month ending	
6	August 31, 2020	5.0%
7	b. for the month beginning September	
8	1, 2020, through the month ending	
9	June 30, 2021	3.5%
10	FY 2022	5.0%
11	FY 2023 through FY 2027	5.25%
12	FY 2028 and each fiscal year thereafter	5.0%;

13 4. The following amounts shall be paid to the Education Reform
14 Revolving Fund of the State Department of Education:

15	Fiscal Year	Amount
16	FY 2021 as follows:	
17	for the month beginning September 1,	
18	2020, through the month ending June 30,	
19	2021	16.5%;

20 5. In addition to the allocations made pursuant to paragraphs
21 1, 2 and 3 of this subsection, of the taxes collected on premiums
22 the following amounts shall be allocated and disbursed annually for
23 FY 2023 through FY 2027:

24

- 1 a. Forty Thousand Six Hundred Twenty-five Dollars
2 (\$40,625.00) to the Oklahoma Firefighters Pension and
3 Retirement Fund,
4 b. Sixteen Thousand Two Hundred Fifty Dollars
5 (\$16,250.00) to the Oklahoma Police Pension and
6 Retirement System, and
7 c. Five Thousand Six Hundred Twenty-five Dollars
8 (\$5,625.00) to the Oklahoma Law Enforcement Retirement
9 Fund; and

10 6. All the balance and remainder of the taxes and fees provided
11 in Section 624 of this title shall be paid to the State Treasurer to
12 the credit of the General Revenue Fund of the state to provide
13 revenue for general functions of state government. The Insurance
14 Commissioner shall keep an accurate record of all such funds and
15 make an itemized statement and furnish same to the State Auditor and
16 Inspector, as to all other departments of this state. The report
17 shall be accompanied by an affidavit of the Insurance Commissioner
18 or the Chief Clerk of such office certifying to the correctness
19 thereof.

20 E. The disbursements provided for in subsections A, B, C and D
21 of this section shall be made monthly. The Insurance Commissioner
22 shall report annually to the Governor, the Speaker of the House of
23 Representatives, the President Pro Tempore of the Senate and the
24

1 State Auditor and Inspector, the amounts collected and disbursed
2 pursuant to this section.

3 F. Notwithstanding any other provision of law to the contrary,
4 no tax credit authorized by law enacted on or after July 1, 2008,
5 which may be used to reduce any insurance premium tax liability
6 shall be used to reduce the amount of insurance premium tax revenue
7 apportioned to the Oklahoma Firefighters Pension and Retirement
8 System, the Oklahoma Police Pension and Retirement System, the
9 Oklahoma Law Enforcement Retirement System or the Education Reform
10 Revolving Fund.

11 G. For fiscal year 2023, and each subsequent fiscal year,
12 before any other apportionment otherwise required by this section is
13 made, there shall be apportioned to the Medicaid Contingency
14 Revolving Fund, created in Section 1010.8 of Title 56 of the
15 Oklahoma Statutes, the portion of premium taxes and fees collected
16 under Section 624 of this title from contracted entities of the
17 Ensuring Access to Medicaid program of the Oklahoma Health Care
18 Authority for funding for the Medicaid Expansion Program.

19 SECTION 23. RECODIFICATION 56 O.S. 2021, Section 4004,
20 as amended by Section 19 of this act, shall be recodified as Section
21 4002.15 of Title 56 of the Oklahoma Statutes, unless there is
22 created a duplication in numbering.

23 SECTION 24. REPEALER 56 O.S. 2021, Sections 1010.2,
24 1010.3, 1010.4, and 1010.5, are hereby repealed.

1 SECTION 25. REPEALER 56 O.S. 2021, Sections 4002.3 and
2 4002.9, are hereby repealed.

3 SECTION 26. REPEALER 63 O.S. 2021, Sections 5009.5,
4 5011, and 5028, are hereby repealed.

5 SECTION 27. This act shall become effective July 1, 2022.

6 SECTION 28. It being immediately necessary for the preservation
7 of the public peace, health or safety, an emergency is hereby
8 declared to exist, by reason whereof this act shall take effect and
9 be in full force from and after its passage and approval.

10 SECTION 29. This act shall become effective only if Engrossed
11 Senate Bill No. 1396 of the 2nd Session of the 58th Oklahoma
12 Legislature is enacted into law."

13 Passed the House of Representatives the 28th day of April, 2022.

14

15

16

Presiding Officer of the House of
Representatives

17

18 Passed the Senate the ____ day of _____, 2022.

19

20

21

Presiding Officer of the Senate

22

23

24

1 ENGROSSED SENATE
2 BILL NO. 1337

By: McCortney of the Senate

3 and

4 McEntire of the House

5
6 [state Medicaid program - legislative intent -
7 definitions - capitated contracts - requests for
8 proposals - award of contracts to provider-led
9 entities - enrollment and assignment of Medicaid
10 members - network adequacy standards - essential
11 community providers - Oklahoma Health Care Authority
12 monitoring, oversight, and enforcement - duties of
13 contracted entities - determination and review
14 requirements - processing and adjudication of claims
15 - readiness review - scorecard - provider
16 reimbursement - capitation rates - supplemental
17 payments - reports - advisory committee - measures
18 and goals - federal approval - recodification -
19 repealers - codification - effective date]

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

21 SECTION 30. NEW LAW A new section of law to be codified
22 in the Oklahoma Statutes as Section 4002.1a of Title 56, unless
23 there is created a duplication in numbering, reads as follows:

24 It is the intent of the Legislature to transform the state's
current Medicaid program to provide budget predictability for the
taxpayers of this state while ensuring quality care to those in
need. The state Medicaid program shall be designed to achieve the
following goals:

1 1. Improve health outcomes for Medicaid members and the state
2 as a whole;

3 2. Ensure budget predictability through shared risk and
4 accountability;

5 3. Ensure access to care, quality measures, and member
6 satisfaction;

7 4. Ensure efficient and cost-effective administrative systems
8 and structures; and

9 5. Ensure a sustainable delivery system that is a provider-led
10 effort and that is operated and managed by providers to the maximum
11 extent possible.

12 SECTION 31. AMENDATORY 56 O.S. 2021, Section 4002.2, is
13 amended to read as follows:

14 Section 4002.2. As used in ~~this act~~ the Ensuring Access to
15 Medicaid Act:

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

18 2. ~~"Claims denial error rate" means the rate of claims denials~~
19 ~~that are overturned on appeal;~~ "Accountable care organization" means
20 a network of physicians, hospitals, and other health care providers
21 that provides coordinated care to Medicaid members;

22 2. "Capitated contract" means a contract between the Oklahoma
23 Health Care Authority and a contracted entity for delivery of
24 services to Medicaid members in which the Authority pays a fixed,

1 per-member-per-month rate based on actuarial calculations as
2 provided by Section 4002.12 of this title;

3 3. "Clean claim" means a properly completed billing form with
4 Current Procedural Terminology, 4th Edition or a more recent
5 edition, the Tenth Revision of the International Classification of
6 Diseases coding or a more recent revision, or Healthcare Common
7 Procedure Coding System coding where applicable that contains
8 information specifically required in the Provider Billing and
9 Procedure Manual of the Oklahoma Health Care Authority;

10 4. "Commercial plan" means an organization or entity that
11 undertakes to provide or arrange for the delivery of health care
12 services to Medicaid members on a prepaid basis and is subject to
13 all applicable federal and state laws and regulations;

14 5. "Contracted entity" means an organization or entity that
15 enters into or will enter into a capitated contract with the
16 Oklahoma Health Care Authority for the delivery of services
17 specified in this act that will assume financial risk, operational
18 accountability and statewide or regional functionality as defined in
19 this act in managing comprehensive health outcomes of Medicaid
20 members. For purposes of this act, the term contracted entity
21 includes an accountable care organization, a provider-led entity, a
22 commercial plan, or a dental benefit manager, or any other entity as
23 determined by the Authority;

1 6. "Dental benefit manager" means an entity ~~under contract with~~
2 ~~the Oklahoma Health Care Authority to manage and deliver dental~~
3 ~~benefits and services to enrollees of the capitated managed care~~
4 ~~delivery model of the state Medicaid program~~ that handles claims
5 payment and prior authorizations and coordinates dental care with
6 participating providers and Medicaid members;

7 ~~5.~~ 7. "Essential community provider" ~~has the same meaning as~~
8 ~~provided by~~ means:

9 a. a Federally Qualified Health Center,

10 b. a community mental health center,

11 c. an Indian health care provider,

12 d. a rural health clinic,

13 e. a state operated mental health hospital,

14 f. a long term care hospital serving children (LTCH-C),

15 g. a teaching hospital owned, jointly owned, or

16 affiliated with and designated by the University

17 Hospitals Authority, University Hospitals Trust,

18 Oklahoma State University Medical Authority, or

19 Oklahoma State University Medical Trust,

20 h. a provider employed by or contracted with, or

21 otherwise a member of the faculty practice plan of:

22 (1) a public accredited medical school in this state,

23 or

1 (2) a hospital or health care entity directly or
2 indirectly owned or operated by the University
3 Hospitals Trust or the Oklahoma State University
4 Medical Trust,

5 i. a county department of health, district department of
6 health, cooperative department of health, or city-
7 county health department,

8 j. a comprehensive community addiction recovery center,

9 k. any additional Medicaid provider as approved by the
10 Authority if the provider either offers services that
11 are not available from any other provider within a
12 reasonable access standard or provides a substantial
13 share of the total units of a particular service
14 utilized by Medicaid members within the region during
15 the last three (3) years, and the combined capacity of
16 other service providers in the region is insufficient
17 to meet the total needs of the Medicaid members, or

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

21 ~~6. "Managed care organization" means a health plan under~~
22 ~~contract with the Oklahoma Health Care Authority to participate in~~
23 ~~and deliver benefits and services to enrollees of the capitated~~
24 ~~managed care delivery model of the state Medicaid program;~~

1 7. ~~“Material change” includes, but is not limited to, any~~
2 ~~change in overall business operations such as policy, process or~~
3 ~~protocol which affects, or can reasonably be expected to affect,~~
4 ~~more than five percent (5%) of enrollees or participating providers~~
5 ~~of the managed care organization or dental benefit manager;~~

6 8. “Local Oklahoma provider organization” means any state
7 provider association, accountable care organization, certified
8 community behavioral health clinic, federally qualified health
9 center, Native American tribe or tribal association, hospital or
10 health system, academic medical institution, licensed provider
11 currently practicing, foster child or parent associations, or other
12 local Oklahoma provider organization as approved by Authority;

13 9. “Medical necessity” has the same meaning as provided by
14 rules of promulgated by the Oklahoma Health Care Authority Board;

15 ~~9.~~ 10. “Participating provider” means a provider who has a
16 contract with or is employed by a managed care organization
17 contracted entity or dental benefit manager to provide services to
18 enrollees under the capitated managed care delivery model of the
19 state Medicaid program Medicaid members as authorized by this act;
20 and

21 ~~10.~~ 11. “Provider” means a health care or dental provider
22 licensed or certified in this state;

23 12. “Provider-led entity” means an organization or entity that
24 meets the following criteria:

1 a. a majority of the entity's ownership is held by
2 Medicaid providers in this state or is held by an
3 entity that directly or indirectly owns or is under
4 common ownership with Medicaid providers in this
5 state, and

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

8 (1) have experience serving Medicaid members and:

9 (a) are licensed in this state as physicians,
10 physician assistants, nurse practitioners,
11 or licensed behavioral health providers, or

12 (b) are employed by:

13 i. a hospital, long-term care facility or
14 other medical facility licensed and
15 operating in this state, or

16 ii. an inpatient or outpatient mental
17 health or substance abuse treatment
18 facility or program licensed or
19 certified by this state and operating
20 in this state,

21 (2) represent the providers or facilities described
22 in division 1 of this subparagraph including but
23 not limited to individuals who are employed by a
24 statewide provider association, or

1 (3) are nonclinical administrators of clinical
2 practices serving Medicaid members;

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

5 14. "Urban region" means all counties of this state with a
6 county population of not less than five hundred thousand (500,000),
7 combined into one region.

8 SECTION 32. NEW LAW A new section of law to be codified
9 in the Oklahoma Statutes as Section 4002.3a of Title 56, unless
10 there is created a duplication in numbering, reads as follows:

11 A. 1. The Oklahoma Health Care Authority shall enter into
12 capitated contracts with contracted entities for the delivery of
13 Medicaid services as specified in this act to transform the delivery
14 system of the state Medicaid program for the Medicaid populations
15 listed in this section.

16 2. The Authority shall not issue any request for proposals or
17 enter into any contract to transform the delivery system of the
18 state Medicaid program for any Medicaid population that is not
19 expressly included in this section.

20 B. 1. No later than January 1, 2023, the Oklahoma Health Care
21 Authority shall issue a request for proposals to enter into public-
22 private partnerships with contracted entities other than dental
23 benefit managers to cover all Medicaid services other than dental
24 services for the following Medicaid populations:

- 1 a. pregnant women,
- 2 b. children,
- 3 c. deemed newborns,
- 4 d. parents and caretaker relatives, and
- 5 e. the expansion population.

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

- 10 a. physical health services including but not limited to
11 primary care,
- 12 b. behavioral health services, and
- 13 c. prescription drug services.

14 C. 1. No later than January 1, 2023, the Authority shall issue
15 a request for proposals to enter into public-private partnerships
16 with dental benefit managers to cover dental services for the
17 following Medicaid populations:

- 18 a. pregnant women,
 - 19 b. children,
 - 20 c. parents and caretaker relatives,
 - 21 d. the expansion population, and
 - 22 e. members of the Children's Specialty Plan as provided
23 by subsection D of this section.
- 24

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.

4 D. 1. No later than January 1, 2023, either as part of the
5 request for proposals referenced in subsection B of this section or
6 as a separate request for proposals, the Authority shall issue a
7 request for proposals to enter into public-private partnerships with
8 one contracted entity to administer a Children's Specialty Plan that
9 covers all Medicaid services other than dental services and is
10 designed to provide care to:

- 11 a. children in foster care and former foster care
- 12 children up to age twenty-five (25),
- 13 b. juvenile justice involved children, and
- 14 c. children receiving adoption assistance.

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

22 SECTION 33. NEW LAW A new section of law to be codified
23 in the Oklahoma Statutes as Section 4002.3b of Title 56, unless
24 there is created a duplication in numbering, reads as follows:

1 A. All capitated contracts shall be the result of requests for
2 proposals issued by the Oklahoma Health Care Authority and
3 submission of competitive bids by contracted entities pursuant to
4 the Oklahoma Central Purchasing Act.

5 B. Statewide capitated contracts may be awarded to any
6 contracted entity including but not limited to a provider-led
7 entity.

8 C. The Authority shall award no less than three statewide
9 capitated contracts to provide comprehensive integrated health
10 services including but not limited to medical, behavioral health,
11 and pharmacy services and no less than two capitated contracts to
12 provide dental coverage to Medicaid members as specified in Section
13 3 of this act.

14 D. 1. Except as specified in paragraph 2 of this subsection,
15 at least one capitated contract to provide statewide coverage to
16 Medicaid members shall be awarded to a provider-led entity, as long
17 as the provider-led entity submits a responsive reply to the
18 Authority's request for proposals demonstrating ability to fulfill
19 the contract requirements.

20 2. If no provider-led entity submits a responsive reply to the
21 Authority's request for proposals demonstrating ability to fulfill
22 the contract requirements, the Authority shall not be required to
23 contract for statewide coverage to a provider-led entity.

24

1 3. The Authority shall develop a scoring methodology for the
2 request for proposals that affords preferential scoring to provider-
3 led entities, as long as the provider-led entity otherwise
4 demonstrates ability to fulfill the contract requirements. The
5 preferential scoring methodology shall include opportunities to
6 award additional points to provider-led entities based on certain
7 factors including but not limited to:

- 8 a. broad provider participation in ownership and
9 governance structure,
- 10 b. demonstrated experience in care coordination and care
11 management for Medicaid members across a variety of
12 service types including but not limited to primary
13 care and behavioral health,
- 14 c. demonstrated experience in Medicare accountable care
15 organizations or other Medicare alternative payment
16 models, Medicare value-based payment arrangements, or
17 Medicare risk-sharing arrangements including but not
18 limited to innovation models of the Center for
19 Medicare and Medicaid Innovation of the Centers for
20 Medicare and Medicaid Services, or value-based payment
21 arrangements or risk-sharing arrangements in the
22 commercial health care market,
- 23 d. demonstrated experience in improving health outcomes
24 for Medicaid members, and

1 e. other relevant factors identified by the Authority.

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

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

7 2. The provider-led entity demonstrates the ability, and
8 agrees, to expand its coverage area to the entire state within a
9 time frame specified in the request for proposals.

10 F. At the discretion of the Authority, capitated contracts may
11 be extended to ensure against gaps in coverage that may result from
12 termination of a capitated contract; provided, the total contracting
13 period for a capitated contract shall not exceed seven (7) years.

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

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

22 SECTION 34. NEW LAW A new section of law to be codified
23 in the Oklahoma Statutes as Section 4002.3c of Title 56, unless
24 there is created a duplication in numbering, reads as follows:

1 A. The Oklahoma Health Care Authority shall require each
2 contracted entity to ensure that Medicaid members who do not elect a
3 primary care provider are assigned to a provider, prioritizing
4 existing patient-provider relationships.

5 B. The Authority shall develop and implement a process for
6 assignment of Medicaid members to contracted entities.

7 C. The Authority may only utilize an opt-in enrollment process
8 for the voluntary enrollment of American Indians and Alaska Natives.

9 D. In the event of the termination of a capitated contract with
10 a contracted entity during the contract duration, the Authority
11 shall reassign members to a remaining contracted entity with
12 demonstrated performance and capability. If no remaining contracted
13 entity is able to assume management for such members, the Authority
14 may select another contracted entity by application, as specified in
15 rules promulgated by the Oklahoma Health Care Authority Board, if
16 the financial, operation and performance requirements can be met, at
17 the discretion of the Authority.

18 SECTION 35. AMENDATORY 56 O.S. 2021, Section 4002.4, is
19 amended to read as follows:

20 Section 4002.4. A. The Oklahoma Health Care Authority shall
21 develop network adequacy standards for all ~~managed care~~
22 ~~organizations and dental benefit managers~~ contracted entities that,
23 at a minimum, meet the requirements of 42 C.F.R., Sections ~~438.14~~
24 438.3 and 438.68. ~~Network adequacy standards established under this~~

1 ~~subsection shall be designed to ensure enrollees covered by the~~
2 ~~managed care organizations and dental benefit managers who reside in~~
3 ~~health professional shortage areas (HPSAs) designated under Section~~
4 ~~332(a)(1) of the Public Health Service Act (42 U.S.C., Section~~
5 ~~254e(a)(1)) have access to in-person health care and telehealth~~
6 ~~services with providers, especially adult and pediatric primary care~~
7 ~~practitioners.~~

8 B. ~~All managed care organizations and dental benefit managers~~
9 ~~shall meet or exceed network adequacy standards established by the~~
10 ~~Authority under subsection A of this section to ensure sufficient~~
11 ~~access to providers for enrollees of the state Medicaid program.~~

12 C. ~~All managed care organizations and dental benefit managers~~
13 ~~shall~~ The Authority shall require all contracted entities to
14 contract to the extent possible and practicable with all essential
15 community providers, all 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. The Authority shall establish such
18 requirements as may be necessary to prohibit contracted entities
19 from excluding essential community providers, providers who receive
20 directed payments in accordance with 42 C.F.R., Part 438 and such
21 other providers as the Authority may specify from contracts with
22 contracted entities.

23 ~~D.~~ C. To ensure models of care are developed to meet the needs
24 of Medicaid members, each contracted entity must contract with at

1 least one essential community provider for a model of care
2 containing care coordination, care management, utilization
3 management, disease management, network management, or another model
4 of care as approved by Authority. Such contractual arrangements
5 must be in place within eighteen (18) months of the effective date
6 of the contracts awarded pursuant to the requests for proposals
7 authorized by Section 3 of this act.

8 D. All managed care organizations and dental benefit managers
9 contracted entities shall formally credential and recredential
10 network providers at a frequency required by a single, consolidated
11 provider enrollment and credentialing process established by the
12 Authority in accordance with 42 C.F.R., Section 438.214.

13 E. All managed care organizations and dental benefit managers
14 contracted entities shall be accredited in accordance with 45
15 C.F.R., Section 156.275 by an accrediting entity recognized by the
16 United States Department of Health and Human Services.

17 F. 1. If the Oklahoma Health Care Authority awards a capitated
18 contract to a provider-led entity for the urban region under Section
19 4 of this act, the provider-led entity shall, as provided by the
20 contract with the Authority, expand its coverage area beyond the
21 urban region to counties for which the provider-led entity can
22 demonstrate evidence of network adequacy as required under 42
23 C.F.R., Sections 438.3 and 438.68 and as approved by Authority. If
24

1 approved, the additional county or counties shall be added to the
2 urban region during the next open enrollment period.

3 2. As provided by Section 4 of this act and by the contract
4 with the Authority, the provider-led entity shall expand its
5 coverage area to every county of this state within the time frame
6 specified by such contract.

7 3. If the Authority awards a capitated contract to a provider-
8 led entity for the urban region under Section 4 of this act, the
9 provider-led entity must include in its network all providers in the
10 coverage area that are designated as essential community providers
11 by the Authority, unless the Authority approves an alternative
12 arrangement for securing the types of services offered by the
13 essential community providers.

14 SECTION 36. NEW LAW A new section of law to be codified
15 in the Oklahoma Statutes as Section 4002.4a of Title 56, unless
16 there is created a duplication in numbering, reads as follows:

17 A. 1. The Oklahoma Health Care Authority shall develop
18 standard contract terms for contracted entities to include but not
19 be limited to all requirements stipulated by this act. The
20 Authority shall oversee and monitor performance of contracted
21 entities and shall enforce the terms of capitated contracts as
22 required by paragraph 2 of this subsection.

23 2. The Authority shall require each contracted entity to meet
24 all contractual and operational requirements as defined in the

1 requests for proposals issued pursuant to Section 3 of this act.
2 Such requirements shall include but not be limited to reimbursement
3 and capitation rates, insurance reserve requirements as specified by
4 the Insurance Department, acceptance of risk as defined by the
5 Authority, operational performance expectations including the
6 assessment of penalties, member marketing guidelines, other
7 applicable state and federal regulatory requirements, and all
8 requirements of this act including but not limited to the
9 requirements stipulated in this section.

10 B. The Authority shall develop methods to ensure program
11 integrity against provider fraud, waste, and abuse.

12 C. The Authority shall develop processes for providers and
13 Medicaid members to report violations by contracted entities of
14 applicable administrative rules, state law or federal law.

15 SECTION 37. AMENDATORY 56 O.S. 2021, Section 4002.5, is
16 amended to read as follows:

17 Section 4002.5. A. A contracted entity shall be responsible
18 for all administrative functions for members enrolled in its plan
19 including but not limited to claims processing, authorization of
20 health services, care and case management, grievances and appeals,
21 and other necessary administrative services.

22 B. A contracted entity shall hold a certificate of authority as
23 a health maintenance organization issued by the Insurance
24 Department.

1 C. 1. To ensure providers have a voice in the direction and
2 operation of the contracted entities selected by the Authority under
3 Section 4 of this act, each contracted entity shall have a shared
4 governance structure that includes:

5 a. representatives of local Oklahoma provider

6 organizations who are Medicaid providers,

7 b. essential community providers, and

8 c. a representative from a teaching hospital owned,

9 jointly owned, or affiliated with and designated by

10 the University Hospitals Authority, University

11 Hospitals Trust, Oklahoma State University Medical

12 Authority, or Oklahoma State University Medical Trust.

13 2. No less than one-third (1/3) of the contracted entity's
14 board of directors shall be comprised of representatives of local
15 Oklahoma provider organizations.

16 3. No less than two members of the contracted entity's clinical
17 and quality committees shall be representatives of local Oklahoma
18 provider organizations, and the committees shall be chaired or co-
19 chaired by a representative of a local Oklahoma provider
20 organization.

21 D. A managed care organization or dental benefit manager
22 contracted entity shall promptly notify the Authority of all changes
23 materially affecting the delivery of care or the administration of
24 its program.

1 ~~B. E.~~ A ~~managed care organization or dental benefit manager~~
2 contracted entity shall have a medical loss ratio that meets the
3 standards provided by 42 C.F.R., Section 438.8.

4 ~~C. F.~~ A ~~managed care organization or dental benefit manager~~
5 contracted entity shall provide patient data to a provider upon
6 request to the extent allowed under federal or state laws, rules or
7 regulations including, but not limited to, the Health Insurance
8 Portability and Accountability Act of 1996.

9 ~~D. G.~~ A ~~managed care organization or dental benefit manager~~
10 contracted entity or a subcontractor of ~~such managed care~~
11 ~~organization or dental benefit manager~~ a contracted entity shall not
12 enforce a policy or contract term with a provider that requires the
13 provider to contract for all products that are currently offered or
14 that may be offered in the future by the ~~managed care organization~~
15 ~~or dental benefit manager~~ contracted entity or subcontractor.

16 ~~E. H.~~ Nothing in this act or in a contract between the
17 Authority and a ~~managed care organization or dental benefit manager~~
18 contracted entity shall prohibit the ~~managed care organization or~~
19 ~~dental benefit manager~~ contracted entity from contracting with a
20 statewide or regional accountable care organization ~~to implement the~~
21 ~~capitated managed care delivery model of the state Medicaid program.~~

22 I. All contracted entities shall:

23 1. Use the same open drug formulary, which shall be established
24 by the Authority; and

1 2. Ensure broad access to pharmacies including but not limited
2 to pharmacies contracted with covered entities under Section 340B of
3 the Public Health Service Act. Such access shall, at a minimum,
4 meet the requirements of the Patient's Right to Pharmacy Choice Act,
5 Section 6958 et seq. of Title 36 of the Oklahoma Statutes.

6 J. Each contracted entity and each participating provider shall
7 submit data through the state designated entity for health
8 information exchange to ensure effective systems and connectivity to
9 support clinical coordination of care, the exchange of information,
10 and the availability of data to the Authority to manage the state
11 Medicaid program.

12 SECTION 38. AMENDATORY 56 O.S. 2021, Section 4002.6, is
13 amended to read as follows:

14 Section 4002.6. A. ~~A managed care organization~~ contracted
15 entity shall meet all requirements established by the Oklahoma
16 Health Care Authority pertaining to prior authorizations. The
17 Authority shall establish requirements that ensure timely
18 determinations by contracted entities when prior authorizations are
19 required including expedited review in urgent and emergent cases
20 that at a minimum meet the criteria of this section.

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

1 ~~B. Review and issue determinations made by a managed care~~
2 ~~organization or, as appropriate, by a dental benefit manager for~~
3 ~~prior authorization for care ordered by primary care or specialist~~
4 ~~providers shall be timely and shall occur in accordance with the~~
5 ~~following:~~

6 ~~1. Within seventy-two (72) hours of receipt of the~~

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

17 ~~2. Within one (1) business day of receipt of the.~~

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

23 ~~3. E. Notwithstanding the provisions of paragraphs 1 or 2 of~~
24 ~~this subsection C of this section, a contracted entity shall make a~~

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

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

16 ~~5. Within twenty-four (24) hours of receipt of the.~~

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 ~~managed care organization~~ contracted entity
21 shall not require prior authorization on any covered prescription
22 drug for which the Authority does not require prior authorization.

23 ~~C. Upon issuance of an adverse determination on a prior~~
24 ~~authorization request under subsection B of this section, the~~

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

14 ~~D. The Authority shall ensure that a provider offers to provide~~
15 ~~to an enrollee in a timely manner services authorized by a managed~~
16 ~~care organization or dental benefit manager.~~

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

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

22 2. Require contracted entities to provide a prompt opportunity
23 for peer-to-peer conversations upon adverse determination; and
24

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

3 SECTION 39. AMENDATORY 56 O.S. 2021, Section 4002.7, is
4 amended to read as follows:

5 Section 4002.7. ~~A managed care organization or dental benefit~~
6 ~~manager shall~~

7 A. The Oklahoma Health Care Authority shall establish
8 requirements for fair processing and adjudication of claims that
9 ensure prompt reimbursement of providers by contracted entities. A
10 contracted entity shall comply with the following requirements with
11 respect to processing and adjudication of claims for payment
12 submitted in good faith by providers for health care items and
13 services furnished by such providers to enrollees of the state
14 Medicaid program: all such requirements.

15 ~~1. B. A managed care organization or dental benefit manager~~
16 contracted entity shall process a clean claim in the time frame
17 provided by Section 1219 of Title 36 of the Oklahoma Statutes and no
18 less than ninety percent (90%) of all clean claims shall be paid
19 within fourteen (14) days of submission to the ~~managed care~~
20 ~~organization or dental benefit manager~~ contracted entity. A clean
21 claim that is not processed within the time frame provided by
22 Section 1219 of Title 36 of the Oklahoma Statutes shall bear simple
23 interest at the monthly rate of one and one-half percent (1.5%)
24 payable to the provider. A claim filed by a provider within six (6)

1 months of the date the item or service was furnished to ~~an enrollee~~
2 a member shall be considered timely. If a claim meets the
3 definition of a clean claim, the ~~managed care organization or dental~~
4 ~~benefit manager~~ contracted entity shall not request medical records
5 of the ~~enrollee~~ member prior to paying the claim. Once a claim has
6 been paid, the ~~managed care organization or dental benefit manager~~
7 contracted entity may request medical records if additional
8 documentation is needed to review the claim for medical necessity~~†~~.

9 ~~2.~~ 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, the ~~managed care organization or dental~~
12 ~~benefit manager~~ contracted entity shall establish a process by which
13 the provider may identify and provide such additional information as
14 may be necessary to substantiate the claim. Any such claim denial
15 shall include the following:

16 a. ~~a~~

17 1. A detailed explanation of the basis for the denial~~†~~; and

18 b. ~~a~~

19 2. A detailed description of the additional information
20 necessary to substantiate the claim~~†~~.

21 ~~3.~~ D. Postpayment audits by a ~~managed care organization or~~
22 ~~dental benefit manager~~ contracted entity shall be subject to the
23 following requirements:

24 a. ~~subject~~

1 1. Subject to subparagraph b of this paragraph, insofar as a
2 ~~managed care organization or dental benefit manager~~ contracted
3 entity conducts postpayment audits, the ~~managed care organization or~~
4 ~~dental benefit manager~~ contracted entity shall employ the
5 postpayment audit process determined by the Authority~~;~~;

6 b. ~~the~~

7 2. The Authority shall establish a limit on the percentage of
8 claims with respect to which postpayment audits may be conducted by
9 a ~~managed care organization or dental benefit manager~~ contracted
10 entity for health care items and services furnished by a provider in
11 a plan year~~;~~; and

12 e. ~~the~~

13 3. The Authority shall provide for the imposition of financial
14 penalties under such contract in the case of any ~~managed care~~
15 ~~organization or dental benefit manager~~ contracted entity with
16 respect to which the Authority determines has a claims denial error
17 rate of greater than five percent (5%). The Authority shall
18 establish the amount of financial penalties and the time frame under
19 which such penalties shall be imposed on ~~managed care organizations~~
20 ~~and dental benefit managers~~ contracted entities under this
21 subparagraph, in no case less than annually~~;~~; and~~.~~.

22 4. E. A ~~managed care organization~~ contracted entity may only
23 apply readmission penalties pursuant to rules promulgated by the
24 Oklahoma Health Care Authority Board. The Board shall promulgate

1 rules establishing a program to reduce potentially preventable
2 readmissions. The program shall use a nationally recognized tool,
3 establish a base measurement year and a performance year, and
4 provide for risk-adjustment based on the population of the state
5 Medicaid program covered by the ~~managed care organizations and~~
6 ~~dental benefit managers~~ contracted entities.

7 SECTION 40. AMENDATORY 56 O.S. 2021, Section 4002.10, is
8 amended to read as follows:

9 Section 4002.10. ~~A.~~ The Oklahoma Health Care Authority shall
10 require a ~~managed care organization or dental benefit manager~~ all
11 contracted entities to participate in a readiness review in
12 accordance with 42 C.F.R., Section 438.66. The readiness review
13 shall assess the ability and capacity of the ~~managed care~~
14 ~~organization or dental benefit manager~~ contracted entity to perform
15 satisfactorily in such areas as may be specified in 42 C.F.R.,
16 Section 438.66. ~~In addition, the readiness review shall assess~~
17 ~~whether:~~

18 1. ~~The managed care organization or dental benefit manager has~~
19 ~~entered into contracts with providers to the extent necessary to~~
20 ~~meet network adequacy standards prescribed by Section 4 of this act;~~

21 2. ~~The contracts described in paragraph 1 of this subsection~~
22 ~~offer, but do not require, value-based payment arrangements as~~
23 ~~provided by Section 12 of this act; and~~

24

1 ~~3. The managed care organization or dental benefit manager and~~
2 ~~the providers described in paragraph 1 of this subsection have~~
3 ~~established and tested data infrastructure such that exchange of~~
4 ~~patient data can reasonably be expected to occur within one hundred~~
5 ~~twenty (120) calendar days of execution of the transition of the~~
6 ~~delivery system described in subsection B of this section. The~~
7 ~~Authority shall assess its ability to facilitate the exchange of~~
8 ~~patient data, claims, coordination of benefits and other components~~
9 ~~of a managed care delivery model.~~

10 ~~B. The Oklahoma Health Care Authority may only execute the~~
11 ~~transition of the delivery system of the state Medicaid program to~~
12 ~~the capitated managed care delivery model of the state Medicaid~~
13 ~~program ninety (90) days after the Centers for Medicare and Medicaid~~
14 ~~Services has approved all contracts entered into between the~~
15 ~~Authority and all managed care organizations and dental benefit~~
16 ~~managers following submission of the readiness reviews to the~~
17 ~~Centers for Medicare and Medicaid Services.~~

18 SECTION 41. AMENDATORY 56 O.S. 2021, Section 4002.11, is
19 amended to read as follows:

20 Section 4002.11. No later than one year following the execution
21 of the delivery model transition described in ~~Section 10 of this act~~
22 the Ensuring Access to Medicaid Act, the Oklahoma Health Care
23 Authority shall create a scorecard that compares ~~managed care~~
24 ~~organizations~~ each contracted entity and separately compares each

1 dental benefit ~~managers~~ manager. The scorecard shall report the
2 average speed of authorizations of services, rates of denials of
3 Medicaid reimbursable services when a complete authorization request
4 is submitted in a timely manner, enrollee member satisfaction survey
5 results, and such other criteria as the Authority may require. The
6 scorecard shall be compiled quarterly and shall consist of the
7 information specified in this section from the prior ~~year~~ quarter.
8 The Authority shall provide the most recent quarterly scorecard to
9 all initial ~~enrollees~~ members during enrollment choice counseling
10 following the eligibility determination and prior to initial
11 enrollment. The Authority shall provide the most recent quarterly
12 scorecard to all ~~enrollees~~ members at the beginning of each
13 enrollment period. The Authority shall publish each quarterly
14 scorecard on its public Internet website.

15 SECTION 42. AMENDATORY 56 O.S. 2021, Section 4002.12, is
16 amended to read as follows:

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

1 ~~July 1, 2026, such reimbursement rates shall be equal to or greater~~
2 ~~than:~~

3 ~~1. For an item or service provided by a participating provider~~
4 ~~who is in the network of the managed care organization or dental~~
5 ~~benefit manager, one hundred percent (100%) of the reimbursement~~
6 ~~rate for the applicable service in the applicable fee schedule of~~
7 ~~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 managed care~~
10 ~~organization or dental benefit manager, ninety percent (90%) of the~~
11 ~~reimbursement rate for the applicable service in the applicable fee~~
12 ~~schedule of the Authority as of January 1, 2021.~~

13 ~~B. A managed care organization or dental benefit manager shall~~
14 ~~offer value-based payment arrangements to all providers in its~~
15 ~~network capable of entering into value-based payment arrangements.~~
16 ~~Such arrangements shall be optional for the provider. The quality~~
17 ~~measures used by a managed care organization or dental benefit~~
18 ~~manager to determine reimbursement amounts to providers in value-~~
19 ~~based payment arrangements shall align with the quality measures of~~
20 ~~the Authority for managed care organizations or dental benefit~~
21 ~~managers.~~

22 ~~C. Notwithstanding any other provision of this section, the~~
23 ~~Authority shall comply with payment methodologies required by~~
24 ~~federal law or regulation for specific types of providers including,~~

1 ~~but not limited to, Federally Qualified Health Centers, rural health~~
2 ~~clinics, pharmacies, Indian Health Care Providers and emergency~~
3 ~~services~~ Medicaid members.

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

8 C. Capitation rates established by the Oklahoma Health Care
9 Authority and paid to contracted entities under capitated contracts
10 shall be:

11 1. Actuarially sound. Actuarial calculations must include
12 assumptions consistent with industry and local standards; and

13 2. Risk-adjusted and shall include a portion that is at risk
14 for achievement of quality and outcomes measures.

15 D. The Authority may establish a symmetric risk corridor for
16 contracted entities.

17 SECTION 43. NEW LAW A new section of law to be codified
18 in the Oklahoma Statutes as Section 4002.12a of Title 56, unless
19 there is created a duplication in numbering, reads as follows:

20 A. The Oklahoma Health Care Authority shall ensure the
21 sustainability of the transformed Medicaid delivery system.

22 B. The Authority shall ensure that existing revenue sources
23 designated for the state share of Medicaid expenses are designed to
24

1 maximize federal matching funds for the benefit of providers and the
2 state.

3 C. The Authority shall develop a plan, utilizing waivers or
4 Medicaid state plan amendments as necessary, to preserve or increase
5 supplemental payments available to providers with existing revenue
6 sources as provided in the Oklahoma Statutes including but not
7 limited to:

8 1. Hospitals that participate in the Supplemental Hospital
9 Offset Payment Program as provided by Section 3241.3 of Title 63 of
10 the Oklahoma Statutes;

11 2. Hospitals in this state that have Level I trauma centers as
12 defined by the American College of Surgeons that provide inpatient
13 and outpatient services and are owned or operated by the University
14 Hospitals Trust, or affiliates or locations of those hospitals
15 designated by the Trust as part of the hospital trauma system; and

16 3. Providers employed by or contracted with, or otherwise a
17 member of the faculty practice plan of:

18 a. a public, accredited Oklahoma medical school, or

19 b. a hospital or health care entity directly or
20 indirectly owned or operated by the University
21 Hospitals Trust or the Oklahoma State University
22 Medical Trust.

23 D. Subject to approval by the Centers for Medicare and Medicaid
24 Services, the Authority shall preserve and, to the maximum extent

1 permissible under federal law, improve existing levels of funding
2 through directed payments or other mechanisms outside the capitated
3 rate to contracted entities including where applicable the use of an
4 average commercial rate methodology.

5 E. On or before January 31, 2023, the Authority shall submit a
6 report to the Oklahoma Health Care Authority Board, the Chair of the
7 Senate Appropriations Committee, and the Chair of the House
8 Appropriation and Budget Committee that includes the Authority's
9 plans to continue or enhance all supplemental payment programs under
10 the reforms provided for in this act. If Medicaid-specific funding
11 cannot be maintained as currently implemented and authorized by
12 state law, the Authority shall propose to the Legislature any
13 modifications necessary to preserve supplemental payments and
14 minimize budgetary disruptions to providers.

15 F. On or before July 1, 2023, the Authority shall submit a
16 report to the Governor, the President Pro Tempore of the Senate and
17 the Speaker of the House of Representatives that includes at a
18 minimum:

19 1. A description of the selection process of the contracted
20 entities;

21 2. Plans for enrollment of Medicaid members in health plans of
22 contracted entities;

23 3. Medicaid member network access standards;

24 4. Performance and quality metrics;

1 5. Maintenance of existing funding mechanisms described in this
2 section;

3 6. A description of the requirements and other provisions
4 included in capitated contracts; and

5 7. A full and complete copy of each executed capitated
6 contract.

7 SECTION 44. AMENDATORY 56 O.S. 2021, Section 4002.13, is
8 amended to read as follows:

9 Section 4002.13. A. ~~There is hereby created the MC~~ The
10 Oklahoma Health Care Authority shall establish a Medicaid Delivery
11 System Quality Advisory Committee for the purpose of performing the
12 duties specified in subsection B of this section.

13 B. The ~~primary power and duty of the~~ Committee shall ~~be~~ have
14 the power and duty to make recommendations to the Administrator of
15 the Oklahoma Health Care Authority and the Oklahoma Health Care
16 Authority Board on quality measures used by ~~managed care~~
17 ~~organizations and dental benefit managers~~ contracted entities in the
18 capitated ~~managed~~ care delivery model of the state Medicaid program
19 and to monitor the implementation of and adherence to such quality
20 measures.

21 C. 1. The Committee shall be comprised of members appointed by
22 the Administrator of the Oklahoma Health Care Authority. Members
23 shall serve at the pleasure of the Administrator.

24

1 2. A majority of the members shall be providers participating
2 in the capitated ~~managed~~ care delivery model of the state Medicaid
3 program, and such providers may include members of the Advisory
4 Committee on Medical Care for Public Assistance Recipients. Other
5 members shall include, but not be limited to, representatives of
6 hospitals and integrated health systems, other members of the health
7 care community, and members of the academic community having
8 subject-matter expertise in the field of health care or subfields of
9 health care, ~~or other applicable fields including, but not limited~~
10 ~~to, statistics, economics or public policy.~~

11 3. The Committee shall select from among its membership a chair
12 and vice chair.

13 ~~F.~~ D. 1. The Committee may meet as often as may be required in
14 order to perform the duties imposed on it.

15 2. A quorum of the Committee shall be required to approve any
16 final ~~action~~ recommendations of the Committee. A majority of the
17 members of the Committee shall constitute a quorum.

18 3. Meetings of the Committee shall not be subject to the
19 Oklahoma Open Meeting Act.

20 ~~F.~~ E. Members of the Committee shall receive no compensation or
21 travel reimbursement.

22 ~~G.~~ F. The Oklahoma Health Care Authority shall provide staff
23 support to the Committee. To the extent allowed under federal or
24 state law, rules or regulations, the Authority, the State Department

1 of Health, the Department of Mental Health and Substance Abuse
2 Services and the Department of Human Services shall as requested
3 provide technical expertise, statistical information, and any other
4 information deemed necessary by the chair of the Committee to
5 perform the duties imposed on it.

6 SECTION 45. NEW LAW A new section of law to be codified
7 in the Oklahoma Statutes as Section 4002.14 of Title 56, unless
8 there is created a duplication in numbering, reads as follows:

9 A. The transformed delivery system of the state Medicaid
10 program and capitated contracts awarded under the transformed
11 delivery system shall be designed with uniform defined measures and
12 goals that are consistent across contracted entities including but
13 not limited to adjusted health outcomes, quality of care, member
14 satisfaction, access to care, network adequacy, and cost.

15 B. Each contracted entity shall use nationally recognized,
16 standardized provider quality metrics as established by the Oklahoma
17 Health Care Authority and, where applicable, may use additional
18 quality metrics if the measures are mutually agreed upon by the
19 Authority, the contracted entity and participating providers. The
20 Authority shall develop processes for determining quality metrics
21 and cascading quality metrics from contracted entities to
22 subcontractors and providers.

23 C. The Authority may use consultants, organizations, or
24 measures used by organizations, health plans, the federal

1 government, or other states to develop effective measures for
2 outcomes and quality including but not limited to the National
3 Committee for Quality Assurance (NCQA) or the Healthcare
4 Effectiveness Data and Information Set (HEDIS) established by NCQA,
5 the Physician Consortium for Performance Improvement (PCPI) or any
6 measures developed by PCPI.

7 D. Each component of the quality metrics established by the
8 Authority shall be subject to specific accountability measures
9 including but not limited to penalties for noncompliance.

10 SECTION 46. AMENDATORY 56 O.S. 2021, Section 4004, is
11 amended to read as follows:

12 Section 4004. A. The Oklahoma Health Care Authority shall seek
13 any federal approval necessary to implement ~~this act~~ the Ensuring
14 Access to Medicaid Act. This shall include, but not be limited to,
15 submission to the Centers for Medicare and Medicaid Services of any
16 appropriate demonstration waiver application or Medicaid state plan
17 amendment necessary to accomplish the requirements of this act
18 within the required timeframes.

19 B. The Oklahoma Health Care Authority Board shall promulgate
20 rules to implement ~~this act~~ the Ensuring Access to Medicaid Act.

21 SECTION 47. AMENDATORY 63 O.S. 2021, Section 5009, is
22 amended to read as follows:

23 Section 5009. A. ~~On and after July 1, 1993, the Oklahoma~~
24 ~~Health Care Authority shall be the state entity designated by law to~~

1 ~~assume the responsibilities for the preparation and development for~~
2 ~~converting the present delivery of the Oklahoma Medicaid Program to~~
3 ~~a managed care system. The system shall emphasize:~~

4 1. ~~Managed care principles, including a capitated, prepaid~~
5 ~~system with either full or partial capitation, provided that highest~~
6 ~~priority shall be given to development of prepaid capitated health~~
7 ~~plans;~~

8 2. ~~Use of primary care physicians to establish the appropriate~~
9 ~~type of medical care a Medicaid recipient should receive; and~~

10 3. ~~Preventative care.~~

11 ~~The Authority shall also study the feasibility of allowing a~~
12 ~~private entity to administer all or part of the managed care system.~~

13 ~~B.~~ On and after January 1, 1995, the Oklahoma Health Care
14 Authority shall be the designated state agency for the
15 administration of the Oklahoma Medicaid Program.

16 1. The Authority shall contract with the Department of Human
17 Services for the determination of Medicaid eligibility and other
18 administrative or operational functions related to the Oklahoma
19 Medicaid Program as necessary and appropriate.

20 2. To the extent possible and appropriate, upon the transfer of
21 the administration of the Oklahoma Medicaid Program, the Authority
22 shall employ the personnel of the Medical Services Division of the
23 Department of Human Services.

1 3. The Department of Human Services and the Authority shall
2 jointly prepare a transition plan for the transfer of the
3 administration of the Oklahoma Medicaid Program to the Authority.
4 The transition plan shall include provisions for the retraining and
5 reassignment of employees of the Department of Human Services
6 affected by the transfer. The transition plan shall be submitted to
7 the Governor, the President Pro Tempore of the Senate and the
8 Speaker of the House of Representatives on or before January 1,
9 1995.

10 ~~C.~~ B. In order to provide adequate funding for the unique
11 training and research purposes associated with the demonstration
12 program conducted by the entity described in paragraph 7 of
13 subsection B of Section 6201 of Title 74 of the Oklahoma Statutes,
14 and to provide services to persons without regard to their ability
15 to pay, the Oklahoma Health Care Authority shall analyze the
16 feasibility of establishing a Medicaid reimbursement methodology for
17 nursing facilities to provide a separate Medicaid payment rate
18 sufficient to cover all costs allowable under Medicare principles of
19 reimbursement for the facility to be constructed or operated, or
20 constructed and operated, by the organization described in paragraph
21 7 of subsection B of Section 6201 of Title 74 of the Oklahoma
22 Statutes.

23 SECTION 48. AMENDATORY 25 O.S. 2021, Section 304, is
24 amended to read as follows:

1 Section 304. As used in the Oklahoma Open Meeting Act:

2 1. "Public body" means the governing bodies of all
3 municipalities located within this state, boards of county
4 commissioners of the counties in this state, boards of public and
5 higher education in this state and all boards, bureaus, commissions,
6 agencies, trusteeships, authorities, councils, committees, public
7 trusts or any entity created by a public trust, including any
8 committee or subcommittee composed of any of the members of a public
9 trust or other legal entity receiving funds from the Rural Economic
10 Action Plan Fund as authorized by Section 2007 of Title 62 of the
11 Oklahoma Statutes, task forces or study groups in this state
12 supported in whole or in part by public funds or entrusted with the
13 expending of public funds, or administering public property, and
14 shall include all committees or subcommittees of any public body.
15 Public body shall not include the state judiciary, the Council on
16 Judicial Complaints when conducting, discussing, or deliberating any
17 matter relating to a complaint received or filed with the Council,
18 the Legislature, or administrative staffs of public bodies,
19 including, but not limited to, faculty meetings and athletic staff
20 meetings of institutions of higher education when those staffs are
21 not meeting with the public body, or entry-year assistance
22 committees. Furthermore, public body shall not include the
23 multidisciplinary teams provided for in Section 1-9-102 of Title 10A
24 of the Oklahoma Statutes and subsection C of Section 1-502.2 of

1 Title 63 of the Oklahoma Statutes or any school board meeting for
2 the sole purpose of considering recommendations of a
3 multidisciplinary team and deciding the placement of any child who
4 is the subject of the recommendations. Furthermore, public body
5 shall not include meetings conducted by stewards designated by the
6 Oklahoma Horse Racing Commission pursuant to Section 203.4 of Title
7 3A of the Oklahoma Statutes when the stewards are officiating at
8 races or otherwise enforcing rules of the Commission. Furthermore,
9 public body shall not include the board of directors of a Federally
10 Qualified Health Center. Furthermore, public body shall not include
11 the Medicaid Delivery System Quality Advisory Committee of the
12 Oklahoma Health Care Authority created in Section 4002.13 of Title
13 56 of the Oklahoma Statutes;

14 2. "Meeting" means the conduct of business of a public body by
15 a majority of its members being personally together or, as
16 authorized by Section 307.1 of this title, together pursuant to a
17 videoconference. Meeting shall not include informal gatherings of a
18 majority of the members of the public body when no business of the
19 public body is discussed;

20 3. "Regularly scheduled meeting" means a meeting at which the
21 regular business of the public body is conducted;

22 4. "Special meeting" means any meeting of a public body other
23 than a regularly scheduled meeting or emergency meeting;

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1 5. "Emergency meeting" means any meeting called for the purpose
2 of dealing with an emergency. For purposes of the Oklahoma Open
3 Meeting Act, an emergency is defined as a situation involving injury
4 to persons or injury and damage to public or personal property or
5 immediate financial loss when the time requirements for public
6 notice of a special meeting would make such procedure impractical
7 and increase the likelihood of injury or damage or immediate
8 financial loss;

9 6. "Continued or reconvened meeting" means a meeting which is
10 assembled for the purpose of finishing business appearing on an
11 agenda of a previous meeting. For the purposes of the Oklahoma Open
12 Meeting Act, only matters on the agenda of the previous meeting at
13 which the announcement of the continuance is made may be discussed
14 at a continued or reconvened meeting;

15 7. "Videoconference" means a conference among members of a
16 public body remote from one another who are linked by interactive
17 telecommunication devices or technology and/or technology permitting
18 both visual and auditory communication between and among members of
19 the public body and/or between and among members of the public body
20 and members of the public. During any videoconference, both the
21 visual and auditory communications functions shall attempt to be
22 utilized; and

23 8. "Teleconference" means a conference among members of a
24 public body remote from one another who are linked by

1 telecommunication devices and/or technology permitting auditory
2 communication between and among members of the public body and/or
3 between and among members of the public body and members of the
4 public.

5 SECTION 49. RECODIFICATION 56 O.S. 2021, Section 4004,
6 as amended by Section 17 of this act, shall be recodified as Section
7 4002.15 of Title 56 of the Oklahoma Statutes, unless there is
8 created a duplication in numbering.

9 SECTION 50. REPEALER 56 O.S. 2021, Sections 1010.2
10 1010.3, 1010.4, and 1010.5, are hereby repealed.

11 SECTION 51. REPEALER 56 O.S. 2021, Sections 4002.3,
12 4002.8, and 4002.9, are hereby repealed.

13 SECTION 52. REPEALER 63 O.S. 2021, Sections 5009.5,
14 5011, and 5028, are hereby repealed.

15 SECTION 53. This act shall become effective November 1, 2022.

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1 Passed the Senate the 23rd day of March, 2022.

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Presiding Officer of the Senate

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5 Passed the House of Representatives the ____ day of _____,

6 2022.

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Presiding Officer of the House
of Representatives

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