

COMMITTEE AMENDMENT
HOUSE OF REPRESENTATIVES
State of Oklahoma

SPEAKER:

CHAIR:

I move to amend SB1337 _____
Of the printed Bill
Page _____ Section _____ Lines _____
Of the Engrossed Bill

By striking the Title, the Enacting Clause, the entire bill, and by inserting in lieu thereof the following language:

AMEND TITLE TO CONFORM TO AMENDMENTS

Adopted: _____

Amendment submitted by: Marcus McEntire _____

Reading Clerk

1 STATE OF OKLAHOMA

2 2nd Session of the 58th Legislature (2022)

3 PROPOSED
4 COMMITTEE SUBSTITUTE
5 FOR ENGROSSED
6 SENATE BILL NO. 1337

By: McCortney of the Senate

and

McEntire of the House

7
8 PROPOSED COMMITTEE SUBSTITUTE

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

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

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

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

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

11 2. Ensure budget predictability through shared risk and
12 accountability;

13 3. Ensure access to care, quality measures, and member
14 satisfaction;

15 4. Ensure efficient and cost-effective administrative systems
16 and structures; and

17 5. Ensure a sustainable delivery system that is a provider-led
18 effort and that is operated and managed by providers to the maximum
19 extent possible.

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

22 Section 4002.2 As used in ~~this act~~ the Ensuring Access to
23 Medicaid Act:

24

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

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

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

8 ~~3.~~ 4. "Capitated contract" means a contract between the
9 Oklahoma Health Care Authority and a contracted entity for delivery
10 of services to Medicaid members in which the Authority pays a fixed,
11 per-member-per-month rate based on actuarial calculations as
12 provided by Section 4002.12 of this title;

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

- 16 a. children in foster care and former foster care,
- 17 b. children up to twenty-five (25) years of age,
- 18 c. juvenile justice involved children, and
- 19 d. children receiving adoption assistance;

20 6. "Clean claim" means a properly completed billing form with
21 Current Procedural Terminology, 4th Edition or a more recent
22 edition, the Tenth Revision of the International Classification of
23 Diseases coding or a more recent revision, or Healthcare Common
24 Procedure Coding System coding where applicable that contains

1 information specifically required in the Provider Billing and
2 Procedure Manual of the Oklahoma Health Care Authority;

3 ~~4.~~ 7. "Commercial plan" means an organization or entity that
4 undertakes to provide or arrange for the delivery of health care
5 services to Medicaid members on a prepaid basis and is subject to
6 all applicable federal and state laws and regulations;

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

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

23 ~~5.~~ 10. "Essential community provider" has the same meaning as
24 provided by means:

- 1 a. a Federally Qualified Health Center,
- 2 b. a community mental health center,
- 3 c. a Native American health care provider,
- 4 d. a rural health clinic,
- 5 e. a state-operated mental health hospital,
- 6 f. a long-term care hospital serving children (LTCH-C),
- 7 g. a teaching hospital owned, jointly owned, or
- 8 affiliated with and designated by the University
- 9 Hospitals Authority, University Hospitals Trust,
- 10 Oklahoma State University Medical Authority, or
- 11 Oklahoma State University Medical Trust,
- 12 h. a provider employed by or contracted with, or
- 13 otherwise a member of the faculty practice plan of:
- 14 (1) a public, accredited medical school in this
- 15 state, or
- 16 (2) a hospital or health care entity directly or
- 17 indirectly owned or operated by the University
- 18 Hospitals Trust or the Oklahoma State University
- 19 Medical Trust,
- 20 i. a county department of health or city-county health
- 21 department,
- 22 j. a comprehensive community recovery center,
- 23
- 24

- 1 k. any additional Medicaid provider as approved by the
2 Authority if the provider either offers services that
3 are not available from any other provider within a
4 reasonable access standard or provides a substantial
5 share of the total units of a particular service
6 utilized by Medicaid members within the region during
7 the last three (3) years, and the combined capacity of
8 other service providers in the region is insufficient
9 to meet the total needs of the Medicaid members,
10 l. a hospital licensed by the State of Oklahoma,
11 including all hospitals participating in Section
12 3241.1 et. seq. of Title 63 of the Oklahoma Statutes,
13 m. Certified Community Behavioral Health Clinics (CCBHC),
14 or
15 n. any provider not otherwise mentioned in this paragraph
16 that meets the definition of "essential community
17 provider" under 45 C.F.R., Section 156.235;

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

22 ~~7.~~ 11. "Material change" includes, but is not limited to, any
23 change in overall business operations such as policy, process or
24 protocol which affects, or can reasonably be expected to affect,

1 more than five percent (5%) of enrollees or participating providers
2 of the contracted entity, managed care organization or dental
3 benefit manager;

4 ~~8.~~ 12. "Local Oklahoma provider organization" means any state
5 provider association, accountable care organization, Certified
6 Community Behavioral Health Clinic, Federally Qualified Health
7 Center, Native American tribe or tribal association, hospital or
8 health system, academic medical institution, currently practicing
9 licensed provider, or other local Oklahoma provider organization as
10 approved by the Authority;

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

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

19 ~~10.~~ 15. "Provider" means a health care or dental provider
20 licensed or certified in this state or an enrolled provider of
21 SoonerCare services as of the time of passage of this act;

22 16. "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 state
5 and is a not-for-profit or tax-exempt organization, 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,
24

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

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

9 18. "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 3. If the state seeks to expand this program in the future to
2 include other populations, it must obtain stakeholder input from
3 providers who serve these populations at least twelve (12) months
4 prior to issuing a request for proposals and such input should
5 include, but not be limited to, listening sessions, meetings, and/or
6 opportunities to provide written feedback.

7 B. 1. No later than July 1, 2022, the Oklahoma Health Care
8 Authority shall issue a request for proposals to enter into public-
9 private partnerships with contracted entities other than dental
10 benefit managers to cover all Medicaid services other than dental
11 services for the following Medicaid populations:

- 12 a. pregnant women,
- 13 b. children,
- 14 c. deemed newborns,
- 15 d. parents and caretaker relatives, and
- 16 e. the expansion population.

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

- 21 a. physical health services including, but not limited
22 to:
 - 23 (1) primary care,
 - 24 (2) inpatient and outpatient services, and

- 1 (3) emergency room services,
- 2 b. behavioral health services, and
- 3 c. prescription drug services.

4 3. The Authority shall specify the services not covered in the
5 request for proposals referenced in paragraph 1 of this subsection.
6 Capitated contracts referenced in this subsection shall not cover
7 providers of Durable Medical Equipment or Complex Rehabilitation
8 Technology as defined in 317:30-5-211.1 of the Oklahoma
9 Administrative Code.

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

- 14 a. pregnant women,
- 15 b. children,
- 16 c. parents and caretaker relatives,
- 17 d. the expansion population, and
- 18 e. members of the Children's Specialty Plan as provided
19 by subsection D of this section.

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

23 D. 1. No later than July 1, 2022, either as part of the
24 request for proposals referenced in subsection B of this section or

1 as a separate request for proposals, the Authority shall issue a
2 request for proposals to enter into public-private partnerships with
3 one contracted entity to administer a Children's Specialty Plan.

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

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

11 E. The Authority shall not implement the transformation of the
12 Medicaid delivery system until it receives written confirmation from
13 the Centers for Medicare and Medicaid Services that a managed care
14 directed payment program equal to ninety percent (90%) of the
15 average commercial rate methodology for hospital services has been
16 approved for Year 1 of the transformation and will be included in
17 the budget neutrality cap baseline spending level for purposes of
18 Oklahoma's 1115 waiver renewal.

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

22 A. All capitated contracts shall be the result of requests for
23 proposals issued by the Oklahoma Health Care Authority and
24

1 submission of competitive bids by contracted entities pursuant to
2 the Oklahoma Central Purchasing Act.

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

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

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

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

22 3. The Authority shall develop a scoring methodology for the
23 request for proposals that affords preferential scoring to provider-
24 led entities, as long as the provider-led entity otherwise

1 demonstrates ability to fulfill the contract requirements. The
2 preferential scoring methodology shall include opportunities to
3 award additional points to provider-led entities based on certain
4 factors including, but not limited to:

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

22 E. The Authority may select at least one provider-led entity
23 for the urban region if:
24

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

4 2. The provider-led entity demonstrates the ability, and
5 agrees, to expand its coverage area to the entire state within a
6 time frame set by the Authority but not mandated before seven (7)
7 years.

8 F. At the discretion of the Authority, capitated contracts may
9 be extended to ensure there are no gaps in coverage that may result
10 from termination of a capitated contract; provided, the total
11 contracting period for a capitated contract shall not exceed five
12 (5) years. During the five-year initial term, OHCA shall open
13 another request for proposal at year three (3) for a provider-led
14 entity to place bids and begin enrollment prior to the next open
15 enrollment period.

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

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

24

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

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

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

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

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

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

23 Section 4002.4 A. The Oklahoma Health Care Authority shall
24 develop network adequacy standards for all ~~managed care~~

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

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

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

1 C.F.R., Part 438 and such other providers as the Authority may
2 specify from contracts with contracted entities.

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

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

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

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

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

6 2. As provided by Section 4 of this act and by the contract
7 with the Authority, the provider-led entity shall expand its
8 coverage area to every county of this state on a timeline set by the
9 Authority but no sooner than seven (7) years.

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

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

19 2. The Authority shall require each contracted entity to meet
20 all contractual and operational requirements as defined in the
21 requests for proposals issued pursuant to Section 3 of this act.
22 Such requirements shall include but not be limited to reimbursement
23 and capitation rates, insurance reserve requirements as specified by
24 the Insurance Department, acceptance of risk as defined by the

1 Authority, operational performance expectations including the
2 assessment of penalties, member marketing guidelines, other
3 applicable state and federal regulatory requirements, and all
4 requirements of this act including, but not limited to, the
5 requirements stipulated in this section.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

19 I. All contracted entities shall:

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

22 2. Ensure broad access to pharmacies including, but not limited
23 to, pharmacies contracted with covered entities under Section 340B
24 of the Public Health Service Act. Such access shall, at a minimum,

1 meet the requirements of the Patient's Right to Pharmacy Choice Act,
2 Section 6958 et seq. of Title 36 of the Oklahoma Statutes.

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

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

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

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

22 ~~B. Review and issue determinations made by a managed care~~
23 ~~organization or, as appropriate, by a dental benefit manager for~~
24 ~~prior authorization for care ordered by primary care or specialist~~

1 ~~providers shall be timely and shall occur in accordance with the~~
2 ~~following:~~

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

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

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

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

20 ~~3. E. Notwithstanding the provisions of paragraphs 1 or 2 of~~
21 ~~this subsection~~ C of this section, a contracted entity shall make a
22 determination on a request as expeditiously as necessary and, in any
23 event, within twenty-four (24) hours of receipt of the request for
24 service if adhering to the provisions of ~~paragraphs 1 or 2 of this~~

1 subsection C or D of this section could jeopardize the ~~enrollee's~~
2 member's life, health or ability to attain, maintain or regain
3 maximum function. In the event of a medically emergent matter, the
4 ~~managed care organization or dental benefit manager~~ contracted
5 entity shall not impose limitations on providers in coordination of
6 post-emergent stabilization health care including pre-certification
7 or prior authorization~~7.~~

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

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

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

20 ~~E. H.~~ Upon issuance of an adverse determination on a prior
21 authorization request under subsection B of this section, the
22 managed care organization or dental benefit manager shall provide
23 the requesting provider, within seventy-two (72) hours of receipt of
24 such issuance, with reasonable opportunity to participate in a peer-

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

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

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

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

19 2. Require contracted entities to provide a prompt opportunity
20 for peer-to-peer conversations with Oklahoma licensed clinical staff
21 of the same or similar specialty upon adverse determination; and

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

24

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

3 Section 4002.7 ~~A managed care organization or dental benefit~~
4 ~~manager shall~~

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

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

1 definition of a clean claim, the ~~managed care organization or dental~~
2 ~~benefit manager~~ contracted entity shall not request medical records
3 of the ~~enrollee~~ member prior to paying the claim. Once a claim has
4 been paid, the ~~managed care organization or dental benefit manager~~
5 contracted entity may request medical records if additional
6 documentation is needed to review the claim for medical necessity~~7.~~

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

14 a. a

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

16 b. a

17 2. A detailed description of the additional information
18 necessary to substantiate the claim~~7.~~

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

22 a. ~~subject~~

23 1. Subject to ~~subparagraph b~~ paragraph 2 of this ~~paragraph~~
24 subsection, insofar as a ~~managed care organization or dental benefit~~

1 ~~manager~~ contracted entity conducts postpayment audits, the ~~managed~~
2 ~~care organization or dental benefit manager~~ contracted entity shall
3 employ the postpayment audit process determined by the Authority~~;~~;

4 ~~b.~~ the

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

10 ~~c.~~ the

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

20 4. E. A ~~managed care organization~~ contracted entity may only
21 apply readmission penalties pursuant to rules promulgated by the
22 Oklahoma Health Care Authority Board. The Board shall promulgate
23 rules establishing a program to reduce potentially preventable
24 readmissions. The program shall use a nationally recognized tool,

1 establish a base measurement year and a performance year, and
2 provide for risk-adjustment based on the population of the state
3 Medicaid program covered by the ~~managed care organizations and~~
4 ~~dental benefit managers~~ contracted entities.

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

7 Section 4002.8 A. A ~~managed care organization or dental~~
8 ~~benefit manager~~ contracted entity shall utilize uniform procedures
9 established by the Authority under subsection B of this section for
10 the review and appeal of any adverse determination by the ~~managed~~
11 ~~care organization or dental benefit manager sought~~ contracted entity
12 by any enrollee or provider adversely affected by such
13 determination.

14 B. The Authority shall develop procedures for ~~enrollee~~
15 enrollees or providers to seek review by the ~~managed care~~
16 ~~organization or dental benefit manager~~ contracted entity of any
17 adverse determination made by the ~~managed care organization or~~
18 ~~dental benefit manager~~ contracted entity. A provider shall have six
19 (6) months from the receipt of a claim denial to file an appeal.

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

23 1. Medical review staff of the ~~managed care organization or~~
24 ~~dental benefit manager~~ contracted entity shall be licensed or

1 credentialed health care clinicians with relevant clinical training
2 or experience; and

3 2. All ~~managed care organizations and dental benefit managers~~
4 contracted entities shall use medical review staff for such appeals
5 and shall not use any automated claim review software or other
6 automated functionality for such appeals.

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

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

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

24

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

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

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

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

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

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

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

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

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

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

20 B. A managed care organization or dental benefit manager shall
21 offer value-based payment arrangements to all providers in its
22 network capable of entering into value-based payment arrangements.
23 Such arrangements shall be optional for the provider but shall be
24 tied to reimbursement incentives when quality metrics are met. The

1 quality measures used by a managed care organization or dental
2 benefit manager to determine reimbursement amounts to providers in
3 value-based payment arrangements shall align with the quality
4 measures of the Authority for managed care organizations or dental
5 benefit managers.

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

12 D. All rural health clinics (RHCs) shall be offered contracts
13 that will reimburse them using the methodology in place for each
14 specific RHC prior to January 1, 2023, including any and all annual
15 rate updates. Future RHC developments will be based on the federal
16 program rules and requirements, and this new commercially managed
17 Medicaid program will not interfere with the program as designed.

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

23 F. The Authority is given flexibility to work with physicians
24 and other providers not including hospitals to design a

1 reimbursement rate not to exceed the purpose of paragraph 1 of
2 subsection C of Section 3241.3 of Title 63 of the Oklahoma Statutes
3 with two components: a base rate no less than one hundred percent
4 (100%) of the Medicare rate; and an incentive payment that is
5 determined by value-based outcomes. Physicians and providers may
6 contract with multiple contracted entities.

7 G. Psychologist reimbursement shall reflect outcomes and
8 include bill codes beyond reimbursement for therapy to be able to
9 obtain reimbursement for testing and assessment.

10 H. Coverage for Medicaid transportation services by licensed
11 Oklahoma emergency medical services should be reimbursed at no less
12 than the published Medicaid rates in effect on the date of enactment
13 of this act. All currently published Medicaid HCPC codes paid by
14 OHCA will continue to be paid by the contracted entity. The
15 contracted entity will continue to follow the reimbursement policies
16 established OHCA for the ambulance providers at the time of passage
17 of this act. Such policies shall include but are not limited to:
18 emergency medical transportation not being required for prior
19 authorization; and the contracted entities will accept the CMS
20 modifiers currently in use by Medicare at the time of the transport
21 of a member that is a dual-eligible.

22 I. The Authority shall specify in the requests for proposals a
23 reasonable time frame in which a contracted entity shall have
24

1 entered into a certain percentage, as determined by the Authority,
2 of value-based contracts with providers.

3 J. Capitation rates established by the Oklahoma Health Care
4 Authority and paid to contracted entities under capitated contracts
5 shall be updated annually and in accordance with 42 C.F.R. Section
6 438.36(c) and approved as actuarially sound as determined by CMS in
7 accordance with 42 C.F.R. Section 438.4 and the following:

8 1. Actuarial calculations must include utilization and
9 expenditure assumptions consistent with industry and local
10 standards; and

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

13 K. The Authority may establish a symmetric risk corridor for
14 contracted entities.

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

18 Any dental managed care program shall include the following
19 components:

20 1. All dental claims reviewed, and reimbursements made within
21 fourteen (14) days following a clean claim submission to a
22 contracted entity;

23 2. There shall be no deletions to the list of covered dental
24 procedures as of the date of this act, as well as those that do or

1 do not require pre-authorization, including in-office sedation or
2 anesthesia;

3 3. At least two ODA-appointed representatives to provide input
4 during the request for proposal process, as well as any negotiating
5 and structuring of contracts with any contracted entity;

6 4. The Authority shall award a contract to more than one
7 contracted entity for dental;

8 5. The Authority shall not require a dentist to enroll
9 exclusively with one contracted entity;

10 6. All contracted entities with a dental contract shall be
11 required to maintain a Medicaid Dental Advisory Committee, comprised
12 exclusively of Oklahoma-licensed dentists and specialists, to
13 conduct all pre-authorizations and claims reviews and appeals; and

14 7. The state shall employ an Oklahoma-licensed dentist to serve
15 as the Medicaid Dental Director overseeing all contracted entities
16 with a dental contract.

17 SECTION 16. NEW LAW A new section of law to be codified
18 in the Oklahoma Statutes as Section 4002.12b 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
4 a directed payment program with an average commercial rate
5 methodology equal to ninety percent (90%) of the average commercial
6 rate methodology for hospital services, subject to approval by the
7 Centers for Medicare and Medicaid Services. The directed payment
8 methodology shall be found in Sections 3241.2 through 3241.4 of
9 Title 63 of the Oklahoma Statutes.

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

22 F. On or before January 1, 2023, the Authority shall submit a
23 report to the Governor, the President Pro Tempore of the Oklahoma
24

1 State Senate and the Speaker of the Oklahoma House of
2 Representatives that includes at a minimum:

3 1. A description of the selection process of the contracted
4 entities;

5 2. Plans for enrollment of Medicaid members in health plans of
6 contracted entities;

7 3. Medicaid member network access standards;

8 4. Performance and quality metrics;

9 5. Maintenance of existing funding mechanisms described in this
10 section;

11 6. A description of the requirements and other provisions
12 included in capitated contracts; and

13 7. A full and complete copy of each executed capitated
14 contract.

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

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

21 B. ~~The primary power and duty of the Committee shall be~~ have
22 the power and duty to make recommendations to the Administrator of
23 the Oklahoma Health Care Authority and the Oklahoma Health Care
24 Authority Board on quality measures used by ~~managed care~~

1 ~~organizations and dental benefit managers~~ contracted entities in the
2 capitated ~~managed~~ care delivery model of the state Medicaid program
3 and to monitor the implementation of and adherence to such quality
4 measures.

5 C. 1. The Committee shall be comprised of members appointed by
6 the Administrator of the Oklahoma Health Care Authority. Members
7 shall serve at the pleasure of the Administrator.

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

18 3. The Committee shall select from among its membership a chair
19 and vice chair.

20 ~~E.~~ D. 1. The Committee may meet as often as may be required in
21 order to perform the duties imposed on it.

22 2. A quorum of the Committee shall be required to approve any
23 final ~~action~~ recommendations of the Committee. A majority of the
24 members of the Committee shall constitute a quorum.

1 3. Meetings of the Committee shall be subject to the Oklahoma
2 Open Meeting Act.

3 ~~F.~~ E. Members of the Committee shall receive no compensation or
4 travel reimbursement.

5 ~~G.~~ F. The Oklahoma Health Care Authority shall provide staff
6 support to the Committee. To the extent allowed under federal or
7 state law, rules or regulations, the Authority, the State Department
8 of Health, the Department of Mental Health and Substance Abuse
9 Services and the Department of Human Services shall as requested
10 provide technical expertise, statistical information, and any other
11 information deemed necessary by the chair of the Committee to
12 perform the duties imposed on it.

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

16 A. The transformed delivery system of the state Medicaid
17 program and capitated contracts awarded under the transformed
18 delivery system shall be designed with uniform defined measures and
19 goals that are consistent across contracted entities including, but
20 not limited to, adjusted health outcomes, social determinants of
21 health, quality of care, member satisfaction, provider satisfaction,
22 access to care, network adequacy, and cost.

23 B. Each contracted entity shall use nationally recognized,
24 standardized provider quality metrics as established by the Oklahoma

1 Health Care Authority and, where applicable, may use additional
2 quality metrics if the measures are mutually agreed upon by the
3 Authority, the contracted entity, and participating providers. The
4 Authority shall develop processes for determining quality metrics
5 and cascading quality metrics from contracted entities to
6 subcontractors and providers.

7 C. The Authority may use consultants, organizations, or
8 measures used by health plans, the federal government, or other
9 states to develop effective measures for outcomes and quality
10 including, but not limited to, the National Committee for Quality
11 Assurance (NCQA) or the Healthcare Effectiveness Data and
12 Information Set (HEDIS) established by NCQA, the Physician
13 Consortium for Performance Improvement (PCPI) or any measures
14 developed by PCPI.

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

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

20 Section 4004. A. The Oklahoma Health Care Authority shall seek
21 any federal approval necessary to implement ~~this act~~ the Ensuring
22 Access to Medicaid Act. This shall include, but not be limited to,
23 submission to the Centers for Medicare and Medicaid Services of any
24 appropriate demonstration waiver application or Medicaid State Plan

1 amendment necessary to accomplish the requirements of this act
2 within the required time frames. Prior to implementation of the
3 managed care contracts, the Authority shall obtain federal approval
4 of a managed care directed payment program equal to ninety percent
5 (90%) of the average commercial rate methodology for hospital
6 services. Dental managed care shall be exempt from the requirement
7 of CMS approval of the directed payment program.

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

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

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

17 1. ~~Managed care principles, including a capitated, prepaid~~
18 ~~system with either full or partial capitation, provided that highest~~
19 ~~priority shall be given to development of prepaid capitated health~~
20 ~~plans;~~

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

23 3. ~~Preventative care.~~

24

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

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

6 1. The Authority shall contract with the Department of Human
7 Services for the determination of Medicaid eligibility and other
8 administrative or operational functions related to the Oklahoma
9 Medicaid Program as necessary and appropriate.

10 2. To the extent possible and appropriate, upon the transfer of
11 the administration of the Oklahoma Medicaid Program, the Authority
12 shall employ the personnel of the Medical Services Division of the
13 Department of Human Services.

14 3. The Department of Human Services and the Authority shall
15 jointly prepare a transition plan for the transfer of the
16 administration of the Oklahoma Medicaid Program to the Authority.
17 The transition plan shall include provisions for the retraining and
18 reassignment of employees of the Department of Human Services
19 affected by the transfer. The transition plan shall be submitted to
20 the Governor, the President Pro Tempore of the Senate and the
21 Speaker of the House of Representatives on or before January 1,
22 1995.

23 ~~C.~~ B. In order to provide adequate funding for the unique
24 training and research purposes associated with the demonstration

1 program conducted by the entity described in paragraph 7 of
2 subsection B of Section 6201 of Title 74 of the Oklahoma Statutes,
3 and to provide services to persons without regard to their ability
4 to pay, the Oklahoma Health Care Authority shall analyze the
5 feasibility of establishing a Medicaid reimbursement methodology for
6 nursing facilities to provide a separate Medicaid payment rate
7 sufficient to cover all costs allowable under Medicare principles of
8 reimbursement for the facility to be constructed or operated, or
9 constructed and operated, by the organization described in paragraph
10 7 of subsection B of Section 6201 of Title 74 of the Oklahoma
11 Statutes.

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

14 Section 5009.2 A. The Advisory Committee on Medical Care for
15 Public Assistance Recipients, created by the Oklahoma Health Care
16 Authority pursuant to 42 Code of Federal Regulations, Section
17 431.12, for the purpose of advising the Authority about health and
18 medical care services, shall include among its membership of no more
19 than fifteen (15) the following:

20 1. Board-certified physicians and other representatives of the
21 health professions who are familiar with the medical needs of low-
22 income population groups and with the resources available and
23 required for their care. The Advisory Committee shall, at all
24 times, include at least one physician from each of the six classes

1 of physicians listed in Section 725.2 of Title 59 of the Oklahoma
2 Statutes. The Advisory Committee shall at all times include at
3 least one pharmacist and one psychologist licensed in this state.

4 All such physicians and other representatives of the health
5 professions shall be participating providers in the State Medicaid
6 Plan;

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

8 a. Medicaid recipients, and

9 b. representatives from consumer organizations including
10 a member representing nursing homes, a member
11 representing individuals with developmental
12 disabilities and a member representing one or more
13 behavioral health professions;

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

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

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

22 a. monitor provider relations with the Oklahoma Health
23 Care Authority, and

24 b. create a forum to address grievances; ~~and~~

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

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

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

9 B. The Advisory Committee shall meet bimonthly to review and
10 make recommendations related to:

11 1. Policy development and program administration;

12 2. Policy changes proposed by the Authority prior to
13 consideration of such changes by the Authority;

14 3. Financial concerns related to the Authority and the
15 administration of the programs under the Authority; and

16 4. Other pertinent information related to the management and
17 operation of the Authority and the delivery of health and medical
18 care services.

19 C. 1. The Administrator of the Authority shall provide such
20 staff support and independent technical assistance as needed by the
21 Advisory Committee to enable the Advisory Committee to make
22 effective recommendations.

23 2. The Advisory Committee shall elect from among its members a
24 chair and a vice-chair who shall serve one-year terms. A member may

1 serve more than one (1), but not more than four (4), consecutive
2 one-year terms as chair or vice-chair. A majority of the members of
3 the Advisory Committee shall constitute a quorum to transact
4 business, but no vacancy shall impair the right of the remaining
5 members to exercise all of the powers of the Advisory Committee.

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

10 D. The Authority shall give due consideration to the comments
11 and recommendations of the Advisory Committee in the Authority's
12 deliberations on policies, administration, management and operation
13 of the Authority.

14 SECTION 22. NEW LAW A new section of law to be codified
15 in the Oklahoma Statutes as Section 307.1 of Title 36, unless there
16 is created a duplication in numbering, reads as follows:

17 The Insurance Department shall develop methods to ensure program
18 integrity against fraud, waste, and abuse by any contracted entity
19 as defined by Section 4002.2 of Title 56 of the Oklahoma Statutes.
20 The Insurance Department and the Oklahoma Health Care Authority
21 shall establish a provider grievance committee to advise the
22 Oklahoma Health Care Authority and Insurance Department on
23 imposition of penalties on the contracted entities that do not
24 comply with established statutes and regulations.

1 SECTION 23. AMENDATORY 36 O.S. 2021, Section 312.1, is
2 amended to read as follows:

3 Section 312.1 A. For the fiscal year ending June 30, 2004, the
4 Insurance Commissioner shall report and disburse one hundred percent
5 (100%) of the fees and taxes collected under Section 624 of this
6 title to the State Treasurer to be deposited to the credit of the
7 Education Reform Revolving Fund of the State Department of
8 Education. The Insurance Commissioner shall keep an accurate record
9 of all such funds and make an itemized statement and furnish same to
10 the State Auditor and Inspector, as to all other departments of this
11 state. The report shall be accompanied by an affidavit of the
12 Insurance Commissioner or the Chief Clerk of such office certifying
13 to the correctness thereof.

14 B. The Insurance Commissioner shall apportion an amount of the
15 taxes and fees received from Section 624 of this title, which shall
16 be at least One Million Two Hundred Fifty Thousand Dollars
17 (\$1,250,000.00) each year, but which shall also be computed on an
18 annual basis by the Commissioner as the amount of insurance premium
19 tax revenue loss attributable to the provisions of subsection H of
20 Section 625.1 of this title and increased if necessary to reflect
21 the annual computation, and which shall be apportioned before any
22 other amounts, as follows:

23 1. The following amounts shall be paid to the Oklahoma
24 Firefighters Pension and Retirement Fund in the manner provided for

1 in Sections 49-119, 49-120 and 49-123 of Title 11 of the Oklahoma
2 Statutes:

3	Fiscal Year	Amount
4	FY 2006 through FY 2020	65.0%
5	FY 2021 as follows:	
6	a. for the month beginning July 1,	
7	2020, through the month ending	
8	August 31, 2020	65.0%
9	b. for the month beginning September	
10	1, 2020, through the month ending	
11	June 30, 2021	45.5%
12	FY 2022 and each fiscal year thereafter	65.0%;

13 2. The following amounts shall be paid to the Oklahoma Police
14 Pension and Retirement System pursuant to the provisions of Sections
15 50-101 through 50-136 of Title 11 of the Oklahoma Statutes:

16	Fiscal Year	Amount
17	FY 2006 through FY 2020	26.0%
18	FY 2021 as follows:	
19	a. for the month beginning July 1,	
20	2020, through the month ending	
21	August 31, 2020	26.0%
22	b. for the month beginning September	
23	1, 2020, through the month ending	
24	June 30, 2021	18.2%

1 FY 2022 and each fiscal year thereafter 26.0%;

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

4 Fiscal Year	Amount
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5 FY 2006 through FY 2020	9.0%
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6 FY 2021 as follows:

7 a. for the month beginning July 1, 8 2020, through the month ending 9 August 31, 2020	9.0%
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10 b. for the month beginning September 11 1, 2020, through the month ending 12 June 30, 2021	6.3%
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13 FY 2022 and each fiscal year thereafter 9.0%; and

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

16 Fiscal Year	Amount
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17 FY 2021 as follows:

18 for the month beginning September 1, 19 2020, through the month ending June 30, 20 2021	30.0%.
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21 C. After the apportionment required by subsection B of this
22 section, for the fiscal years beginning July 1, 2004, and ending
23 June 30, 2009, the Insurance Commissioner shall report and disburse
24 all of the fees and taxes collected under Section 624 of this title

1 and Section 2204 of this title, and the same are hereby apportioned
2 as follows:

3 1. Thirty-four percent (34%) of the taxes collected on premiums
4 shall be allocated and disbursed for the Oklahoma Firefighters
5 Pension and Retirement Fund, in the manner provided for in Sections
6 49-119, 49-120 and 49-123 of Title 11 of the Oklahoma Statutes;

7 2. Seventeen percent (17%) of the taxes collected on premiums
8 shall be 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 3. Six and one-tenth percent (6.1%) of the taxes collected on
12 premiums shall be allocated and disbursed to the Law Enforcement
13 Retirement Fund; and

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

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1 D. After the apportionment required by subsection B of this
2 section, the Insurance Commissioner shall report and disburse all of
3 the fees and taxes collected under Section 624 of this title and
4 Section 2204 of this title, and the same are hereby apportioned as
5 follows:

6 1. Of the taxes collected on premiums the following shall be
7 allocated and disbursed for the Oklahoma Firefighters Pension and
8 Retirement Fund, in the manner provided for in Sections 49-119, 49-
9 120 and 49-123 of Title 11 of the Oklahoma Statutes:

10	Fiscal Year	Amount
11	FY 2006 through FY 2020	36.0%
12	FY 2021 as follows:	
13	a. for the month beginning July 1,	
14	2020, through the month ending	
15	August 31, 2020	36.0%
16	b. for the month beginning September	
17	1, 2020, through the month ending	
18	June 30, 2021	25.2%
19	FY 2022	36.0%
20	FY 2023 through FY 2027	37.8%
21	FY 2028 and each fiscal year thereafter	36.0%;

22 2. Of the taxes collected on premiums the following shall be
23 allocated and disbursed to the Oklahoma Police Pension and
24

1 Retirement System pursuant to the provisions of Sections 50-101
2 through 50-136 of Title 11 of the Oklahoma Statutes:

3	Fiscal Year	Amount
4	FY 2006 through FY 2020	14.0%
5	FY 2021 as follows:	
6	a. for the month beginning July 1,	
7	2020, through the month ending	
8	August 31, 2020	14.0%
9	b. for the month beginning September	
10	1, 2020, through the month ending	
11	June 30, 2021	9.8%
12	FY 2022	14.0%
13	FY 2023 through FY 2027	14.7%
14	FY 2028 and each fiscal year thereafter	14.0%;

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

17	Fiscal Year	Amount
18	FY 2006 through FY 2020	5.0%
19	FY 2021 as follows:	
20	a. for the month beginning July 1,	
21	2020, through the month ending	
22	August 31, 2020	5.0%

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b. for the month beginning September 1, 2020, through the month ending June 30, 2021 3.5%

FY 2022 5.0%

FY 2023 through FY 2027 5.25%

FY 2028 and each fiscal year thereafter 5.0%;

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

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

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

- a. Forty Thousand Six Hundred Twenty-five Dollars (\$40,625.00) to the Oklahoma Firefighters Pension and Retirement Fund,
- b. Sixteen Thousand Two Hundred Fifty Dollars (\$16,250.00) to the Oklahoma Police Pension and Retirement System, and

1 c. Five Thousand Six Hundred Twenty-five Dollars
2 (\$5,625.00) to the Oklahoma Law Enforcement Retirement
3 Fund; and

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

14 E. The disbursements provided for in subsections A, B, C and D
15 of this section shall be made monthly. The Insurance Commissioner
16 shall report annually to the Governor, the Speaker of the House of
17 Representatives, the President Pro Tempore of the Senate and the
18 State Auditor and Inspector, the amounts collected and disbursed
19 pursuant to this section.

20 F. Notwithstanding any other provision of law to the contrary,
21 no tax credit authorized by law enacted on or after July 1, 2008,
22 which may be used to reduce any insurance premium tax liability
23 shall be used to reduce the amount of insurance premium tax revenue
24 apportioned to the Oklahoma Firefighters Pension and Retirement

1 System, the Oklahoma Police Pension and Retirement System, the
2 Oklahoma Law Enforcement Retirement System or the Education Reform
3 Revolving Fund.

4 G. For fiscal year 2023, and each subsequent fiscal year,
5 before any other apportionment otherwise required by this section is
6 made, there shall be apportioned to the Medicaid Contingency
7 Revolving Fund, created in Section 1010.8 of Title 56 of the
8 Oklahoma Statutes, the portion of premium taxes and fees collected
9 under Section 624 of this title from contracted entities of the
10 Ensuring Access to Medicaid program of the Oklahoma Health Care
11 Authority and to provide the state share of Medicaid expansion costs
12 as outlined in Section 1 et seq. of Article XXV-A of the Oklahoma
13 Constitution.

14 SECTION 24. RECODIFICATION 56 O.S. 2021, Section 4004,
15 as amended by Section 20 of this act, shall be recodified as Section
16 4002.15 of Title 56 of the Oklahoma Statutes, unless there is
17 created a duplication in numbering.

18 SECTION 25. REPEALER 56 O.S. 2021, Sections 1010.2,
19 1010.3, 1010.4, and 1010.5, are hereby repealed.

20 SECTION 26. REPEALER 56 O.S. 2021, Sections 4002.3 and
21 4002.9, are hereby repealed.

22 SECTION 27. REPEALER 63 O.S. 2021, Sections 5009.5,
23 5011, and 5028, are hereby repealed.

24 SECTION 28. This act shall become effective July 1, 2022.

1 SECTION 29. It being immediately necessary for the preservation
2 of the public peace, health or safety, an emergency is hereby
3 declared to exist, by reason whereof this act shall take effect and
4 be in full force from and after its passage and approval.

5 SECTION 30. NEW LAW A new section of law not to be
6 codified in the Oklahoma Statutes reads as follows:

7 This act shall become effective only if Senate Bill No. 1396 of
8 the 2nd Session of the 58th Oklahoma Legislature is enacted into
9 law.

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