

OKLAHOMA STATE SENATE  
CONFERENCE  
COMMITTEE REPORT

May 16, 2022

Mr. President:

Mr. Speaker:

The Conference Committee, to which was referred

SB1337

By: McCortney of the Senate and McEntire et al. of the House

Title: State Medicaid program; directing Oklahoma Health Care Authority to enter into capitated contracts to transform Medicaid delivery system for certain Medicaid populations; modifying various provisions of the Ensuring Access to Medicaid Act. Conditional effective date. Effective date. Emergency.

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together with Engrossed House Amendments thereto, beg leave to report that we have had the same under consideration and herewith return the same with the following recommendations:

1. That the House recede from all Amendments.
2. That the attached Conference Committee Substitute be adopted.

Respectfully submitted,

SENATE CONFEREES:

  
\_\_\_\_\_  
McCortney

\_\_\_\_\_  
Hicks

  
\_\_\_\_\_  
Dossett (J.A.)

  
\_\_\_\_\_  
Montgomery

  
\_\_\_\_\_  
Garvin

\_\_\_\_\_  
Rosino




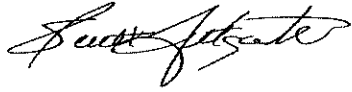
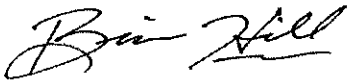
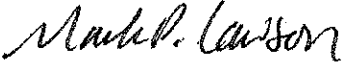


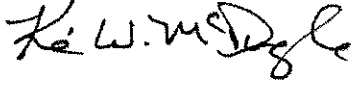


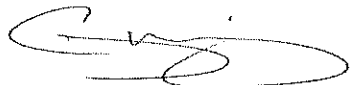

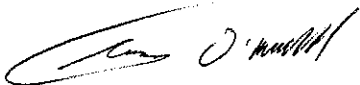


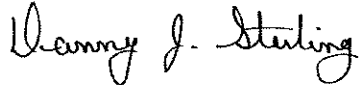
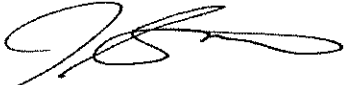




  
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Haste

HOUSE CONFEREES:

General Conference Committee on Appropriations

Senate Action \_\_\_\_\_ Date \_\_\_\_\_ House Action \_\_\_\_\_ Date \_\_\_\_\_

SB1337 CCR (B)  
**HOUSE CONFEREES**

Baker, Rhonda		Bennett, Forrest	<hr/>
Blancett, Meloyde	<hr/>	Boatman, Jeff	
Dills, Sheila		Echols, Jon	<hr/>
Fetgatter, Scott		Ford, Ross	<hr/>
Goodwin, Regina	<hr/>	Hill, Brian	
Kannady, Chris	<hr/>	Lawson, Mark	
Lepak, Mark	<hr/>	Martinez, Ryan	
McBride, Mark		McDugle, Kevin	
McEntire, Marcus		Miller, Nicole	
Mize, Garry		Munson, Cyndi	<hr/>
Newton, Carl		Nichols, Monroe	<hr/>
O'Donnell, Terry		Osburn, Mike	
Pfeiffer, John		Roberts, Dustin	<hr/>
Roberts, Sean	<hr/>	Russ, Todd	<hr/>
Sterling, Danny		Strom, Judd	
Virgin, Emily	<hr/>	Walke, Collin	
Wallace, Kevin		West, Josh	
West, Tammy			

1 STATE OF OKLAHOMA

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

3 CONFERENCE COMMITTEE SUBSTITUTE  
4 FOR ENGROSSED

5 SENATE BILL NO. 1337

By: McCortney of the Senate

and

6 McEntire, Randleman, and  
7 Sims of the House

8  
9 CONFERENCE COMMITTEE SUBSTITUTE

10 An Act relating to the state Medicaid program;  
11 providing legislative intent; amending 56 O.S. 2021,  
12 Section 4002.2, which relates to definitions used in  
13 the Ensuring Access to Medicaid Act; modifying,  
14 adding, and eliminating certain definitions;  
15 requiring the Oklahoma Health Care Authority to enter  
16 into certain contracts; requiring legislative  
17 authorization for certain contracts; requiring the  
18 Authority to issue requests for proposals to cover  
19 specified Medicaid populations; requiring  
20 specification of services covered and not covered;  
21 requiring program implementation by specified date  
22 subject to certain condition; requiring certain  
23 coordination of services; requiring certain federal  
24 approval prior to program implementation; requiring  
certain bids; allowing certain entities to be awarded  
contracts; specifying number of contracts to be  
awarded; requiring selection of provider-led entity  
for statewide coverage except under specified  
condition; requiring the Authority to develop certain  
preferential scoring methodology; providing factors  
for developed methodology; authorizing selection of  
provider-led entity for urban region under certain  
conditions; allowing extension of contracts in  
certain situations; requiring new contracts to be  
made after the end of the contract term; authorizing  
certain delay in contract implementation; requiring  
the Authority to develop process for assignment of  
members to contracted entities; stipulating

1 requirements for American Indians and Alaska Natives;  
2 stipulating procedures for continuity of member care  
3 management in event of contract termination; granting  
4 certain right to Medicaid members; requiring  
5 contracted entity to provide certain notification;  
6 directing assignment of members to primary care  
7 provider under certain condition; requiring  
8 development of certain assignment process; amending  
9 56 O.S. 2021, Section 4002.4, which relates to  
10 network adequacy standards; requiring time and  
11 distance standards; removing certain requirements;  
12 modifying terminology; increasing contracting  
13 requirements for certain providers; requiring certain  
14 expansion of provider-led entity coverage area;  
15 requiring approval of the Authority; requiring the  
16 Authority to develop certain contract terms;  
17 requiring contracted entities to meet all  
18 requirements; requiring the Authority to develop  
19 certain methods and processes; amending 56 O.S. 2021,  
20 Section 4002.5, which relates to duties of contracted  
21 entities; making contracted entity responsible for  
22 all administrative functions for enrolled members;  
23 requiring contracted entity to hold certificate of  
24 authority as health maintenance organization;  
requiring contracted entity to have certain shared  
governance structure consisting of specified members;  
modifying terminology; providing certain  
construction; prohibiting certain contracting  
practices by contracted entity; requiring the use of  
certain drug formulary; ensuring broad access to  
pharmacies; requiring submission of data through  
state-designated entity for health information  
exchange; amending 56 O.S. 2021, Section 4002.6,  
which relates to determination and review  
requirements; mandating compliance by contracted  
entity with prior authorization requirements;  
requiring the Authority to establish certain  
requirements; modifying terminology; modifying peer-  
to-peer review procedures; directing establishment of  
internal and external review and appeal requirements;  
directing the Authority to establish requirements for  
internal and external reviews; amending 56 O.S. 2021,  
Section 4002.7, which relates to requirements for  
processing and adjudicating claims; directing the  
Authority to establish certain requirements;  
modifying terms; amending 56 O.S. 2021, Section  
4002.8, which relates to uniform procedures for

1 review and appeal for adverse determinations;  
2 modifying terms; amending 56 O.S. 2021, Section  
3 4002.10, which relates to readiness review; modifying  
4 terms; removing certain requirements; amending 56  
5 O.S. 2021, Section 4002.11, which relates to  
6 scorecard comparing contracted entities and dental  
7 benefit managers; limiting certain reporting  
8 criteria; modifying scoring time period; modifying  
9 terms; amending 56 O.S. 2021, Section 4002.12, which  
10 relates to reimbursement of providers; imposing  
11 termination date on minimum reimbursement rates;  
12 modifying terms; modifying value-based payment  
13 criteria; setting certain requirements for certain  
14 services and providers; directing establishment of  
15 incentive payment for certain providers; requiring  
16 the Authority to specify time frame for attainment of  
17 certain percentage of value-based contracts;  
18 requiring capitation rates to be updated annually,  
19 actuarially sound, and risk-adjusted; authorizing the  
20 Authority to establish symmetric risk corridor;  
21 directing the Authority to establish process for  
22 recovery of certain funds; requiring certain  
23 determination and monitoring by the Authority;  
24 requiring contracted entity to meet certain primary  
care spending level; requiring dental benefit manager  
to maintain certain advisory committee; exempting  
dental providers from mandatory capitated contracts  
with dental benefit managers; requiring the Authority  
to ensure sustainability of transformed Medicaid  
delivery system; requiring the Authority to develop  
plan to preserve or increase supplemental payments;  
directing the Authority to preserve and expand levels  
of funding through directed payments subject to  
certain conditions; requiring the Authority to submit  
certain reports to specified individuals and  
entities; stipulating criteria of reports; amending  
56 O.S. 2021, Section 4002.13, which relates to the  
Quality Advisory Committee; renaming committee;  
modifying terms; requiring transformed Medicaid  
delivery system to include uniform defined measures  
and goals; requiring contracted entities to use  
established quality metrics; allowing use of  
additional quality metrics subject to certain  
agreement; requiring the Authority to develop  
processes for determining quality metrics;  
authorizing the Authority to use consultants,  
organizations, or third-party measures to develop

1 outcome measures; subjecting quality metrics to  
2 accountability measures and penalties; amending 56  
3 O.S. 2021, Section 4004, which relates to federal  
4 approval; directing the Authority to take certain  
5 action to seek federal approval; requiring obtainment  
6 of certain federal approval prior to implementation  
7 of certain contracts; amending 63 O.S. 2021, Section  
8 5009, which relates to the Oklahoma Medicaid program;  
9 removing obsolete provisions relating to conversion  
10 of delivery system; amending 36 O.S. 2021, Section  
11 624, which relates to insurance premium tax;  
12 directing certain proceeds to specified fund;  
13 providing certain construction; creating Medicaid  
14 Health Improvement Revolving Fund; specifying funding  
15 sources; stating allowed expenses; stipulating  
16 process for expenditures; renumbering 56 O.S. 2021,  
17 Section 4004, as amended by Section 20 of this act;  
18 repealing 56 O.S. 2021, Sections 1010.2, 1010.3,  
19 1010.4, 1010.5, and 1010.8, which relate to the  
20 Oklahoma Medicaid Program Reform Act of 2003;  
21 repealing 56 O.S. 2021, Sections 4002.3 and 4002.9,  
22 which relate to the Ensuring Access to Medicaid Act;  
23 repealing 63 O.S. 2021, Sections 5009.5, 5011, and  
24 5028, which relate to the Oklahoma Health Care  
Authority Act; providing for codification; providing  
a conditional effective date; providing an effective  
date; and declaring an emergency.

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

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

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

1 need. The state Medicaid program shall be designed to achieve the  
2 following goals:

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

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

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

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

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

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

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

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

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

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

1        ~~3.~~ 4. "Capitated contract" means a contract between the  
2 Oklahoma Health Care Authority and a contracted entity for delivery  
3 of services to Medicaid members in which the Authority pays a fixed,  
4 per-member-per-month rate based on actuarial calculations;

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

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

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

21        ~~4.~~ 7. "Commercial plan" means an organization or entity that  
22 undertakes to provide or arrange for the delivery of health care  
23 services to Medicaid members on a prepaid basis and is subject to  
24 all applicable federal and state laws and regulations;



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

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

17       ~~5.~~ 10. "Essential community provider" has the same meaning as  
18 provided by means:

- 19       a. a Federally Qualified Health Center,
- 20       b. a community mental health center,
- 21       c. an Indian Health Care Provider,
- 22       d. a rural health clinic,
- 23       e. a state-operated mental health hospital,
- 24       f. a long-term care hospital serving children (LTCH-C),

- 1        g. a teaching hospital owned, jointly owned, or  
2        affiliated with and designated by the University  
3        Hospitals Authority, University Hospitals Trust,  
4        Oklahoma State University Medical Authority, or  
5        Oklahoma State University Medical Trust,
- 6        h. a provider employed by or contracted with, or  
7        otherwise a member of the faculty practice plan of:
- 8            (1) a public, accredited medical school in this  
9            state, or
- 10           (2) a hospital or health care entity directly or  
11           indirectly owned or operated by the University  
12           Hospitals Trust or the Oklahoma State University  
13           Medical Trust,
- 14        i. a county department of health or city-county health  
15        department,
- 16        j. a comprehensive community addiction recovery center,
- 17        k. a hospital licensed by the State of Oklahoma including  
18        all hospitals participating in the Supplemental  
19        Hospital Offset Payment Program,
- 20        l. a Certified Community Behavioral Health Clinic  
21        (CCBHC),
- 22        m. a provider employed by or contracted with a primary  
23        care residency program accredited by the Accreditation  
24        Council for Graduate Medical Education,

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

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

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

23          8. 12. "Governing body" means a group of individuals appointed  
24          by the contracted entity who approve policies, operations,

1 profit/loss ratios, executive employment decisions, and who have  
2 overall responsibility for the operations of the contracted entity  
3 of which they are appointed;

4 13. "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 14. "Medical necessity" has the same meaning as provided by  
12 rules ~~of~~ promulgated by the Oklahoma Health Care Authority Board;

13 ~~9.~~ 15. "Participating provider" means a provider who has a  
14 contract with or is employed by a ~~managed care organization or~~  
15 ~~dental benefit manager~~ contracted entity 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.~~ 16. "Provider" means a health care or dental provider  
20 licensed or certified in this state or a provider that meets the  
21 Authority's provider enrollment criteria to contract with the  
22 Authority as a SoonerCare provider;

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

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:

- 10           a. all counties of this state with a county population of  
11           not less than five hundred thousand (500,000)  
12           according to the latest Federal Decennial Census, and  
13           b. all counties that are contiguous to the counties  
14           described in subparagraph a of this paragraph,  
15           combined into one region.

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

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

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

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

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

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. Capitated contracts referenced in this subsection shall  
18 cover all Medicaid services other than dental services including:

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

1 c. prescription drug services.

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

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

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

10 a. pregnant women,

11 b. children,

12 c. parents and caretaker relatives,

13 d. the expansion population, and

14 e. members of the Children's Specialty Plan as provided  
15 by subsection D of this section.

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

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

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



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

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

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

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

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

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

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

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

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

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

23           2. If no provider-led entity submits a responsive reply to the  
24 Authority's request for proposals demonstrating ability to fulfill

1 the contract requirements, the Authority shall not be required to  
2 contract for statewide coverage with a provider-led entity.

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

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

1 arrangements or risk-sharing arrangements in the  
2 commercial health care market, and

3 d. other relevant factors identified by the Authority.

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

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

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

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

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

21 H. At the discretion of the Authority, subject to appropriate  
22 notice to the Legislature and the Centers for Medicare and Medicaid  
23 Services, the Authority may approve a delay in the implementation of  
24

1 one or more capitated contracts to ensure financial and operational  
2 readiness.

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

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

8 B. The Authority may only utilize an opt-in enrollment process  
9 for the voluntary enrollment of American Indians and Alaska Natives.  
10 Notwithstanding any other provision of this act, the Authority shall  
11 comply with all Indian provisions associated with Medicaid managed  
12 care including, but not limited to, the Social Security Act,  
13 1932(a)(2)(C), the American Recovery and Reinvestment Act of 2009,  
14 P.L. 111-5 (Feb. 17, 2009), Section 5006, the Children's Health  
15 Insurance Program Reauthorization Act of 2009, P.L. 111-3 (Feb. 4,  
16 2009), and the Centers for Medicare and Medicaid Services (CMS)  
17 managed care protections, 25 C.F.R., 438.14.

18 C. In the event of the termination of a capitated contract with  
19 a contracted entity during the contract duration, the Authority  
20 shall reassign members to a remaining contracted entity with  
21 demonstrated performance and capability. If no remaining contracted  
22 entity is able to assume management for such members, the Authority  
23 may select another contracted entity by application, as specified in  
24 rules promulgated by the Oklahoma Health Care Authority Board, if

1 the financial, operation, and performance requirements can be met,  
2 at the discretion of the Authority.

3 SECTION 6. NEW LAW A new section of law to be codified  
4 in the Oklahoma Statutes as Section 4002.3d of Title 56, unless  
5 there is created a duplication in numbering, reads as follows:

6 A. Every Medicaid member enrolled in a contracted entity shall  
7 have the right to select his or her primary care provider and to  
8 change his or her primary care provider at any time, as long as the  
9 selected primary care provider is a participating provider. Any  
10 parent or guardian of a Medicaid member who is a minor child  
11 enrolled in a contracted entity shall have the right to select the  
12 primary care provider for the member's minor child and to change the  
13 primary care provider at any time, as long as the selected primary  
14 care provider is a participating provider.

15 B. If a member, or parent or guardian of a member who is a  
16 minor child, does not select a primary care provider, the contracted  
17 entity shall notify the member, parent, or guardian that he or she  
18 needs to select a primary care provider and shall send the member,  
19 parent, or guardian the name, contact information, employer, and any  
20 other applicable information as determined by the Oklahoma Health  
21 Care Authority of the three primary care providers nearest to the  
22 member's home address that are contracted with the contracted  
23 entity.

1 C. 1. If, after the contracted entity sends the information  
2 described in subsection B of this section, the member, parent, or  
3 guardian does not select a primary care provider within a time  
4 determined by the Authority, the contracted entity shall assign the  
5 member to a primary care provider in accordance with the process  
6 described in paragraph 2 of this subsection.

7 2. The Authority shall develop and implement a process for the  
8 assignment by contracted entities of Medicaid members who do not  
9 select a primary care provider to a primary care provider. The  
10 process shall prioritize existing patient-provider relationships and  
11 geographic proximity of the patient to the provider, and shall  
12 assign families to the same primary care provider to the extent  
13 possible.

14 SECTION 7. AMENDATORY 56 O.S. 2021, Section 4002.4, is  
15 amended to read as follows:

16 Section 4002.4. A. The Oklahoma Health Care Authority shall  
17 develop network adequacy standards for all ~~managed-care~~  
18 ~~organizations and dental benefit managers~~ contracted entities that,  
19 at a minimum, meet the requirements of 42 C.F.R., Sections ~~438.14~~  
20 438.3 and 438.68. Network adequacy standards established under this  
21 subsection shall include distance and time standards and shall be  
22 designed to ensure enrollees members covered by the ~~managed-care~~  
23 ~~organizations and dental benefit managers~~ contracted entities who  
24 reside in health professional shortage areas (HPSAs) designated

1 under Section 332(a)(1) of the Public Health Service Act (42 U.S.C.,  
2 Section 254e(a)(1)) have access to in-person health care and  
3 telehealth services with providers, especially adult and pediatric  
4 primary care practitioners.

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

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

20 ~~D. C.~~ To ensure models of care are developed to meet the needs  
21 of Medicaid members, each contracted entity must contract with at  
22 least one local Oklahoma provider organization for a model of care  
23 containing care coordination, care management, utilization  
24 management, disease management, network management, or another model



1 of care as approved by the Authority. Such contractual arrangements  
2 must be in place within twelve (12) months of the effective date of  
3 the contracts awarded pursuant to the requests for proposals  
4 authorized by Section 3 of this act.

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

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

14 F. 1. If the Authority awards a capitated contract to a  
15 provider-led entity for the urban region under Section 4 of this  
16 act, the provider-led entity shall expand its coverage area to every  
17 county of this state within the time frame set by the Authority  
18 under subsection E of Section 4 of this act.

19 2. The expansion of the provider-led entity's coverage area  
20 beyond the urban region shall be subject to the approval of the  
21 Authority. The Authority shall approve expansion to counties for  
22 which the provider-led entity can demonstrate evidence of network  
23 adequacy as required under 42 C.F.R., Sections 438.3 and 438.68.  
24 When approved, the additional county or counties shall be added to

1 the provider-led entity's region during the next open enrollment  
2 period.

3 SECTION 8. NEW LAW A new section of law to be codified  
4 in the Oklahoma Statutes as Section 4002.4a of Title 56, unless  
5 there is created a duplication in numbering, reads as follows:

6 A. 1. The Oklahoma Health Care Authority shall develop  
7 standard contract terms for contracted entities to include, but not  
8 be limited to, all requirements stipulated by this act. The  
9 Authority shall oversee and monitor performance of contracted  
10 entities and shall enforce the terms of capitated contracts as  
11 required by paragraph 2 of this subsection.

12 2. The Authority shall require each contracted entity to meet  
13 all contractual and operational requirements as defined in the  
14 requests for proposals issued pursuant to Section 3 of this act.  
15 Such requirements shall include but not be limited to reimbursement  
16 and capitation rates, insurance reserve requirements as specified by  
17 the Insurance Department, acceptance of risk as defined by the  
18 Authority, operational performance expectations including the  
19 assessment of penalties, member marketing guidelines, other  
20 applicable state and federal regulatory requirements, and all  
21 requirements of this act including, but not limited to, the  
22 requirements stipulated in this section.

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

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

4 SECTION 9. AMENDATORY 56 O.S. 2021, Section 4002.5, is  
5 amended to read as follows:

6 Section 4002.5. A. A contracted entity shall be responsible  
7 for all administrative functions for members enrolled in its plan  
8 including, but not limited to, claims processing, authorization of  
9 health services, care and case management, grievances and appeals,  
10 and other necessary administrative services.

11 B. A contracted entity selected by the Oklahoma Health Care  
12 Authority under Section 4 of this act shall obtain a certificate of  
13 authority as a health maintenance organization issued by the  
14 Insurance Department prior to the execution of the contract between  
15 the contracted entity and the Authority.

16 C. 1. To ensure providers have a voice in the direction and  
17 operation of the contracted entities selected by the Oklahoma Health  
18 Care Authority under Section 4 of this act, each contracted entity  
19 shall have a shared governance structure that includes:

- 20 a. representatives of local Oklahoma provider  
21 organizations who are Medicaid providers,  
22 b. essential community providers, and  
23 c. a representative from a teaching hospital owned,  
24 jointly owned, or affiliated with and designated by

1           the University Hospitals Authority, University  
2           Hospitals Trust, Oklahoma State University Medical  
3           Authority, or Oklahoma State University Medical Trust.

4           2. No less than one-third (1/3) of the contracted entity's  
5 local governing body shall be comprised of representatives of local  
6 Oklahoma provider organizations.

7           3. No less than two members of the contracted entity's clinical  
8 and quality committees shall be representatives of local Oklahoma  
9 provider organizations, and the committees shall be chaired or co-  
10 chaired by a representative of a local Oklahoma provider  
11 organization.

12           D. A managed care organization or dental benefit manager  
13 contracted entity shall promptly notify the Authority of all changes  
14 materially material changes affecting the delivery of care or the  
15 administration of its program.

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

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

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

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

14        I. Nothing in this act, in a contract between the Authority and  
15 a contracted entity, or in a contract between a contracted entity  
16 and a provider shall prohibit any provider from contracting with  
17 more than one contracted entity.

18        J. A contracted entity shall not withhold, fail to offer, or  
19 make impracticable a contract with a provider on the basis of  
20 independent practice or lack of hospital system affiliation.

21        K. All contracted entities shall:

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

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

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

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

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 11. 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<sub>7</sub>.

11 ~~2.~~ 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<sub>7i</sub> and

20 b. a

21 2. A detailed description of the additional information  
22 necessary to substantiate the claim<sub>7</sub>.

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<sub>7</sub>;

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<sub>7</sub>; and

16           e. 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 12. 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 13. 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 14. 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~~ 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 15. 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  
7 Health Care Authority shall establish minimum rates of reimbursement  
8 from ~~managed care organizations and dental benefit managers~~  
9 contracted entities to providers who elect not to enter into value-  
10 based payment arrangements under subsection B of this section or  
11 other alternative payment agreements for health care items and  
12 services furnished by such providers to enrollees of the state  
13 Medicaid program. Until July 1, 2026, such reimbursement rates  
14 shall be 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~~ contracted entity, one hundred percent (100%) of the  
18 reimbursement rate for the applicable service in the applicable fee  
19 schedule of 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~~ contracted entity, ninety  
23 percent (90%) of the reimbursement rate for the applicable service  
24

1 in the applicable fee schedule of the Authority as of January 1,  
2 2021.

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

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

20 D. A contracted entity shall offer all rural health clinics  
21 (RHCs) contracts that reimburse RHCs using the methodology in place  
22 for each specific RHC prior to January 1, 2023, including any and  
23 all annual rate updates. The contracted entity shall comply with  
24 all federal program rules and requirements, and the transformed

1 Medicaid delivery system shall not interfere with the program as  
2 designed.

3 E. The Oklahoma Health Care Authority shall establish minimum  
4 rates of reimbursement from contracted entities to Certified  
5 Community Behavioral Health Clinic (CCBHC) providers who elect  
6 alternative payment arrangements equal to the prospective payment  
7 system rate under the Medicaid State Plan.

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

11 G. Psychologist reimbursement shall reflect outcomes.  
12 Reimbursement shall not be limited to therapy and shall include but  
13 not be limited to testing and assessment.

14 H. Coverage for Medicaid ground transportation services by  
15 licensed Oklahoma emergency medical services shall be reimbursed at  
16 no less than the published Medicaid rates as set by the Authority.  
17 All currently published Medicaid Healthcare Common Procedure Coding  
18 System (HCPCS) codes paid by the Authority shall continue to be paid  
19 by the contracted entity. The contracted entity shall comply with  
20 all reimbursement policies established by the Authority for the  
21 ambulance providers. Contracted entities shall accept the modifiers  
22 established by the Centers for Medicare and Medicaid Services  
23 currently in use by Medicare at the time of the transport of a  
24 member that is dually eligible for Medicare and Medicaid.

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

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

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

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

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

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

23 M. 1. The Authority shall, through the financial reporting  
24 required under subsection G of Section 17 of this act, determine the

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

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

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

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

14 A. All dental benefit managers shall maintain a Medicaid Dental  
15 Advisory Committee, comprised exclusively of Oklahoma-licensed  
16 dentists and specialists, to advise dental benefit managers  
17 regarding quality measures.

18 B. Dental providers shall not be required to enter into  
19 capitated contracts with a dental benefit manager.

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

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

1 B. The Authority shall ensure that existing revenue sources  
2 designated for the state share of Medicaid expenses are designed to  
3 maximize federal matching funds for the benefit of providers and the  
4 state.

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

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

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

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

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

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

1 D. Subject to approval by the Centers for Medicare and Medicaid  
2 Services, the Authority shall preserve and, to the maximum extent  
3 permissible under federal law, improve existing levels of funding  
4 through directed payments or other mechanisms outside the capitated  
5 rate to contracted entities, including, where applicable, the use of  
6 a directed payment program with an average commercial rate  
7 methodology under the Supplemental Hospital Payment Program Act.

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

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

23 1. A description of the selection process of the contracted  
24 entities;

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

3           3. Medicaid member network access standards;

4           4. Performance and quality metrics;

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

7           6. A description of the requirements and other provisions  
8 included in capitated contracts; and

9           7. A full and complete copy of each executed capitated  
10 contract.

11           G. 1. Each contracted entity shall report to the Authority in  
12 time intervals determined by the Authority and through a process  
13 determined by the Authority all claims data, expenditures, and such  
14 other financial reporting information as may be required by the  
15 Authority.

16           2. The Authority shall compile and analyze the information  
17 described in paragraph 1 of this subsection and annually submit a  
18 report summarizing such information, devoid of any personally  
19 identifying information, to the President Pro Tempore of the Senate,  
20 the Speaker of the House of Representatives, and the Oklahoma Health  
21 Care Authority Board.

22           SECTION 18.           AMENDATORY           56 O.S. 2021, Section 4002.13, is  
23 amended to read as follows:



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

5 B. The ~~primary power and duty of the~~ Committee shall ~~be~~ have  
6 the power and duty to make recommendations to the Administrator of  
7 the Oklahoma Health Care Authority and the Oklahoma Health Care  
8 Authority Board on quality measures used by ~~managed care~~  
9 ~~organizations and dental benefit managers~~ contracted entities in the  
10 capitated ~~managed~~ care delivery model of the state Medicaid program.

11 C. 1. The Committee shall be comprised of members appointed by  
12 the Administrator of the Oklahoma Health Care Authority. Members  
13 shall serve at the pleasure of the Administrator.

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

1           3. The Committee shall select from among its membership a chair  
2 and vice chair.

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

5           2. A quorum of the Committee shall be required to approve any  
6 final ~~action~~ recommendations of the Committee. A majority of the  
7 members of the Committee shall constitute a quorum.

8           3. Meetings of the Committee shall be subject to the Oklahoma  
9 Open Meeting Act.

10          ~~F.~~ E. Members of the Committee shall receive no compensation or  
11 travel reimbursement.

12          ~~G.~~ F. The Oklahoma Health Care Authority shall provide staff  
13 support to the Committee. To the extent allowed under federal or  
14 state law, rules or regulations, the Authority, the State Department  
15 of Health, the Department of Mental Health and Substance Abuse  
16 Services and the Department of Human Services shall as requested  
17 provide technical expertise, statistical information, and any other  
18 information deemed necessary by the chair of the Committee to  
19 perform the duties imposed on it.

20          SECTION 19.           NEW LAW           A new section of law to be codified  
21 in the Oklahoma Statutes as Section 4002.14 of Title 56, unless  
22 there is created a duplication in numbering, reads as follows:

23           A. The transformed delivery system of the state Medicaid  
24 program and capitated contracts awarded under the transformed

1 delivery system shall be designed with uniform defined measures and  
2 goals that are consistent across contracted entities including, but  
3 not limited to, adjusted health outcomes, social determinants of  
4 health, quality of care, member satisfaction, provider satisfaction,  
5 access to care, network adequacy, and cost.

6 B. Prior to implementation of the transformed Medicaid delivery  
7 system, each contracted entity shall use nationally recognized,  
8 standardized provider quality metrics as established by the Oklahoma  
9 Health Care Authority and, where applicable, may use additional  
10 quality metrics if the measures are mutually agreed upon by the  
11 Authority, the contracted entity, and participating providers. The  
12 Authority shall develop processes for determining quality metrics  
13 and cascading quality metrics from contracted entities to  
14 subcontractors and providers.

15 C. The Authority may use consultants, organizations, or  
16 measures used by health plans, the federal government, or other  
17 states to develop effective measures for outcomes and quality  
18 including, but not limited to, the National Committee for Quality  
19 Assurance (NCQA) or the Healthcare Effectiveness Data and  
20 Information Set (HEDIS) established by NCQA, the Physician  
21 Consortium for Performance Improvement (PCPI) or any measures  
22 developed by PCPI.

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

4 SECTION 20. AMENDATORY 56 O.S. 2021, Section 4004, is  
5 amended to read as follows:

6 Section 4004. A. 1. The Oklahoma Health Care Authority shall  
7 seek any federal approval necessary to implement ~~this act~~ the  
8 Ensuring Access to Medicaid Act. This shall include, but not be  
9 limited to, submission to the Centers for Medicare and Medicaid  
10 Services of any appropriate demonstration waiver application or  
11 Medicaid State Plan amendment necessary to accomplish the  
12 requirements of this act within the required time frames.

13 2. Prior to implementation of contracts with any contracted  
14 entities except dental benefit managers, the Authority shall obtain  
15 federal approval of a managed care directed payment program with an  
16 average commercial rate methodology under the Supplemental Hospital  
17 Offset Payment Program Act. Contracts with dental benefit managers  
18 shall be exempt from the requirement stipulated by this paragraph.

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

21 SECTION 21. 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 22.           AMENDATORY           36 O.S. 2021, Section 624, is  
24 amended to read as follows:

1 Section 624. A. Every insurance company, copartnership,  
2 insurance association, interinsurance exchange, person, insurer,  
3 nonprofit hospital service and medical indemnity corporation, or  
4 health maintenance organization doing business in this state in the  
5 execution or exchange of contracts of insurance, indemnity or health  
6 maintenance services, or as an insurance company of any nature or  
7 character whatsoever, hereinafter referred to in this article as an  
8 insurance company or company, shall annually, on or before the first  
9 day of March, report under oath of the president or secretary or  
10 other chief officer of such company to the Insurance Commissioner  
11 the total amount of direct written premiums, membership,  
12 application, policy and/or registration fees charged during the  
13 preceding calendar year, or since the last return of such direct  
14 written premiums, membership, application, policy and/or  
15 registration fees was made by such company, from insurance of every  
16 kind upon persons or on the lives of persons resident in this state,  
17 or upon real and personal property located within this state, and/or  
18 upon any other risks insured within this state, provided, that with  
19 respect to the tax payable annually, considerations received for  
20 annuity contracts and payments received by a health maintenance  
21 organization from the Secretary of Health and Human Services  
22 pursuant to a contract issued under the provisions of 42 U.S.C.,  
23 Section 1395mm(g) shall no longer be deemed to be premiums for  
24 insurance and shall no longer be subject to the tax imposed by this

1 section. Every such company shall, at the same time, pay to the  
2 Insurance Commissioner:

3 1. An annual license fee as prescribed by Section 321 of this  
4 title; and

5 2. An annual tax on all of the direct written premiums after  
6 all returned premiums are deducted, and on all membership,  
7 application, policy and/or registration fees, installment and/or  
8 finance fees or charges collected thereby, for the privileges of  
9 having written, continued and/or serviced insurance on lives,  
10 property and/or other risks in this state and of having made and  
11 serviced investments therein during the then expiring license year  
12 except premiums or fees paid by any county, city, town or school  
13 district funds or by their duly constituted authorities performing a  
14 public service organized pursuant to Sections 1001 through 1008 of  
15 Title 74 of the Oklahoma Statutes, or Sections 176 through 180.4 of  
16 Title 60 of the Oklahoma Statutes. Provided, no deduction shall be  
17 made from premiums for dividends paid to policyholders. Except as  
18 set forth in this paragraph, the rate of taxation for all entities  
19 subject to the tax shall be two and twenty-five one-hundredths  
20 percent (2.25%). If any insurance company or other entity liable  
21 for the taxes levied pursuant to the provisions of this section  
22 fails to remit such taxes in a timely manner, it shall remain liable  
23 therefor together with interest thereon at an annual rate equal to  
24 the average United States Treasury Bill rate of the preceding



1 calendar year as certified by the State Treasurer on the first  
2 regular business day in January of each year, plus four percentage  
3 points.

4 a. The rate of taxation for all life insurance policies  
5 insuring the life of an employee or director for the  
6 benefit of the employer or a trust sponsored by the  
7 employer, which is purchased by the employer or trust  
8 sponsored by the employer for the benefit of its  
9 employees, shall be computed for each policy at the  
10 rate of:

- 11 (1) two and twenty-five one-hundredths percent  
12 (2.25%) of policy year premium up to One Hundred  
13 Thousand Dollars (\$100,000.00), and  
14 (2) one-tenth of one percent (1/10 of 1%) of policy  
15 year premium exceeding One Hundred Thousand  
16 Dollars (\$100,000.00).

17 b. Premiums on which taxes are paid under division (2) of  
18 subparagraph a of this paragraph are not subject to  
19 Section 628 of this title. The Commissioner shall  
20 promulgate rules regarding the sale of life insurance  
21 policies subject to division (2) of subparagraph a of  
22 this paragraph.

23 c. Proceeds from the premium tax collected under this  
24 paragraph from contracted entities under the Ensuring

1           Access to Medicaid Act shall be deposited in the  
2           Medicaid Health Improvement Revolving Fund created in  
3           Section 23 of this act. The provisions of this  
4           subparagraph shall not be construed to affect or  
5           modify the apportionments provided in Section 312.1 of  
6           this title.

7           B. For all insurance companies or other entities taxed pursuant  
8 to this section, the annual license fee and tax and all required  
9 membership, application, policy, registration, and agent appointment  
10 fees shall be in lieu of all other state taxes or fees, except those  
11 taxes and fees provided for in the Insurance Code, and the taxes and  
12 fees of any subdivision or municipality of the state, except ad  
13 valorem taxes and the tax required to be paid pursuant to Section  
14 50001 of Title 68 of the Oklahoma Statutes. Provided, such license  
15 fee, tax and membership, application, policy, registration, and  
16 appointment fees shall be in lieu of any and all ad valorem taxes  
17 levied on intangible personal property. Any company, except health  
18 maintenance organizations, failing to make such returns and payments  
19 promptly and correctly shall forfeit and pay to the Insurance  
20 Commissioner, in addition to the amount of the taxes and fees and  
21 interest, the sum of Five Hundred Dollars (\$500.00) or an amount  
22 equal to one percent (1%) of the unpaid amount, whichever is  
23 greater; and the company so failing or neglecting for sixty (60)  
24 days shall thereafter be debarred from transacting any business of

1 insurance in this state until the taxes, fees and penalties are  
2 fully paid, and the Insurance Commissioner shall revoke the license  
3 or certificate of authority granted to the agent or agents of that  
4 company to transact business in this state. Provided, that when any  
5 such insurance company, copartnership, insurance association,  
6 interinsurance exchange, person, insurer, or nonprofit hospital  
7 service and indemnity corporation, applies for the first time for a  
8 license to do business in Oklahoma, it shall, at the time of making  
9 such application, pay a license fee as prescribed by Section 1425 of  
10 this title, and, on or before the first day of March, following, pay  
11 the premium tax, membership, application, policy, registration, and  
12 agent appointment fees, as hereinbefore provided. Such license fee,  
13 tax and membership, application, policy, registration, and  
14 appointment fees shall be in lieu of all other state taxes or fees,  
15 except those taxes and fees provided for in the Insurance Code, and  
16 the taxes and fees of any subdivision or municipality of the state,  
17 except ad valorem taxes and the tax required to be paid pursuant to  
18 Section 50001 of Title 68 of the Oklahoma Statutes.

19 C. Any health maintenance organization failing to file premium  
20 tax returns and payments promptly and correctly shall forfeit and  
21 pay to the Insurance Commissioner, in addition to the amount of the  
22 taxes, the sum of Five Hundred Dollars (\$500.00) or an amount equal  
23 to one percent (1%) of the unpaid amount, whichever is greater. Any  
24 health maintenance organization failing or neglecting to pay the tax

1 and penalty shall be debarred from operating in this state and the  
2 Insurance Commissioner shall revoke the license of the health  
3 maintenance organization, until such taxes and penalties are fully  
4 paid.

5 SECTION 23. NEW LAW A new section of law to be codified  
6 in the Oklahoma Statutes as Section 1010.8A of Title 56, unless  
7 there is created a duplication in numbering, reads as follows:

8 There is hereby created in the State Treasury a revolving fund  
9 for the Oklahoma Health Care Authority to be designated the  
10 "Medicaid Health Improvement Revolving Fund". The fund shall be a  
11 continuing fund, not subject to fiscal year limitations, and shall  
12 consist of all monies received from the premium tax levied on  
13 contracted entities under paragraph 2 of subsection A of Section 624  
14 of Title 36 of the Oklahoma Statutes and such other funds as may be  
15 provided by law. All monies accruing to the credit of the fund are  
16 hereby appropriated and may be budgeted and expended by the  
17 Authority for the following purposes:

- 18 1. To supplement the state Medicaid program;
- 19 2. To supplement the Supplemental Hospital Offset Payment  
20 Program; and
- 21 3. To supplement the Rate Preservation Fund created in Section  
22 5020A of Title 63 of the Oklahoma Statutes.

23 Expenditures from the fund shall be made upon warrants issued by  
24 the State Treasurer against claims filed as prescribed by law with

1 the Director of the Office of Management and Enterprise Services for  
2 approval and payment.

3 SECTION 24. RECODIFICATION 56 O.S. 2021, Section 4004,  
4 as amended by Section 20 of this act, shall be recodified as Section  
5 4002.15 of Title 56 of the Oklahoma Statutes, unless there is  
6 created a duplication in numbering.

7 SECTION 25. REPEALER 56 O.S. 2021, Sections 1010.2,  
8 1010.3, 1010.4, 1010.5, and 1010.8, are hereby repealed.

9 SECTION 26. REPEALER 56 O.S. 2021, Sections 4002.3 and  
10 4002.9, are hereby repealed.

11 SECTION 27. REPEALER 63 O.S. 2021, Sections 5009.5,  
12 5011, and 5028, are hereby repealed.

13 SECTION 28. The provisions of this act shall not become  
14 effective as law unless Enrolled Senate Bill No. 1396 of the 2nd  
15 Session of the 58th Oklahoma Legislature becomes effective as law.

16 SECTION 29. This act shall become effective July 1, 2022.

17 SECTION 30. It being immediately necessary for the preservation  
18 of the public peace, health or safety, an emergency is hereby  
19 declared to exist, by reason whereof this act shall take effect and  
20 be in full force from and after its passage and approval.

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