Bill Summary
1st Session of the 58th Legislature

Bill No.:	**SB 131**
Version:	**CCR**
Request No.:	**2217**
Author:	**Sen. McCortney**
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Bill Analysis

SB 131 creates the Ensuring Access to Medicaid Act. The measure specifies which Medicaid populations may be required to enroll in managed care plans by the Oklahoma Health Care Authority, which populations may voluntarily enroll in managed care plans, and which populations the Authority is prohibited from requiring managed care enrollment for or offering enrollment to. The measure directs the Authority to develop network adequacy standards for all managed care organizations and dental benefit managers. Managed care organizations and dental benefits managers are required by the measure to contract to the extent possible and practicable with all essential community providers, all providers who receive directed payments, and other providers the Authority may specify.

Additionally, managed care organizations and dental benefits managers are required to notify the Authority of all changes materially affecting the delivery of care or the administration of its program and must meet certain medical loss ratios. Such organizations are prohibited from requiring providers to contract for all products that are currently offered or that may be offered in the future by the managed care organization or dental benefit manager or subcontractor. Managed care organizations are required by the measure to make a determination on a request for an authorization of the transfer of a hospital inpatient to a post-acute care or long-term acute care facility within 24 hours of receipt of the request. The measure also establishes deadlines for managed care organizations and dental benefit managers to determine prior authorization for care ordered by primary care or specialist providers. Denials of prior authorization requests shall be subject to peer-to-peer review unless such requests are for services not covered by the state Medicaid program.

Managed care organizations and dental benefit managers are required to comply with certain requirements outlined in the measure as it relates to processing and adjudication of claims for payment submitted in good faith by providers for health care items and services furnished by such providers to enrollees. Such requirements include processing clean claims within 14 days, establishing a process a provider may provide such additional information as may be necessary to substantiate a claim, conducting postpayment audits in accordance with the requirements of the measure, and applying readmission penalties in compliance with rules and regulations promulgated by the Authority.

The Authority is directed by the measure to establish procedures for enrollees or providers to seek review by the managed care organization or dental benefit manager of any adverse determination made by the managed care organization or dental benefit manager. Providers shall

have 6 months from the receipt of a claim denial to file an appeal. Additionally, the Authority shall require managed care organizations and dental benefit managers to participate in readiness reviews. Such reviews shall assess the criteria outlined in the measure. A managed care organization or dental benefit manager found to be in violation of the provisions of this measure shall be subject to 1 or more non-compliance remedies of the Authority.

The Oklahoma Health Care Authority may only execute the transition of the delivery system of the state Medicaid program to the capitated managed care delivery model 90 days after the Centers for Medicare and Medicaid Services has approved all contracts entered into between the Authority and all managed care organizations and dental benefit managers following submission of the readiness reviews to the Centers for Medicare and Medicaid Services. The Authority is also directed to create a scorecard that compares managed care organizations and dental benefit managers within 1 year of transitioning to the delivery model. Additionally, the Authority is directed to establish minimum rates of reimbursement from managed care organizations and dental benefit managers to providers who elect not to enter into value-based payment arrangements and fixes the rates until July 1, 2026 at percentages of the fee schedule of the Authority. Managed care organizations are required to offer value-based payment arrangements to providers, but may not require such arrangements.

The measure also creates the MC Quality Advisory Committee to make recommendations to the Administrator of the Oklahoma Health Care Authority and the Oklahoma Health Care Authority Board on quality measures used by managed care organizations and dental benefit managers in the capitated managed care delivery model of the state Medicaid program. A majority of the members shall be providers participating in the capitated managed care delivery model of the state Medicaid program.

CCR Changes

The Conference Committee Report for SB 131 substitutes the engrossed language with the language described above.

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