ENGROSSED HOUSE AMENDMENT
TO
ENGROSSED SENATE BILL NO. 1675 By: McCortney of the Senate

and

McEntire of the House

An Act relating to the state Medicaid program; amending Section 3, Chapter 395, O.S.L. 2022 (56 O.S. Supp. 2023, Section 4002.3a), which relates to capitated contracts for delivery of Medicaid services; extending certain deadlines; amending 56 O.S. 2021, Section 4002.4, as amended by Section 7, Chapter 395, O.S.L. 2022 (56 O.S. Supp. 2023, Section 4002.4), which relates to network adequacy standards for contracted entities; imposing certain deadline on credentialing or recredentialing by contracted entities; amending 56 O.S. 2021, Section 4002.6, as last amended by Section 2, Chapter 331, O.S.L. 2023 (56 O.S. Supp. 2023, Section 4002.6), which relates to requirements for prior authorizations; modifying and adding deadlines for certain determinations and reviews; requiring certain reviews to be conducted by Oklahoma-licensed clinical staff; amending 56 O.S. 2021, Section 4002.7, as amended by Section 11, Chapter 395, O.S.L. 2022 (56 O.S. Supp. 2023, Section 4002.7), which relates to requirements for processing and adjudicating claims; expanding certain provisions to include downgraded claims; specifying certain limit on claims subject to postpayment audits; amending 56 O.S. 2021, Section 4002.12, as last amended by Section 1, Chapter 308, O.S.L. 2023 (56 O.S. Supp. 2023, Section 4002.12), which relates to minimum rates of reimbursement; extending certain deadline; updating statutory references; updating statutory language; and declaring an emergency.

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

"[Medicaid program – capitated contracts – entity – deadlines – contracted entities – credentialing – recredentialing – authorizations – deadlines – clinical staff – claims – audits – reimbursement - deadlines –

emergency]

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

SECTION 1. AMENDATORY 56 O.S. 2021, Section 4002.2, as last amended by Section 1, Chapter 334, O.S.L. 2022 (56 O.S. Supp. 2023, Section 4002.2), is amended to read as follows:

Section 4002.2 As used in the Ensuring Access to Medicaid Act:

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

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

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

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

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

a. children in foster care,

b. former foster care children up to twenty-five (25) years of age,

c. ~~juvenile justice involved~~ juvenile-justice-involved children, and

d. children receiving adoption assistance;

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

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

services to Medicaid members on a prepaid basis and is subject to all applicable federal and state laws and regulations;

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

9. "Dental benefit manager" means an entity that handles claims payment and prior authorizations and coordinates dental care with participating providers and Medicaid members;

10. "Essential community provider" means:

a. a Federally Qualified Health Center,

b. a community mental health center,

c. an Indian Health Care Provider,

d. a rural health clinic,

e. a state-operated mental health hospital,

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

g. a teaching hospital owned, jointly owned, or affiliated with and designated by the University Hospitals Authority, University Hospitals Trust, Oklahoma State University Medical Authority, or Oklahoma State University Medical Trust,

h. a provider employed by or contracted with, or otherwise a member of the faculty practice plan of:

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

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

i. a county department of health or city-county health department,

j. a comprehensive community addiction recovery center,

k. a hospital licensed by the State of Oklahoma including all hospitals participating in the Supplemental Hospital Offset Payment Program,

l. a Certified Community Behavioral Health Clinic (CCBHC),

m. a provider employed by or contracted with a primary care residency program accredited by the Accreditation Council for Graduate Medical Education,

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

o. a pharmacy or pharmacist, or

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

11. "Material change" includes, but is not limited to, any change in overall business operations such as policy, process or protocol which affects, or can reasonably be expected to affect, more than five percent (5%) of enrollees or participating providers of the contracted entity;

12. "Governing body" means a group of individuals appointed by the contracted entity who approve policies, operations, profit/loss ratios, executive employment decisions, and who have overall responsibility for the operations of the contracted entity of which they are appointed;

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

14. "Medical necessity" has the same meaning as ~~provided by rules promulgated by the Oklahoma Health Care Authority Board~~ "medically necessary" in Section 6592 of Title 36 of the Oklahoma Statutes;

15. "Participating provider" means a provider who has a contract with or is employed by a contracted entity to provide services to Medicaid members as authorized by the Ensuring Access to Medicaid Act;

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

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

~~a. a majority of the entity's ownership is held by Medicaid providers in this state or is held by an entity that directly or indirectly owns or is under~~

~~common ownership with Medicaid providers in this state, or~~

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

~~(1)~~

a. have experience serving Medicaid members and:

~~(a)~~

(1) are licensed in this state as physicians, physician assistants, nurse practitioners, certified nurse-midwives, or certified registered nurse anesthetists,

~~(b)~~

(2) at least one board member is a licensed behavioral health provider, or

~~(c)~~

(3) are employed by:

~~i.~~

(a) a hospital or other medical facility licensed by this state and operating in this state, or

~~ii.~~

(b) an inpatient or outpatient mental health or substance abuse treatment facility or

program licensed or certified by this state and operating in this state,

~~(2)~~

b. represent the providers or facilities described in ~~division (1) of this~~ subparagraph a of this paragraph including, but not limited to, individuals who are employed by a statewide provider association, or

~~(3)~~

c. are nonclinical administrators of clinical practices serving Medicaid members;

18. "Provider-owned entity" means an organization or entity that a majority of the entity's ownership is held by Medicaid providers in this state or is held by an entity that directly or indirectly owns or is under common ownership with Medicaid providers in this state;

19. "Statewide" means all counties of this state including the urban region; and

~~19.~~ 20. "Urban region" means:

a. all counties of this state with a county population of not less than five hundred thousand (500,000) according to the latest Federal Decennial Census, and

b. all counties that are contiguous to the counties described in subparagraph a of this paragraph, combined into one region.

SECTION 2. AMENDATORY Section 3, Chapter 395, O.S.L. 2022 (56 O.S. Supp. 2023, Section 4002.3a), is amended to read as follows:

Section 4002.3a A. 1. The Oklahoma Health Care Authority (OHCA) shall enter into capitated contracts with contracted entities for the delivery of Medicaid services as specified in ~~this act~~ the Ensuring Access to Medicaid Act to transform the delivery system of the state Medicaid program for the Medicaid populations listed in this section.

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

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

a. pregnant women,

b. children,

c. deemed newborns under 42 C.F.R., Section 435.117,

d. parents and caretaker relatives, and

e. the expansion population.

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

a. physical health services including, but not limited to:

(1) primary care,

(2) inpatient and outpatient services, and

(3) emergency room services,

b. behavioral health services, and

c. prescription drug services.

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

4. Subject to the requirements and approval of the Centers for Medicare and Medicaid Services, the implementation of the program shall be no later than ~~October 1, 2023~~ April 1, 2024.

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

a. pregnant women,

b. children,

c. parents and caretaker relatives,

d. the expansion population, and

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

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

3. Subject to the requirements and approval of the Centers for Medicare and Medicaid Services, the implementation of the program shall be no later than ~~October 1, 2023~~ April 1, 2024.

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

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

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

4. Subject to the requirements and approval of the Centers for Medicare and Medicaid Services, the implementation of the program shall be no later than ~~October 1, 2023~~ April 1, 2024.

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

SECTION 3. AMENDATORY Section 4, Chapter 395, O.S.L. 2022 (56 O.S. Supp. 2023, Section 4002.3b), is amended to read as follows:

Section 4002.3b A. All capitated contracts shall be the result of requests for proposals issued by the Oklahoma Health Care Authority and submission of competitive bids by contracted entities pursuant to the Oklahoma Central Purchasing Act.

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

C. The Authority shall award no less than ~~three~~ four statewide capitated contracts to provide comprehensive integrated health

services including, but not limited to, medical, behavioral health, and pharmacy services and no less than two statewide capitated contracts to provide dental coverage to Medicaid members as specified in Section ~~3~~ 4002.3a of this ~~act~~ title. At least one statewide capitated contract shall be a provider-owned entity.

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

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

3. The Authority shall develop a scoring methodology for the request for proposals that affords preferential scoring to provider-led entities and provider-owned entities, as long as the provider-led entity and provider-owned entity otherwise ~~demonstrates~~ demonstrate an ability to fulfill the contract requirements. The preferential scoring methodology shall include opportunities to

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

a. broad provider participation in ownership and governance structure,

b. demonstrated experience in care coordination and care management for Medicaid members across a variety of service types including, but not limited to, primary care and behavioral health,

c. demonstrated experience in Medicare or Medicaid accountable care organizations or other Medicare or Medicaid alternative payment models, Medicare or Medicaid value-based payment arrangements, or Medicare or Medicaid risk-sharing arrangements including, but not limited to, innovation models of the Center for Medicare and Medicaid Innovation of the Centers for Medicare and Medicaid Services, or value-based payment arrangements or risk-sharing arrangements in the commercial health care market, and

d. other relevant factors identified by the Authority.

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

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

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

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

G. At the end of the contracting period, the Authority shall solicit and award new contracts as provided by this section and ~~Section 3 of this act~~ Section 4002.3a of this title.

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

SECTION 4. AMENDATORY 56 O.S. 2021, Section 4002.4, as amended by Section 7, Chapter 395, O.S.L. 2022 (56 O.S. Supp. 2023, Section 4002.4), is amended to read as follows:

Section 4002.4 A. The Oklahoma Health Care Authority shall develop network adequacy standards for all contracted entities that, at a minimum, meet the requirements of 42 C.F.R., Sections 438.3 and

438.68. Network adequacy standards established under this subsection shall include distance and time standards and shall be designed to ensure members covered by the contracted entities who reside in health professional shortage areas (HPSAs) designated under Section 332(a)(1) of the Public Health Service Act (42 U.S.C., Section 254e(a)(1)) have access to in-person health care and telehealth services with providers, especially adult and pediatric primary care practitioners.

B. The Authority shall require all contracted entities to offer or extend contracts with all essential community providers, all providers who receive directed payments in accordance with 42 C.F.R., Part 438 and such other providers as the Authority may specify. The Authority shall establish such requirements as may be necessary to prohibit contracted entities from excluding essential community providers, providers who receive directed payments in accordance with 42 C.F.R., Part 438 and such other providers as the Authority may specify from contracts with contracted entities.

C. To ensure models of care are developed to meet the needs of Medicaid members, each contracted entity must contract with at least one local Oklahoma provider organization for a model of care containing care coordination, care management, utilization management, disease management, network management, or another model of care as approved by the Authority. Such contractual arrangements must be in place within twelve (12) months of the effective date of

the contracts awarded pursuant to the requests for proposals authorized by ~~Section 3 of this act~~ Section 4002.3a of this title.

D. All contracted entities shall formally credential and recredential network providers at a frequency required by a single, consolidated provider enrollment and credentialing process established by the Authority in accordance with 42 C.F.R., Section 438.214. A contracted entity shall complete credentialing or recredentialing of a provider within sixty (60) calendar days of receipt of a completed application.

E. All contracted entities shall be accredited in accordance with 45 C.F.R., Section 156.275 by an accrediting entity recognized by the United States Department of Health and Human Services.

F. 1. If the Authority awards a capitated contract to a provider-led entity for the urban region under ~~Section 4 of this act~~ Section 4002.3b of this title, the provider-led entity shall expand its coverage area to every county of this state within the time frame set by the Authority under subsection E of ~~Section 4 of this act~~ Section 4002.3b of this title.

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

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

SECTION 5. AMENDATORY 56 O.S. 2021, Section 4002.6, as last amended by Section 2, Chapter 331, O.S.L. 2023 (56 O.S. Supp. 2023, Section 4002.6), is amended to read as follows:

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

B. A contracted entity shall 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 twenty-four (24) hours of receipt of the request.

C. A contracted entity shall make a determination on a request for any member who is not hospitalized at the time of the request within seventy-two (72) hours of receipt of the request; provided, that if the request does not include sufficient or adequate documentation, the review and determination shall occur within a time frame and in accordance with a process established by the Authority. The process established by the Authority pursuant to this subsection shall include a time frame of at least forty-eight

(48) hours within which a provider may submit the necessary documentation.

D. A contracted entity shall make a determination on a request for services for a hospitalized member including, but not limited to, acute care inpatient services or equipment necessary to discharge the member from an inpatient facility within ~~one (1) business day~~ twenty-four (24) hours of receipt of the request.

E. Notwithstanding the provisions of subsection C of this section, a contracted entity shall make a determination on a request as expeditiously as necessary and, in any event, within twenty-four (24) hours of receipt of the request for service if adhering to the provisions of subsection C or D of this section could jeopardize the member's life, health or ability to attain, maintain or regain maximum function. In the event of a medically emergent matter, the contracted entity shall not impose limitations on providers in coordination of post-emergent stabilization health care including pre-certification or prior authorization.

F. Notwithstanding any other provision of this section, a contracted entity shall make a determination on a request for inpatient behavioral health services within twenty-four (24) hours of receipt of the request.

G. A contracted entity shall make a determination on a request for covered prescription drugs that are required to be prior authorized by the Authority within twenty-four (24) hours of receipt

of the request. The contracted entity shall not require prior authorization on any covered prescription drug for which the Authority does not require prior authorization.

H. A contracted entity shall make a determination on a request for coverage of biomarker testing in accordance with ~~Section 3 of this act~~ Section 4003 of this title.

I. Upon issuance of an adverse determination on a prior authorization request under subsection B of this section, the contracted entity shall provide the requesting provider, within seventy-two (72) hours of receipt of such issuance, with reasonable opportunity to participate in a peer-to-peer review process with a provider who practices in the same specialty, but not necessarily the same sub-specialty, and who has experience treating the same population as the patient on whose behalf the request is submitted; provided, however, if the requesting provider determines the services to be clinically urgent, the contracted entity shall provide such opportunity within twenty-four (24) hours of receipt of such issuance. Services not covered under the state Medicaid program for the particular patient shall not be subject to peer-to-peer review.

J. The Authority shall ensure that a provider offers to provide to a member in a timely manner services authorized by a contracted entity.

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

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

2. Require contracted entities to provide ~~a prompt~~ an opportunity for peer-to-peer conversations with ~~licensed~~ Oklahoma-licensed clinical staff of the same or similar specialty ~~which shall include, but not be limited to, Oklahoma-licensed clinical staff upon~~ within twenty-four (24) hours of the adverse determination; and

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

SECTION 6. AMENDATORY 56 O.S. 2021, Section 4002.7, as amended by Section 11, Chapter 395, O.S.L. 2022 (56 O.S. Supp. 2023, Section 4002.7), is amended to read as follows:

Section 4002.7 A. The Oklahoma Health Care Authority shall establish requirements for fair processing and adjudication of claims that ensure prompt reimbursement of providers by contracted entities. A contracted entity shall comply with all such requirements.

B. A contracted entity shall process a clean claim in the time frame provided by Section 1219 of Title 36 of the Oklahoma Statutes and no less than ninety percent (90%) of all clean claims shall be paid within fourteen (14) days of submission to the contracted

entity. A clean claim that is not processed within the time frame provided by Section 1219 of Title 36 of the Oklahoma Statutes shall bear simple interest at the monthly rate of one and one-half percent (1.5%) payable to the provider. A claim filed by a provider within six (6) months of the date the item or service was furnished to a member shall be considered timely. If a claim meets the definition of a clean claim, the contracted entity shall not request medical records of the member prior to paying the claim. Once a claim has been paid, the contracted entity may request medical records if additional documentation is needed to review the claim for medical necessity.

C. In the case of a denial of a claim including, but not limited to, a denial on the basis of the level of emergency care indicated on the claim, or in the case of a downcoded claim, the contracted entity shall establish a process by which the provider may identify and provide such additional information as may be necessary to substantiate the claim. Any such claim denial or downcode shall include the following:

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

2. A detailed description of the additional information necessary to substantiate the claim.

D. Postpayment audits by a contracted entity shall be subject to the following requirements:

1. Subject to paragraph 2 of this subsection, insofar as a contracted entity conducts postpayment audits, the contracted entity shall employ the postpayment audit process determined by the Authority;

2. The Authority shall establish a limit, not to exceed three percent (3%), on the percentage of claims with respect to which postpayment audits may be conducted by a contracted entity for health care items and services furnished by a provider in a plan year; and

3. The Authority shall provide for the imposition of financial penalties under such contract in the case of any contracted entity with respect to which the Authority determines has a claims denial error rate of greater than five percent (5%). The Authority shall establish the amount of financial penalties and the time frame under which such penalties shall be imposed on contracted entities under this paragraph, in no case less than annually.

E. A contracted entity may only apply readmission penalties pursuant to rules promulgated by the Oklahoma Health Care Authority Board. The Board shall promulgate rules establishing a program to reduce potentially preventable readmissions. The program shall use a nationally recognized tool, establish a base measurement year and a performance year, and provide for risk-adjustment based on the population of the state Medicaid program covered by the contracted entities.

SECTION 7. AMENDATORY 56 O.S. 2021, Section 4002.12, as last amended by Section 1, Chapter 308, O.S.L. 2023 (56 O.S. Supp. 2023, Section 4002.12), is amended to read as follows:

Section 4002.12 A. ~~Until July 1, 2026, the~~ The Oklahoma Health Care Authority shall establish minimum rates of reimbursement from contracted entities to providers who elect not to enter into value-based payment arrangements under subsection B of this section or other alternative payment agreements for health care items and services furnished by such providers to enrollees of the state Medicaid program. Except as provided by subsection I of this section, ~~until July 1, 2026,~~ such reimbursement rates shall be equal to or greater than:

1. For an item or service provided by a participating provider who is in the network of the contracted entity, one hundred percent (100%) of the reimbursement rate for the applicable service in the applicable fee schedule of the Authority; or

2. For an item or service provided by a non-participating provider or a provider who is not in the network of the contracted entity, ninety percent (90%) of the reimbursement rate for the applicable service in the applicable fee schedule of the Authority as of January 1, 2021.

B. A contracted entity shall offer value-based payment arrangements to all providers in its network capable of entering into value-based payment arrangements. Such arrangements shall be

optional for the provider but shall be tied to reimbursement incentives when quality metrics are met. The quality measures used by a contracted entity to determine reimbursement amounts to providers in value-based payment arrangements shall align with the quality measures of the Authority for contracted entities. Reimbursement under a value-based arrangement shall be in addition to the minimum rate established in Section 4002.3a of this title or one hundred percent (100%) of the minimum rate floor, whichever is greater.

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

D. A contracted entity shall offer all rural health clinics (RHCs) contracts that reimburse RHCs using the methodology in place for each specific RHC prior to January 1, 2023, including any and all annual rate updates. The contracted entity shall comply with all federal program rules and requirements, and the transformed Medicaid delivery system shall not interfere with the program as designed.

E. The Oklahoma Health Care Authority shall establish minimum rates of reimbursement from contracted entities to Certified

Community Behavioral Health Clinic (CCBHC) providers who elect alternative payment arrangements equal to the prospective payment system rate under the Medicaid State Plan.

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

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

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

I. 1. The rate paid to participating pharmacy providers is independent of subsection A of this section and shall be the same as the fee-for-service rate employed by the Authority for the Medicaid program as stated in the payment methodology ~~at~~ in OAC 317:30-5-78,

unless the participating pharmacy provider elects to enter into other alternative payment agreements.

2. A pharmacy or pharmacist shall receive direct payment or reimbursement from the Authority or contracted entity when providing a health care service to the Medicaid member at a rate no less than that of other health care providers for providing the same service.

J. Notwithstanding any other provision of this section, anesthesia shall continue to be reimbursed equal to or greater than the ~~Anesthesia Fee Schedule~~ anesthesia fee schedule established by the Authority as of January 1, 2021. Anesthesia providers may also enter into value-based payment arrangements under this section or alternative payment arrangements for services furnished to Medicaid members.

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

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

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

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

M. The Authority may establish a symmetric risk corridor for contracted entities.

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

O. 1. The Authority shall, through the financial reporting required under subsection G of Section 4002.12b of this title, determine the percentage of health care expenses by each contracted entity on primary care services.

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

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

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

Passed the House of Representatives the 25th day of April, 2024.

_____
Presiding Officer of the House of Representatives

Passed the Senate the ____ day of _____, 2024.

_____
Presiding Officer of the Senate

ENGROSSED SENATE
BILL NO. 1675 By: McCortney of the Senate

and

McEntire of the House

An Act relating to the state Medicaid program; amending Section 3, Chapter 395, O.S.L. 2022 (56 O.S. Supp. 2023, Section 4002.3a), which relates to capitated contracts for delivery of Medicaid services; extending certain deadlines; amending 56 O.S. 2021, Section 4002.4, as amended by Section 7, Chapter 395, O.S.L. 2022 (56 O.S. Supp. 2023, Section 4002.4), which relates to network adequacy standards for contracted entities; imposing certain deadline on credentialing or recredentialing by contracted entities; amending 56 O.S. 2021, Section 4002.6, as last amended by Section 2, Chapter 331, O.S.L. 2023 (56 O.S. Supp. 2023, Section 4002.6), which relates to requirements for prior authorizations; modifying and adding deadlines for certain determinations and reviews; requiring certain reviews to be conducted by Oklahoma-licensed clinical staff; amending 56 O.S. 2021, Section 4002.7, as amended by Section 11, Chapter 395, O.S.L. 2022 (56 O.S. Supp. 2023, Section 4002.7), which relates to requirements for processing and adjudicating claims; expanding certain provisions to include downgraded claims; specifying certain limit on claims subject to postpayment audits; amending 56 O.S. 2021, Section 4002.12, as last amended by Section 1, Chapter 308, O.S.L. 2023 (56 O.S. Supp. 2023, Section 4002.12), which relates to minimum rates of reimbursement; extending certain deadline; updating statutory references; updating statutory language; and declaring an emergency.

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

SECTION 9. AMENDATORY Section 3, Chapter 395, O.S.L. 2022 (56 O.S. Supp. 2023, Section 4002.3a), is amended to read as follows:

Section 4002.3a. A. 1. The Oklahoma Health Care Authority (OHCA) shall enter into capitated contracts with contracted entities for the delivery of Medicaid services as specified in ~~this act~~ the Ensuring Access to Medicaid Act to transform the delivery system of the state Medicaid program for the Medicaid populations listed in this section.

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

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

a. pregnant women,

b. children,

c. deemed newborns under 42 C.F.R., Section 435.117,

d. parents and caretaker relatives, and

e. the expansion population.

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

a. physical health services including, but not limited to:

(1) primary care,

(2) inpatient and outpatient services, and

(3) emergency room services,

b. behavioral health services, and

c. prescription drug services.

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

4. Subject to the requirements and approval of the Centers for Medicare and Medicaid Services, the implementation of the program shall be no later than ~~October 1, 2023~~ April 1, 2024.

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

a. pregnant women,

b. children,

c. parents and caretaker relatives,

d. the expansion population, and

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

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

3. Subject to the requirements and approval of the Centers for Medicare and Medicaid Services, the implementation of the program shall be no later than ~~October 1, 2023~~ April 1, 2024.

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

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

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

4. Subject to the requirements and approval of the Centers for Medicare and Medicaid Services, the implementation of the program shall be no later than ~~October 1, 2023~~ April 1, 2024.

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

SECTION 10. AMENDATORY 56 O.S. 2021, Section 4002.4, as amended by Section 7, Chapter 395, O.S.L. 2022 (56 O.S. Supp. 2023, Section 4002.4), is amended to read as follows:

Section 4002.4. A. The Oklahoma Health Care Authority shall develop network adequacy standards for all contracted entities that, at a minimum, meet the requirements of 42 C.F.R., Sections 438.3 and 438.68. Network adequacy standards established under this subsection shall include distance and time standards and shall be designed to ensure members covered by the contracted entities who reside in health professional shortage areas (HPSAs) designated under Section 332(a)(1) of the Public Health Service Act (42 U.S.C., Section 254e(a)(1)) have access to in-person health care and

telehealth services with providers, especially adult and pediatric primary care practitioners.

B. The Authority shall require all contracted entities to offer or extend contracts with all essential community providers, all providers who receive directed payments in accordance with 42 C.F.R., Part 438 and such other providers as the Authority may specify. The Authority shall establish such requirements as may be necessary to prohibit contracted entities from excluding essential community providers, providers who receive directed payments in accordance with 42 C.F.R., Part 438 and such other providers as the Authority may specify from contracts with contracted entities.

C. To ensure models of care are developed to meet the needs of Medicaid members, each contracted entity must contract with at least one local Oklahoma provider organization for a model of care containing care coordination, care management, utilization management, disease management, network management, or another model of care as approved by the Authority. Such contractual arrangements must be in place within twelve (12) months of the effective date of the contracts awarded pursuant to the requests for proposals authorized by ~~Section 3 of this act~~ Section 4002.3a of this title.

D. All contracted entities shall formally credential and recredential network providers at a frequency required by a single, consolidated provider enrollment and credentialing process established by the Authority in accordance with 42 C.F.R., Section

438.214. A contracted entity shall complete credentialing or recredentialing of a provider within sixty (60) calendar days of receipt of a completed application.

E. All contracted entities shall be accredited in accordance with 45 C.F.R., Section 156.275 by an accrediting entity recognized by the United States Department of Health and Human Services.

F. 1. If the Authority awards a capitated contract to a provider-led entity for the urban region under ~~Section 4 of this act~~ Section 4002.3b of this title, the provider-led entity shall expand its coverage area to every county of this state within the time frame set by the Authority under subsection E of ~~Section 4 of this act~~ Section 4002.3b of this title.

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

SECTION 11. AMENDATORY 56 O.S. 2021, Section 4002.6, as last amended by Section 2, Chapter 331, O.S.L. 2023 (56 O.S. Supp. 2023, Section 4002.6), is amended to read as follows:

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

B. A contracted entity shall 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 twenty-four (24) hours of receipt of the request.

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

D. A contracted entity shall make a determination on a request for services for a hospitalized member including, but not limited to, acute care inpatient services or equipment necessary to

discharge the member from an inpatient facility within ~~one (1) business day~~ twenty-four (24) hours of receipt of the request.

E. Notwithstanding the provisions of subsection C of this section, a contracted entity shall make a determination on a request as expeditiously as necessary and, in any event, within twenty-four (24) hours of receipt of the request for service if adhering to the provisions of subsection C or D of this section could jeopardize the member's life, health or ability to attain, maintain or regain maximum function. In the event of a medically emergent matter, the contracted entity shall not impose limitations on providers in coordination of post-emergent stabilization health care including pre-certification or prior authorization.

F. Notwithstanding any other provision of this section, a contracted entity shall make a determination on a request for inpatient behavioral health services within twenty-four (24) hours of receipt of the request.

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

H. A contracted entity shall make a determination on a request for coverage of biomarker testing in accordance with ~~Section 3 of this act~~ Section 4003 of this title.

I. Upon issuance of an adverse determination on a prior authorization request under subsection B of this section, the contracted entity shall provide the requesting provider, within seventy-two (72) hours of receipt of such issuance, with reasonable opportunity to participate in a peer-to-peer review process with a provider who practices in the same specialty, but not necessarily the same sub-specialty, and who has experience treating the same population as the patient on whose behalf the request is submitted; provided, however, if the requesting provider determines the services to be clinically urgent, the contracted entity shall provide such opportunity within twenty-four (24) hours of receipt of such issuance. Services not covered under the state Medicaid program for the particular patient shall not be subject to peer-to-peer review.

J. The Authority shall ensure that a provider offers to provide to a member in a timely manner services authorized by a contracted entity.

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

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

2. Require contracted entities to provide ~~a prompt~~ an opportunity for peer-to-peer conversations with ~~licensed~~ Oklahoma-licensed clinical staff of the same or similar specialty ~~which shall include, but not be limited to, Oklahoma-licensed clinical staff upon~~ within twenty-four (24) hours of the adverse determination; and

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

SECTION 12. AMENDATORY 56 O.S. 2021, Section 4002.7, as amended by Section 11, Chapter 395, O.S.L. 2022 (56 O.S. Supp. 2023, Section 4002.7), is amended to read as follows:

Section 4002.7. A. The Oklahoma Health Care Authority shall establish requirements for fair processing and adjudication of claims that ensure prompt reimbursement of providers by contracted entities. A contracted entity shall comply with all such requirements.

B. A contracted entity shall process a clean claim in the time frame provided by Section 1219 of Title 36 of the Oklahoma Statutes and no less than ninety percent (90%) of all clean claims shall be paid within fourteen (14) days of submission to the contracted entity. A clean claim that is not processed within the time frame provided by Section 1219 of Title 36 of the Oklahoma Statutes shall bear simple interest at the monthly rate of one and one-half percent

(1.5%) payable to the provider. A claim filed by a provider within six (6) months of the date the item or service was furnished to a member shall be considered timely. If a claim meets the definition of a clean claim, the contracted entity shall not request medical records of the member prior to paying the claim. Once a claim has been paid, the contracted entity may request medical records if additional documentation is needed to review the claim for medical necessity.

C. In the case of a denial of a claim including, but not limited to, a denial on the basis of the level of emergency care indicated on the claim, or in the case of a downgraded claim, the contracted entity shall establish a process by which the provider may identify and provide such additional information as may be necessary to substantiate the claim. Any such claim denial or downgrade shall include the following:

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

2. A detailed description of the additional information necessary to substantiate the claim.

D. Postpayment audits by a contracted entity shall be subject to the following requirements:

1. Subject to paragraph 2 of this subsection, insofar as a contracted entity conducts postpayment audits, the contracted entity shall employ the postpayment audit process determined by the Authority;

2. The Authority shall establish a limit, not to exceed three percent (3%), on the percentage of claims with respect to which postpayment audits may be conducted by a contracted entity for health care items and services furnished by a provider in a plan year; and

3. The Authority shall provide for the imposition of financial penalties under such contract in the case of any contracted entity with respect to which the Authority determines has a claims denial error rate of greater than five percent (5%). The Authority shall establish the amount of financial penalties and the time frame under which such penalties shall be imposed on contracted entities under this paragraph, in no case less than annually.

E. A contracted entity may only apply readmission penalties pursuant to rules promulgated by the Oklahoma Health Care Authority Board. The Board shall promulgate rules establishing a program to reduce potentially preventable readmissions. The program shall use a nationally recognized tool, establish a base measurement year and a performance year, and provide for risk-adjustment based on the population of the state Medicaid program covered by the contracted entities.

SECTION 13. AMENDATORY 56 O.S. 2021, Section 4002.12, as last amended by Section 1, Chapter 308, O.S.L. 2023 (56 O.S. Supp. 2023, Section 4002.12), is amended to read as follows:

Section 4002.12. A. Until July 1, ~~2026~~ 2027, the Oklahoma Health Care Authority shall establish minimum rates of reimbursement from contracted entities to providers who elect not to enter into value-based payment arrangements under subsection B of this section or other alternative payment agreements for health care items and services furnished by such providers to enrollees of the state Medicaid program. Except as provided by subsection I of this section, until July 1, ~~2026~~ 2027, such reimbursement rates shall be equal to or greater than:

1. For an item or service provided by a participating provider who is in the network of the contracted entity, one hundred percent (100%) of the reimbursement rate for the applicable service in the applicable fee schedule of the Authority; or

2. For an item or service provided by a non-participating provider or a provider who is not in the network of the contracted entity, ninety percent (90%) of the reimbursement rate for the applicable service in the applicable fee schedule of the Authority as of January 1, 2021.

B. A contracted entity shall offer value-based payment arrangements to all providers in its network capable of entering into value-based payment arrangements. Such arrangements shall be optional for the provider but shall be tied to reimbursement incentives when quality metrics are met. The quality measures used by a contracted entity to determine reimbursement amounts to

providers in value-based payment arrangements shall align with the quality measures of the Authority for contracted entities.

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

D. A contracted entity shall offer all rural health clinics (RHCs) contracts that reimburse RHCs using the methodology in place for each specific RHC prior to January 1, 2023, including any and all annual rate updates. The contracted entity shall comply with all federal program rules and requirements, and the transformed Medicaid delivery system shall not interfere with the program as designed.

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

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

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

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

I. 1. The rate paid to participating pharmacy providers is independent of subsection A of this section and shall be the same as the fee-for-service rate employed by the Authority for the Medicaid program as stated in the payment methodology ~~at~~ in OAC 317:30-5-78, unless the participating pharmacy provider elects to enter into other alternative payment agreements.

2. A pharmacy or pharmacist shall receive direct payment or reimbursement from the Authority or contracted entity when providing a health care service to the Medicaid member at a rate no less than that of other health care providers for providing the same service.

J. Notwithstanding any other provision of this section, anesthesia shall continue to be reimbursed equal to or greater than the ~~Anesthesia Fee Schedule~~ anesthesia fee schedule established by the Authority as of January 1, 2021. Anesthesia providers may also enter into value-based payment arrangements under this section or alternative payment arrangements for services furnished to Medicaid members.

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

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

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

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

M. The Authority may establish a symmetric risk corridor for contracted entities.

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

O. 1. The Authority shall, through the financial reporting required under subsection G of Section 4002.12b of this title, determine the percentage of health care expenses by each contracted entity on primary care services.

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

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

SECTION 14. It being immediately necessary for the preservation of the public peace, health or safety, an emergency is hereby declared to exist, by reason whereof this act shall take effect and be in full force from and after its passage and approval.

Passed the Senate the 7th day of March, 2024.

_____
Presiding Officer of the Senate

Passed the House of Representatives the ____ day of _____, 2024.

_____
Presiding Officer of the House of Representatives