

OKLAHOMA STATE SENATE
CONFERENCE
COMMITTEE REPORT

May 27, 2024

Mr. President:

Mr. Speaker:

The Conference Committee, to which was referred

SB1675

By: McCortney of the Senate and McEntire of the House

Title: Medicaid; modifying various provisions of the Ensuring Access to Medicaid Act. Emergency.

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 (Request #3813) be adopted.

Respectfully submitted,


SENATE CONFEREES:





McCortney


Rosino


Haste



Daniels


Pugh


Hicks

HOUSE CONFEREES:

General Conference Committee on Appropriations

Senate Action _____ Date _____ House Action _____ Date _____

SB1675 CCR (A)
HOUSE CONFEREES

Baker, Rhonda

Bennett, Forrest

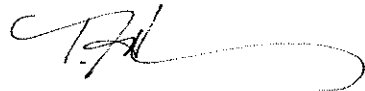
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Echols, Jon

Ford, Ross

Hasenbeck, Toni

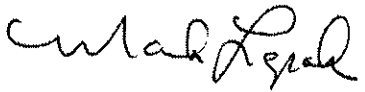


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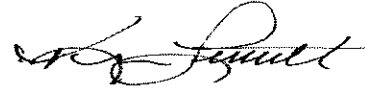
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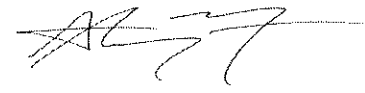
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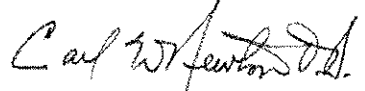
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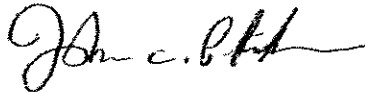


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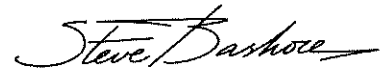
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Ranson, Trish

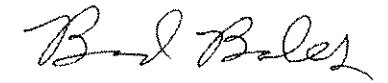
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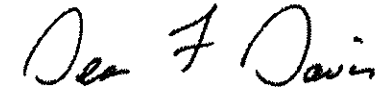


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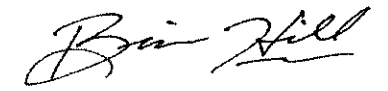


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Goodwin, Regina

Hill, Brian

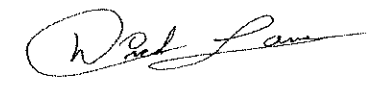


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Lawson, Mark



Lowe, Dick




McBride, Mark

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Munson, Cyndi



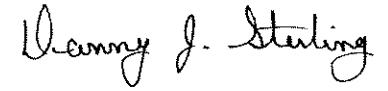
Nichols, Monroe

Osburn, Mike



Provenzano, Melissa

Sterling, Danny



Vancuren, Mark

Wallace, Kevin

West, Tammy

Tammy West

STATE OF OKLAHOMA

2nd Session of the 59th Legislature (2024)

CONFERENCE COMMITTEE SUBSTITUTE
FOR ENGROSSED

SENATE BILL NO. 1675

By: McCortney of the Senate

and

McEntire of the House

CONFERENCE COMMITTEE SUBSTITUTE

An Act relating to the state Medicaid program; amending 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), which relates to definitions in the Ensuring Access to Medicaid Act; adding and modifying definitions; 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 Section 4, Chapter 395, O.S.L. 2022 (56 O.S. Supp. 2023, Section 4002.3b), which relates to capitated contracts; broadening certain provisions to cover provider-owned entities; requiring selection of provider-owned entity under certain conditions; 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; broadening certain provisions to cover provider-owned 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 downcoded claims; 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 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;

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

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

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

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

22 8. "Contracted entity" means an organization or entity that
23 enters into or will enter into a capitated contract with the
24 Oklahoma Health Care Authority for the delivery of services

1 specified in the Ensuring Access to Medicaid Act that will assume
2 financial risk, operational accountability, and statewide or
3 regional functionality as defined in the Ensuring Access to Medicaid
4 Act in managing comprehensive health outcomes of Medicaid members.
5 For purposes of the Ensuring Access to Medicaid Act, the term
6 contracted entity includes an accountable care organization, a
7 provider-led entity, a commercial plan, a dental benefit manager, or
8 any other entity as determined by the Authority;

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

12 10. "Essential community provider" means:

- 13 a. a Federally Qualified Health Center,
- 14 b. a community mental health center,
- 15 c. an Indian Health Care Provider,
- 16 d. a rural health clinic,
- 17 e. a state-operated mental health hospital,
- 18 f. a long-term care hospital serving children (LTCH-C),
- 19 g. a teaching hospital owned, jointly owned, or
20 affiliated with and designated by the University
21 Hospitals Authority, University Hospitals Trust,
22 Oklahoma State University Medical Authority, or
23 Oklahoma State University Medical Trust,
- 24

- 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~~ this state 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

1 licensed provider, or other local Oklahoma provider organization as
2 approved by the Authority;

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

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

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

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

17 a. ~~a majority of the entity's ownership is held by~~
18 ~~Medicaid providers in this state or is held by an~~
19 ~~entity that directly or indirectly owns or is under~~
20 ~~common ownership with Medicaid providers in this~~
21 ~~state, or,~~

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

24 ~~(1)~~

1 a. have experience serving Medicaid members and:

2 ~~(a)~~

3 (1) are licensed in this state as physicians,
4 physician assistants, ~~nurse practitioners,~~
5 ~~certified nurse midwives, or certified registered~~
6 ~~nurse anesthetists~~ or Advanced Practice
7 Registered Nurses,

8 ~~(b)~~

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

11 ~~(c)~~

12 (3) are employed by:

13 ~~i.~~

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

17 ~~ii.~~

18 (b) an inpatient or outpatient mental health or
19 substance abuse treatment facility or
20 program licensed or certified by this state
21 and operating in this state,

22 ~~(2)~~

23 b. represent the providers or facilities described in

24 ~~division (1) of this subparagraph~~ a of this paragraph

1 including, but not limited to, individuals who are
2 employed by a statewide provider association, or
3 ~~(3)~~

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

6 18. "Provider-owned entity" means an organization or entity, a
7 majority of whose ownership is held by Medicaid providers in this
8 state or is held by an entity that directly or indirectly owns or is
9 under common ownership with Medicaid providers in this state;

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

12 ~~19.~~ 20. "Urban region" means:

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

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

19 SECTION 2. AMENDATORY Section 3, Chapter 395, O.S.L.
20 2022 (56 O.S. Supp. 2023, Section 4002.3a), is amended to read as
21 follows:

22 Section 4002.3a. A. 1. The Oklahoma Health Care Authority
23 (OHCA) shall enter into capitated contracts with contracted entities
24 for the delivery of Medicaid services as specified in ~~this act~~ the

1 Ensuring Access to Medicaid Act to transform the delivery system of
2 the state Medicaid program for the Medicaid populations listed in
3 this section.

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

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

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

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

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

1 (2) inpatient and outpatient services, and

2 (3) emergency room services,

3 b. behavioral health services, and

4 c. prescription drug services.

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

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

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

13 a. pregnant women,

14 b. children,

15 c. parents and caretaker relatives,

16 d. the expansion population, and

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

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

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

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

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

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

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

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

1 the Authority from exploring alternative opportunities with the
2 Centers for Medicare and Medicaid Services to maximize the average
3 commercial rate benefit.

4 SECTION 3. AMENDATORY Section 4, Chapter 395, O.S.L.
5 2022 (56 O.S. Supp. 2023, Section 4002.3b), is amended to read as
6 follows:

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

11 B. Statewide capitated contracts may be awarded to any
12 contracted entity including, but not limited to, a any provider-led
13 entity or provider-owned entity, or both.

14 C. The Authority shall award no less than three statewide
15 capitated contracts to provide comprehensive integrated health
16 services including, but not limited to, medical, behavioral health,
17 and pharmacy services and no less than two statewide capitated
18 contracts to provide dental coverage to Medicaid members as
19 specified in Section ~~3~~ 4002.3a of this ~~act~~ title.

20 D. 1. Except as specified in paragraph ~~2~~ 3 of this subsection,
21 at least one capitated contract to provide statewide coverage to
22 Medicaid members shall be awarded to a provider-led entity, as long
23 as the provider-led entity submits a responsive reply to the
24

1 Authority's request for proposals demonstrating ability to fulfill
2 the contract requirements.

3 2. Effective with the next procurement cycle, and except as
4 specified in paragraph 3 of this subsection, at least one capitated
5 contract to provide statewide coverage to Medicaid members shall be
6 awarded to a provider-owned entity, as long as the provider-owned
7 entity submits a responsive reply to the Authority's request for
8 proposals demonstrating ability to fulfill the contract
9 requirements.

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

15 ~~3.~~ 4. The Authority shall develop a scoring methodology for the
16 request for proposals that affords preferential scoring to provider-
17 led entities and provider-owned entities, as long as the provider-
18 led entity and provider-owned entity otherwise ~~demonstrates~~
19 demonstrate an ability to fulfill the contract requirements. The
20 preferential scoring methodology shall include opportunities to
21 award additional points to provider-led entities and provider-owned
22 entities based on certain factors including, but not limited to:

- 23 a. broad provider participation in ownership and
24 governance structure,

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

5 c. demonstrated experience in Medicare or Medicaid
6 accountable care organizations or other Medicare or
7 Medicaid alternative payment models, Medicare or
8 Medicaid value-based payment arrangements, or Medicare
9 or Medicaid risk-sharing arrangements including, but
10 not limited to, innovation models of the Center for
11 Medicare and Medicaid Innovation of the Centers for
12 Medicare and Medicaid Services, or value-based payment
13 arrangements or risk-sharing arrangements in the
14 commercial health care market, and

15 d. other relevant factors identified by the Authority.

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

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

21 2. The provider-led entity or provider-owned entity
22 demonstrates the ability, and agrees continually, to expand its
23 coverage area throughout the contract term and to develop statewide
24

1 operational readiness within a time frame set by the Authority but
2 not mandated before five (5) years.

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

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

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

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

19 Section 4002.4. A. The Oklahoma Health Care Authority shall
20 develop network adequacy standards for all contracted entities that,
21 at a minimum, meet the requirements of 42 C.F.R., Sections 438.3 and
22 438.68. Network adequacy standards established under this
23 subsection shall include distance and time standards and shall be
24 designed to ensure members covered by the contracted entities who

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

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

15 C. To ensure models of care are developed to meet the needs of
16 Medicaid members, each contracted entity must contract with at least
17 one local Oklahoma provider organization for a model of care
18 containing care coordination, care management, utilization
19 management, disease management, network management, or another model
20 of care as approved by the Authority. Such contractual arrangements
21 must be in place within twelve (12) months of the effective date of
22 the contracts awarded pursuant to the requests for proposals
23 authorized by ~~Section 3 of this act~~ Section 4002.3a of this title.
24

1 D. All contracted entities shall formally credential and
2 recredential network providers at a frequency required by a single,
3 consolidated provider enrollment and credentialing process
4 established by the Authority in accordance with 42 C.F.R., Section
5 438.214. A contracted entity shall complete credentialing or
6 recredentialing of a provider within sixty (60) calendar days of
7 receipt of a completed application.

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

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

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

entity's or provider-owned 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

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

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

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

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

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

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

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

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

21 J. The Authority shall ensure that a provider offers to provide
22 to a member in a timely manner services authorized by a contracted
23 entity.
24

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

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

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

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

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

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

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

1 entity. A clean claim that is not processed within the time frame
2 provided by Section 1219 of Title 36 of the Oklahoma Statutes shall
3 bear simple interest at the monthly rate of one and one-half percent
4 (1.5%) payable to the provider. A claim filed by a provider within
5 six (6) months of the date the item or service was furnished to a
6 member shall be considered timely. If a claim meets the definition
7 of a clean claim, the contracted entity shall not request medical
8 records of the member prior to paying the claim. Once a claim has
9 been paid, the contracted entity may request medical records if
10 additional documentation is needed to review the claim for medical
11 necessity.

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

- 19 1. A detailed explanation of the basis for the denial; and
20 2. A detailed description of the additional information
21 necessary to substantiate the claim.

22 D. Postpayment audits by a contracted entity shall be subject
23 to the following requirements:
24

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

5 2. The Authority shall establish a limit on the percentage of
6 claims with respect to which postpayment audits may be conducted by
7 a contracted entity for health care items and services furnished by
8 a provider in a plan year; and

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

16 E. A contracted entity may only apply readmission penalties
17 pursuant to rules promulgated by the Oklahoma Health Care Authority
18 Board. The Board shall promulgate rules establishing a program to
19 reduce potentially preventable readmissions. The program shall use
20 a nationally recognized tool, establish a base measurement year and
21 a performance year, and provide for risk-adjustment based on the
22 population of the state Medicaid program covered by the contracted
23 entities.
24

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~~ 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

1 optional for the provider but shall be tied to reimbursement
2 incentives when quality metrics are met. The quality measures used
3 by a contracted entity to determine reimbursement amounts to
4 providers in value-based payment arrangements shall align with the
5 quality measures of the Authority for contracted entities.

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

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

19 E. The Oklahoma Health Care Authority shall establish minimum
20 rates of reimbursement from contracted entities to Certified
21 Community Behavioral Health Clinic (CCBHC) providers who elect
22 alternative payment arrangements equal to the prospective payment
23 system rate under the Medicaid State Plan.
24

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

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

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

18 I. 1. The rate paid to participating pharmacy providers is
19 independent of subsection A of this section and shall be the same as
20 the fee-for-service rate employed by the Authority for the Medicaid
21 program as stated in the payment methodology ~~at~~ in OAC 317:30-5-78,
22 unless the participating pharmacy provider elects to enter into
23 other alternative payment agreements.
24

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

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

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

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

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

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

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

22 SECTION 8. It being immediately necessary for the preservation
23 of the public peace, health or safety, an emergency is hereby
24

declared to exist, by reason whereof this act shall take effect and
be in full force from and after its passage and approval.

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