STATE OF OKLAHOMA

1st Session of the 60th Legislature (2025)

SENATE BILL 875 By: Rosino

AS INTRODUCED

An Act relating to the state Medicaid program; amending Section 4, Chapter 395, O.S.L. 2022, as amended by Section 3, Chapter 448, O.S.L. 2024 (56 O.S. Supp. 2024, Section 4002.3b), which relates to capitated contracts; making contracted entities ineligible for capitated contracts for failure to meet certain minimum expense requirement; amending 56 O.S. 2021, Section 4002.12, as last amended by Section 7, Chapter 448, O.S.L. 2024 (56 O.S. Supp. 2024, Section 4002.12), which relates to minimum rates of reimbursement; making contracted entities ineligible for capitated contracts for failure to meet certain minimum expense requirement; providing an effective date; and declaring an emergency.

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

SECTION 1. AMENDATORY Section 4, Chapter 395, O.S.L. 2022, as amended by Section 3, Chapter 448, O.S.L. 2024 (56 O.S. Supp. 2024, 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, any provider-led entity or provider-owned entity, or both.

C. The Authority shall award no less than three 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 4002.3a of this title.

D. 1. Except as specified in paragraph 3 of this subsection, 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. Effective with the next procurement cycle, and except as specified in paragraph 3 of this subsection, at least one capitated contract to provide statewide coverage to Medicaid members shall be awarded to a provider-owned entity, as long as the provider-owned entity submits a responsive reply to the Authority's request for proposals demonstrating ability to fulfill the contract requirements.

3. 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.

4. 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 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 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.

I. Effective with the next procurement cycle, a contracted entity that currently holds a capitated contract with the Authority under the Ensuring Access to Medicaid Act shall be ineligible for a capitated contract award for the subsequent procurement cycle if the contracted entity fails to meet the minimum primary care expense requirement stipulated in subsection O of Section 4002.12 of this title.

SECTION 2. AMENDATORY 56 O.S. 2021, Section 4002.12, as last amended by Section 7, Chapter 448, O.S.L. 2024 (56 O.S. Supp. 2024, Section 4002.12), is amended to read as follows:

Section 4002.12. A. Until July 1, 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, 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 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 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.

4. If a contracted entity fails to meet the minimum primary care expense requirement stipulated in paragraph 2 of this subsection, the contracted entity shall be ineligible for a capitated contract award for the subsequent procurement cycle as provided by subsection I of Section 4002.3b of this title.

SECTION 3. This act shall become effective July 1, 2025.

SECTION 4. 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.

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