An Act

ENROLLED SENATE
BILL NO. 131

By: McCortney, Garvin and Treat of the Senate

and

McEntire, Newton, Bush, Fugate, Pae, McDugle, Roe, Moore, Talley, Cornwell, Marti, Fetgatter, Culver, Lawson, Humphrey and Waldron of the House

An Act relating to the state Medicaid program; creating the "Ensuring Access to Medicaid Act"; defining terms; authorizing Oklahoma Health Care Authority to require enrollment in certain delivery model for certain individuals; providing for voluntary enrollment by certain individuals; specifying enrollment process for certain individuals; prohibiting requirement or offer of enrollment for certain individuals; directing Authority to develop certain network adequacy standards; requiring managed care organizations and dental benefit managers to meet or exceed network adequacy requirements; requiring contracting with certain providers; requiring certain credentialing and recredentialing process for providers; requiring accreditation for managed care organizations and dental benefit managers; requiring certain notification for material change; requiring medical loss ratio to meet certain standards; requiring certain provision of patient data upon request; prohibiting enforcement of certain policy or contract term; prohibiting contract from disallowing certain contract with accountable care organization; stipulating timeframes for certain authorizations; providing for peer-to-peer review; requiring

Authority to ensure timely offering of authorized services; setting certain requirements for processing and adjudication of claims; requiring managed care organizations and dental benefit managers to utilize certain procedures for review and appeal; directing Authority to develop certain procedures; providing requirements for appeal of adverse determination based on medical necessity; providing for fair hearing; providing for non-compliance remedies; requiring managed care organization or dental benefit manager to participate in readiness review; specifying criteria of readiness review; allowing execution of transition of certain delivery system under certain condition; directing Authority to create certain quarterly scorecard; specifying criteria of scorecard; requiring Authority to provide scorecard to enrollees and publish on its Internet website; directing Authority to establish minimum rates of reimbursement for certain providers; setting minimum rates for certain time period; requiring managed care organization or dental benefit manager to offer value-based payment arrangements to certain providers; requiring use of certain quality measures for value-based payments; directing Authority to comply with federally required payment methodologies; creating the MC Quality Advisory Committee; providing for duties, membership, selection of chair and vice chair, meetings, quorum and staff support; prohibiting compensation; providing for codification; and providing an effective date.

SUBJECT: Medicaid

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

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

This act shall be known and may be cited as the "Ensuring Access to Medicaid Act".

SECTION 2. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 4002.2 of Title 56, unless there is created a duplication in numbering, reads as follows:

As used in this act:

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

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

3. "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;

4. "Dental benefit manager" means an entity under contract with the Oklahoma Health Care Authority to manage and deliver dental benefits and services to enrollees of the capitated managed care delivery model of the state Medicaid program;

5. "Essential community provider" has the same meaning as provided by 45 C.F.R., Section 156.235;

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

7. "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 managed care organization or dental benefit manager;

8. "Medical necessity" has the same meaning as provided by rules of the Oklahoma Health Care Authority Board;

9. "Participating provider" means a provider who has a contract with or is employed by a managed care organization or dental benefit manager to provide services to enrollees under the capitated managed care delivery model of the state Medicaid program; and

10. "Provider" means a health care or dental provider licensed or certified in this state.

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

A. Unless expressly authorized by the Legislature, the Oklahoma Health Care Authority may only require enrollment in a capitated managed care delivery model of the state Medicaid program for eligible individuals from an enrollee population of the state Medicaid program delineated as a mandatory enrollment population in the SoonerSelect Request for Proposals awarded in January of 2021 or the SoonerSelect Dental Program Request for Proposals awarded in February of 2021.

B. 1. Unless expressly authorized by the Legislature, enrollment in a capitated managed care delivery model of the state Medicaid program shall be voluntary for eligible individuals from an enrollee population of the state Medicaid program delineated as a voluntary enrollment population in the SoonerSelect Request for Proposals awarded in January of 2021 or the SoonerSelect Dental Program Request for Proposals awarded in February of 2021.

2. The Authority may only utilize an opt-in enrollment process for the voluntary enrollment of individuals in the American Indian/Alaska Native population.

C. Unless expressly authorized by the Legislature, the Authority shall not:

1. Require enrollment in a capitated managed care delivery model of the state Medicaid program for eligible individuals from any enrollee population of the state Medicaid program delineated as

an excluded population in or omitted entirely from the SoonerSelect Request for Proposals awarded in January of 2021 or the SoonerSelect Dental Program Request for Proposals awarded in February of 2021; or

2. Offer voluntary enrollment in a capitated managed care delivery model of the state Medicaid program to eligible individuals from any enrollee population of the state Medicaid program delineated as an excluded population in or omitted entirely from the SoonerSelect Request for Proposals awarded in January of 2021 or the SoonerSelect Dental Program Request for Proposals awarded in February of 2021.

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

A. The Oklahoma Health Care Authority shall develop network adequacy standards for all managed care organizations and dental benefit managers that, at a minimum, meet the requirements of 42 C.F.R., Sections 438.14 and 438.68. Network adequacy standards established under this subsection shall be designed to ensure enrollees covered by the managed care organizations and dental benefit managers 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. All managed care organizations and dental benefit managers shall meet or exceed network adequacy standards established by the Authority under subsection A of this section to ensure sufficient access to providers for enrollees of the state Medicaid program.

C. All managed care organizations and dental benefit managers shall contract to the extent possible and practicable 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.

D. All managed care organizations and dental benefit managers 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.

E. All managed care organizations and dental benefit managers 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.

SECTION 5. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 4002.5 of Title 56, unless there is created a duplication in numbering, reads as follows:

A. A managed care organization or dental benefit manager shall promptly notify the Authority of all changes materially affecting the delivery of care or the administration of its program.

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

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

D. A managed care organization or dental benefit manager or a subcontractor of such managed care organization or dental benefit manager shall not enforce a policy or contract term with a provider that requires the provider to contract for all products that are currently offered or that may be offered in the future by the managed care organization or dental benefit manager or subcontractor.

E. Nothing in a contract between the Authority and a managed care organization or dental benefit manager shall prohibit the managed care organization or dental benefit manager from contracting with a statewide or regional accountable care organization to implement the capitated managed care delivery model of the state Medicaid program.

SECTION 6. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 4002.6 of Title 56, unless there is created a duplication in numbering, reads as follows:

A. A managed care organization 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.

B. Review and issue determinations made by a managed care organization or, as appropriate, by a dental benefit manager for prior authorization for care ordered by primary care or specialist providers shall be timely and shall occur in accordance with the following:

1. Within seventy-two (72) hours of receipt of the request for any patient who is not hospitalized at the time of the request; provided, that if the request does not include sufficient or adequate documentation, the review and issue 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 paragraph shall include a time frame of at least forty-eight (48) hours within which a provider may submit the necessary documentation;

2. Within one (1) business day of receipt of the request for services for a hospitalized patient including, but not limited to, acute care inpatient services or equipment necessary to discharge the patient from an inpatient facility;

3. Notwithstanding the provisions of paragraphs 1 or 2 of this subsection, 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 paragraphs 1 or 2 of this subsection could jeopardize the enrollee's life, health or ability to attain, maintain or regain maximum function. In the event of a medically emergent matter, the managed care organization or dental benefit manager shall not impose limitations on providers in coordination of post-emergent stabilization health care including pre-certification or prior authorization;

4. Notwithstanding any other provision of this subsection, within twenty-four (24) hours of receipt of the request for inpatient behavioral health services; and

5. Within twenty-four (24) hours of receipt of the request for covered prescription drugs that are required to be prior authorized by the Authority. The managed care organization shall not require prior authorization on any covered prescription drug for which the Authority does not require prior authorization.

C. Upon issuance of an adverse determination on a prior authorization request under subsection B of this section, the managed care organization or dental benefit manager 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 managed care organization or dental benefit manager 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.

D. The Authority shall ensure that a provider offers to provide to an enrollee in a timely manner services authorized by a managed care organization or dental benefit manager.

SECTION 7. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 4002.7 of Title 56, unless there is created a duplication in numbering, reads as follows:

A managed care organization or dental benefit manager shall comply with the following requirements with respect to processing and adjudication of claims for payment submitted in good faith by providers for health care items and services furnished by such providers to enrollees of the state Medicaid program:

1. A managed care organization or dental benefit manager 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 managed care organization or dental benefit manager. 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 an enrollee shall be considered timely. If a claim meets the definition of a clean claim, the managed care organization or dental benefit manager shall not request medical records of the enrollee prior to paying the claim. Once a claim has been paid, the managed care organization or dental benefit manager may request medical records if additional documentation is needed to review the claim for medical necessity;

2. 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, the managed care organization or dental benefit manager 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 shall include the following:

a. a detailed explanation of the basis for the denial, and

b. a detailed description of the additional information necessary to substantiate the claim;

3. Postpayment audits by a managed care organization or dental benefit manager shall be subject to the following requirements:

a. subject to subparagraph b of this paragraph, insofar as a managed care organization or dental benefit manager conducts postpayment audits, the managed care organization or dental benefit manager shall employ the postpayment audit process determined by the Authority,

b. the Authority shall establish a limit on the percentage of claims with respect to which postpayment

audits may be conducted by a managed care organization or dental benefit manager for health care items and services furnished by a provider in a plan year, and

c. the Authority shall provide for the imposition of financial penalties under such contract in the case of any managed care organization or dental benefit manager 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 managed care organizations and dental benefit managers under this subparagraph, in no case less than annually; and

4. A managed care organization 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 managed care organizations and dental benefit managers.

SECTION 8. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 4002.8 of Title 56, unless there is created a duplication in numbering, reads as follows:

A. A managed care organization or dental benefit manager shall utilize uniform procedures established by the Authority under subsection B of this section for the review and appeal of any adverse determination by the managed care organization or dental benefit manager sought by any enrollee or provider adversely affected by such determination.

B. The Authority shall develop procedures for enrollee or providers to seek review by the managed care organization or dental benefit manager of any adverse determination made by the managed care organization or dental benefit manager. A provider shall have six (6) months from the receipt of a claim denial to file an appeal. With respect to appeals of adverse determinations made by a managed

care organization or dental benefit manager on the basis of medical necessity, the following requirements shall apply:

1. Medical review staff of the managed care organization or dental benefit manager shall be licensed or credentialed health care clinicians with relevant clinical training or experience; and

2. All managed care organizations and dental benefit managers shall use medical review staff for such appeals and shall not use any automated claim review software or other automated functionality for such appeals.

C. Upon receipt of notice from the managed care organization or dental benefit manager that the adverse determination has been upheld on appeal, the enrollee or provider may request a fair hearing from the Authority. The Authority shall develop procedures for fair hearings in accordance with 42 C.F.R., Part 431.

SECTION 9. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 4002.9 of Title 56, unless there is created a duplication in numbering, reads as follows:

In addition to such other remedies or penalties as may be prescribed by law, a managed care organization or dental benefit manager found to be in violation of the provisions of or rules promulgated under this act or of the terms and conditions of the contract entered into between the managed care organization or dental benefit manager and the Oklahoma Health Care Authority shall be subject to one or more non-compliance remedies of the Authority.

SECTION 10. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 4002.10 of Title 56, unless there is created a duplication in numbering, reads as follows:

A. The Oklahoma Health Care Authority shall require a managed care organization or dental benefit manager to participate in a readiness review in accordance with 42 C.F.R., Section 438.66. The readiness review shall assess the ability and capacity of the managed care organization or dental benefit manager to perform satisfactorily in such areas as may be specified in 42 C.F.R., Section 438.66. In addition, the readiness review shall assess whether:

1. The managed care organization or dental benefit manager has entered into contracts with providers to the extent necessary to meet network adequacy standards prescribed by Section 4 of this act;

2. The contracts described in paragraph 1 of this subsection offer, but do not require, value-based payment arrangements as provided by Section 12 of this act; and

3. The managed care organization or dental benefit manager and the providers described in paragraph 1 of this subsection have established and tested data infrastructure such that exchange of patient data can reasonably be expected to occur within one hundred twenty (120) calendar days of execution of the transition of the delivery system described in subsection B of this section. The Authority shall assess its ability to facilitate the exchange of patient data, claims, coordination of benefits and other components of a managed care delivery model.

B. The Oklahoma Health Care Authority may only execute the transition of the delivery system of the state Medicaid program to the capitated managed care delivery model of the state Medicaid program ninety (90) days after the Centers for Medicare and Medicaid Services has approved all contracts entered into between the Authority and all managed care organizations and dental benefit managers following submission of the readiness reviews to the Centers for Medicare and Medicaid Services.

SECTION 11. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 4002.11 of Title 56, unless there is created a duplication in numbering, reads as follows:

No later than one year following the execution of the delivery model transition described in Section 10 of this act, the Oklahoma Health Care Authority shall create a scorecard that compares managed care organizations and dental benefit managers. The scorecard shall report the average speed of authorizations of services, rates of denials of services, enrollee satisfaction survey results and such other criteria as the Authority may require. The scorecard shall be compiled quarterly and shall consist of the information specified in this section from the prior year. The Authority shall provide the most recent quarterly scorecard to all initial enrollees during

enrollment choice counseling following the eligibility determination and prior to initial enrollment. The Authority shall provide the most recent quarterly scorecard to all enrollees at the beginning of each enrollment period. The Authority shall publish each quarterly scorecard on its Internet website.

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

A. The Oklahoma Health Care Authority shall establish minimum rates of reimbursement from managed care organizations and dental benefit managers to providers who elect not to enter into value-based payment arrangements under subsection B of this section for health care items and services furnished by such providers to enrollees of the state Medicaid program. 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 managed care organization or dental benefit manager, 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 managed care organization or dental benefit manager, 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 managed care organization or dental benefit manager 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. The quality measures used by a managed care organization or dental benefit manager to determine reimbursement amounts to providers in value-based payment arrangements shall align with the quality measures of the Authority for managed care organizations or dental benefit managers.

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.

SECTION 13. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 4002.13 of Title 56, unless there is created a duplication in numbering, reads as follows:

A. There is hereby created the MC Quality Advisory Committee for the purpose of performing the duties specified in subsection B of this section.

B. The primary power and duty of the Committee shall be to make recommendations to the Administrator of the Oklahoma Health Care Authority and the Oklahoma Health Care Authority Board on quality measures used by managed care organizations and dental benefit managers in the capitated managed care delivery model of the state Medicaid program.

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

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

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

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

2. A quorum of the Committee shall be required to approve any final action of the Committee. A majority of the members of the Committee shall constitute a quorum.

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

F. Members of the Committee shall receive no compensation or travel reimbursement.

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

SECTION 14. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 4004 of Title 56, unless there is created a duplication in numbering, reads as follows:

A. The Oklahoma Health Care Authority shall seek any federal approval necessary to implement this act.

B. The Oklahoma Health Care Authority Board shall promulgate rules to implement this act.

SECTION 15. This act shall become effective September 1, 2021.

Passed the Senate the 19th day of May, 2021.

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Presiding Officer of the Senate

Passed the House of Representatives the 20th day of May, 2021.

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Presiding Officer of the House
of Representatives

OFFICE OF THE GOVERNOR

Received by the Office of the Governor this _____

day of _____, 20_____, at _____ o'clock _____ M.

By: _____

Approved by the Governor of the State of Oklahoma this _____

day of _____, 20_____, at _____ o'clock _____ M.

_____
Governor of the State of Oklahoma

OFFICE OF THE SECRETARY OF STATE

Received by the Office of the Secretary of State this _____

day of _____, 20 _____, at _____ o'clock _____ M.

By: _____