STATE OF OKLAHOMA

1st Session of the 60th Legislature (2025)

SENATE BILL 252 By: Standridge

AS INTRODUCED

An Act relating to the state Medicaid program; amending Section 3, Chapter 395, O.S.L. 2022, as amended by Section 2, Chapter 448, O.S.L. 2024 (56 O.S. Supp. 2024, Section 4002.3a), which relates to capitated contracts; excluding prescription drug services from certain provisions; directing certain program delivery model for prescription drug services; requiring certain transition, contracts, and reimbursement; directing amendment of specified contracts; providing certain construction; requiring the Oklahoma Health Care Authority to seek certain federal approval; 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; conforming language; amending 56 O.S. 2021, Section 4002.5, as last amended by Section 1, Chapter 243, O.S.L. 2023 (56 O.S. Supp. 2024, Section 4002.5), which relates to contracted entity responsibilities; conforming language; updating statutory references; 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; conforming language; and providing an effective date.

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

SECTION 1. AMENDATORY Section 3, Chapter 395, O.S.L. 2022, as amended by Section 2, Chapter 448, O.S.L. 2024 (56 O.S. Supp. 2024, 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 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 and prescription drug 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 and prescription drug services including:

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

(1) primary care,

(2) inpatient and outpatient services, and

(3) emergency room services, and

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 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 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 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.

F. 1. Upon receipt of federal approval as described in paragraph 3 of this subsection, the Authority shall cover prescription drug services through a fee-for-service delivery model. The Authority shall transition prescription drug coverage of all Medicaid members covered by a contracted entity to direct coverage by the Authority, shall enter into such contracts with pharmacists and pharmacy providers as are necessary to ensure network adequacy as required by federal regulation, and shall directly reimburse such pharmacists and pharmacy providers. The Authority shall amend its contracts with all contracted entities as necessary to implement the provisions of this subsection.

2. Nothing in this subsection shall be construed to prohibit the Authority from:

a. implementing value-based payment arrangements with Medicaid providers through direct contractual agreements,

b. implementing cost-saving measures for prescription drug services including, but not limited to, participation in the Medicaid Drug Rebate Program, or

c. contracting with a pharmacy benefits administrator that is located in this state to administer claims and perform other administrative functions on behalf of the Authority; provided, however, the Authority shall not contract with a pharmacy benefits manager.

3. The Authority shall seek any federal approval necessary to implement the provisions of this section.

SECTION 2. 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~~,~~ and 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.

SECTION 3. AMENDATORY 56 O.S. 2021, Section 4002.5, as last amended by Section 1, Chapter 243, O.S.L. 2023 (56 O.S. Supp. 2024, Section 4002.5), is amended to read as follows:

Section 4002.5. A. A contracted entity shall be responsible for all administrative functions for members enrolled in its plan including, but not limited to, claims processing, authorization of health services, care and case management, grievances and appeals, and other necessary administrative services.

B. Prior to the execution of a contract between a contracted entity and the Oklahoma Health Care Authority, the contracted entity shall obtain the appropriate certificate of authority issued by the Insurance Department.

1. A contracted entity shall obtain a certificate of authority issued by the Insurance Department to operate as a health maintenance organization when the contracted services to be delivered include physical health services, behavioral health services, and prescription drug services.

2. A contracted entity shall obtain a certificate of authority issued by the Insurance Department to operate as an accident and health insurer or as a prepaid dental plan organization when the contracted services to be delivered include dental services.

C. 1. To ensure providers have a voice in the direction and operation of the contracted entities selected by the Oklahoma Health

Care Authority under Section 4002.3b of this title, each contracted entity shall have a shared governance structure that includes:

a. representatives of local Oklahoma provider organizations who are Medicaid providers,

b. essential community providers, and

c. a representative from 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.

2. No less than one-third (1/3) of the contracted entity's local governing body shall be comprised of representatives of local Oklahoma provider organizations.

3. No less than two members of the contracted entity's clinical and quality committees shall be representatives of local Oklahoma provider organizations, and the committees shall be chaired or co-chaired by a representative of a local Oklahoma provider organization.

D. A contracted entity shall promptly notify the Authority of all material changes affecting the delivery of care or the administration of its program.

E. A contracted entity shall have a medical loss ratio that meets the standards provided by 42 C.F.R., Section 438.8.

F. A contracted entity 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.

G. A contracted entity or a subcontractor of a contracted entity 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 contracted entity or subcontractor.

H. Nothing in ~~this act~~ the Ensuring Access to Medicaid Act or in a contract between the Authority and a contracted entity shall prohibit the contracted entity from contracting with a statewide or regional accountable care organization.

I. Nothing in ~~this act~~ the Ensuring Access to Medicaid Act, in a contract between the Authority and a contracted entity, or in a contract between a contracted entity and a provider shall prohibit any provider from contracting with more than one contracted entity.

J. A contracted entity shall not withhold, fail to offer, or make impracticable a contract with a provider on the basis of independent practice or lack of hospital system affiliation.

K. ~~All contracted entities shall:~~

~~1. Use the same drug formulary, which shall be established by the Authority; and~~

~~2. Ensure broad access to pharmacies including, but not limited to, pharmacies contracted with covered entities under Section 340B of the Public Health Service Act. Such access shall, at a minimum, meet the requirements of the Patient's Right to Pharmacy Choice Act, Section 6958 et seq. of Title 36 of the Oklahoma Statutes.~~

~~L.~~ Each contracted entity and each participating provider shall submit data through the state-designated entity for health information exchange to ensure effective systems and connectivity to support clinical coordination of care, the exchange of information, and the availability of data to the Authority to manage the state Medicaid program.

SECTION 4. 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~~ 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.~~ J. 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.~~ K. 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.~~ L. The Authority may establish a symmetric risk corridor for contracted entities.

~~N.~~ M. 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.~~ N. 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 5. This act shall become effective November 1, 2025.

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