Oklahoma Health Care Authority

The Oklahoma Health Care Authority (OHCA) values your feedback and input. It is very important that you provide your comments regarding the proposed rule change by the comment due date. Comments can be submitted on the OHCA's Proposed Changes Blog.

OHCA COMMENT DUE DATE: July 21, 2021

The proposed policy is an Emergency Rule. The proposed policy was presented at the July 6, 2021 Tribal Consultation. Additionally, this proposal is scheduled to be presented to the Medical Advisory Committee on July 8, 2021 and the OHCA Board of Directors in August or a date to be determined.

SUMMARY:
Ensuring Access to Medicaid Act - The proposed policy changes will comply with Senate Bill 131 (SB131), otherwise known as the "Ensuring Access to Medicaid Act" by addressing the specific requirements that are outlined throughout the bill. The requirements include, but are not limited to, enrollment and voluntary enrollment into a managed care delivery model, developing specific network adequacy standards, prior authorization requirements, and developing requirements for appeals and hearings.

REFERENCE: APA WF 21-15 Emergency Rule

LEGAL AUTHORITY:
The Oklahoma Health Care Authority Act, Section 5007 (C)(2) of Title 63 of Oklahoma Statutes; The Oklahoma Health Care Authority Board; Title 56 of the Oklahoma Statutes, Sections 4002-4004; Title 42 of the Code of Federal Regulations, Part 438

RULE IMPACT STATEMENT:

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY

SUBJECT: Rule Impact Statement
APA WF # 21-15

A. Brief description of the purpose of the rule:

The proposed policy changes will comply with Senate Bill 131 (SB131), otherwise known as the "Ensuring Access to Medicaid Act" by addressing the specific requirements that are outlined throughout the bill. The requirements include, but are not

limited to, enrollment and voluntary enrollment into a managed care delivery model, developing specific network adequacy standards, prior authorization requirements, and developing requirements for appeals and hearings.

B. A description of the classes of persons who most likely will be affected by the proposed rule, including classes that will bear the cost of the proposed rule, and any information on cost impacts received by the agency from any private or public entities:

No classes of persons will be affected by the proposed rule changes unless the OHCA enters into a contract(s) with managed care organizations and/or dental benefits managers.

C. A description of the classes of persons who will benefit from the proposed rule:

No classes of persons will benefit by the proposed rule changes unless the OHCA enters into a contract(s) with managed care organizations and/or dental benefits managers.

D. A description of the probable economic impact of the proposed rule upon the affected classes of persons or political subdivisions, including a listing of all fee changes and, whenever possible, a separate justification for each fee change:

There is no probable economic impact of the proposed rule changes upon any classes of persons or political unless the OHCA enters into a contract(s) with managed care organizations and/or dental benefits managers.

E. The probable costs and benefits to the agency and to any other agency of the implementation and enforcement of the proposed rule, the source of revenue to be used for implementation and enforcement of the proposed rule, and any anticipated effect on state revenues, including a projected net loss or gain in such revenues if it can be projected by the agency:

The proposed rule changes are budget neutral unless the OHCA enters into a contract(s) with managed care organizations and/or dental benefits managers.

F. A determination of whether implementation of the proposed rule will have an economic impact on any political subdivisions or require their cooperation in implementing or enforcing the rule:

The proposed rule changes will not have an economic impact or require the cooperation of any political subdivisions unless the OHCA enters into a contract(s) with managed care organizations and/or dental benefits managers.

G. A determination of whether implementation of the proposed rule will have an adverse effect on small business as provided by the Oklahoma Small Business Regulatory Flexibility Act:

The proposed rule changes will not have an adverse effect on small business as provided by the Oklahoma Small Business Regulatory Flexibility Act at this time.

H. An explanation of the measures the agency has taken to minimize compliance costs and a determination of whether there are less costly or non-regulatory methods or less intrusive methods for achieving the purpose of the proposed rule:

The agency has taken measures to determine that there is no less costly or non-regulatory method or less intrusive method for achieving the purpose of the proposed rule at this time.

I. A determination of the effect of the proposed rule on the public health, safety, and environment and, if the proposed rule is designed to reduce significant risks to the public health, safety, and environment, an explanation of the nature of the risk and to what extent the proposed rule will reduce the risk:

The proposed rule changes should have a positive effect on the public health, safety, and environment. If OHCA enters into a contract(s) with managed care organizations and/or dental benefits managers, SoonerCare members will have access to additional services like enhanced care management and other value-added benefits offered by the managed care organizations and/or dental benefits managers.

J. A determination of any detrimental effect on the public health, safety, and environment if the proposed rule is not implemented:

The agency has determined that the proposed rule changes will not have a detrimental effect on the public health, safety, and environment.

K. The date the rule impact statement was prepared and if modified, the date modified:

Prepared: July 6, 2021

RULE TEXT:

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY

CHAPTER 55. MANAGED CARE

SUBCHAPTER 1. GENERAL PROVISIONS

317:55-1-1. Purpose; use of manuals

The purpose of this Chapter is to provide detailed rules which govern the delivery of health care services provided by managed care organizations or dental benefits managers as required by the "Ensuring Access to Medicaid Act", 2021 Okla. Sess. Law Serv. Ch. 542 (S.B. 131), Title 56 of the Oklahoma Statutes, Sections 4002-4004 and 42 Code of Federal Regulations (C.F.R.), Part 438. The Oklahoma Health Care Authority may also develop manuals and medical guidelines that formalize terms, conditions, and applicable policy of awarded contracts.

317:55-1-2. Monitoring system for all managed care programs

In accordance with 42 C.F.R. § 438.66, the Oklahoma Health Care Authority will monitor each managed care organization or dental benefits manager to assess its ability and capacity to comply with program- and contract-specific requirements and to assess its ability to perform satisfactorily in all major operational areas.

317:55-1-3. Definitions

The following words and terms, when used in this Chapter, will have the following meaning, unless the context clearly indicates otherwise:

"1115 waiver" means the demonstration waiver, as amended and including all active special terms and conditions (STCs) at a specific point in time, that authorizes Oklahoma Health Care Authority (OHCA) to operate a program in which one or more requirements of Title XIX of the Social Security Act (Act) are waived based on the waiver authority of section 1115 of the Act.

"1915(c) waiver" means any waiver, authorized by section 1915(c) of the Act, that allows specific coverage of home- and community-based services to a limited group of Medicaid-eligible individuals as an alternative to institutional care.

"Accountable care organization" or **"ACO"** means a group of clinicians, hospitals, or other health care providers who come together voluntarily to give coordinated high-quality care to a designated group of patients.

"Act" means the Social Security Act.

"Adult" means an individual twenty-one (21) years of age or older, unless otherwise specified by statute, regulation, and/or

policy adopted by the OHCA. For eligibility criteria policy for children and adults, please refer to Oklahoma Administrative Code (OAC) 317:35-5-2.

"Adverse determination" means a determination by a health carrier, including an managed care organization or dental benefits manager, or its designee that an admission, availability of care, continued stay or other health care service that is a covered benefit has been reviewed and, based upon the information provided, does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, and the requested service or payment for services is therefore denied, reduced or terminated.

"Alternative benefit plan" means the benefit package delivered to expansion adults which is developed by OHCA and approved by the Centers for Medicare and Medicaid Services (CMS) in accordance with the requirements of Subpart C of 42 C.F.R. Part 440.

"American Indian/Alaska Native" or **"AI/AN"** means any individual as defined in 25 U.S.C. §§ 1603(13), 1603(28) or 1679(a) or who has been determined eligible as an Indian under 42 C.F.R. § 136.12.

"Appeal" means a review by an MCO or DBM of an adverse benefit determination.

"Authorized representative" means a competent adult who has the managed care enrollee's signed, written authorization to act on the managed care enrollee's behalf during the grievance, appeal, and State fair hearing process. The written authority to act will specify any limits of the representation.

"Capitation payment" means a payment, based on an actuarially sound capitation rate for the provision of Oklahoma Medicaid State Plan services under a managed care contract, that OHCA makes periodically to the MCO or DBM behalf of each enrollee enrolled in that MCO or DBM, regardless of whether the enrollee actually receives services during the period covered by the payment.

"Capitation rate" means the actuarially sound per-enrollee, per-month amount, including any adjustments, that OHCA agrees to pay an MCO or DBM for the provision of State Plan services.

"Child" means an individual under twenty-one (21) years of age, unless otherwise specified by statute, regulation, and/or policy adopted by the OHCA. For eligibility criteria policy for children and adults, please refer to OAC 317:35-5-2.

"Children's Health Insurance Program" or **"CHIP"** means a federal Medicaid program authorized under Title XXI of the Social Security Act.

"Choice counseling" means the provision of information and services designed to assist eligibles in making enrollment decisions related to the managed care program. Choice counseling includes answering questions and identifying factors to consider when choosing among MCOs or DBMs, as well as when choosing a

patient-centered medical home provider or dental home provider. Choice counseling does not include making recommendations for or against enrollment into a specific MCO or DBM.

"Chronic condition" means a condition that is expected to last one (1) year or more and requires ongoing medical attention and/or limits activities of daily living (ADL).

"Civil monetary damage" means a damage imposed by OHCA which the MCO must pay for acting or failing to act in accordance with 42 C.F.R. § 438.700 et seq. Amounts may not exceed those specified in 42 C.F.R. § 438.704.

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

"Clean claim" means a properly completed billing form with coding based on Current Procedural Terminology (CPT), 4th Edition or a more recent edition, the Tenth Revision of the International Classification of Diseases or a more recent revision, or Healthcare Common Procedure Coding System (HCPCS), where applicable, to provide information specifically required in the OHCA Provider Billing and Procedure Manual.

"C.F.R." means the Code of Federal Regulations.

"Contract" means the risk contract or the written and executed agreement between OHCA and a health plan or managed care organization or dental benefit manager for health plan or managed care services and includes the solicitation, the bid, the contract addenda, appendices, attachments, and amendments, and any documents incorporated into the contract by reference or otherwise, as well as any document or information subject to the rules on legally binding procurement in Chapter 10 of these rules.

"Copayment" means a fixed amount that an enrollee pays for a covered health care service when the enrollee receives the service.

"Cost sharing" means the State's requirement that an enrollee bear some of the cost of their care through mechanisms such as copayments, deductibles, and other similar charges.

"Deemed newborn" means children born to SoonerCare enrolled mothers and determined eligible under 42 C.F.R. § 435.117.

"Dental benefits manager" or **"DBM"** means a health plan under contract with the OHCA to manage and deliver dental benefits and services to enrollees and designated as a pre-paid ambulatory health plan (PAHP) under 42 C.F.R. Part 438.

"Dental home" or **"DH"** means the care coordinated delivery system as defined within the contract between OHCA and a DBM.

"Disenrollment" means OHCA's removal of an enrollee from participation in a specific MCO or DBM or from participation in the managed care program.

"Dual eligible individuals" means individuals eligible for both Medicaid and Medicare.

"Eligible" means an individual who has been deemed eligible for

Medicaid in the State of Oklahoma and is eligible for participation in the managed care program but who is not yet enrolled in an MCO or DBM.

"Emergency services" means medical services provided for a medical condition, including injury, manifesting itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in placing the individual's health, or the health of an unborn child, in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any bodily organs or parts.

"Enrollee" means an individual who has been deemed eligible for Medicaid in the State of Oklahoma, who has been deemed eligible for enrollment in a managed care program, and who is currently enrolled in a managed care program.

"Enrollee handbook" means a guidebook prepared as a model by OHCA and modified and distributed by the MCO or DBM to its enrollees. The enrollee handbook is designed to help the enrollee understand the MCO or DBM, the managed care program, and the rights and responsibilities that come with enrollment in the program.

"Enrollment" means the OHCA process by which an eligible becomes an enrollee with an MCO or DBM.

"Enrollment activities" means activities that OHCA performs or conducts related to distributing, collecting, or processing enrollment materials, taking enrollments by technological device or in person, or enrolling or disenrolling eligibles into any MCO or DBM.

"Essential community provider" means a provider defined by 45 C.F.R. § 156.235.

"Essential hospital services" means tertiary care hospital services to which the MCO must provide access, including but not limited to neonatal, perinatal, pediatric, trauma and burn services.

"Expansion adult" means an individual nineteen (19) or older and under age sixty-five (65), with income at or below one hundred thirty-eight percent (138%) of the federal poverty level (FPL) determined eligible in accordance with 42 C.F.R. § 435.119), and who are not categorically related to the aged, blind, and disabled.

"Former foster children" or **"FFC"** means individuals under age twenty-six (26) determined eligible in accordance with 42 C.F.R. § 435.150 who were in foster care under the responsibility of the State or an Indian Tribe within Oklahoma and enrolled in SoonerCare on the date of attaining age eighteen (18) or aging out of foster care.

"Foster children (FC)" means children in foster care under the responsibility of the State, including children and youth who are

in State custody due to abuse or neglect.

"Fraud" means intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or State law.

"Grievance" means an enrollee's expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a provider or employee or failure to respect the enrollee's rights regardless of whether remedial action is requested. A grievance includes an enrollee's right to dispute an extension of time to make an authorization decision when proposed by the MCO or DBM.

"Grievance and appeal system" means the processes the MCO or DBM must implement in accordance with 42 C.F.R. Part 438, Subpart F, to handle enrollee grievances and appeals, as well as the processes to collect and track information about them.

"Health care services" means all Medicaid State Plan services provided, according to contract, by the MCO or DBM in any setting. Health care services may include but are not limited to medical care, behavioral health care, dental care, and pharmacy services.

"Health plan" means the same in these rules as at 36 O.S. § 4405.1.

"Implementation" means the process by which OHCA and the MCO or DBM performs actions and responsibilities to actively implement a managed care program or contract for the first time. Implementation also means, depending on its use, the moment in time that such actions and responsibilities are fully completed.

"Implementation period" means the period of time, as defined in contract, during which implementation occurs.

"Indian health care provider" or **"IHCP"** means a health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. § 1603).

"Initial enrollment" means an eligible's enrollment in an MCO or DBM during the initial enrollment period.

"Initial enrollment period" means the first period of time, as defined in contract, prior to or immediately following managed care program or contract implementation, when eligibles can first enroll in an MCO or DBM for the managed care program.

"Managed care organization" or **"MCO"** means a health plan designated as a managed care organization pursuant to 42 C.F.R. 438.2 and under contract with OHCA to participate in the managed care program and to deliver health care services to enrollees.

"Managed care program" or **"managed care"** or **"MCP"** means a health care delivery system organized to manage cost, utilization, and quality that is operated by a state as authorized under sections 1915(a), 1915(b), 1932(a), or 1115(a) of the Social Security Act and relevant state law.

"Manual" or **"guide"** means any document, outside of the Medicaid State Plan, any Medicaid waiver, and the rules, that is created by or for OHCA for use in interpreting or implementing contractual terms. "Manual" is synonymous with guide, guidebook, companion guide, manual, reference book, dictionary, handbook, model, instructions, primer, workbook, or any other words denoting a document that is handled as a matter of convenience.

"Material change" means, but not limited to, any change in the 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 MCO or DBM.

"Medical necessity" means a standard for evaluating the appropriateness of services as established under OAC 317:30-3-1.

"National Provider Identifier (NPI)" means a unique identification number for covered health care providers. Covered health care providers and all MCOs, DBMs, and health care clearinghouses must use an NPI in the administrative and financial transactions adopted under the Health Insurance Portability and Accountability Act (HIPAA). The NPI is a ten-position, intelligence-free numeric identifier (ten-digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty. The NPI must be used in lieu of legacy provider identifiers in the HIPAA standards transactions.

"Non-participating provider" means a physician or other provider who has not contracted with or is not employed by the MCO or DBM to deliver services under the managed care program.

"Non-urgent sick visit" means medical care given for an acute onset of symptoms which is not emergent or urgent in nature but which requires face-to-face medical attention within seventy-two (72) hours of enrollee notification of a non-urgent condition, as clinically indicated. Examples of non-urgent sick visits include cold symptoms, sore throat, and nasal congestion.

"Open enrollment" means an eligible's selection of and enrollment in an MCO or DBM during the open enrollment period.

"Open enrollment period" means the annual period of time, as defined by contract, when managed care enrollees and eligibles can enroll in and select an MCO or DBM for the managed care program.

"Parent and caretaker relative" means an individual determined eligible under 42 C.F.R. § 435.110.

"Participating provider" means a physician or other provider who

has a contract with or is employed by an MCO or DBM to provide health care services to enrollees under the capitated managed care delivery model of the managed care program.

"Patient-centered medical home" or **"PCMH"** means, in this chapter, the care coordinated delivery system as defined within the contract between OHCA and an MCO.

"Pregnant women" means women determined eligible for SoonerCare under 42 C.F.R. § 435.116.

"Presumptive eligibility" means limited period of managed care program eligibility for individuals who are categorically related to certain eligibility groups listed in OAC 317:35-6-38(a)(1)(A)(i) through (vi) and are also determined by a qualified hospital, on the basis of preliminary information provided by the applicant on a completed HPE application, to be eligible for managed care program services.

"Primary care dentist" or **"PCD"** means a provider under contract with a DBM to provide primary health care services, as contracted, and case management, including all medically necessary referrals for specialty services and prior authorizations. In these rules, "dental home provider" or "DH provider" bears the same meaning as "primary care dentist" or "PCD".

"Primary care provider" or **"PCP"** means a provider under contract with an MCO to provide primary health care services, as contracted, and case management, including securing all medically necessary referrals for specialty services and prior authorizations. In these rules, "patient-centered medical home provider" or "PCMH provider" bears the same meaning as "primary care provider" or "PCP".

"Prior authorization" or **"PA"** means a requirement that an enrollee, through the enrollee's provider, obtain the MCO's or DBM's approval before a requested medical service is provided or before services by a non-participating provider are received. Prior authorization is not a guarantee of claims payment; however, failure to obtain prior authorization may result in denial of the claim or reduction in payment of the claim.

"Provider" means a health care services provider licensed or certified in this State.

"Provider agreement" means an agreement between the MCO or DBM and a participating provider that describes the conditions under which the participating provider agrees to furnish covered health care services to enrollees.

"Risk contract" means a contract between OHCA and an MCO, prepaid inpatient health plan (PIHP), or prepaid ambulatory health plan (PAHP), as those terms are defined at 42 C.F.R. § 438.2, under which the contractor assumes risk for the cost of the services covered under the contract and incurs loss if the cost of furnishing the services exceeds the payments under the contract.

"SoonerCare" means the Oklahoma Medicaid program.

"Soon-To-Be-Sooner" means Oklahoma's separate CHIP providing coverage to unborn children of families earning up to and including one hundred eighty-five percent (185%) of the FPL.

"Specialty Children's Plan" means the single statewide managed care plan, as contracted with a single MCO, that will coordinate and deliver health care services, as defined by contract, in a highly coordinated manner to the specialty population. The specialty population includes Medicaid eligibles who are FFC, select juvenile justice involved Office of Juvenile Affairs (OJA), in foster care (FC), children with an open prevention services case (PSC) through case workers or receiving adoption assistance (AA).

"State Plan" means an agreement between OHCA and CMS describing how Oklahoma administers its Medicaid and CHIP programs.

"Steady state enrollment" means the period of time, as defined by contract, when an individual, who first became an eligible during steady state operations or who became eligible again during steady state operations after more than two (2) months lapse of eligibility, can first enroll in and select an MCO or DBM for the managed care program.

"Steady state operations" or **"steady state"** means the period of time, as defined by contract, after initial implementation and prior to contract termination, during which all managed care program elements are expected to be operational.

"Third party liability" or **"TPL"** means all or part of the expenditures for a managed care enrollee's medical assistance furnished under the Oklahoma Medicaid State Plan that may be the liability of a third-party individual, entity or program.

"Value-added benefit" means any benefit or service offered by an MCO or DBM when that benefit or service is not a covered benefit per the State Plan. These benefits are subject to change annually as determined by the MCO or DBM and OHCA.

"Value-based payment arrangement" means a payment arrangement between an MCO or DBM and its participating providers when payment is intentionally aligned with quality measures OHCA applies to the MCO or DBM.

"Value-based purchasing" means the provisions of a contract for managed care services when those provisions intentionally align OHCA payments to the MCO or DBM under contract with quality measures or other performance factors OHCA may apply to the MCO or DBM.

SUBCHAPTER 3. GENERAL PROGRAM INFORMATION

PART 1. ELIGIBILITY

317:55-3-1. Mandatory populations

(a) **Mandatory MCO enrollment.** Per 56 O.S. § 4002.3, eligibles in

the following categories will be mandatorily enrolled in the MCP and with an MCO:

(1) Expansion adults;
(2) Parents and caretaker relatives;
(3) Pregnant women;
(4) Deemed newborns;
(5) Children; and
(6) All other populations requiring mandatory coverage pursuant to in 42 C.F.R. Part 435, Subpart B (§§ 435.100 435.172), unless otherwise covered by SoonerCare.

(b) **Mandatory Specialty Children's Plan enrollment.** Per 56 O.S. § 4002.3, eligibles in the following categories, upon entering custody of the State, will be mandatorily enrolled in the MCP and with the MCO under contract to provide the Specialty Children's Plan:

(1) Foster children (FC); and
(2) Certain children in the custody of OJA.

(c) **Mandatory Specialty Children's Plan enrollment, opt out.** Per 56 O.S. § 4002.3, eligibles in the following categories will be mandatorily enrolled in the MCP and with the MCO under contract to provide the Specialty Children's Plan, if they do not select a different MCO during initial enrollment, open enrollment, or steady state enrollment:

(1) Former foster care (FFC); and
(2) Children receiving adoption assistance (AA).

(d) **Mandatory DBM enrollment.** Per 56 O.S. § 4002.3, the following eligibles will be mandatorily enrolled in the MCP and with a DBM:

(1) Expansion adults;
(2) Parents and caretaker relatives;
(3) Pregnant women;
(4) Deemed newborns;
(5) Former foster children;
(6) Certain children in the custody of OJA;
(7) Foster care children;
(8) Children receiving adoption assistance; and
(9) Children.

317:55-3-2. Excluded populations

(a) Per 56 O.S. § 4002.3, individuals in the following categories will be excluded from enrollment in a MCP contracted with one (1) or more MCOs:

(1) Dual eligible individuals;
(2) Individuals enrolled in the Medicare Savings Program, including Qualified Medicare Beneficiaries (QMB), Specified Low Income Medicare Beneficiaries (SLMB), Qualified Disabled Workers (QDW) and Qualified Individuals (QI);
(3) Persons with a nursing facility or intermediate care

facility for individuals with intellectual disabilities (ICF/IID) level of care, except that enrollees who are transitioning into long-term care will remain enrolled in any MCO for up to sixty (60) days while the enrollee's level of care determination is pending. Prior to disenrollment from an MCO, such excepted enrollees will receive a facility's pre-admission screening and resident review (PASRR) process. If OHCA approves the PASRR and designates the nursing facility or ICF/IID level of care, reimbursement will be made to the facility and the enrollee will be disenrolled from their MCO;

(4) Individuals during a period of presumptive eligibility;

(5) Individuals infected with tuberculosis eligible for tuberculosis-related services under 42 C.F.R. § 435.215;

(6) Individuals determined eligible for SoonerCare on the basis of needing treatment for breast or cervical cancer under 42 C.F.R. § 435.213;

(7) Individuals enrolled in a 1915(c) waiver;

(8) Undocumented persons eligible for emergency services only in accordance with 42 C.F.R. § 435.139;

(9) Insure Oklahoma employee sponsored insurance (ESI) dependent children in accordance with the Oklahoma Title XXI State Plan;

(10) Coverage of pregnancy-related services under Title XXI for the benefit of unborn children (Soon- to-be-Sooners), as allowed by 42 C.F.R. § 457.10; and

(11) Individuals determined eligible for Medicaid on the basis of age, blindness or disability.

(b) Per 56 O.S. § 4002.3, eligibles in the following categories will be excluded from enrollment in a MCP contracted with one (1) or more DBMs:

(1) Dual eligible individuals;

(2) Individuals enrolled in the Medicare Savings Program, including QMB, SLMB, QDW and QI;

(3) Persons with a nursing facility or ICF-IID level of care, except that enrollees who are transitioning into long-term care will remain enrolled in any DBM for up to sixty (60) days while the enrollee's level of care determination is pending. Prior to disenrollment from a DBM, such excepted enrollees will receive a facility's PASRR process. If OHCA approves the PASRR and designates the nursing facility or ICF/IID level of care, reimbursement will be made to the facility and the enrollee will be disenrolled from the DBM.

(4) Individuals during a period of presumptive eligibility;

(5) Individuals infected with tuberculosis eligible for tuberculosis-related services under 42 C.F.R. § 435.215;

(6) Individuals determined eligible for SoonerCare on the basis of needing treatment for breast or cervical cancer under 42 C.F.R. § 435.213;

(7) Individuals enrolled in a §1915(c) waiver;
(8) Undocumented persons eligible only for emergency services in accordance with 42 C.F.R. § 435.139;
(9) Insure Oklahoma Employee Sponsored Insurance (ESI) dependent children in accordance with the Oklahoma Title XXI State Plan;
(10) Coverage of Pregnancy-related services under Title XXI for the benefit of unborn children (Soon-to-be-Sooners), as allowed by 42 C.F.R. § 457.10; and
(11) Individuals determined eligible for Medicaid on the basis of age, blindness or disability.

317:55-3-3. Voluntary enrollment and disenrollment

(a) Per 56 O.S. § 4002.3, AI/AN populations that are eligible for SoonerCare will have the option to:
(1) Voluntarily enroll in the MCP through an opt-in process;
(2) Enroll in an MCO or DBM at each open enrollment period, regardless of initial selection or past disenrollment from the MCP;
(3) Receive services from an IHCP;
(4) Choose the IHCP as the enrollee's PCMH provider or DH provider, if the provider has the capacity to provide such services;
(5) Obtain services covered under the contract from out-of-network IHCPs when the enrollee is otherwise eligible to receive the IHCP's services;
(6) Self-refer for services provided by IHCPs to AI/AN enrollees;
(7) Obtain services covered under the contract from out-of-network IHCPs when the AI/AN enrollee is otherwise eligible to receive the IHCP's services; and
(8) Disenroll from any MCO or DBM at any time without cause.
(b) Children receiving prevention services from child welfare services have the option to enroll in the MCO contract to provide health care services under the Specialty Children's Plan.

PART 3. SCOPE AND ADMINISTRATION

317:55-3-4. Grievances and appeals

(a) **Filing.** Grievances and appeals are to be initially filed with each enrollee's MCO or DBM. Grievances may be filed with the enrollee's MCO or DBM at any time, either orally or in writing. A provider or an authorized representative may file an appeal, grievance, or request for a State fair hearing on behalf of an enrollee, provided that the provider or authorized representative has obtained the enrollee's written consent.
(b) **Levels of appeal.** Pursuant to 42 C.F.R. § 438.402, MCOs and

DBMs will only have one (1) level of appeal. Enrollees and providers may file an appeal to OHCA seeking the review of a final adverse benefit determination rendered by an MCO or DBM.
(c) **Governing rules.** The provisions at OAC 317:2-1-1 et seq. will govern any enrollee or provider right to file a grievance, complaint, appeal or request for a State fair hearing pursuant to 56 O.S. § 4002-4004, 42 C.F.R. Parts 431 or 438, or the managed care contract.

317:55-3-5. Intermediate sanctions
(a) **Intermediate sanctions obligation.** OHCA will establish intermediate sanctions that it may impose on an MCO if OHCA makes any of the determinations specified in 42 C.F.R. § 438.700(b)—(d).
(b) **Adoption of intermediate sanctions.** OHCA adopts the intermediate sanctions as provided at 42 C.F.R. § 438.702.
(c) **Imposition of sanctions.** If OHCA makes a determination per 42 C.F.R. §§ 438.700 or 438.706 and thereby imposes intermediate sanctions as listed at 42 C.F.R. §§ 438.702 or 438.706, OHCA will consider the totality of and follow all relevant regulations at 42 C.F.R. Part 438, Subpart I.
(d) **Required imposition of temporary management.** In accordance with 42 C.F.R. § 438.706(b), OHCA will impose the intermediate sanction of temporary management, regardless of any other sanction that may be imposed, if OHCA finds that an MCO has repeatedly failed to meet substantive requirements in sections 1903(m) or 1932 of the Act or 42 C.F.R. Part 438. In this situation, OHCA will also grant enrollees the right to terminate enrollment without cause, as described in 42 C.F.R. § 438.702(a)(3), and must notify the affected enrollees of their right to terminate enrollment. Notwithstanding any other Section of these rules, OHCA will not delay imposition of temporary management to provide a hearing before imposing this sanction. OHCA will continue this sanction until the MCO can ensure that the sanctioned behavior will not recur.
(e) **Retained authority.** OHCA retains authority to impose additional sanctions under State statutes or State regulations that address areas of noncompliance specified in 42 C.F.R. § 438.700, as well as additional areas of noncompliance. Nothing in 42 C.F.R. Part 438, Subpart I, prevents OHCA from exercising that authority.
(f) **Notice.** Before imposing an intermediate sanction, OHCA will give the affected MCO timely written notice that explains the basis and nature of the sanction and any other appeal rights that OHCA elects to provide.
(g) **Right to request fair hearing.** Though not required under federal regulation, OHCA provides each MCO the right, upon notice of a sanction other than optional or required temporary management, to request a fair hearing before an administrative law judge (ALJ)

retained by OHCA. The cost of actions necessary to process an MCO's request will be paid by OHCA.

(1) An MCO must file any request for fair hearing within thirty (30) days after receiving the notice.

(2) The ALJ has jurisdiction to hear any request under this section. The ALJ will review the appeal for legal authority and jurisdiction. If legal authority and jurisdictional requirements are met, the ALJ will conduct an administrative hearing according to the hearing practices of OAC 317:2-1-5, provide proposed findings of fact and conclusions of law to the parties, and send written notice to the parties of the final order sustaining or denying imposition of the sanction.

(3) At the ALJ's discretion, the ALJ will:

(A) Establish a scheduling order;

(B) Establish reasonable procedures such as authorizing pleadings to be filed by facsimile or electronic mail;

(C) Rule on all interlocutory motions;

(D) Require briefing of any or all issues;

(E) Conduct hearings in a forum and manner as determined by the ALJ;

(F) Rule on the admissibility of all evidence;

(G) Question witnesses;

(H) Impose appropriate sanctions against any person failing to obey an order of the ALJ or authorized under the rules in this section which will include:

(i) Refusing to allow the person to assert or oppose designated claims or defenses, or prohibiting that person from introducing designated matters in evidence;

(ii) Excluding all testimony of an unresponsive or evasive witness; or

(iii) Expelling the person from further participation in the hearing;

(I) Take official notice of any material fact not appearing as evidence in the record, if the fact is among traditional matters of judicial notice;

(J) Administer oaths or affirmations;

(K) Determine the location of the hearing and manner in which it will be conducted;

(L) Allow either party to request that the hearing be recorded by a court reporter with costs to be borne by the requesting party. The original of such transcription, if ordered, will be given to the ALJ with a copy to be given to the requesting party;

(M) Recess and reconvene the hearing;

(N) Set and/or limit the time frame of the hearing;

(O) Make proposed findings of facts and conclusions of law; and

(P) Sustain or deny OHCA's imposition of the sanction(s).

317:55-3-6. Non-compliance damages and remedies

If OHCA finds an MCO or DBM to be in violation of the provisions of 56 O.S. §§ 4002-4004, rules promulgated thereto, or the terms and conditions of the contract, OHCA may enforce any damages or remedies for non-compliance as required by CMS, as provided for in the contract, or as permitted by State or federal law.

317:55-3-7. Termination of managed care contract

(a) **Termination of an MCO, permitted by 42 C.F.R. § 438.708.** Members impacted by the contract termination of an MCO will be enrolled with a different MCO or be provided Medicaid benefits through options as prescribed in the Oklahoma Medicaid State Plan. OHCA may terminate a contract with an MCO if OHCA determines that the MCO:

(1) Failed to carry out the substantive terms of the contract; or

(2) Failed to meet applicable requirements of sections 1903(m), 1905(t), or 1932 of the Act.

(b) **Termination permitted by contract, MCO or DBM.** Grounds for termination include:

(1) **Mutual consent.** OHCA and the MCO or DBM may terminate the contract by a mutually written agreement. The MCO or DBM does not have the right to appeal the termination. Enrollees impacted by the contract termination will be enrolled with a different MCO or DBM of their choosing or, if no choice is made, a default MCO or DBM.

(2) **Termination for convenience.** OHCA may terminate a contract for convenience, in whole or part, with a sixty (60) day written notice to the MCO or DBM if the State determines that termination is in the State's best interest. Any partial termination of the contract will not be construed as a waiver of, and will not affect, the rights and obligations of any party regarding portions of the contract that remain in effect. Upon receipt of notice of such termination, the MCO or DBM will immediately comply with the notice terms and take all necessary steps to minimize the incurrence of costs allocable to the work affected by the notice.

(3) **Termination for unavailability of funds.** OHCA may terminate a contract for lack of the availability of funds with written notice to the managed care. OHCA will give written notice to the MCO or DBM, effective the close of business on the day specified. OHCA is the final authority on the availability of funds, and the MCO or DBM does not have the right to appeal this termination.

(4) **Termination for lack of authority.** In the event that the

State is determined, in whole or part, to lack federal or State approval or authority to contract with an MCO or DBM, OHCA may terminate the contract immediately, effective on the close of business on the day specified. The MCO or DBM does not have the right to appeal this termination.

(5) **Termination for default.** OHCA may terminate the contract, in whole or in part, whenever the MCO has failed to carry out the terms of the contract or meet the applicable readiness requirements of §§ 1932, 1903(m) or 1905(t) of the Act.

(6) **Termination for financial instability.** In the event that OHCA, in its sole discretion, deems an MCO or DBM to be financially unstable to the point of threatening the ability of OHCA to obtain the services provided for under this contract, or to conduct business in the normal course, makes a general assignment for the benefit of creditors or suffers or permits the appointment of a receiver for its business or its assets, then OHCA may, at its option, immediately terminate the contract effective on the close of business on the date specified. In the event OHCA elects to terminate the contract under this provision, the MCO or DBM will be notified in writing specifying the date of termination. In the event of the filing of a petition in bankruptcy court by or against a principal subcontractor, the MCO or DBM will immediately advise OHCA. The MCO or DBM will ensure that all tasks related to the subcontract are performed in accordance with the terms of the contract.

(7) **Termination for debarment.** Section 1932(d)(1) of the Act prohibits affiliations with individuals debarred by federal agencies. The MCO will not knowingly have an individual or affiliate, as defined in Section 1932(d)(1)(C), who has been debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.

(c) **Notice and pre-termination hearing**. Prior to terminating an MCO's contract for default, financial instability, or debarment, OHCA will provide the MCO a pre-termination hearing. OHCA will:

(1) Give the MCO written notice of the intent to terminate, the reason for termination, and the time and place of the hearing. The notice will detail how the MCO has failed to carry out the terms of the contract and/or failed to comply with the requirements of 1932, 1903(m) and 1905(t) of the Act. A time period will be provided, if applicable, in which the MCO is allowed to cure the default prior to the pre-termination hearing. If the MCO cures the default within the specified timeframe, no further action is required;

(2) After the hearing, the MCO will receive written notice of

the decision affirming or reversing the proposed termination of the contract. In the event the decision is affirmed the notice is to include the effective date of the termination; and

(3) Upon affirmation of a decision, OHCA will give enrollees of the MCO written notice, comporting with the content requirements of 42 C.F.R § 438.10, of the termination and information identifying options for receiving Medicaid services following the effective date of termination. This notice will be provided within five (5) business days of the affirming decision.

(d) **Hearing timing**. Though not required under federal regulation, OHCA provides each MCO the right, upon notice of a termination, to request a fair hearing before an administrative law judge (ALJ) retained by OHCA. The cost of actions necessary to process an MCO's request will be paid by OHCA.

(1) An MCO will file any request for fair hearing within thirty (30) days after receiving the notice.

(2) The ALJ has jurisdiction to hear any request under this section. The ALJ will review the appeal for legal authority and jurisdiction. If legal authority and jurisdictional requirements are met, the ALJ will conduct an administrative hearing according to the hearing practices of OAC 317:2-1-5, provide proposed findings of fact and conclusions of law to the parties, and send written notice to the parties of the final order sustaining or denying imposition of the sanction.

(3) At the ALJ's discretion, the ALJ will:

(A) Establish a scheduling order;

(B) Establish reasonable procedures such as authorizing pleadings to be filed by facsimile or electronic mail;

(C) Rule on all interlocutory motions;

(D) Require briefing of any or all issues;

(E) Conduct hearings in a forum and manner as determined by the ALJ;

(F) Rule on the admissibility of all evidence;

(G) Question witnesses;

(H) Impose appropriate sanctions against any person failing to obey an order of the ALJ or authorized under the rules in this section which will include:

(i) Refusing to allow the person to assert or oppose designated claims or defenses, or prohibiting that person from introducing designated matters in evidence;

(ii) Excluding all testimony of an unresponsive or evasive witness; or

(iii) Expelling the person from further participation in the hearing;

(I) Take official notice of any material fact not appearing as evidence in the record, if the fact is among traditional matters of judicial notice;

(J) Administer oaths or affirmations;
(K) Determine the location of the hearing and manner in which it will be conducted;
(L) Allow either party to request that the hearing be recorded by a court reporter with costs to be borne by the requesting party. The original of such transcription, if ordered, will be given to the ALJ with a copy to be given to the requesting party;
(M) Recess and reconvene the hearing;
(N) Set and/or limit the time frame of the hearing;
(O) Make proposed findings of facts and conclusions of law; and
(P) Sustain or deny OHCA's imposition of the termination(s).

317:55-3-8. Record retention

In addition to the requirements found at OAC 317:30-3-15 and 317:30-5-70.2, the MCO or DBM and its affiliates, subcontractors, and employees must retain records in compliance with the provisions and spirit of 42 C.F.R. §§ 438.3(h) and (u), to the extent applicable.

PART 5. REQUIRED FEDERAL AUTHORIZATIONS

317:55-3-9. Authorizations

Prior to the implementation of any MCP authorized under 42 C.F.R. Part 438, OHCA will receive the following authorizations:
(1) Federal authority through a State Plan Amendment or waiver of the Act;
(2) CMS approval of each contract in relation to the MCP;
(3) CMS approval of all contract rates authorized under the MCP; and
(4) CMS approval of direct payment arrangements authorized under the MCP.

317:55-3-10. Timing

OHCA may only execute transition to a managed care delivery system ninety (90) days after CMS has approved all contracts entered into between OHCA and all MCOs or DBMs following OHCA's submission of readiness review results to CMS, pursuant to 42 C.F.R. § 438.66.

SUBCHAPTER 5. REQUIREMENTS FOR MANAGED CARE ORGANIZATIONS AND DENTAL BENEFITS MANAGERS

317:55-5-1. MCO or DBM accreditation

All MCOs and DBMs will be accredited in accordance with 45 C.F.R. § 165.275 by an accrediting entity recognized by the United

States Department of Health and Human Services.

317:55-5-2. MCO or DBM readiness

(a) According to 42 C.F.R. § 438.66, during implementation and prior to enrollment effective dates, the MCO or DBM will participate in a readiness review process. To be deemed eligible to effect enrollments, the MCO or DBM will complete all readiness review activities to the satisfaction of OHCA and CMS. The readiness reviews will be conducted through one (1) or more desk reviews and one or more on-site reviews. The MCO or DBM must satisfactorily demonstrate readiness for MCP operations, including but not limited to focus areas identified at 42 C.F.R. § 438.66(b). At any stage(s) of the readiness review process, OHCA may but is not required to provide an MCO or DBM with notice(s) of deficiency and reasonable opportunity(ies) to cure the deficiency. As between the parties to the managed care contract, OHCA has sole authority to determine the readiness of any MCO or DBM.

(b) As a part of any readiness review, OHCA will ensure the MCO or DBM meets the requirements at 56 O.S. § 4002.10.

PART 1. PROVIDER REQUIREMENTS

317:55-5-3. Provider contracts and credentialing standards

(a) All MCOs and DBMs will formally credential and recredential network providers at a frequency required by a single, consolidated provider enrollment and credentialing process established by OHCA in accordance with 42 C.F.R. § 438.214 and in coordination with MCOs and DBMs.

(b) All MCOs and DBMs will contract to the extent possible and practicable with all essential community providers who receive directed payments in accordance with 42 C.F.R. Part 438 and any other providers as specified by OHCA through contract.

(c) Every MCO and DBM will contract with every participating provider through a written provider agreement that:

(1) Identifies the contractual obligations between the MCO or DBM and the participating provider; and

(2) Incorporates any provision required by the contract between OHCA and the MCO or DBM for inclusion in the provider agreement.

(d) An MCO or DBM or any subcontractor thereof will not enforce with any provider a policy or contract term that requires the provider to contract for all products currently offered or that may be offered in the future by the MCO, DBM, or subcontractor.

317:55-5-4. Network adequacy standards

In accordance with 42 C.F.R. § 438.604, the MCO or DBM will submit documentation for which OHCA will base its certification to CMS that the MCO or DBM has complied with requirements for

availability and accessibility of services, including health professional shortage areas and adequacy of the MCO's or DBM's network, as set forth in 42 C.F.R. §§ 438.206, 438.14 and 438.68.

317:55-5-5. Prior authorization requirements, generally

The OHCA will establish prior authorization requirements that are consist with 56 O.S. §§ 4002-4004. MCOs and DBMs may establish prior authorization of benefits to the extent these are consistent with OHCA's policies and rules. The MCO or DBM may propose to impose additional prior authorization requirements, subject to OHCA's review and approval, except for those benefits identified in the Oklahoma Medicaid State Plan, rules, or practices as exempt from prior authorization. The MCO or DBM may be less restrictive on the requirements of a prior authorization than OHCA but may not impose greater restrictions.

317:55-5-6. Notification of material change

An MCO or DBM will promptly, within one (1) business day, notify OHCA of all changes materially affecting the delivery of care or the administration of the MCP.

317:55-5-7. Patient data

An MCO or DBM will 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.

PART 2. FINANCE

317:55-5-8. Capitation rates

OHCA will contract with an actuary, as defined at 42 C.F.R. § 438.2, to establish actuarially sound capitation rates, as described at 42 C.F.R. §§ 438.3(c), 438.4, and 438.5, for OHCA to pay to MCOs and DBMs.

317:55-5-9. Medical loss ratio

An MCO or DBM will have a medical loss ratio that, at minimum, meets the standards provided by 42 C.F.R. § 438.8.

317:55-5-10. Value-based purchasing

In any contract for managed care services, OHCA may include provisions in which payments OHCA makes to an MCO or DBM are based in whole or in part on quality measures and/or any other performance metric as defined in the contract.

317:55-5-11. Special contract provisions related to payment

(a) **Federal regulation.** Any special contract provision related to

payment, as described at 42 C.F.R. § 438.6, will meet all related standards within the federal regulation.

(b) **Provider payments.**

(1) OHCA will establish minimum rates of reimbursement paid by MCOs and DBPs to providers who choose not to enter into value-based payment arrangements for health care items and services furnished by such providers to enrollees.

(A) For participating providers, the reimbursement rate until July 1, 2026, will be equal to or greater than one hundred percent (100%) of the reimbursement rate for the applicable item or service per the applicable OHCA fee schedule.

(B) For non-participating providers and subject to CMS approval as a directed payment or otherwise, the reimbursement rate, until July 1, 2026, will be equal to or greater than ninety percent (90%) of the reimbursement rate for the applicable item or service provided by a non-participating provider per the applicable OHCA fee schedule as of January 1, 2021.

(2) Notwithstanding any other provision of this section, OHCA will comply with payment methodologies required by federal law or regulation for specific types of providers including, but not limited to, Federally Qualified Health Centers (FQHCs), rural health clinics (RHCs), pharmacies, Indian Health Care Providers (IHCPs), and emergency services.

(c) **Optional value-based payments.** The MCO or DBM will offer optional value-based payment arrangements to all providers. Reimbursement amounts to providers in value-based payment arrangements align with the quality measures OHCA applies to MCOs or DBMs, respectively.

317:55-5-12. Hospital readmission damages

The OHCA will establish a hospital readmission damage program to reduce potentially preventable readmissions. The program will use a nationally recognized tool to establish a base measurement year and a performance year and will provide for risk-adjustment based on the population of the state Medicaid program covered by the MCOs or DBMs. The program will be fully described in the managed care contract so that the program will be founded on contract-current tools, populations, and other factors.

317:55-5-13. Claims processing and methodology; post payment audits

(a) **Claims payment systems.** The MCO or DBM will maintain a claims payment system capable of processing and adjudicating claims for payment in an accurate and timely manner and in full compliance with all State and federal laws.

(b) **Claim filing.** A claim that is filed by a provider within six

(6) months of the date the item or service was furnished will be considered timely, per Oklahoma Administrative Code (OAC) 317:30-3-11.

(c) **Clean claims.** The MCO or DBM will process a clean claim within the time frame outlined in 36 O.S. § 1219.

(1) The MCO or DBM will ensure that at least ninety percent (90%) of clean claims received from all providers are paid within fourteen (14) days of receipt.

(2) A clean claim that is not processed within the time frame will bear simple interest at the monthly rate of one and one-half percent (1.5%), which is payable to the provider.

(d) **Additional documentation.** After a claim has been paid but not prior to payment, the MCO or DBM may request medical records, if additional documentation is needed to review the claim for medical necessity.

(e) **Claim denials.**

(1) A claim denial will include the following information:

(A) Detailed explanation of the basis for the denial; and

(B) Detailed description of the additional information necessary to substantiate the claim.

(2) The MCO or DBM will establish a process for all claim denials by which the provider may identify and provide additional information to substantiate the claim.

(3) A provider will have six (6) months from the receipt of a claim denial to file an appeal per OAC 317:2-3-10.

(f) **Post payment audits.**

(1) In accordance with OAC 317:30-5-70.2, the MCO or DBM will comply with the post payment audit process established by OHCA.

(2) The MCO or DBM will adhere to limits set forth by OHCA regarding the percentage of claims that can be subjected to post payment audits.

(3) An MCO or DBM who has a claims denial error rate of greater than five percent (5%) will be subject to damages as set forth by OHCA in the managed care contract.

PART 3. THE MANAGED CARE QUALITY ADVISORY COMMITTEE

317:55-5-14. Managed care quality advisory committee

(a) The Chief Executive Officer (CEO) of OHCA will establish and appoint members to the MC Quality Advisory Committee (Committee). Committee members serve without compensation and at the pleasure of the CEO. The Committee will consist of:

(1) Participating providers as a majority of the Committee members;

(2) Representatives of hospitals and health systems;

(3) Members of the health care community; and

(4) Members of the academic community with an expertise in

health care or other applicable field.
(b) The primary power and duty of the Committee is set forth at 56 O.S. § 4002.13.
(c) Committee meetings will be subject to the Oklahoma Open Meeting Act.
(d) The Committee will select from among its membership a chair and vice chair.
(e) The Committee may meet as often as may be required in order to perform the duties imposed on it.
(f) A quorum of the Committee will be required to approve any final action of the Committee. A majority of the members of the Committee will constitute a quorum.

317:55-5-15. Quality scorecard
(a) Within one (1) year of beginning steady state operations of any MCP, OHCA will create a quality scorecard, in accordance with 56 O.S. § 4002.11, that compares MCOs to one another and DBMs to one another.
(b) OHCA will provide the most recent quarterly scorecard for initial enrollees during choice counseling.
(c) OHCA will provide the most recent quarterly scorecard to all enrollees at the beginning of each open enrollment period.
(d) OHCA will publish each quarterly scorecard on its website.

PART 10. ACCOUNTABLE CARE ORGANIZATIONS

317:55-5-16. Accountable care organization, no prohibition
OHCA will not contract with or otherwise prohibit an MCO or DBM from contracting with a statewide or regional ACO to implement the capitated managed care delivery model of the State Medicaid program.

317:55-5-17. Accountable care organization, duties
(a) Any MCO or DBM that contracts with an ACO will retain full responsibility as to all terms of the MCO's or DBM's managed care contract with OHCA.
(b) The MCO or DBM will track and report quality metrics of any contracted ACO in accordance with the terms of the MCO's or DBM's managed care contract with OHCA.
(c) The MCO or DBM will timely and accurately collect and analyze data related to patient utilization and costs. All such data and analysis will be shared with OHCA.
(d) The MCO or DBM in coordination with the ACO must use collected data to improve quality and target patients for care management interventions and program.