Oklahoma Health Care Authority
MEDICAL ADVISORY COMMITTEE
July 8th, 2021
1:00 – 3:30 PM

Charles Ed McFall Board Room

AGENDA

I. Welcome, Roll Call, and Public Comment Instructions: **Chairman, Jason Rhynes, O.D.**

II. Action Item: Approval of Minutes of the June 10th, 2021: **Medical Advisory Committee Meeting**

III. Public Comments (2 minute limit)

IV. MAC Member Comments/Discussion

V. SoonerCare Operations Update: **Derek Lieser, Senior Director of Eligibility & Coverage Services**

VI. Proposed Rule Changes: Presentation, Discussion, and Vote: **Sandra Puebla, Senior Director of Federal & State Authorities**

   A. APA WF 21-12 Purchasing Rules Revisions
   B. APA WF 21-13 Grievance Procedures and Process Rules Revisions
   C. APA WF 21-14 Expansion Adults into SoonerCare Choice
   D. APA WF 21-15 Ensuring Access to Medicaid Act

VII. New Business: **Chairman, Jason Rhynes, O.D.**

VIII. Future Meeting: **Chairman, Jason Rhynes, O.D.**
September 9, 2021
November 4, 2021

IX. Adjourn **Chairman, Jason Rhynes, O.D.**

Oklahoma Health Care Authority
MEDICAL ADVISORY COMMITTEE
MINUTES of the June 10, 2021 Meeting
4345 N. Lincoln Blvd., Oklahoma City, OK 73105

I. Welcome, Roll Call, and Public Comment Instructions:

Chairman, Dr. Jason Rhynes called the meeting to order at 1:00 PM.

Delegates present were: Ms. Sarah Baker, Dr. Joe Catalano, Mr. Victor Clay, Ms. Wanda Felty, Mr. Mark Jones, Ms. Jennifer King, Dr. Craig Kupiec, Ms. Annette Mays, Ms. Melissa Miller, Ms. Toni Pratt-Reid, Dr. Jason Rhynes, Dr. Dwight Sublett, Ms. Mitzi McCullock, Mr. Jeff Tallent, and Dr. Whitney Yeates.

Alternates present were: Dr. Chad Douglas, Ms. Tandie Hasting, and Mr. Tony Fullbright, providing a quorum.

***Delegates absent without an alternate were*:** Ms. Debra Billingsly, Ms. Mary Brinkley, Dr. Erin Balzer, Mr. Victor Clay, Dr. Arlen Foulks, Ms. Terrie Fritz, Ms. Allison Garrison, Mr. Steve Goforth, Dr. Lori Holmquist-Day, Ms. Tina Johnson, Mr. James Patterson, Dr. J. Daniel Post, and Dr. Raymond Smith.

II. Approval of the May 13, 2021 Minutes

Medical Advisory Committee

The motion to approve the minutes was by Mr. Jeff Tallent and seconded by Dr. Joe Catalano and passed unanimously.

III. Public Comments (2 minute limit):

Dr. David Kendrick a physician who practices internal medicine in pediactrics. He is on faculty at the University of Oklahoma school of Community Medicine in Tulsa, where he chairs the department of Medical Informatics. Since 2009, he has been the founder and CEO of a non-profit organization called MyHealth Access Network, which has served as health information exchange in Oklahoma. Over that time MyHealth has grown to encompass about 85% of the heath care activity in Oklahoma being connected, which includes about 110,000 clinical encounters a day, statewide. Depending on your metrics, they count adjusted patient days, and hospital activity, federal required health centers who are all participants. The tribal health systems, behavioral health, and then the payers, including the OHCA, OSDH, and DMH. Dr. Kendrick is in support of a rule which will be presented on Health information exchange. The broad membership of MyHealth was having worked together to help build health information exchange for more than a decade. Dr. Kendrick was disappointed by the award of the health information exchange contract to an out of state software vendor, but we have worked with Carter to formulate a plan to work together and closely in the future. In the meantime, he wanted to make sure that they could re-assure all the members of MyHealth, that it will not suddenly go away, and the support that it provides which includes connecting t federal agencies and

programs, to stay in good standing with Medicare. This opens a door for other organizations with OKSHINE to be able to provide health information exchange services, which will prevent most of Oklahoma healthcare providers from having to rip out the wiring in their house so to speak. This will be a good partnership and are looking forward to working with them.

IV. MAC Member Comments/Discussion:

There were no MAC member comments.

V. Financial Report:

Tasha Black, Senior Director of Financial Services

Ms. Black presented the financial report ending in March 2021. OHCA is 3.6% under budget in revenues and 5.2% under budget in expenditures with the result that our budget variance is a positive $52,989,927. The budget variance is primarily attributed to the following: Medicaid Program Variance is a positive 49.1 million state dollars, and administration is a positive 2.1 million state dollars. Drug Rebate is 3.0 million state dollars over budget. Taxes and Fees, which also included tobacco tax, is 2.9 million state dollars over budget. For more detailed information, see item 5 in the MAC agenda.

VI. SoonerCare Operations Update:

Melinda Thomason, Senior Director for Stakeholder Engagement

Ms. Thomason spoke to the committee about the adult expansion population. She discussed what the benefits are, along with, who makes up the expansion group, when it will go into effect, and what the requirements are. For more detailed information, please follow the link. https://oklahoma.gov/content/dam/ok/en/okhca/docs/about/expansion/Adult%20Expansion%20Population.pdf

VIII. Legislative Update:

Christina Foss, Legislative Liaison

Ms. Ellen Buettner presented the legislative update to the MAC, discussing a record number of bills were sent to the Governor, 598 total. He signed 582 of those bills, 2 became law without a signature, and vetoed 11 bills, with no veto overrides this session. 3 bills are still on his desk waiting for action by the end of today. Governor Stitt signed the budget bills, including the GA bill. Most state agencies will see a little over 7% increase in appropriations over last year. OHCA will see close to a 20% increase which includes all of our budget request bills, as well as the funding for expansion. The legislator will be back this fall. Likely in October to do a special session on the re-districting process. Special sessions are called for very specific reasons, and we believe this will be the only

issue on that agenda. There were 3 major budget bills that impact the OHCA, one being, SB1045 which is the SHOPP increase. SB1046 was OHCA's specific limits bill, which included our general program growth, adult dental benefits, as well as funding for alternative treatments for pain management benefits. SB689 was the MAC restructuring was signed by the governor, as well as SB207 which relates to the CEO appeals, and SB434 is the Tribal shared savings bill.
SB131, which is the managed care guardrails, we are currently still working through our legal analysis and process the issue. SB574 is the information technology advisory board related to the health information network exchange.

IX. <u>Proposed Rule Changes: Presentation, Discussion, and Vote:</u>
Sandra Puebla, Director of Federal & State Authorities

The following work folders were posted on the Oklahoma Health Care Authority (OHCA) public website for a public comment period.

APA WF # 21-08 Statewide HIE (OKSHINE) - The proposed policy is necessary to comply with Senate Bill 574 and Oklahoma Statutes 63 § 1-133, which creates the state designated health information exchange, Oklahoma State Health Information Network and Exchange (OKSHINE).The proposed new policy will outline the program description, definitions, user requirements, and needed certifications of the Oklahoma State Health Information Network and Exchange (OKSHINE). The implementation of OKSHINE will allow for statewide interoperability and the sharing of Medicaid and public health information.
Budget Impact:

The SFY 2021 total cost is $4,052,999 ($3,647,699 in federal share and $405,300 in state share). The SFY 2022 total cost is $16,092,660 ($9,045,165 in federal share and $7,047,495 in state share).
Tribal Consultation: **June 8, 2021**
The rule change motion to approve was by Mr. Jeff Tallent and seconded by Dr. Joe Catalano and passed unanimously.

APA WF # 21-09 Supplemental Hospital Offset Payment Program (SHOPP) - The proposed changes will amend the Supplemental Hospital Offset Payment Program (SHOPP) policy to comply with Senate Bill 1045.

The proposed changes will define "directed payments" as specific payments made by managed care plans to providers under certain circumstances that assist states in furthering the goals and priorities of their Medicaid programs. The measure provides that funds from SHOPP may be used to fund supplemental or directed payments. Policy changes will also modify the assessment calculation methodology from a rate needed to generate an amount up to the sum of certain expenses to a fixed rate. Additionally, the proposed changes render the portion of the SHOPP fee attributable to certain expenses null and void if federal matching funds for the program become unavailable. Finally, other

changes in the policy eliminate the termination date of the program and removes a cap on quarterly transfers of funds; grammar and language cleanup; aligns the SHOPP rule with current business practice; and includes needed changes for the funding of expansion adults and services through managed care.

Budget Impact: There is no cost impact. However, the agency estimates that for SFY2022 there will be an increase in state share of $37,209,936, for SFY2023 there will be an increase in state share of $89,574,388, and for SFY2024 there will be an increase in state share of $135, 766,567.

SB1045 directs OHCA to use the collected state share to fund Medicaid expansion and other programs, if needed

Tribal Consultation: **June 8, 2021**

Comment: Ms. Mitzi McCullock stated the Oklahoma Hospital Association applauds Medicaid expansion coverage beginning July 1st. In full transparency, the OHA objects to this proposed SHOPP fee and increase. The federal government has provided the state with eight quarters of increased FMAP for this very purpose that we believe will more than pay for the states share of the cost of Medicaid expansion. On behalf of the 68 hospitals who will be paying an increased fee on January 1st of next year, we know we must abstain from this vote. OHA is not opposed in doing our part, but we are disappointed that this fee is not going to be used as a backstop after all federal funds are exhausted.

The rule change motion to approve was by Dr. Sublett and seconded by Dr. Craig Kupiec with 1 no, and 4 abstaining, and passed.

X. MAC Meeting Dates for Calendar 2021:

Chairman, Jason Rhynes, O.D.

September 9, 2021
November 4, 2021

XI. **New Business:**

Chairman, Jason Rhynes, O.D.

Ms. Melody Anthony stated that there is no update on the next steps as far as the ruling goes, because Kevin Corbett has to meet with Governor Stitt. However, we now have adult dental, and expansion which are two wins for the OHCA. Our team is currently concentrating on how to educate the adult population on what it means to have health insurance, how to contact a PCP, and what the dental benefits are.

XII. Adjourn:

Chairman, Jason Rhynes, O.D.

Chairman Rhynes asked for a motion to adjourn. Motion was provided by Dr. Joe Catalano and seconded by Mr. Jeff Tallent there was no dissent and the meeting adjourned at 2:14pm.

SOONERCARE ADULT EXPANSION MAC UPDATE

JULY 2021

THE FOUNDATION OF MEDICAID EXPANSION

- Oklahoma's Medicaid SoonerCare program currently covers children, pregnant women and needy caretaker adults.
- Oklahoma's Medicaid TXIX program currently covers elderly adults, disabled adults and those that are currently in state custody.
- On June 30, 2020, the Oklahoma Medicaid Expansion Initiative, State Question 802, passed by a majority vote to expand Medicaid eligibility to adults ages 19-64 whose income is 138% (133% with a 5% disregard) of the federal poverty level or lower.

https://oklahoma.gov/ohca/about/medicaid-expansion/expansion.html

FUNDING

THE FUNDING

90% of costs for expansion enrollees will be paid by the federal government. Maximizing federal funding allows the state the ability to:

- **Promote** integrated care and improve health outcomes
- **Pursue** substance use disorder and serious mental illness waivers
- **Coordinate** with jails and prisons to help former inmates apply for SoonerCare
- **Help** jails and prisons capture additional SoonerCare funding

ADULT EXPANSION POPULATION

ADULT EXPANSION POPULATION

- Who makes up the adult expansion group?
  - Adults age 19-64
  - Non-pregnant adults
- What are the eligibility requirements?
  (Federal regulation §435.119)
    - FPL at or below 133% (138% with disregards)
    - Citizenship/alienage
    - Residence
    - Are not entitled to or enrolled in Medicare benefits
    - Cooperation with child support (AI/AN exceptions apply)
    - Not otherwise eligible as Parent/Caretaker Relative (NCT) or Former Foster Care (FFC)
    - For an adult who is the parent of a dependent child, the child must also be on Medicaid, CHIP or have other minimum essential coverage.
- When does adult expansion go into effect?
  - Adults can apply starting June 1 for coverage beginning July 1.

GROUPS TO BE REPROCESSED AND INCLUDED IN EXPANSION

- SoonerPlan: Current members that qualify for expansion have been moved into SoonerCare.
- Parent Caretaker Adults: Current members that qualify for expansion have been moved into SoonerCare.
- Insure Oklahoma Individual Plan: All members were eligible to move to expansion have been moved into SoonerCare.
- Insure Oklahoma Employer Sponsor Insurance: Current members that qualify for expansion have been moved into SoonerCare.
- Adults who were not previously categorically related: These members had to applied by April 1st and met eligibility requirements to be reprocessed for expansion.

BY THE NUMBERS

SoonerCare

EXPANSION TOTALS

June 28, 2021

OKLAHOMA
Health Care Authority

122,642

Total Individuals Approved
for Benefits Through Expansion
since June 1, 2021

Gender

Female: 78,460
Male: 44,182

Location

Urban: 72,102
Rural: 50,540

Age

19 to 24 Years Old	31,815
25 to 34 Years Old	36,308
35 to 44 Years Old	28,977
45 to 54 Years Old	15,570
55 to 64 Years Old	9,972

Race

American Indian or Alaskan Native	15,352
Asian or Pacific Islander	3,362
Black or African American	12,649
White	75,369
Declined to Answer	8,441
Two or More Races	7,469

BENEFITS AND COVERAGE

Adult Expansion Benefit

Coverage

Expansion adults will receive full-scope SoonerCare benefits. This is important to highlight for individuals who may have earlier only had SoonerPlan or Insure Oklahoma as they now may have a richer benefit package.

Comparison Chart

Cost-Sharing/Co-Pays

Cost-sharing copay caps are monthly.

This means the maximum out-of-pocket cost will be 5% of the household monthly income for copays.

This is regardless of whether a copay is for medical services or prescriptions.

Pharmacy/DME Benefits

Six covered prescriptions per month.

DME benefits cover items such as oxygen equipment and supplies, wheelchairs, walkers and hospital beds.

Prior Authorizations

A prior authorization is required before SoonerCare will pay for some medical procedures or medications. The specialist will ask SoonerCare to authorize the treatment. The member and provider will be notified about the final determination.

SoonerCare

Expansion adults will receive SoonerCare Traditional (Fee for Service).

Expansion adults will fall into the category ‘Adults 21 and over’.

COMPARE OUR BENEFI

be medically necessary

	SoonerCare Traditional		SoonerCare Choice	
	Children Under 21	*Adults 21 and Over*	*Children Under 21*	*Adults 21 and Over*
Ambulance or Emergency Transportation	**Covered** *Emergency Only*	**Covered** *Emergency Only*	**Covered** *Emergency Only*	**Covered** *Emergency Only*
Behavioral Health and Substance Abuse Services *(Some services may require prior authorization.)*	**Covered**	**Covered** *Some services may require a $3 copay; Behavioral Health Inpatient - $10 per day, up to a maximum of $75*	**Covered**	**Covered** *Some services may require a $3 copay; Behavioral Health Inpatient - $10 per day, up to a maximum of $75*
Child Health Wellness Screens *(Including health and immunization history; physical exams, various health assessments and counseling; lab and screening tests and necessary follow-up care.)*	**Covered**	**N/A**	**Covered**	**N/A**
Dental Services	**Cleanings** *(Twice a year.)* **X-rays Fillings Crowns**	**Emergency Extractions**	**Cleanings** *(Twice a year.)* **X-rays Fillings Crowns**	**Emergency Extractions**
Diabetic Supplies *(100 glucose strips and lancets per month; one spring-loaded lancet device, three replacement batteries per year. Additional supplies require prior authorization.)*	**Covered** *Plus one glucometer per year.*	**Covered** *$4 per claim.*	**Covered** *Plus one glucometer per year.*	**Covered** *$4 per claim.*
Durable Medical Equipment	**Covered** *When prescribed by medical provider and may require prior authorization.*	**Covered** *When prescribed by medical provider and may require prior authorization. $4 copay per claim.*	**Covered** *When prescribed by medical provider and may require prior authorization.*	**Covered** *When prescribed by medical provider and may require prior authorization. $4 copay per claim.*

Since these members will be in SoonerCare Traditional, they <u>will not</u> need to select a medical home or PCP.

You can find the full chart on our website at:

https://oklahoma.gov/ohca/individuals/mysoonercare/soonercare-benefits.html

NEW ADULT DENTAL BENEFIT

BENEFITS BEGIN 07/01/2021

OKLAHOMA
Health Care Authority

Serving Oklahomans
through SoonerCare

Kevin Corbett | Chief Executive Officer

J. Kevin Stitt | Governor

OHCA 2021-01

July 1, 2021

RE: **Adult Dental Service**

Dear member,

The Oklahoma Health Care Authority (OHCA) is pleased to announce that effective July 1, 2021 the adult dental benefit is expanding. The new SoonerCare adult dental benefit includes certain diagnostic, preventive, and treatment services. For more information on the new SoonerCare adult dental benefit, please visit: the OHCA website.

Additionally, effective July 1, 2021, non-exempt SoonerCare adult members will be charged a $4 copay per visit for dental services. There is no copay for emergency dental services. Individuals exempted from adult dental services copays include:

- Pregnant women
- Institutionalized individuals
- Individuals receiving hospice care
- American Indians/Alaskan Natives who receive or have ever received services furnished by an Indian health care provider or through referral under contract health services
- Individuals receiving Medicaid coverage for breast and cervical cancer
- Individuals under age 21

For more information on copay amounts, visit: https://oklahoma.gov/ohca/soonercare-benefits. Copays are due at the time of the visit. Providers cannot deny service based on a member's inability to pay the copay. You may be billed for copays if you were unable to pay them when you received services. If you get a bill and do not believe you have to pay for the charges, please call OHCA at 800-522-0114.

Covered Benefits		
Treatments	**Prior Authorization Required**	**Other Limitations**
Comprehensive oral evaluation	No	You have not been seen by any dentist for more than thirty-six (36) months.
Periodic oral evaluation	No	Limited to one (1) every six (6) months.
Limited oral evaluations	No	Limited to two (2) visits for the same dentist when evaluated prior to a comprehensive or periodic evaluation.
Images	No	Panoramic images as medically necessary, limited to once per three (3) years. Limited to one (1) set of bitewing images every twelve (12) months.
Dental cleanings	No	Limited to once every one hundred eighty-four (184) days.
Smoking and tobacco use cessation counseling	No	Limited to eight (8) sessions per year per individual with documented tobacco use.
Medically necessary extractions	No	Medically necessary extracti defined in Oklahoma Admin Code (OAC) 317:30-5-695. Tooth extraction must have medical need documented
Medical and surgical services	No	Medical and surgical services are performed by a dentist or physician to

You can find the full chart on our website at:

https://oklahoma.gov/ohca/individuals/soonercare-dental.html

NOTIFYING MEMBERS

- A dental benefit guide has been completed for members and providers.
- Beginning in July, Member Education will incorporate adult dental benefit information as part of their training series to Agency Partners.
- Community Partner training on dental benefits in July.
- Members calling to inquiry about medical/dental benefits will be provided up to date benefit information and online resources for reference.
- The member education webpage will encompass dental benefit information. (https://oklahoma.gov/ohca/individuals/toolkit.html)

NOTIFYING PROVIDERS

- Beginning July 8th, Provider Education is hosting webinars for adult dental benefits and have surveys out for providers to tell us what they would like to be educated on in regard to Adult Expansion.
- Registration is open and posted on the public website under the provider training page. https://oklahoma.gov/ohca/providers/provider-training.html

OKLAHOMA
Health Care Authority

GET IN TOUCH

4345 N. Lincoln Blvd.
Oklahoma City, OK 73105

okhca.org
mysoonercare.org

Agency: 405-522-7300
Helpline: 800-987-7767

July MAC
Proposed Rules Amendment Summaries

The following work folders were posted on the Oklahoma Health Care Authority (OHCA) public website for a public comment period.

APA WF 21-12 Purchasing Rules Revisions — The proposed revisions will re-establish agency-specific rules for purchasing and procurement. Revisions include provisions related to procurement definitions, procurement ethics and prohibited conduct, conflicts of interest, and procurement of goods and services and professional services.

Budget Impact: Budget neutral

Tribal Consultation: July 6, 2021

APA WF 21-13 Grievance Procedures and Process Rules Revisions — The proposed revisions will revise existing appeals rules to clarify appeals related to the aged, blind, and disabled populations. The proposed rules will also establish appeals rules related to Agency-level appeals for providers and beneficiaries whose initial grievance and/or appeal occurs with an agency contractor. Additional revisions will clarify contract award protest process based on whether the OMES Director considers the appeal or assigns the appeal to an administrative law judge.

Budget Impact: Budget neutral

Tribal Consultation: July 6, 2021

APA WF 21-14 Patient Centered Medical Home (PCMH) — The proposed revisions will add expansion adults, as per 42 C.F.R. 435.119, as a group eligible to receive services through the patient centered medical home (PCMH) service delivery model.

Budget Impact: Agency staff has determined that the proposed changes would potentially result in a combined federal and state spending of $8,829,743 total, with $882,974 in state share for State Fiscal Year (SFY) 2022."

Tribal Consultation: July 6, 2021

APA WF 21-15 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. These requirements include, but are not limited to, enrollment and voluntary enrollment into an alternative delivery model, developing specific network adequacy standards, prior authorization requirements, and developing requirements for appeals and hearings.

Budget Impact: Budget neutral

Tribal Consultation: July 6, 2021

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 10. PURCHASING

317:10-1-1. Purpose

~~(a) The purpose of this Chapter is to describe the rules governing the contracting and purchasing requirements of the Oklahoma Health Care Authority (OHCA). The Contracts and Purchasing Divisions are internal divisions of the OHCA. These divisions provide the mechanism for the acquisition of goods, equipment, non-professional and professional services for the operation of the OHCA. These rules are superseded by the Office of Management and Enterprise Services (OMES) Purchasing rules (OAC 260:115) whenever OMES has final authority on an acquisition.~~

~~(b) Different rules apply depending on which of the above three entities is making the acquisition and whether the purchase is for professional services or non-professional services and products. When an acquisition is made by OMES, the OMES Purchasing rules at OAC 260:115 apply. When an acquisition is made by OHCA, these rules must be read in conjunction with the OMES rules.~~

(a) The purpose of this Chapter is to describe the rules governing the contracting and purchasing requirements of the Oklahoma Health Care Authority (OHCA), as directed by 74 O.S. § 85.39. OHCA maintains two (2) internal units that are responsible for the acquisition of goods, equipment, non-professional services, and professional services for the operation of OHCA.

(b) The rules of this Chapter are superseded by the Office of Management and Enterprise Services (OMES) [Oklahoma Administrative Code (OAC) 260:115,] as amended from time to time, whenever OMES has final authority on an acquisition. When an acquisition is made by OMES, the OMES purchasing rules at OAC 260:115 apply. When an acquisition is made by OHCA, the rules of this Chapter should be read in conjunction with the OMES rules.

317:10-1-2. Definitions

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

~~**"Authority Board"** means the board designated by the Oklahoma Legislature to establish policies and adopt and promulgate rules for the OHCA.~~

~~**"Chief Executive Officer"** or **"CEO"** means the highest ranking administrator at the OHCA.~~

"Acquisition" means items, products, materials, supplies, services, and equipment that OHCA acquires by purchase, lease-purchase, lease with option to purchase, or rental.

"Administrative review" means the process by which OHCA ensures that a bid submission is complete and accurate; confirms that the

bidder understood the solicitation specifications; and ascertains that all materials and any required signatures are submitted.

"Award" or **"contract award"** means the process by which OHCA formally notifies a bidder that OHCA has accepted the bidder's bid or offer.

"Best and final offer" or **"BAFO"** means a final offer submitted in writing by a bidder initially or after negotiations are completed and containing the bidder's most favorable terms for price, service, and/or products to be delivered.

"Best price" means the lowest available price for the goods and/or services that are subject of a solicitation.

"Best value" means evaluation criteria which may include but is not limited to the acquisition's operational cost a state agency would incur; the quality of the acquisition, or its technical competency; the reliability of the bidder's delivery and implementation schedules; the acquisition's facilitation of data transfer and systems integration; the acquisition's warranties and guarantees and the bidder's return policy; the bidder's financial stability; the acquisition's adherence to the state agency's planning documents and announced strategic program; the bidder's industry and program experience and record of successful past performance with acquisitions of this complexity; the anticipated acceptance by user groups; and the acquisition's use of proven development methodology, and innovative use of current technologies.

"Bid" means any response to a solicitation, including any and all required forms; required documents and information; and supplemental documents and information.

"Bidder" means an individual, entity, or service vendor that submits a bid in response to a solicitation.

"Bid evaluation" means the process of conducting any evaluative activity that could reasonably be expected to result in determining the value, nature, character, or quality of a bid.

"Bid evaluator" means an employee or officer of the State of Oklahoma who is actively engaged in Oklahoma Health Care Authority's (OHCA) process to evaluate, score, or select a bid, regardless of whether a contract is awarded to the bid evaluated and/or scored by that employee or officer.

"Bid specifications" means the information OHCA will use for bid evaluation, when such information is exactly detailed within a solicitation and is based on the subject matter of the solicitation, the type of solicitation, and the needs to be met by the supplier(s) awarded a contract from the solicitation.

"Central Purchasing Division" means the Central Purchasing Division of the Office of Management and Enterprise Services (OMES).

"Certification" means the process of a bidder providing OHCA with an official document attesting to a status or level of achievement in response to a solicitation.

"Certified Procurement Officer" or **"CPO"** means a state agency procurement official certified as a procurement officer or analyst by the State Purchasing Director under the provisions of the Oklahoma Central Purchasing Act.

"C.F.R." means the Code of Federal Regulations as may be amended from time to time.

"Chief Executive Officer" or **"CEO"** means the highest-ranking administrator at the OHCA.

"Chief Information Officer" means the chief administrative officer of the Information Services Division of the Office of Management and Enterprise Services.

"Clarification" means a bidder's explanation of all or part of a bid that does not change, alter, or supplement the bid.

"CMS" means the Centers for Medicare & Medicaid Services.

"Closing date/time" means the date and Central Time a solicitation specifies responses must be received by OHCA.

"Competitive solicitation" or **"solicitation"** means an invitation to bid for the provision of goods or services through specified documents submitted to the Central Purchasing Division or a state agency pursuant to terms, conditions, and other requirements of a solicitation. The competitive solicitation process may be electronic when the terms of the solicitation expressly permit electronic submission and the requirements of applicable statutes and rules are met. When used in this chapter, "competitive solicitation" is synonymous with "invitation to bid," "request for proposal," "request for information," or "request for quotation."

"Conflict plan" means the written statement detailing the accommodations and/or remedies associated with a specific OHCA employee's or officer's conflict of interest in the procurement process or resulting contract.

"Conflict of interest" means a situation in which a person is in a position to derive personal benefit from actions or decisions made in their official capacity, a situation in which the concerns or aims of two (2) different parties are incompatible, a situation prohibited or constrained by law, or a situation that would appear inappropriate to a reasonable individual.

"Contract" means the written and binding agreement between OHCA and the bidder resulting from the competitive solicitation.

"Contracting official" or **"contracting officer"** means the OHCA CEO or the OHCA officer or employee to whom contracting authority has been delegated by the OHCA CEO, unless specified otherwise.

"Contractor" means any individual or entity contracted with OHCA for the provision of any goods or services. A bidder becomes a contractor upon contract award and execution.

"Days" means calendar days unless otherwise specified.

"Debar" or **"debarment"** means action taken by the State Purchasing Director to exclude any business entity from inclusion on the Supplier List, bidding, offering to bid, receiving an award of contract with the state of Oklahoma for acquisitions by state agencies, or a contract the OMES awards or administers. Debarment may also result in cancellation of existing contracts with the State of Oklahoma.

"Employee" or **"officer"** means a natural person that works for OHCA, unless otherwise specified, regardless of title or designation and regardless of manner of appointment, election, or hiring. "Employee or officer" does not mean a member of the Authority Board in the member's capacity as a board member.

"Enrollment activities" means activities performed or conducted by OHCA related to distributing, collecting, or processing enrollment materials, taking enrollments by technological device or in person, or enrolling or disenrolling, including by algorithm, Medicaid beneficiaries with respect to any health plan or managed care services contract.

"Fiscal year" means the period of time from July 1 of a calendar year through June 30 of the succeeding calendar year.

"Former employee" means a natural person whose work as an employee or officer for OHCA ended by any means at some point prior to the currently referenced moment.

"Health plan" means any person or entity that is licensed as a health maintenance organization (HMO) by the state of Oklahoma to provide or arrange for the delivery of basic health care services to enrollees on a prepaid basis, except for copayments or deductibles for which the enrollee is responsible, or both, that meets the definition of an HMO as delineated in the Oklahoma Medicaid State Plan and that contracts with the State to provide services to enrollees.

"Invoice" means an accounting document issued by an individual or entity that details the goods and/or services provided and the amount of money owed for the goods and/or services when the document conforms to all invoicing provisions of the contract and that records the details of the transaction.

"Managed care entity" or **"MCE"** means any entity permitted under 42 C.F.R. Part 438 to contract with a state for services provided under a risk contract or a nonrisk contract within the state's Medicaid managed care program, including but not limited to managed care organization (MCO), primary care case management (PCCM), primary care case management entity (PCCM entity), prepaid

ambulatory health plan (PAHP), and prepaid inpatient health plan (PIHP).

"Managed care organization" or **"MCO"** means the same in these rules as defined at 42 C.F.R. § 438.2.

"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.

"Mandatory specification" means any specification of a solicitation when the terms "shall", "must", "will", or "is required" are used to describe, define, or announce the specification. This definition refers only to the use of such words in a solicitation and does not refer to the use of such words in this chapter.

"Material deficiency" or **"material deviation"** means a bidder's failure to provide information necessary to evaluate a competitive solicitation.

"Medicaid" means the medical assistance program jointly administered by the federal and state governments and authorized by 42 U.S.C. § 1396a to provide health care benefits for certain low-income persons.

"Minor deficiency" or **"minor informality"** means an immaterial defect in a bid or variation in a bid from the exact requirements of a competitive solicitation that may be corrected or waived without prejudice to other bidders. A minor deficiency or informality does not affect the price, quantity, quality, delivery, or conformance to specifications and is negligible in comparison to the total cost or scope of the acquisition.

"Multi-award" means the process by which OHCA formally, by written determination, notifies two or more bidders that OHCA has accepted the bidders' bid to furnish an indefinite quantity or category of item, where more than one supplier is needed to meet the contract requirements for quantity, delivery, service, or product compatibility.

"Non-collusion certification" means a certification submitted by a bidder with any competitive bid or contract executed by the state for goods or services in accordance with 74 O.S. § 85.22.

"Nonresponsive" means a bid or proposal that has been determined not to conform to essential requirements of a solicitation.

"OAC" means the Oklahoma Administrative Code as may be amended from time to time.

"Office of Management and Enterprise Services" or **"Office"** or **"OMES"** means the Oklahoma Office of Management and Enterprise Services.

"Oklahoma Central Purchasing Act" means 74 O.S. §§ 85.1 et seq.

"Oklahoma Health Care Authority" or **"OHCA"** or **"Authority"** means the single state agency designated to administer the medical programs which make available appropriate medical services to eligible individuals through the Title XIX Medicaid Program and which has authority to procure, administer and monitor contracts, issue performance deficiency notices, and assess non-compliance damages.

"OHCA Board" means the board designated by the Oklahoma Legislature to establish policies and adopt and promulgate rules for the OHCA.

"Oklahoma Information Technology (IT) Accessibility Standards" or **"IT Accessibility Standards"** means the accessibility standards adopted by the Office of Management and Enterprise Services (Reference OAC 250:15) to address all technical standard categories of Section 508 of the Rehabilitation Act (Reference 29 U.S.C. § 794d), as amended by the Workforce Investment Act of 1998 (Reference P.L. 105-220, August 7, 1998) and adopted at 62 O.S. §§ 34.28, 34.29, 34.30, and 34.16, to be used by each state agency in procuring, maintaining, or using information technology, and in the development and implementation of custom-designed information technology systems, web sites, and other emerging information technology systems.

"Oral presentation evaluation" means the process, through the bidder's participation in an interactive dialogue or non-interactive presentation, by which OHCA assesses a bidder's capability, past performance, work plans or approaches, staffing resources, transition plans, sample tasks, or fit with the OHCA.

"O.S." or **"Okla. Stat."** means the Oklahoma Statutes as may be amended from time to time.

"Permissible specification" means any specification in a solicitation when the terms "can", "may", or "should" are used to describe, define, or announce the specification. This definition refers only to the use of such words in a solicitation and does not refer to the use of such words in this chapter.

"Privatize" means to enter into contract for the performance of a duty or function which is currently being performed by a state employee.

"Procurement" means buying, purchasing, renting, leasing, or otherwise acquiring any goods or services. The term also means all functions that pertain to the obtaining of any goods or services, including but not limited to the description of requirements, selection, and solicitation of sources, preparation and award of contracts, and all phases of contract administration.

"Professional services" means services which are predominantly advisory or intellectual in character, involve privatized functions, or involve support rather than supplying equipment, supplies, or other merchandise. Professional services include

those services requiring special, usually advanced, education, or skill.

"Prejudice" means the effect on an affected bidder's substantial rights when a procurement decision related to a different bidder, if such decision is found to be in error, would yield a more favorable result for the affected bidder if the decision error were corrected.

"Purchasing" means the Purchasing Department of the Oklahoma Health Care Authority.

"Purchasing manager" means the Purchasing Manager of the Oklahoma Health Care Authority.

"Registered supplier" means a supplier that registers with the Central Purchasing Division pursuant to 74 O.S. § 85.33.

"Remedy" means to cure, alter, correct, or change.

"Request for information" or **"RFI"** means a non-binding procurement practice used to obtain information, comments, and feedback from interested parties or potential suppliers prior to issuing a solicitation.

"Request for proposal" or **"RFP"** means a type of solicitation OHCA or the State Purchasing Director issues to suppliers to request submission of proposals for acquisitions.

"Request for quotation" or **"RFQ"** means a simplified written or oral solicitation OHCA or the State Purchasing Director issues to suppliers to request submission of a quote for acquisitions.

"Requisition number" means an identifier OHCA or OMES assigns to a requisition.

"Responsible supplier" means a supplier who demonstrates capabilities, in all respects, to fully perform the requirements of a contract and which will ensure good faith performance, including but not limited to finances, credit history, experience, integrity, perseverance, reliability, capacity, facilities and equipment, and performance history.

"Responsive" means a bid or proposal that has been determined to conform to the essential requirements of a solicitation.

"Risk contract" means a contract between OHCA and a managed care organization (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.

"Sole brand acquisition" means an acquisition that by specification restricts the acquisition to one manufacturer or brand name.

"Sole source acquisition" means an acquisition that by specification restricts the acquisition to one supplier.

"Split purchase" means dividing a known quantity or failing to consolidate a known quantity of an acquisition for the purpose of evading a competitive bidding requirement.

"State Purchasing Director" means the director of the Central Purchasing Division of the Office of Management and Enterprise Services appointed by the OMES Director and includes any employee or agent of the State Purchasing Director, acting within the scope of delegated authority. (Reference 74 O.S. § 85.2) Unless otherwise stated, the term includes employees of the Central Purchasing Division and state agency purchasing officials certified by the State Purchasing Director to which the State Purchasing Director has lawfully delegated authority to act on his or her behalf. In regard to the procurement of information technology or telecommunications, the term means the Chief Information Officer of the Office of Management and Enterprise Services.

"Statement of work" or **"scope of work"** means a detailed description of the work which OHCA requires a contractor or supplier to perform or accomplish.

"Supplier" or **"vendor"** means an individual or business entity that sells or desires to sell acquisitions, including goods and/or services to OHCA. (Reference 74 O.S. § 85.2)

"Supplier list" means a list of individuals or business entities that have registered with the Central Purchasing Division in order to receive notification of solicitations for commodities specified in their registration application.

"Supplier performance evaluation" means information a state agency or OMES Procurement provides to the State Purchasing Director, in a manner the OMES Director prescribes, that documents the quality of service or products provided by a supplier.

"Supplier registration" means a process a supplier uses to register with the Central Purchasing Division to automatically receive solicitations based on a commodity class for a specified period of time.

"Technical proposal evaluation" means the process, based on established criteria and reliant on evaluators' expertise in assessing the strengths and weaknesses of multiple bids, by which OHCA measures the extent to which a bid will meet OHCA's needs.

"U.S.C." means the United States Code as may be amended from time to time.

"Value based" or **"value-based purchasing"** means the intentional linking of cost to the OHCA's perception of the value of goods or services. In a health plan or managed care contract, these terms refer to provider payments made by the health plan or managed care entity based on improved performance by health care providers.

317:10-1-12. Protest of award

(a) Protests of awards made by ~~the Authority~~OHCA under 74 Okla. Stat. § ~~85.5T~~85.5N are addressed at OAC 317:2-1-1 et seq.
(b) Bidders who wish to protest any other award shall follow the process outlined in the ~~Office of Management and Enterprise Services~~OMES rules at OAC 260:115-3-19.

317:10-1-16. Delegation of authority

The authority to procure needed products and services for ~~the Authority~~OHCA has been delegated to ~~the Authority~~OHCA from the Office of Management and Enterprise Services, Central Purchasing Division. The ~~Authority~~OHCA Board delegates authority for expenditure of funds to the CEO and other ~~Authority~~OHCA officers and personnel according to the dollar limits and types of products stated in (1), (2) and (3) of this Section. Within this authority, the CEO may delegate in writing to other specific individuals the responsibility for the performance of the procurement duties.

(1) **Supply and non-professional services acquisitions.** Each division director or supervisor may initiate any supply or non-professional services acquisition which is within his or her authorized division budget and approved by the CEO or designee. Any single acquisition of this kind over $5,000 up to ~~$500,000~~$1,000,000 must be approved by the CEO~~, Executive Staff~~ or designee. Any single acquisition of this kind over ~~$500,000~~$1,000,000 must be approved by the ~~Authority~~OHCA Board. A contract amendment that would increase the total original contract acquisition cost to an amount that equals or exceeds ~~$500,000~~$1,000,000 for a supply or non-professional services contract must be prior approved by the ~~Authority~~OHCA Board. Any amendment to a contract that would result in a ~~10 percent~~ten percent (10%) or greater increase in the total acquisition cost originally approved by the OHCA Board must be submitted to the OHCA Board for prior approval.

(2) **Professional service contracts.** Acquisitions of professional services must be approved by the CEO or designee. All professional service contracts over ~~$125,000~~$1,000,000 must be approved by the ~~Authority~~OHCA Board. A contract amendment that would increase the total original contract acquisition cost to an amount that equals or exceeds ~~$125,000~~$1,000,000 for a professional service contract must be prior approved by the ~~Authority~~OHCA Board. Any amendment to a contract that would result in a ~~25 percent~~twenty-five percent (25%) or greater increase or a ~~$250,000~~$1,000,000 or greater increase in the total acquisition cost originally approved by the ~~Authority~~OHCA Board must be submitted to the ~~Authority~~OHCA Board for prior approval. Board approval is not required if the increase in total contract acquisition cost results from the exercise of a price increase methodology, option for additional work, or

option to renew that was contained in the previously approved contract.

(3) **Interagency/intergovernmental agreements.** All agreements with another state agency or public agency must be approved by the CEO or designee~~,~~ but are exempt from the ~~Authority~~OHCA Board approval.

317:10-1-21. Procurement ethics, prohibited conduct

(a) **Standard of conduct.** The Oklahoma Central Purchasing Act, State Ethics Commission rules, and other state laws contain regulations, prohibitions, and penalties governing procurement ethics. Transactions relating to the public expenditure of funds require the highest degree of public trust and impeccable standards of conduct.

(b) **One (1) year prohibition on certain contracts.** For one (1) year after the employment termination date of any employee or officer, OHCA is prohibited from entering into a sole source contract, a professional service contract, or a contract for the services of that employee or officer. Refer to 74 O.S. § 85.42(A). An agency may enter into a sole source contract or a contract for professional services at any time with a person who is a qualified interpreter for the deaf. Reference to 74 O.S. § 85.42(D).

(c) **Supplier gratuities.** Employees or officers of the Purchasing and Contracts Development unit, acting within the scope of delegated authority, or any member of their immediate family, under the Oklahoma Central Purchasing Act shall not accept any gift, donation, or gratuity for himself or any member of his immediate family from any supplier or prospective supplier of any acquisition covered by the Oklahoma Central Purchasing Act. This subsection shall not apply to exceptions to the definition of "anything of value" established in rules promulgated by the Oklahoma Ethics Commission.

(d) **State requirement for one (1) year prohibition on certain state officers' or employees' employment with a supplier.** For a period of one (1) year from the date that any contract to privatize is awarded by OHCA, any state officer or employee who exercised discretionary or decision-making authority in awarding a specific contract to privatize is prohibited from becoming an officer or employee of a business organization which is party to that specific contract to privatize. If, within the prohibited period and in violation of state law, any state officer or employee who exercised discretionary or decision-making authority in awarding a specific contract to privatize becomes an officer or employee of a business organization which is party to that specific contract to privatize, then the business organization is prohibited from contracting with OHCA for one (1) year from the date of the violation of state law. Refer to 74 O.S. § 590.

(e) **Agency contract or agreement open for legislative inspection.** Upon request, a contract or any other form of agreement made by OHCA will be open for inspection to any member of the Legislature. OHCA will not direct, put in a contract, or in any way disallow a vendor, client, employer or independent contractor, person, or any other entity from contacting or communicating with any member of the Legislature. Refer to 74 O.S. § 464.1.

(f) **Federal requirement for conflict-of-interest safeguards pertaining to any contract for health plan or managed care services.** Any contract awarded for health plan or managed care services and subject to 42 C.F.R. Part 438 necessitates state conflict-of-interest safeguards at least as effective as those specified at section 27 of the Office of Federal Procurement Policy Act. Refer to 42 C.F.R. § 438.58, citing 41 U.S.C. § 423. In addition to this subsection, OAC 317:10-1-22 describes processes pertaining to the conflict-of-interest safeguards in this section.

(1) The following person(s) shall not, except as provided by law, knowingly disclose a contractor bid or proposal information or source selection information before the award of an OHCA procurement contract to which the information relates:

(A) When such person is:

(i) A present or former employee or officer;

(ii) Acting or has acted for or on behalf of OHCA with respect to a procurement; or

(iii) Advising or has advised OHCA with respect to a procurement; and

(B) By virtue of that office, employment, or relationship has or had access to contractor bid or proposal information or source selection information.

(2) A person shall not, other than as provided by law, knowingly obtain contractor bid or proposal information or source selection information before the award of an OHCA procurement contract to which the information relates.

(3) If an employee or officer who is personally and substantially participating in a procurement under this Section, contacts or is contacted by a procurement bidder regarding possible non-OHCA employment, the employee or officer shall promptly report the contact in writing to the employee's or official's supervisor and to the designated OHCA ethics official (or designee) and either:

(A) Reject the possibility of non-OHCA employment; or

(B) Disqualify himself or herself from further personal and substantial participation in that procurement until such time as OHCA has authorized the employee or official to resume participation in such procurement on the grounds that:

(i) The bidder is no longer a participant in the procurement; or

(ii) All discussions with the bidder regarding possible non-OHCA employment have terminated without an agreement or arrangement for employment.

(4) A former employee or officer shall not accept compensation from a contract-awarded bidder as an employee, officer, director, or consultant of that bidder within a period of one (1) year after such former employee or officer functioned within the scope of employment as:

(A) The procuring contracting officer, the source selection authority, a member of an evaluation committee, or the chief of a financial or technical evaluation team in a procurement in which that contract-awarded bidder was selected for award of a contract in excess of $10,000,000;

(B) A program manager, deputy program manager, or administrative contracting officer for a contract in excess of $10,000,000 awarded to that contract-awarded bidder; or

(C) A primary decision maker who personally made one (1) or more of the following decisions on behalf of OHCA:

(i) To award a contract, subcontract, modification of a contract or subcontract, or a task order or delivery order for that contract-awarded bidder valued in excess of $10,000,000;

(ii) To establish overhead or other rates applicable to a contract or contracts for that contract-awarded bidder valued in excess of $10,000,000;

(iii) To approve issuance of a contract payment or payments to that contract-awarded bidder valued in excess of $10,000,000; or

(iv) to pay or settle a claim in excess of $10,000,000 with that contract-awarded bidder.

(5) A former employee or officer who accepts compensation from any division or affiliate of a contract-awarded bidder that does not produce the same or similar products or services as the entity of the contract-awarded bidder that is responsible for the contract does not violate this section.

(6) With regard to any current or former employee or officer or any bidder who violates this subsection (f), OHCA may take any administrative action and pursue any penalty allowed by state or federal law.

(7) Any employee or officer or former employee or officer may request advice from the appropriate designated OHCA ethics official regarding whether the employee or officer or former employee or officer is or would be precluded by subsection (f)(4) of this section from accepting compensation from a particular contractor.

317:10-1-22. Conflicts of interest

(a) **Types of conflicts of interest.** Three (3) types of conflict-of-interest forms may be used for OHCA to clear conflicts related to procurement.

(1) **General conflicts of interest.** OHCA requires all employees or officers to sign general conflict-of-interest forms annually.

(2) **Contract-specific conflicts of interest.** OHCA requires specific employees or officers, as described within this subsection, to sign a contract-specific conflict-of-interest form related to a specific contract when deemed appropriate to meet any applicable federal or state law or regulation and to avoid impropriety or the appearance of impropriety in connection with the procurement process or the administration of the specific contract. The contract-specific conflict-of-interest form will inform the employee or officer of rights and responsibilities related of role as related to a specific contract, including any potential restrictions on future employment or other business connections with the contractor or with OHCA, and will record any conflicts that pre-date the signing of the form or that arise at any point in time thereafter until the contract is terminated.

(3) **Evaluator-specific conflicts of interest.** OHCA requires employees or officers of any agency or department of the State to sign an evaluator-specific conflict-of-interest form, whenever the employee or officer is appointed, selected, or approved as a bid evaluator or performs any duty of a bid evaluator for a specific contract. The evaluator-specific conflict-of-interest form will inform the employee or officer of rights and responsibilities related to the role of bid evaluator, including any potential restrictions on future employment or other business connection with the contractor or with OHCA, and will record any conflicts that pre-date the signing of the form or that arise at any point in time thereafter until the evaluation is complete and closed. If a bid evaluator is removed from the bid evaluation for any reason, including potential conflict of interest, a substitute bid evaluator with similar expertise will be added to the bid evaluation after signing an evaluator-specific conflict-of-interest form.

(b) **Forms meet or exceed legal standards.** All conflict-of-interest forms shall meet or exceed the applicable legal standards controlling the type of contract and/or type of employee or officer involvement in procurement or administration of a contract, including but not limited to 74 O.S. § 85.42(A), 74 O.S. § 590, and 41 U.S.C. § 423.

(c) **Identification of conflicts of interest.** OHCA will identify conflicts of interest, plan any accommodation, and manage any employee disciplinary action.

(1) The OHCA contracting officer will identify all employee or officer positions required to sign a specific conflict-of-interest form or an evaluator-specific conflict of interest form. For any solicitation for health plan or managed care services, the contracting officer will identify, at minimum, all employees or officers engaged in enrollment activities, when those employees or officers are internally titled manager or above, and all employees and officers engaged as bid evaluators.

(2) OHCA's Human Resources (HR) Department will obtain conflict-of-interest forms:

(A) For general conflict-of-interest forms, from each employee or officer at the time of hiring and annually thereafter.

(B) For contract-specific conflict-of-interest forms, from each employee or officer in an identified position prior to the employee's or officer's participation in contract- or solicitation-specific activities.

(C) For evaluator-specific conflict-of-interest forms, from each employee or officer identified as an evaluator prior to the employee's or officer's participation in evaluation-specific activities.

(3) OHCA HR and OHCA's Legal Department will review the executed conflict-of-interest forms.

(4) If a potential conflict is identified, a conflict plan will be presented to the employee or officer. The conflict plan will include, at minimum, guidelines that the employee or officer must follow to avoid an actual conflict.

(5) The employee or officer will determine if the conflict plan can be accommodated and respond accordingly.

(6) If the accommodation does not resolve the issue, then the employee or officer will face disciplinary action up to and including termination of employment.

(d) Each employee or officer has a responsibility to notify OHCA HR within one (1) business day of becoming aware of a potential conflict, regardless of whether the employee or officer previously executed a conflict-of-interest form. Upon notification, OHCA HR will take appropriate action to identify the potential conflict in writing, either as part of the existing conflict-of-interest form or as a new conflict-of-interest form; develop a conflict plan; and present the conflict plan to the employee or officer.

317:10-1-23. Value-based purchasing

(a) Unless otherwise prohibited by law, OHCA may engage in value-based purchasing with regard to any contract for goods, services, or professional services.

(b) Unless otherwise prohibited by law, OHCA may include in any contract for health plan or managed care services any concept of value-based purchasing as to the transaction between OHCA and the health plan or managed care entity.

(c) Unless otherwise prohibited by law, OHCA may include in any contract for health plan or managed care services any concept of value-based purchasing as to the transaction underlying the provision of health care services or items by providers contracted with any health plan or managed care entity.

317:10-1-24. Bidder obligations arising from bid submission

(a) **One (1) bid.** Bidders may submit only one bid in response to any solicitation. Except as requested by OHCA, no bid may be changed after the response due date and time. If the bidder needs to change a submitted bid prior to the response due date and time, the bidder will withdraw the originally submitted bid and submit a new bid to OHCA by the response date and time. Bidders may withdraw and resubmit a bid at any time prior to the submission deadline. As part of the resubmission process, the bidder will acknowledge in writing that the resubmitted bid supersedes all previously submitted bids by including the following statement on the superseding bid cover page, "This bid supersedes the bid previously submitted". In the body of the submission transfer, whether by email or otherwise, the resubmitted bid should contain the solicitation number and solicitation response due date and time.

(b) **Bidder duties.** The bidder shall submit any bid:

(1) In strict conformance with the instructions provided to bidders along with a completed "Responding Bidder Information" form and any other forms required by the solicitation;

(2) Electronically;

(3) With a completed certification statement, as described in the solicitation, that uses the bidder's legal name and has been executed by an authorized person with full knowledge and acceptance of all certificate provisions;

(4) According to the "Technical Proposal Requirements" of the solicitation;

(5) With relevant information for a designated contact to receive notice, approvals, and requests that are allowed or required by the terms of the solicitation;

(6) As firm, including a guarantee that unit prices are correct, for a minimum of one hundred eighty (180) days after the solicitation closing date; and

(7) In accordance with 74 O.S. § 85.40, requiring the bidder to include in the total bid price all travel expenses, including but not limited to transportation, lodging, and meals, to be incurred by a bidder in performance of the awarded contract.

(c) **Bidder's acknowledgements.** By submitting a bid, the bidder promises, acknowledges, and agrees that:

(1) The bidder will adhere to any additional terms OHCA deems necessary to the performance of the contract, including but not limited to terms related to the contractor's need to access, process, or store Medicaid beneficiary data;

(2) All costs incurred by a bidder in participating in the procurement process is the sole responsibility of the bidder, and the bidder will not be reimbursed for or awarded damages for such costs;

(3) If a bidder fails to notify the contracting officer of an ambiguity, conflict, discrepancy, omission, or other error in the procurement process or in any of the documents provided by OHCA that is known to the bidder, or that reasonably should be known by the bidder, the bidder accepts the risk of submitting a bid and, if awarded the contract, will not be entitled to additional compensation, relief, or time by reason of the error or its later correction; and

(4) Bidder waives any error in the procurement process or documents which is known to the bidder or reasonably should have been known, and such error will not be the grounds of a bid protest.

(d) **Indemnification.** By submitting a bid, the bidder understands, accepts, acknowledges, and agrees to this paragraph in its entirety. OHCA will not indemnify a bidder, any subcontractor, or any other party to an awarded contract. Any contract between the selected bidder and OHCA will not contain any terms limiting the liability of the bidder or providing indemnification by OHCA in favor of the bidder or any third parties. The State of Oklahoma and its agencies do not hold an individual or a private entity harmless from liability or provide indemnity to a private entity or individual. Any attempt by the bidder to add indemnification or limitation of liability provisions in favor of the bidder or third parties to the definitive contract may render the bidder’s bid nonresponsive and subject to rejection. Should OHCA accept a bid that attempts to add indemnification or limitation of liability provisions in favor of the bidder or third parties, such attempts are severable from the remainder of the bid and have no effect on any awarded contract. At no time and in no way will OHCA be deemed to have waived this paragraph through action or inaction.

(e) **Conflict of laws.** With regard to the procurement process to which a bid is submitted and any business relationship or contract

resulting from such procurement process, by submitting a bid, the bidder understands, accepts, acknowledges, and agrees:

(1) That the undertaking and all matters arising out of or relating to the undertaking, including all protests, claims, causes of action, controversies, or matters in dispute between OHCA and the bidder—whether sounding in contract, tort, statute, regulation, or otherwise—shall be governed by, construed, interpreted, and enforced in accordance with the substantive and procedural laws of the State of Oklahoma, including its statutes of limitations, without giving effect to any choice of law or conflict of laws rules or provisions, whether of the State of Oklahoma or any other jurisdiction, that would cause the application of the laws of any jurisdiction other than the State of Oklahoma;

(2) To exclude application of the United Nations Convention on Contracts for the International Sale of Goods; and

(3) That a final judgment in any matter described in (e)(1) of this Section is conclusive and binding and may be enforced in any other jurisdiction.

317:10-1-25. Property of the state

Any bid, including all related and submitted documents and information, is part of the public record(s) and is subject to disclosure; unless otherwise specified in the Oklahoma Open Records Act, the Central Purchasing Act, or other applicable law. All material submitted by a bidder becomes the property of the State of Oklahoma upon submission and will be a matter of public record, subject to the procedures for treatment of proprietary information. OHCA has the right to use all concepts described in any bid, regardless of whether such bid is accepted. By any secured means, including electronic transmission via secure file transfer protocol, OHCA has the right to transmit all material submitted as part of or in connection with a bid, including proprietary information, to any professional services contractor then or afterward contracted with OHCA for provision of professional services related to the solicitation, award, or administration of the contract.

317:10-1-25.1. Proprietary or confidentiality claims

(a) Unless otherwise specified in the Oklahoma Open Records Act, Central Purchasing Act, or other applicable law, documents and information that a bidder submits as part of or in connection with a bid are public records and subject to disclosure after the contract has been awarded pursuant to OAC 260:115-3-9.

(1) No portion of a bid shall be considered confidential after award of the contract except, pursuant to 74 O.S. §85.10,

information in the bid determined to be confidential by the State Purchasing Director or delegate.

(2) A properly submitted confidentiality claim of a potential awardee is reviewed and determined prior to award.

(3) A properly submitted confidentiality claim of a non-awarded bidder is reviewed and determined only when responding to an open records request concerning the bid.

(b) Among the parties to a solicitation, OHCA is the sole and final determiner of the proprietary or confidential nature of a bid in part or in whole.

(1) OHCA has no responsibility to independently review a bid, including any associated documentation or information, for a potential proprietary or confidentiality claim.

(2) OHCA will not consider a proprietary or confidentiality claim if a bid fails to comply with the requirements of this section, the solicitation, and applicable law, including OAC 260:115-3-9. Nonconforming bids will be subject to disclosure pursuant to State law.

(3) A bidder, who wishes to seek an exemption from disclosure under the Oklahoma Open Records Act or other statutory or regulatory requirements, is responsible for asserting any right of confidentiality that may exist. The OHCA will not assert a right of confidentiality on behalf of a bidder.

(c) To claim any portion of a bid as proprietary or confidential, the bidder will:

(1) Specifically identify what information is considered by the bidder to be confidential;

(2) Enumerate the specific grounds, based on applicable laws, which support treatment of the information as exempt from disclosure;

(3) Explain why disclosure is not in the best interest of the public if the information is incorporated into an awarded contract;

(4) Submit all information considered confidential under separate cover as described below; and

(5) Include, for efficient evaluation, the content considered confidential in applicable sections of the bid.

(d) Any bidder with bid information the bidder considers confidential must submit an additional electronic copy of the bid with the claimed information redacted (marked out to be illegible). The additional copy must be clearly labeled "Redacted Copy." If the bidder provides a copy of its bid with proprietary and confidential information redacted and OHCA appropriately supplies the redacted bid to another party under the Oklahoma Open Records Act or other statutory or regulatory requirements, the bidder agrees to indemnify OHCA and to defend the bidder's interest in protecting the referenced redacted material.

(e) OHCA does not consider as confidential a bid marked in total as proprietary and/or confidential (versus specific documents or portions of documents within a bid). Likewise, unless specifically referenced otherwise in a solicitation, resumes, pricing, marketing materials, business references, additional terms proposed by a bidder, and subcontractor information are not confidential and are not exempt from disclosure under the Oklahoma Open Records Act. The foregoing list is not exhaustive but is intended to address information often marked confidential that is not exempt from disclosure.
(f) Subject to the provisions of subsections (a)-(e) above, bids will be open for public inspection following contract award.

317:10-1-26. Withdrawal from solicitation
(a) At any time prior to the submission deadline of any solicitation, a bidder may withdraw a bid and remove itself from consideration by providing written notification, in the form specified in OAC 260:115-3-13, to the OHCA sole point of contact as identified in the solicitation. OHCA does not permit a bidder to withdraw a bid after the response due date and time except as authorized by the OHCA CEO after the bidder provides sufficient proof that the bidder included a significant error in the bid.
(b) Unless properly withdrawn, the submitted bid is deemed to be a binding offer on the part of the bidder.

317:10-1-27. Binding bids
OHCA considers all bids to be firm representations that the responding bidder has carefully investigated and will comply with all OHCA and State terms and conditions relating to the solicitation. A bidder whose bid is accepted for evaluation will be bound by the terms of the solicitation and the contents of the bid for the duration of the solicitation. The bidder will be bound by the terms in its solicitation response unless or until OHCA instructs the bidder to perform any function reflected in the solicitation response in a modified way to the extent it does not substantially alter the specifications or statement of work as defined in the solicitation. Bidders awarded a contract will be governed foremost by applicable law, then by the terms of the solicitation, including any associated model contract, then by any non-rule policy documents created by OHCA for the purposes of interpreting and implementing contract terms.

317:10-1-28. Contracting officer's actions
(a) The contracting officer may reject a bid for any valid reason, including but not limited to those listed at OAC 260:115-7-32(8) and the bidder's:
(1) Failure to submit required information;

(2) Failure to submit the bid by the response date and time unless OHCA has authorized acceptance of bids due to a significant error or incident that occurred which affected the receipt of a bid, per OAC 260:115-3-11;
(3) Failure to comply with bidder instructions or solicitation requirements;
(4) Failure to meet any mandatory specification of the solicitation; however, failure to meet a permissible specification of the solicitation will not be a valid reason to reject a bid;
(5) Failure to submit the bid by the strict deadline as described by date and time within the solicitation; and
(6) Attempted or actual inclusion or imposition of terms or conditions that would modify the requirements of the solicitation, require OHCA to indemnify the bidder or a third party, or limit the bidder's liability.

(b) The contracting officer may take any reasonable action with regard to a solicitation, including but not limited to:
(1) Waiving minor irregularities in any bid if determined to be in the best interest of the State. If granted, a waiver will in no way modify the requirements of the solicitation or the obligations of bidders awarded contracts;
(2) Awarding a contract based on a solicitation and the bid of any selected bidder;
(3) Awarding the contract to more than one (1) bidder;
(4) Rejecting any or all bids received, if deemed to be in the best interest of the State;
(5) Requesting clarification or correction of any bid;
(6) Amending any solicitation or any segment of any solicitation;
(7) Canceling any solicitation, if determined to be in the best interest of the State; or
(8) Discontinuing the solicitation process at any time prior to contract award.

(c) The contracting officer may question the grade and quality of any acquisition delivered to the agency.
(1) The contracting officer or delegate has sole discretion in determining whether the acquisition meets the grade and quality specified in the contract.
(2) If the acquisition fails to meet the contract-specified grade and/or quality, OHCA may take remedial action with the appropriate supplier. Refer to 74 O.S. § 85.6.

317:10-1-29. Deficiencies

In accordance with the OAC 260:115-7-32(10), OHCA has the right but is not required to waive minor deficiencies or informalities if OHCA determines the deficiencies or informalities do

not prejudice another bidder. OHCA may also permit bidders to cure certain non-substantive deficiencies if there is sufficient time prior to the award of the contract.

317:10-1-30. Submission of questions

(a) A bidder may submit written questions by email only to the OHCA sole point of contact as designated in the solicitation and using the "Questions" form, in original format, included in the Bidder's Library.

(b) OHCA will provide written answers to all technical bid and price questions received on or before the dates specified in the solicitation for questions and answers. Answers will be made publicly available in the form of one or more solicitation amendments posted to the Bidder's Library. Only posted answers will be considered official and valid. A bidder will not rely upon, take any action upon, or make any decision based upon any verbal communication with any State employee.

317:10-1-31. Bidder's conference

OHCA may hold a bidder's conference at OHCA offices or virtually on the date and time specified in the solicitation. Additional information about the bidder's conference, if any, will be provided in advance of the session.

317:10-1-32. Bid evaluation

A responsive bid that is not otherwise rejected will proceed to bid evaluation, which will be conducted in accordance with the solicitation. Within any solicitation, the bid specifications for evaluation will be provided and will be based on the subject matter of the solicitation, the type of solicitation, and the needs to be met by the supplier(s) awarded a contract from the solicitation.

(1) The bid evaluation may consist of one (1) or more evaluative activities, including but not limited to:

(A) Best price review;

(B) Best value review;

(C) Certifications;

(D) Administrative review;

(E) Technical proposal evaluation;

(F) Oral presentation evaluation; and

(G) Any other activity that could reasonably be expected to result in determining the value, nature, character, or quality of the bid.

(2) Bids responding to request for quotation will be evaluated solely on a "best price" basis.

(3) Bids responding to request for proposal will be evaluated on a "best value" basis unless the request for proposal specifies otherwise.

(4) A bidder's past performance may be considered when evaluating a bid.
(5) No evaluator acting in their role as an evaluator will make any decision regarding procurement, including but not limited to which, if any, bidder(s) will or will not be awarded the contract, whether a bid will or will not be rejected, and whether a solicitation will be continued or canceled. Evaluators, individually or collectively, may provide bid evaluation information and recommendations to the contracting official. A record of evaluators' numeric scores of bids, made by evaluators individually or collectively, will be maintained as part of the acquisition file.
(6) The contracting official will make all decisions regarding the procurement, including but not limited to which, if any, bidder(s) will or will not be awarded the contract, whether a bid will or will not be rejected, and whether a solicitation will be continued or canceled.

317:10-1-33. Contract award

(a) **Time of award.** OHCA will not award a contract at the time of a bid opening but, if at all, only upon completion of the following:
(1) Bid evaluation;
(2) Documentation of evaluation on each bid;
(3) Determination of the lowest and best or best value bidder;
(4) Verification of Oklahoma and federal debarment status;
(5) Verification, pursuant to applicable provisions of law, that the supplier is registered with the Secretary of State and maintains appropriate franchise tax payment status pursuant to 68 O.S. §§ 1203 and 1204; and
(6) Completion of any award-related administrative tasks.

(b) **Award by item.** If the procurement documents do not specify an all or none bid, more than one (1) bidder may be awarded a contract by item or groups of items.

(c) **No contract award.** OHCA may refrain from awarding a contract during any solicitation when:
(1) No bid meets the requirements of the solicitation;
(2) All bids exceed fair market value for the acquisition;
(3) The bid price exceeds available funds available to OHCA;
(4) OHCA no longer requires the acquisition in the form or manner specified; or
(5) Not awarding the contract is determined to be in the best interest of the state.

(d) **Evaluation tie.** Whenever it is determined that two (2) or more bids are equal, the contracting officer will determine the successful bid by a coin toss.

(e) **Notification of successful bidder.** OHCA will notify the successful bidder(s), if any, within a reasonable time after determination of the contract award.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY

CHAPTER 2. GRIEVANCE PROCEDURES AND PROCESS

SUBCHAPTER ONE. ADMINISTRATIVE APPEALS

317:2-1-1. Purpose

The purpose of this Chapter is to describe the different types of ~~grievances~~administrative appeals addressed by the Oklahoma Health Care Authority (OHCA), consistent with the State fair hearing requirements set out in 42 Code of Federal Regulations (C.F.R.) Part 431, Subpart E. The rules explain the step-by-step processes that must be followed by a party seeking redress from the OHCA. The majority of hearings on eligibility issues for members are conducted by the Oklahoma Department of Human Services~~,~~ and are not contained in this Chapter. Hearings will not be granted when the sole issue to be determined is a Federal or State law requiring an automatic change adversely affecting some or all members.

317:2-1-2. Appeals

(a) **Request for appeals.**

(1) For the purpose of calculating the timeframe for requesting an administrative appeal of an agency action, the date on the written notice shall not be included. The last day of the timeframe shall be included, unless it is a legal holiday as defined by Title 25 of the Oklahoma Statutes (O.S.) Section (§) 82.1, or any other day the Oklahoma Health Care Authority (OHCA) is closed or closes early, in which case, the timeframe runs until the close of the next full business day.

(2) An appeals request that an aggrieved member or provider sends via mail is deemed filed on the date that the agency receives it.

(b) **Member process overview.**

(1) The appeals process allows a member to appeal a decision relating to program benefits. Examples are decisions involving medical services, prior authorizations for medical services, or discrimination complaints.

(2) In order to initiate an appeal, the member must file a LD-1 (Member Complaint/Grievance Form) within thirty (30) calendar days of the date the OHCA sends written notice of its action, in accordance with Oklahoma Administrative Code (OAC) 317:2-1-2(a), above, or, in matters in which a formal notice is not sent by the agency, within thirty (30) days of the date on which the member knew or should have known the facts or circumstances serving as the basis for appeal.

(3) If the LD-1 form is not received timely, the administrative law judge (ALJ) will cause to be issued a letter stating the appeal will not be heard. In the case of tax warrant intercept appeals, if the LD-1 form is not received by OHCA within the timeframe pursuant to 68 O.S. § 205.2, OHCA similarly will cause to be issued a letter stating the appeal will not be heard because it is untimely.

(4) If the LD-1 form is not completely filled out or if necessary documentation is not included, then the appeal will not be heard.

(5) OHCA will advise members that if assistance is needed in reading or completing the grievance form, arrangements will be made to provide such assistance.

(6) Upon receipt of the member's appeal, a fair hearing before the ALJ will be scheduled. The member will be notified in writing of the date and time of the hearing. The member must appear at the hearing, either in person or telephonically. Requests for a telephone hearing must be received in writing on OHCA's LD-4 (Request for Telephonic Hearing) form no later than ten (10) calendar days prior to the scheduled hearing date. Telephonic hearing requests will only be granted by the OHCA's chief executive officer (CEO) or his/her designee, at his/her sole discretion, for good cause shown, including, for example, the member's physical condition, travel distances, or other limitations that either preclude an in-person appearance or would impose a substantial hardship on the member.

(7) The hearing shall be conducted according to OAC 317:2-1-5. The ALJ's decision may be appealed to the CEO of the OHCA, which is a record review at which the parties do not appear (OAC 317:2-1-13).

(8) Member appeals are ordinarily decided within ninety (90) days from the date on which the member's timely request for a fair hearing is received, unless:

(A) The appellant was granted an expedited appeal pursuant to OAC 317:2-1-2.5;

(B) The OHCA cannot reach a decision because the appellant requests a delay or fails to take a required action, as reflected in the record;

(C) There is an administrative or other emergency beyond OHCA's control, as reflected in the record; or

(D) The appellant filed a request for an appeal of a denied step therapy exception request, pursuant to OAC 317:2-1-18.

(9) Tax warrant intercept appeals will be heard directly by the ALJ. A decision is normally rendered by the ALJ within twenty (20) days of the hearing before the ALJ.

(c) **Provider process overview.**

(1) The proceedings as described in this subsection contain the hearing process for those appeals filed by providers. These appeals encompass all subject matter cases contained in OAC 317:2-1-2(d)(2).

(2) All provider appeals are initially heard by the OHCA ALJ under OAC 317:2-1-2(d)(2).

(A) In order to initiate an appeal, a provider must file the appropriate LD form within thirty (30) calendar days of the date the OHCA sends written notice of its action, in accordance with OAC 317:2-1-2(a), above. LD-2 forms should be used for Program Integrity audit appeals; LD-3 forms are to be used for all other provider appeals.

(B) Except for OHCA Program Integrity audit appeals, if the appropriate LD form is not received timely, the ALJ will cause a letter to be issued stating that the appeal will not be heard.

(C) A decision ordinarily will be issued by the ALJ within forty-five (45) days of the close of all evidence in the appeal.

(D) Unless otherwise limited by OAC 317:2-1-7 or 317:2-1-13, the ALJ's decision is appealable to OHCA's CEO.

(d) **ALJ jurisdiction.** The ALJ has jurisdiction of the following matters:

(1) **Member appeals.**

(A) Discrimination complaints regarding the SoonerCare program;

(B) Appeals which relate to the scope of services, covered services, complaints regarding service or care, enrollment, disenrollment, and reenrollment in the SoonerCare Program;

(C) Fee-for-service appeals regarding the furnishing of services, including prior authorizations;

(D) Appeals which relate to the tax warrant intercept system through the OHCA. Tax warrant intercept appeals will be heard directly by the ALJ. A decision will be rendered by the ALJ within twenty (20) days of the hearing;

(E) Proposed administrative sanction appeals pursuant to OAC 317:35-13-7. Proposed administrative sanction appeals will be heard directly by the ALJ. A decision by the ALJ will ordinarily be rendered within twenty (20) days of the hearing before the ALJ. This is the final and only appeals process for proposed administrative sanctions;

(F) Appeals which relate to eligibility determinations made by OHCA;

(G) Appeals of insureds participating in Insure Oklahoma which are authorized by OAC 317:45-9-8; ~~and~~

(H) Appeals which relate to a requested step therapy protocol exception as provided by 63 O.S. § 7310~~.~~; and

(I) Requests for State fair hearing arising from a member's appeal of a managed care adverse benefit determination.

(2) **Provider appeals.**

(A) Whether Pre-admission Screening and Resident Review (PASRR) was completed as required by law;

(B) Denial of request to disenroll member from provider's SoonerCare Choice panel;

(C) Appeals by long-term care facilities for administrative penalty determinations as a result of findings made under OAC 317:30-5-131.2(b)(5)(B) and (d)(8);

(D) Appeals of Professional Service Contract awards and other matters related to the Central Purchasing Act pursuant to Title 74 O.S. §§ 85.1 et seq.;

(E) Drug rebate appeals;

(F) Provider appeals of OHCA Program Integrity audit findings pursuant to OAC 317:2-1-7. This is the final and only appeals process for appeals of OHCA Program Integrity audit findings;

(G) Oklahoma Electronic Health Records Incentive program appeals related only to incentive payments, incentive payment amounts, provider eligibility determinations, and demonstration of adopting, implementing, upgrading, and meaningful use eligibility for incentives;

(H) Supplemental Hospital Offset Payment Program (SHOPP) annual assessment, supplemental payment, fees or penalties as specifically provided in OAC 317:2-1-15; ~~and~~

(I) Appeals from any adjustment made to a long-term care facility's cost report pursuant to OAC 317:30-5-132, including any appeal following a request for reconsideration made pursuant to OAC 317:30-5-132.1~~.~~; and

(J) Request for a State fair hearing arising from provider's appeal of managed care audit findings, for-cause or immediate termination of the provider's managed care contract, or managed care claims denial.

317:2-1-14. Contract award protest process

~~Suppliers who respond to a solicitation issued and awarded by the Authority pursuant to 74 Oklahoma Statutes (O.S.) ' 85.5 (N) may protest the award of a contract under such solicitation.~~

~~(1) A supplier shall submit written notice to the OHCA Legal Division of a protest of an award of a contract by OHCA within ten (10) business days of contract award. The protest shall state supplier facts and reasons for protest.~~

~~(2) The OHCA Legal Division shall review the supplier's protest and contract award documents. Written notice of the decision to sustain or deny the supplier's protest will be sent to the supplier within ten (10) business days of receipt of supplier's written notice.~~

~~(3) If the OHCA Legal Division denies the supplier's protest, the supplier may request a hearing to administratively resolve the matter within thirty (30) calendar days of receipt of the written denial by filing a form LD-3 with the Docket Clerk.~~

~~(4) The process afforded the supplier will be the process found at Oklahoma Administrative Code 317:2-1-2(c).~~

~~(5) The Administrative Law Judge's decision will constitute the final administrative decision of the Oklahoma Health Care Authority.~~

(a) **Protest process.** Suppliers who respond to a solicitation issued and awarded by the Authority pursuant to 74 Oklahoma Statutes (O.S.) § 85.5 (N) may protest the award of a contract under such solicitation to the State Purchasing Director. All remedies available to suppliers through the sealed bid process pursuant to the Oklahoma Central Purchasing Act are also available to online bidders in an online bidding process.

(b) **State Purchasing Director review and determination.** The State Purchasing Director will review the supplier's protest and contract award documents.

(1) The State Purchasing Director may determine to respond to the protest or delegate the responsibility to OHCA by written notice to OHCA.

(2) The State Purchasing Director or OHCA, as applicable, will send to the supplier written notice of the decision to deny or sustain the protest within ten (10) business days of receipt of the protest.

(c) **Supplier appeal of decision to deny protest.** The supplier may appeal a denial of protest by the State Purchasing Director or OHCA to the Office of Management and Enterprise Services (OMES) Director.

(1) The supplier will file such appeal, if at all, within ten (10) business days of the date of the State Purchasing Director's or OHCA's notice of denial pursuant to 75 O.S. § 309 et seq.

(2) The OMES Director may enter an order staying contract performance upon such terms and conditions as the OMES Director determines to be proper. Any request for stay of contract performance must be made in writing and filed during the ten (10) business-day time period in which an appeal may be commenced to the OMES director. The OMES Director shall have continuing jurisdiction to modify any such orders made in

connection with a stay during the pendency of the appeal as appropriate under the circumstances presented.
(3) The OMES Director may hear the appeal or assign the supplier's appeal to an administrative law judge (ALJ) retained by OHCA.
(4) Administrative hearings conducted by OMES will be conducted in accordance with the Administrative Procedures Act at 75 O.S. §§ 309 et seq., and the OMES director shall have all powers granted by law, including any powers delegated to an ALJ by this Section.
(5) Whenever the appeal is assigned to an ALJ retained by OHCA, the ALJ will review the appeal for legal authority and jurisdiction. If legal authority and jurisdictional requirements are met, the ALJ shall conduct an administrative hearing according to the hearing practices of OAC 317:2-1-5 and provide proposed findings of fact and conclusions of law to the OMES director.
(6) The OMES director or the ALJ, as applicable, will send written notice to the parties of the final order sustaining or denying the supplier's appeal.
(7) The cost of actions necessary to process a supplier's appeal, together with any other expenses incurred due to the appeal, will be paid by OHCA.
(8) Whenever the appeal is assigned to the ALJ retained by OHCA, 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 Chapter 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 to the OMES Director; and
(P) Recommend that the OMES Director deny the supplier's appeal or that the contract award be cancelled and rebid.

(d) **Supplier appeal of OMES Director decision to deny appeal.** If the OMES Director denies a supplier's appeal, the supplier may appeal pursuant to provisions of 75 O.S. §§ 309 et seq.

SUBCHAPTER 3. MEMBER GRIEVANCES AND APPEALS, PROVIDER COMPLAINTS, AND STATE FAIR HEARINGS IN MANAGED CARE

317:2-3-1. Definitions

The following words or terms used in the Subchapter shall have the following meaning, unless the context clearly indicates otherwise:

"Adverse benefit determination" means a determination by a health carrier or its designee utilization review organization 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 the service is therefore denied, reduced or terminated and in accordance with Title 36 of Oklahoma Statute (O.S.) § 6475.3.

"Appeal" means a review of an adverse benefit determination performed by a managed care entity or according to managed care law, regulations, and contracts.

"Exigent circumstances" means a situation in which a reasonable person applying the appropriate standard would consider an member's health condition to be urgent with identifiable harm that could reasonably be expected to occur if the requested health care service is not provided promptly. The appropriate standard

requires the assessment of a member's health condition through application, at minimum, of established, accepted standards of medical practice. Evidence of the member's condition may be demonstrated by indications from the treating provider or from the member's medical record, including but not limited to such information as the member's diagnosis, symptoms, or test results.

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

"**Health plan**" means any person or entity that is licensed as a health maintenance organization (HMO) by the State of Oklahoma to provide or arrange for the delivery of basic health care services to enrollees on a prepaid basis, except for copayments or deductibles for which the enrollee is responsible, or both, that meets the definition of an HMO as delineated in the Oklahoma State Medicaid Plan and that contracts with the State to provide services to enrollees. "Health plan" is synonymous with "health carrier".

"**Managed care entity**" or "**MCE**" means any entity permitted under 42 C.F.R. Part 438 to contract with a state for services provided under a risk contract or a nonrisk contract within the state's Medicaid managed care program, including but not limited to managed care organization (MCO), primary care case management (PCCM), primary care case management entity (PCCM entity), prepaid ambulatory health plan (PAHP), and prepaid inpatient health plan (PIHP).

"**Managed care organization**" or "**MCO**" means the same in these rules as defined at 42 Code of Federal Regulations (C.F.R.) § 438.2.

"**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.

"**Member**" means an individual eligible for Medicaid in the State of Oklahoma, eligible for a managed care program, and enrolled in a managed care entity. "Member" is synonymous with "health plan enrollee".

"**Prepaid ambulatory health plan**" or "**PAHP**" means the same in these rules as defined at 42 C.F.R. § 438.2.

"Prepaid inpatient health plan" or **"PIHP"** means the same in these rules as defined at 42 C.F.R. § 438.2.

"Primary care case management" or **"PCCM"** means the same in these rules as defined at 42 C.F.R. § 438.2.

"Primary care case management entity" or **"PCCM entity"** means the same in these rules as defined at 42 C.F.R. § 438.2.

"Prior Authorization (PA)" means a requirement that a member, through a provider, obtain the managed care entity'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. For purposes of these rules, "prior authorization" is included as a determination of health care services within the term "adverse benefit determination".

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

317:2-3-2. Timeframes

(a) For the purpose of calculating a timeframe in this Subchapter, the date on the written notice is not included. The last day of the timeframe is included, unless the last day is a legal holiday, as defined by 25 Oklahoma Statutes (O.S.) § 82.1, or any other day OHCA is closed or closes early, in which case, the timeframe runs until the close of the next full business day.

(b) A grievance or appeal a member sends via mail is deemed filed on the date the MCE receives request.

(c) A request for reconsideration or appeal a provider sends via mail is deemed filed on the date the MCE receives the request.

(d) A request for State fair hearing by a member or provider is deemed filed on the date the OHCA receives the request.

317:2-3-3. Grievance and appeals system

In accordance with state and federal law, including but not limited to 63 Oklahoma Statutes (O.S.) § 7310 and 42 Code of Federal Regulations (C.F.R.) §§ 438.210, 431.213-14, 438.402, 438.404, 438.408, and 438.410, each managed care entity will have an established grievance and appeals system by which to receive, process, and resolve grievances and appeals, including requests for extensions of relevant timeframes, and by which to afford parties proper notice.

317:2-3-4. Member grievances

(a) **Filing.**

(1) **Filing with managed care entity.** Except as described in this section, when the member is enrolled in a managed care

program, the member initially files a grievance with the managed care entity in which the member is enrolled.

(2) **Exception: Filing with OHCA.** When the member is enrolled in a managed care program and the grievance deals with direct interaction with OHCA or its employees or officers, the member first files the grievance with OHCA as an administrative appeal pursuant to applicable rules set forth at Oklahoma Administrative Code (OAC) 317:2-1-2 et seq.

(b) **Timing.** A member may file a grievance, orally or in writing, at any time.

(c) **Provider's and authorized representative's right to file a grievance.** A provider or an authorized representative may file a grievance on behalf of a member, provided that the provider or authorized representative has obtained the member's written consent to do so. The authorized representative of a deceased member's estate may also be a party to the litigation of a grievance, as applicable.

(d) **Clinical expertise in a grievance decision.** When a grievance involves clinical issues or is related to a denial of an expedited resolution of an appeal, the decision maker(s) of such a grievance will have clinical expertise as discussed at OAC 317:2-3-6.

(e) **Consideration of information in an appeal decision.** The decision maker(s) for any appeal will take into account all comments, documents, records, and other information submitted without regard to whether such information was submitted or considered in the initial determination.

(f) **OHCA-established timeframes for grievance decisions.** A grievance related in any way to the member's health condition will be resolved, with notice provided, as expeditiously as the member's health condition requires.

(1) Per 42 Code of Federal Regulations (C.F.R.) § 438.408, the standard resolution of a grievance will occur within ninety (90) calendar days after the managed care entity receives the grievance.

(2) OHCA sets the standard resolution of a grievance to occur within sixty (60) calendar days, inclusive of any extensions, after the managed care entity receives the grievance.

(3) The MCE may extend the timeframe in (f)(2) up to fourteen (14) days if:

(A) The member requests the extension; or

(B) The MCE shows (to the OHCA's satisfaction upon OHCA's request) that there is need for additional information and how the delay is in the member's interest.

(4) If the MCE extends the timeframes not at the request of the member, it must complete all of the following:

(A) Make reasonable efforts to give the member prompt oral notice of the delay; and

(B) Within two (2) calendar days give the member written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision; and

(5) The MCE will adhere to all OHCA rules related to grievances, including but not limited to:

(A) Observing the timeframe for standard resolution of a grievance;

(B) Sending acknowledgement of receiving the grievance in writing to the member or the member's authorized representative within ten (10) calendar days of receipt; and

(C) Sending written notice conforming with this subchapter to the affected parties within three (3) calendar days following resolution of the grievance.

317:2-3-5. Member appeals

(a) **Filing.**

(1) **Filing with managed care entity.** Except as described in this Section, when the member is enrolled in a managed care program, the member initially files an appeal with the managed care entity in which the member is enrolled.

(2) **Exception: Filing with OHCA.** When the member is enrolled in a managed care program, the member initially files administrative appeals with OHCA and follows the appeals rules set forth at Oklahoma Administrative Code (OAC) 317:2-1-2 et seq. whenever the appeal concerns a decision the Oklahoma Health Care Authority (OHCA) made regarding:

(A) Eligibility for Oklahoma Medicaid;

(B) Eligibility for a managed care program;

(C) Enrollment into Oklahoma Medicaid;

(D) Enrollment, including use of an auto-assignment algorithm, into a managed care entity;

(E) Disenrollment from a managed care entity; or

(F) Any other matter, so long as OHCA made the decision in the matter.

(b) **Timing.** A member may file an appeal, orally or in writing, at any time. An administrative appeal or State fair hearing request made to OHCA shall conform with the requirements of OAC 317:2-1-2 et seq. in terms of the manner and timing of any such filing.

(c) **Levels of appeals.** The managed care entity will use only one level of appeals, in accordance with 42 Code of Federal Regulations (C.F.R.) § 438.402.

(d) **Provider's and authorized representative's right to file an appeal.** A provider or an authorized representative may file an

appeal on behalf of a member, provided that the provider or authorized representative has obtained the member's written consent to do so. The authorized representative of a deceased member's estate may also be a party to the litigation of an appeal, as applicable.

(e) **Clinical expertise in an appeal decision.** When an appeal involves clinical issues or is related to a denial based on lack of medical necessity, the decision maker(s) of such an appeal will have clinical expertise as discussed at OAC 317:2-3-6.

(f) **Consideration of information in an appeal decision.** The decision maker(s) for any appeal will take into account all comments, documents, records, and other information submitted without regard to whether such information was submitted or considered in the initial determination.

(g) **OHCA-established timeframes for appeals decisions.** An appeal related in any way to the member's health condition will be resolved, with notice provided, as expeditiously as the member's health condition requires.

(1) Per 42 C.F.R. § 438.408, the standard resolution of an appeal will occur within thirty (30) calendar days after the managed care entity receives the appeal.

(2) OHCA establishes the following timeframes for appeals:

(A) Standard resolution of an appeal will occur within thirty (30) calendar days, excluding any extensions, after the managed care entity receives the appeal;

(B) Expedited resolution of an appeal will occur within seventy-two (72) clock-hours after the MCE receives the appeal;

(C) In exigent circumstances, resolution of a step therapy request appeal will occur within twenty-four (24) clock-hours after the MCE receives the appeal; and

(D) In all other circumstances, resolution of a step therapy request appeal will occur within seventy-two (72) clock-hours after the MCE receives the appeal.

(3) The MCE may extend the timeframes in (g)(2)(A) or (B) up to fourteen (14) days if:

(A) The member requests the extension; or

(B) The MCE shows (to the OHCA's satisfaction upon OHCA's request) that there is need for additional information and how the delay is in the member's interest.

(4) If the MCE extends the timeframes not at the request of the member, it must complete all of the following:

(A) Make reasonable efforts to give the member prompt oral notice of the delay;

(B) Within two (2) calendar days give the member written notice of the reason for the decision to extend the timeframe

and inform the enrollee of the right to file a grievance if he or she disagrees with that decision; and

(C) Resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires.

(5) The MCE will adhere to all OHCA policies related to appeals, including but not limited to:

(A) Observing the timeframes for resolving appeals, including standard resolution, expedited resolution, and resolution of step therapy appeals (in both exigent and other circumstances);

(B) Sending acknowledgement of receiving the appeal in writing to the member or the member's authorized representative within five (5) calendar days of receipt;

(C) Sending written notice conforming with this subchapter to the affected parties within three (3) calendar days following resolution of the appeal; and

(D) Sending documentation, in conformance with OAC 317:2-3-12(d) and any established OHCA forms or processes, to OHCA within fifteen (15) calendar days after a request for State fair hearing.

317:2-3-6. External medical review and clinical expertise

(a) **No external medical review.** The Oklahoma Health Care Authority (OHCA) will not offer an external medical review for the purposes of grievances or appeals.

(b) **Clinical expertise standards.** Individuals making the decision for a grievance or appeal regarding an adverse benefit determination will be unbiased with appropriate clinical expertise in treating the member's condition or disease.

(1) Medical review staff of the MCE will be licensed or credentialed health care clinicians with relevant clinical training and/or experience.

(2) All MCEs will use medical review staff for such appeals and shall not use any automated claim review software or other automated functionality for such appeals.

(3) Bias is deemed to exist if an individual making a decision on a grievance or appeal was involved in, or a subordinate of any individual involved in, any previous level of review or decision regarding the subject matter of the grievance or appeal.

(4) Clinical expertise is deemed necessary for decisions makers whenever:

(A) The denial is based on a lack of medical necessity;

(B) The grievance is regarding a denial of an expedited resolution an appeal; and

(C) The grievance or appeal involves clinical issues.

317:2-3-7. Obligation to pay costs of services

(a) In accordance with 42 Code of Federal Regulations (C.F.R.) § 438.420(d), the MCE may recover from the member the costs of services provided to the member while an appeal or State fair hearing is pending:

(1) To the extent the services were continued solely due to the requirements set forth in 42 C.F.R. §§ 438.420 or 431.230(b); and

(2) The final resolution of the appeal or State fair hearing upholds the MCE's adverse benefit determination.

(b) If OHCA or the MCE reverses a decision to deny, limit, or delay services and these services were not furnished while the appeal or State fair hearing was pending, the MCE will authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires.

(c) If OHCA or the MCE reverses a decision to deny, limit, or delay services and the member received the disputed services while the appeal or State fair hearing was pending, the MCE will pay for these services.

317:2-3-8. Grievances and appeals notice

(a) The MCE will provide timely written notices per OAC 317:2-3-4 and 317:2-3-5.

(b) Each notice will conform to the provisions of 42 Code of Federal Regulations (C.F.R.) § 438.10 related to information provided from an MCE to a member.

(c) At minimum, each notice will:

(1) Be written in a manner and format that may be easily understood and is readily accessible by members;

(2) Use OHCA-developed definitions for terms as those terms are defined in the Model Member Handbook related to the contract;

(3) Use a font size no smaller than twelve-point (12-point);

(4) Be made available in alternative formats and through the provision of auxiliary aids and services in an appropriate manner that takes into consideration the special needs of members with disabilities or limited English proficiency; and

(5) Include a large-print tagline, in minimum eighteen-point (18-point) font, and information on how to request auxiliary aids and services, including the provision of materials in alternative formats.

(d) Per the delegation choice of 42 C.F.R. § 438.228, OHCA does not delegate responsibility to the MCE for timely notices of action under 42 C.F.R. Part 431, Subpart E.

(1) OHCA retains all responsibility for timely notices of action under 42 C.F.R. Part 431, Subpart E, including:

(A) A termination, suspension of, or reduction in covered benefits or services, when termination, suspension, or reduction is determined by OHCA;

(B) A termination, suspension of, or reduction in Medicaid eligibility, when termination, suspension, or reduction is determined by OHCA; and

(C) An increase in beneficiary liability, including determination that a beneficiary will incur a greater amount of medical expenses in order to establish income eligibility or is subject to an increase in premiums or cost sharing charges, when such increase is determined by OHCA.

(2) The foregoing (d)(1) does not apply to:

(A) Any grievance notice required to be sent by the MCE by contract or 42 C.F.R. § 438.408;

(B) Any adverse benefit determination notice based on the termination, suspension, or reduction of authorized covered services, payment denial, or standard, expedited, or untimely service authorization denial or limitation as required to be sent by the MCE by contract or 42 C.F.R. 438.404;

(C) Any appeal resolution notice required to be sent by the MCE by contract or 42 C.F.R. § 438.404 or 438.408; or

(D) Any other notice required to be sent by the MCE by contract or any state or federal law or regulation.

(3) OHCA's decision not to delegate the notices of action required by 42 C.F.R. Part 431 Subpart E applies to any managed care entity under any managed care contract for professional services unless and until this section is revoked.

(4) The random review system required of a state by 42 C.F.R. § 438.228 does not apply to OHCA, because OHCA has not delegated responsibility for the relevant notices of action.

(5) For any notices of action for which OHCA retains responsibility under this section, OHCA will ensure the notice conforms to federal regulations at 42 C.F.R. Part 431, Subpart E, and any applicable requirements under 42 C.F.R. § 438.228. OHCA will send such notices of action by electronic or postal means at least ten (10) days before the date of action, except as permitted when:

(A) OHCA has factual information confirming the death of a beneficiary;

(B) OHCA receives a clear written statement signed by a member that they no longer wish to receive services or that gives information that requires termination or reduction of services and indicates that the member understands that

supplying the information will result in termination or reduction of services;

(C) The member has been admitted to an institution where they are ineligible for further services;

(D) The member's whereabouts are unknown and the post office returns, indicating no forwarding address, OHCA mail sent directly to the member; and

(E) The MCE establishes the fact that the member has been accepted for Medicaid services by another local jurisdiction, state, territory, or commonwealth.

(6) For any notices of action for which OHCA retains responsibility under this Section, OHCA will ensure the notice contains:

(A) A statement of the action OHCA intends to take and the effective date of such action;

(B) A clear statement of the specific reasons supporting the intended action, the specific regulations that support or require the action, and an explanation of the member's rights to request a hearing; and

(C) An explanation of the circumstances under which benefits continue if a hearing is requested.

(7) For any notices of action for which OHCA retains responsibility under this section, OHCA will allow the member a reasonable time, not to exceed ninety (90) days from the date the notice is mailed, to request a State fair hearing.

317:2-3-9. Exhaustion of managed care entity appeals

(a) **Deemed exhaustion of MCE appeals.** If the MCE fails to adhere to any timing or notice requirements as detailed in 42 C.F.R. § 438.408, the member is deemed to have exhausted the MCE's appeal process, and the member or the member's authorized representative may request a State fair hearing.

(b) **Actual exhaustion of MCE appeals.** Except as allowed in (a), a member or the member's authorized representative may request a State fair hearing only after receiving notice from the MCE upholding an adverse benefit determination and only within one hundred twenty (120) days after the date of the notice of appeal resolution.

(c) **Exhaustion of MCE appeals, determination.** OHCA has sole authority to decide whether MCE appeals have been exhausted for any member. Documentation, as submitted to OHCA by the MCE within fifteen (15) calendar days of the request for State fair hearing, will serve as evidence to deemed exhaustion, actual exhaustion, or no exhaustion of the MCE appeals process.

317:2-3-10. Provider complaint system

(a) A participating provider or nonparticipating provider may file a complaint whenever:

(1) The provider is not satisfied with the MCE's policies and procedures; or

(2) The provider is not satisfied with a decision made by the MCE that does not impact the provision of services to members.

(b) The MCE will establish and operate a provider complaint system. Such system will:

(1) Use written policies and procedures for receiving, tracking, dating, storing, responding to, reviewing, reporting, and resolving provider complaints;

(2) Track receipt and resolution of provider complaints, including requests for reconsideration or appeals;

(3) Demonstrate sufficient ability to receive provider complaints by telephone, in writing, or in person;

(4) Designate staff to receive, process, and resolve provider complaints;

(5) Thoroughly investigate each provider complaint;

(6) Ensure an escalation process for provider complaints;

(7) Furnish the provider timely written notification of resolution or results; and

(8) Maintain a tracking system capable of generating reports to OHCA on provider complaint volume and resolution.

(c) The MCE will operate a reconsideration process whereby providers may request the MCE reconsider a decision the MCE has made or intends to make that is adverse to the provider, including, at minimum, reconsiderations of provider audit findings, reconsiderations of provider agreement termination, and reconsiderations of denied claims.

(1) **Request for reconsideration, denied claims.** The MCE will ask that the provider submits a request for reconsideration of a denied claim within six (6) months after the provider receives notice of the denied claim.

(2) **Request for reconsideration, all other reasons.** The MCE will ask that the provider submits a request for reconsideration within fifteen (15) days after the date the provider receives notice of audit findings, termination of provider agreement, or other actions the MCE permits for reconsideration requests.

(3) **Desk review.** The MCE will conduct the reconsideration through a desk review of the request and all related and available documents.

(4) **Reconsideration resolution.** The MCE will resolve all requests for reconsideration within twenty (20) calendar days of the date the MCE receives the request for reconsideration. The MCE will send a reconsideration resolution notice to the

provider within three (3) business days of the MCE finalizing the resolution.

(5) **Notice of Reconsideration Resolution.** The MCE will send a reconsideration resolution notice that contains, at a minimum:

(A) The date of the notice;

(B) The action the MCE has made or intends to make;

(C) The reasons for the action;

(D) The date the action was made or will be made;

(E) The citation to statute, regulation, policy, or procedure, if any, upon which the action was based;

(F) An explanation of the provider's ability to submit an appeal request to the MCE within thirty (30) calendar days of the date recorded on the notice;

(G) The address and contact information for submitting an appeal;

(H) The procedures by which the provider may request an appeal regarding the MCE's action;

(I) The specific change in federal or state law, if any, that requires the action;

(J) The provider's ability to submit a State fair hearing request following completion of the provider appeal process, or, in cases of an action based on a change in law, the circumstances under which a State fair hearing will be granted; and

(K) Any other information required by state or federal statute or regulation, by contract, or by contract-related manual.

(d) The MCE will operate an appeals process whereby a provider may request an appeal of a reconsideration resolution when the underlying matter is based on the MCE's provider audit findings, for-cause or immediate termination of the provider agreement, or a denied claim.

(1) **Request for appeal.** The MCE will require the provider to submit a request for appeal in writing within thirty (30) calendar days after the provider receives notice reconsideration resolution.

(2) **Panel review.** The MCE will conduct the appeal through a panel review including a hearing and review of the request, all related and available documents, and all documents created for or used in connection with the request for reconsideration.

(A) The panel will consist of three (3) or five (5) reviewers, who are employees or officers of the MCE.

(B) Panel members will not have been directly involved with the reconsideration desk review and will not be a subordinate of someone involved directly with the reconsideration desk review.

(C) The panel review hearing will provide the provider or an authorized representative of the provider with a reasonable opportunity to be heard in person or by telecommunications.
(D) The review panel will accept and document any exhibit offered prior to the hearing or during the hearing, so long as the exhibit directly relates to the matter of the appeal.
(E) When the appeal is based on a claim denied on the basis of medical necessity, the following requirements apply:
(i) Medical review staff of the MCE will be licensed or credentialed health care clinicians with relevant clinical training or experience; and
(ii) All MCEs will use medical review staff for such appeals and will not use any automated claim review software or other automated functionality for such appeals.

(3) **Appeal resolution.** The MCE will resolve all appeals within forty-five (45) calendar days of the date the MCE receives the request for appeal. The MCE will send an appeal resolution notice to the provider within three (3) business days of the MCE finalizing the resolution.

(4) **Notice of Appeal Resolution.** The MCE will send an appeal resolution notice that contains, at a minimum:
(A) The date of the notice;
(B) The date of the appeal resolution; and
(C) For decisions not wholly in the provider's favor:
(i) An explanation of the provider's ability to request a State fair hearing within thirty (30) calendar days of the date recorded on the notice;
(ii) How to request a State fair hearing, including the OHCA address and contact information for submitting a request;
(iii) Details on the right to be represented by counsel at the State fair hearing; and
(iv) Any other information required by state or federal statute or regulation, by contract, or by contract-related manual.

(5) **Documentation.** The MCE will furnish to OHCA documentation including all information specified at OAC 317:2-3-13(c)(2) within fifteen (15) calendar days of a provider's request for a State fair hearing.

317:2-3-11. Recordkeeping

In compliance with 42 C.F.R. § 438.3(h) and (u), the MCE will maintain records of each grievances and appeal for ten (10) years after the later of the final date of the contract period or the date of completion of any MCE audit by the State, the Centers for

Medicare and Medicaid Services (CMS), the Office of the Inspector General, or the Comptroller General. Such records will be part of OHCA's ongoing monitoring and will be used to update and revise OHCA's managed care quality strategy. The record will conform with the content requirements at 42 C.F.R. § 438.416.

317:2-3-12. State fair hearing for members

(a) **Right to State fair hearing.** With regard to grievances or appeals first filed with the MCE, a member may request a State fair hearing under 42 C.F.R. 431 Subpart E only after receiving notice from the MCE upholding an adverse benefit determination. The member will have one-hundred twenty (120) days from the date of the adverse benefit determination notice to request a State fair hearing. Refer to 42 C.F.R. §§ 438.402(c)(1)(i) and 438.408(f)(1).

(b) **MCE policies and procedures.** The MCE will implement established policies and procedures that allow a member described in (a) to initiate a State fair hearing process after having exhausted the MCE's appeals process or after the member is deemed to have exhausted the process due to the MCE's failure to adhere to notice and timing requirements.

(c) **Member's request for a State fair hearing.** The MCE will allow the member to request a State fair hearing either through an established MCE process or through an established OHCA process. Any MCE process will ensure that notice of the request for State fair hearing is communicated in writing to the OHCA contracting officer within twenty-four (24) clock-hours of receiving the request.

(d) **MCE documentation obligation.** The MCE will provide documentation to the member, the member's authorized representative, OHCA, and the Office of Administrative Hearings.

(1) **Timing.** The MCE will provide the documentation described in this subsection:

(A) Within twenty-four (24) clock-hours after receiving notification of the request for State fair hearing relating to a step therapy request; or

(B) Within fifteen (15) calendar days after notification of the request for State fair hearing in all other circumstances.

(2) **Information.** Documentation will include, at minimum, the following information:

(A) The name and address of the member and, if applicable, the member's authorized representative;

(B) A summary statement concerning why the member has filed a request for State fair hearing;

(C) A brief chronological summary of the MCE's action in relationship to the matter underlying the member's request for State fair hearing;
(D) The member's appeal request, along with any supporting documentation, if received by the MCE;
(E) Any applicable correspondence between the MCE and the member, including system notes entered by one or more MCE employees based on one or more telephone conversations with the member;
(F) All exhibits offered at any hearing held with the MCE;
(G) All documents the MCE used to reach its decision;
(H) A statement of the legal basis for the MCE's decision;
(I) A citation of the applicable policies and/or legal authorities relied upon by the MCE in making its decision;
(J) A copy of the notice which notified the member of the decision in question;
(K) The names and titles of any MCE employees who will serve as witnesses at the State fair hearing; and
(L) Any other information requested by the member, the member's authorized representative, OHCA, or the Office of Administrative Hearings when the information relates to the State fair hearing or any matter giving rise to the State fair hearing.

(e) **MCE staffing.** The MCE will maintain a sufficient level of staffing to competently perform the functions, requirements, roles, and duties involved in State fair hearing support, including but not limited to documentation, summarization of the arguments presented, and ensuring timely notice and delivery of documents to all parties.

(f) **Performance targets.** OHCA may set performance targets related to State fair hearing requests that are resolved upholding the MCE's original determination when and as OHCA deems necessary or appropriate.

(g) **Post-transition obligations.** After termination or expiration of the managed care contract, the MCE will remain responsible for State fair hearings related to dates of service prior to the contract termination or expiration, including but not limited to the provision of records and representation at State fair hearings.

(h) **Cost of services.** If the State fair hearing officer reverses the MCE's decision to deny authorization of services and the member received the disputed services while the State fair hearing was pending, the MCE will pay for those disputed services.

317:2-3-13. State fair hearing for providers

(a) **Right to State fair hearing.** With regard to provider audit findings, for-cause and immediate termination of the provider's

agreement, and claims denial, a provider may request a State fair hearing within thirty (30) calendar days of the MCE's notice of appeal resolution when that resolution does not favor the provider.

(b) **Information for providers.** As a part of the MCE's provider complaint system, the MCE will provide information to providers on how to request a State fair hearing via filing the appropriate form with the OHCA Docket Clerk.

(c) **MCE documentation obligation.** The MCE will provide documentation to the provider, OHCA, and the Office of Administrative Hearings.

(1) **Timing.** The MCE will provide the documentation described in this subsection within fifteen (15) calendar days after notification of the request for State fair hearing.

(2) **Information.** Documentation will include, at minimum, the following information:

(A) The name and address of the provider;

(B) A summary statement concerning why the provider has filed a request for State fair hearing;

(C) A brief chronological summary of the MCE's action in relationship to the matter underlying the provider's request for State fair hearing;

(D) The provider's appeal request, along with any supporting documentation, if received by the MCE;

(E) Any applicable correspondence between the MCE and the provider, including system notes entered by one or more MCE employees based on one or more telephone conversations with the provider;

(F) All exhibits offered at any hearing held with the MCE;

(G) All documents the MCE used to reach its decision;

(H) A statement of the legal basis for the MCE's decision;

(I) A citation of the applicable policies and/or legal authorities relied upon by the MCE in making its decision;

(J) A copy of the notice which notified the provider of the decision in question;

(K) The names and titles of any MCE employees who will serve as witnesses at the State fair hearing; and

(L) Any other information requested by the provider, OHCA, or the Office of Administrative Hearings when the information relates to the State fair hearing or any matter giving rise to the State fair hearing.

317:2-3-14. Administrative Law Judge (ALJ) jurisdiction

The ALJ has jurisdiction of the following matters:

(1) **Member State fair hearing.** The ALJ has jurisdiction to hear any State fair hearing arising from a member's MCE appeal of an adverse benefit determination.

(2) **Provider State fair hearing.** The ALJ has jurisdiction to hear any State fair hearing arising from a provider's appeal of audit findings, for-cause or immediate termination of the provider's contract with the MCE, or claims denial.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 25. SOONERCARE CHOICE

SUBCHAPTER 7. SOONERCARE

PART 3. ENROLLMENT CRITERIA

317:25-7-12. Enrollment/eligibility requirements

(a) Eligible SoonerCare members mandatorily enrolled in SoonerCare Choice include persons categorically related to AFDC~~, Pregnancy-related services and Aged, Blind or Disabled~~;pregnancy-related services; expansion adult; and aged, blind or disabled who are not dually-eligible for SoonerCare and Medicare.

(b) Children in foster care may voluntarily enroll into SoonerCare Choice.

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.