SOONERSELECT DELIVERY REFORM FREQUENTLY ASKED QUESTIONS

Version 1.0 | Updated Nov. 2, 2022

The Oklahoma Health Care Authority will transition to a new health care program called SoonerSelect, following Gov. J. Kevin Stitt's signing of two delivery reform bills.

SoonerSelect will allow OHCA to better incentivize health outcomes while maintaining oversight and authority over Oklahoma's Medicaid program and the program funding. The agency is committed to improving the health and lives of its members and all Oklahomans and will hold its SoonerSelect partners to high standards through strong accountability measures.

1. **How is this different from the proposed changes of last year?**

   A primary difference is the Oklahoma Health Care Authority's (OHCA) ability to contract with provider-led entities, with evaluation criteria preferring provider-led entities.

   Also, certain directed payments, or payments OHCA directs the contracted entity to make to providers, have been required by statute.

   Additionally, the quality committee is an extra layer of input for the quality strategy and to drive quality outcomes, and value-based purchasing is now statutorily required.

2. **What are contracted entities (CEs)?**

   CEs include provider-led entities, accountable care organizations, managed care organizations, and similar entities that can meet contract requirements.

   CEs will be responsible for providing care management and population health services. They will be expected to provide person-centered and holistic care that identifies and addresses their enrollees' physical health, behavioral health, and community and social support needs.

3. **Are there still plans for urban-only provider-led entities?**

   An urban region provider-led entity may be selected if it meets all contract requirements and is considered able and willing to expand statewide during a five-year runway.

4. **When are proposals due and the contracts awarded?**

   Proposals will be due within 60 days of the release of the Dental RFP and 90 days after the release of the Medical and Specialty Plan RFPs. Contracts are anticipated to be awarded in early 2023.

5. **How will the CEs be selected?**

   There will be an evaluation process each bidder will undergo. The evaluation process will be described within the request for proposal. It will facilitate the assessment of each bidder's ability to fulfill the contract's requirements. Proposals will be due within 60 days of the release of the Dental RFP and 90 days of the release of the Medical and Children's Specialty Plan RFPs.

6. **Will the physician practice management dollar amount be known to the public for each CE?**

   OHCA will post the capitation rates on the procurement webpage when they are available. Dental capitation rates were posted on the website on Nov. 29, 2022.

7. **What are value-based payments?**

   Value-based payment refers to any payment based on factors other than volume — outcomes instead of how many services are provided.

Accountability

8. **How will CEs be held accountable?**

   The contract requires robust program integrity efforts by CEs. Additionally, OHCA will monitor and oversee all elements of CE performance, including program integrity. As required by federal regulation, an external quality review will be conducted by a third-party entity.

   Both federal and state laws and regulations, as well as the contract, requires OHCA to monitor all aspects of performance to ensure safety and soundness for the member. Additionally, each contract rate period will be one year in length, which means a financial actuary will certify rates annually to set rates for OHCA to pay an appropriate amount in capitation.

9. **Will the CEs be responsible for providing care management?**

   Yes. CEs will be responsible for providing care management and population health services. CEs will be expected to provide person-centered and holistic care that identifies and addresses its enrollees' physical health, behavioral health, and community and social support needs.

   To help ensure models of care are developed to meet the needs of Oklahoma's Medicaid members. Senate Bill 1337 requires each contracted entity to contract with at least one local Oklahoma provider organization. A local Oklahoma provider organization can be any state

provider association, accountable care organization, CCBHC, FQHC, Native American tribe or tribal association, hospital or health system, academic medical institution, currently practicing licensed provider or other local Oklahoma provider organization.

10. Is it true that providers will get more money based on the patient's health? If so, what prevents specialists from not diagnosing patients so their patients will look healthier?

Quality initiatives are intended to improve participants' health in the aggregate (surpass national/regional health statistics, for example). Additionally, it would be unethical for specialists/providers to misdiagnose patients.

The contracts require extensive program integrity efforts by each contracted entity. In addition, oversight and monitoring functions performed by OHCA will validate the contracted entity's program integrity efforts.

11. Are there going to be safeguards in place to ensure parity for mental/behavioral health?

Yes. Parity is a required element of the contract and is by federal regulation. OHCA will require each contracted entity to conduct a parity analysis, which will then be subject to validation.

12. What incentives do the CEs have to not immediately reduce payments to physicians, etc., in 2026?

CEs must maintain and show a robust provider network to continue being a CE in Medicaid programs. Sufficient reimbursement encourages providers to become part of a CE's network.

13. How often will CEs report their medical loss ratio (MLR) or profit margin?

Contractors must submit an MLR report for each MLR reporting year. These reports will be due within 12 months of the end of the MRL reporting year.

14. How will OHCA limit the percentage of prepayment and post-payment claim audits for CEs? What is the percentage threshold that will be monitored?

Senate Bill 1337 requires OHCA to establish a limit on the percentage of claims concerning which post-payment audits may be conducted by a CE. That limit has not been set yet.

15. How will OHCA define the claim denial types that will count toward the monitored claim denial error rate?

OHCA will define the claim denial types monitored within the RFP or operational manuals to be used by the CEs. The Senate bill indicates penalties against entities whose claims denial error rate exceeds 5%.

The Provider Experience

16. **Last time the various credentialing became very cumbersome, and I want to know if you can help streamline this process.**

    CEs must align and utilize the same credential verification organization (CVO) as part of its Provider credentialing and re-credentialing process.

17. **As a provider, will we have three separate billing networks, or will all three contract winners use an umbrella system overseen by OHCA?**

    We will require all contracted entities to use a single-point portal.

18. **Will the online billing process continue to include real-time adjudication?**

    Timely filing requirements will continue to apply. The RFP will contain requirements that up to 90% of clean claims are paid within 14 days of receipt, and up to 99% of clean claims are paid within 90 days of receipt.

19. **Will the CEs be required to contract with any willing provider?**

    Under federal regulation, OHCA is prohibited from requiring a CE to execute any provider agreements beyond the number necessary to meet the needs of enrolled members. A CE is also prohibited from excluding any essential community providers, as identified in Senate Bill 1337.

20. **Will these CEs be reaching out to us to get enrolled?**

    Prospective CEs will likely reach out to providers to begin building their proposed provider networks through letters of intent. Once contracts are awarded, providers can contact the CE directly to inquire about enrollment and credentialing.

21. **Will CEs be required to have provider letters of intent in place to submit with their RFP responses?**

    Letters of intent are not required to be submitted with RFP responses. However, through the response process, CEs must demonstrate how they plan to meet network adequacy requirements.

22. **How will OHCA transition prior authorizations to the CEs?**

    CEs will be required to ensure all PAs for covered benefits are in place on the day before the member's enrollment with the CE and remain in place for 90 days following their enrollment. This requirement applies during both initial program implementation and steady-state operations. OHCA will work with the CEs to provide a list of currently approved PAs to facilitate this transition.

23. **Will pharmacy benefit managers manage pharmacy benefits? If so, how can we ensure that patients' out-of-pocket costs will be managed?**

    CEs may subcontract with pharmacy benefit managers. The RFP will require independent payment audits and for the pharmacy benefits manager's or pharmacy benefits administrator's performance to be monitored.

24. **Will the CEs accept Oklahoma Department of Mental Health and Substance Abuses Services providers?**

    Yes.

25. **Speech Pathology Assistants can currently be credentialed providers with Medicaid but cannot be credentialed with most private insurance companies. Will they be permitted to be credentialed providers after this occurs?**

    Yes. CEs must include all OHCA rendering provider types within their provider network.

26. **Will there continue to be a difference in pay between private licensed behavioral health providers and agencies?**

    The reimbursement methodologies currently allowed under the State Plan will be the methodologies utilized by the awarded contracted entities until July 1, 2026.

27. **Will independent behavioral health providers still need to contract with agencies accredited to serve SoonerSelect clients? Or would these individual providers be able to bill for SoonerSelect clients as a private practice?**

    Not all licensed behavioral health professionals are contracted with an agency today. Independent LBHPs can contract on their own (as independent providers). This ability will continue under SoonerSelect.

28. **How do pediatric therapy services (i.e., OT/PT/ST) fit into value-based care? Can you give any specifics or examples?**

    CEs can elect to enter value-based payment arrangements. The RFP will require respondents to propose their value-based payment strategy. Therefore, providing a targeted response for OT/PT/ST is difficult.

29. **How will the RFP dictate the process for member identification?**

    OHCA will continue to be the single-state Medicaid agency. The agency will continue to oversee Oklahomans' enrollment into Medicaid.

30. Will primary care physicians still have the same patient panels? What will OHCA do to help current patient panel members enroll with their existing provider?

If the member does not choose a health plan, OHCA will assign that member to a health plan. OHCA will use the existing provider relationship as a factor.

During the first 90 days, members may switch plans and could switch to a plan based on where the PCP is in-network. Members will also receive choice counseling during the open enrollment period, and counselors will have access to network membership to inform the member.

31. Will CEs be able to require a minimum panel size threshold for PCPs?

Each CE will be required to align members with a primary care provider; however, each entity's medical home program may vary. It is possible that a contracted entity could require a minimum panel size threshold for a PCP.

The Member Experience

32. What information will members have when choosing a contracted entity?

OHCA will provide enrollment counseling to members. Staff will speak with members to help them determine which CE will meet their needs based on prior provider relationships and similar factors. Additionally, the website and other written communications, including member notice letters, will be available. Marketing by the CEs is not allowed, so all information will be vetted by OHCA.

OHCA expects to operate the call center with extended hours during the enrollment period. Open enrollment will be provided annually.

Outside of the implementation time, newly eligible members for SoonerSelect will receive counseling. We'll look at how extended hours may be approached during steady-state operations of SoonerSelect for the benefit of new members.

33. Will members who do not make an active selection be assigned to a CE that includes their current providers?

The health care enrollee will be allowed to choose their provider to the extent possible and appropriate at SoonerCare application. Efforts will be made to align individuals with providers with whom they have had a relationship. Individuals will have up to 90 days from enrollment to change to a different CE.

34. How often can patients change their plan?

Within the first 90 days after initial enrollment into a plan with a CE, the member can change plans without cause. The member can change plans at any time with cause — cause is defined

by federal regulation. The member can also change plans once every 12 months without showing cause.

Cause is listed in federal regulation (42 CFR 438.56(d)(2)) and includes:

1) Member moves out of service area.
2) Plan has moral or religious objections to the member's needed treatment.
3) The member needs related services to be performed at the same time, and they are not all available through the provider network.
4) Other reasons such as poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with the member's care needs.

35. Will all the same services be covered that are currently covered?

Yes, all services covered today will still be covered and will not be reduced.

36. How will this affect ADvantage members? Will their services remain the same?

Individuals served by 1915(c) Home and Community Based waivers are excluded populations for enrollment in SoonerSelect. Services within 1915(c) waivers will not be affected.

Version 1.0 | Updated 11/2/2022