STATE OF OKLAHOMA

1st Session of the 60th Legislature (2025)

COMMITTEE SUBSTITUTE
FOR ENGROSSED
HOUSE BILL 1810 By: Newton of the House

and

Gillespie of the Senate

COMMITTEE SUBSTITUTE

An Act relating to the state Medicaid program; amending 56 O.S. 2021, Section 4002.2, as last amended by Section 1, Chapter 448, O.S.L. 2024 (56 O.S. Supp. 2024, Section 4002.2), which relates to definitions used in the Ensuring Access to Medicaid Act; modifying and adding definitions; amending 56 O.S. 2021, Section 4002.6, as last amended by Section 5, Chapter 448, O.S.L. 2024 (56 O.S. Supp. 2024, Section 4002.6), which relates to prior authorizations; modifying and removing certain requirements of contracted entities; clarifying applicability of certain provisions; providing certain notice and publication requirements; specifying qualifications for review of adverse determinations; requiring implementation of certain application programming interface; stipulating certain time periods for prior authorization determinations; deeming requested services authorized under certain conditions; defining term; prohibiting prior authorization and stipulating certain procedures for emergency services; requiring and prohibiting certain acts related to duration of prior authorizations; requiring certain opportunity for communication; directing certain reimbursement except under specified conditions; amending 56 O.S. 2021, Section 4002.8, as amended by Section 12, Chapter 395, O.S.L. 2022 (56 O.S. Supp. 2024, Section 4002.8), which relates to appeals of adverse determinations; modifying qualifications for review

of appeals; updating statutory language; repealing 56 O.S. 2021, Section 4002.2, as last amended by Section 1, Chapter 206, O.S.L. 2024 (56 O.S. Supp. 2024, Section 4002.2), which relates to definitions; providing an effective date; and declaring an emergency.

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

SECTION 1. AMENDATORY 56 O.S. 2021, Section 4002.2, as last amended by Section 1, Chapter 448, O.S.L. 2024 (56 O.S. Supp. 2024, Section 4002.2), is amended to read as follows:

Section 4002.2. As used in the Ensuring Access to Medicaid Act:

1. "Adverse determination" ~~has the same meaning as provided by Section 6475.3 of Title 36 of the Oklahoma Statutes~~ means a determination by a contracted entity or its designee utilization review entity that an admission, availability of care, continued stay, or other health care service that is a covered Medicaid benefit has been reviewed and, based upon the information provided, does not meet the contracted entity's or the Oklahoma Health Care Authority'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;

2. "Accountable care organization" means a network of physicians, hospitals, and other health care providers that provides coordinated care to Medicaid members;

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

4. "Capitated contract" means a contract between the Oklahoma Health Care Authority and a contracted entity for delivery of services to Medicaid members in which the Authority pays a fixed, per-member-per-month rate based on actuarial calculations;

5. "Children's Specialty Plan" means a health care plan that covers all Medicaid services other than dental services and is designed to provide care to:

a. children in foster care,

b. former foster care children up to twenty-five (25) years of age,

c. juvenile-justice-involved children, ~~and~~

d. children receiving adoption assistance, and

e. on and after July 1, 2026:

(1) children involved in a Family Centered Services (FCS) case through the Child Welfare Services division of the Department of Human Services,

(2) children in the custody of the Department of Human Services and placed at home under court supervision,

(3) children who are placed at home in a trial reunification plan administered by the Department of Human Services, and

(4) Medicaid enrolled parents and guardians whose children are in an FCS case, are in trial reunification, or are in the custody of the Department of Human Services in foster care or under court supervision;

6. "Clean claim" means a properly completed billing form with Current Procedural Terminology, 4th Edition or a more recent edition, the Tenth Revision of the International Classification of Diseases coding or a more recent revision, or Healthcare Common Procedure Coding System coding where applicable that contains information specifically required in the Provider Billing and ~~Procedure~~ Procedures Manual of the Oklahoma Health Care Authority, as defined in 42 C.F.R., Section 447.45(b);

7. "Clinical criteria" means the written policies, written screening procedures, determination rules, determination abstracts, clinical protocols, practice guidelines, medical protocols, and any other criteria or rationale used by a contracted entity to determine the necessity and appropriateness of health care services;

8. "Commercial plan" means an organization or entity that undertakes to provide or arrange for the delivery of health care services to Medicaid members on a prepaid basis and is subject to all applicable federal and state laws and regulations;

~~8.~~ 9. "Contracted entity" means an organization or entity that enters into or will enter into a capitated contract with the

Oklahoma Health Care Authority for the delivery of services specified in the Ensuring Access to Medicaid Act that will assume financial risk, operational accountability, and statewide or regional functionality as defined in the Ensuring Access to Medicaid Act in managing comprehensive health outcomes of Medicaid members. For purposes of the Ensuring Access to Medicaid Act, the term contracted entity includes an accountable care organization, a provider-led entity, a commercial plan, a dental benefit manager, or any other entity as determined by the Authority;

~~9.~~ 10. "Dental benefit manager" means an entity that handles claims payment and prior authorizations and coordinates dental care with participating providers and Medicaid members;

~~10.~~ 11. "Essential community provider" means:

a. a Federally Qualified Health Center,

b. a community mental health center,

c. an Indian Health Care Provider,

d. a rural health clinic,

e. a state-operated mental health hospital,

f. a long-term care hospital serving children (LTCH-C),

g. a teaching hospital owned, jointly owned, or affiliated with and designated by the University Hospitals Authority, University Hospitals Trust, Oklahoma State University Medical Authority, or Oklahoma State University Medical Trust,

h. a provider employed by or contracted with, or otherwise a member of the faculty practice plan of:

(1) a public, accredited medical school in this state, or

(2) a hospital or health care entity directly or indirectly owned or operated by the University Hospitals Trust or the Oklahoma State University Medical Trust,

i. a county department of health or city-county health department,

j. a comprehensive community addiction recovery center,

k. a hospital licensed by this state including all hospitals participating in the Supplemental Hospital Offset Payment Program,

l. a Certified Community Behavioral Health Clinic (CCBHC),

m. a provider employed by or contracted with a primary care residency program accredited by the Accreditation Council for Graduate Medical Education,

n. any additional Medicaid provider as approved by the Authority if the provider either offers services that are not available from any other provider within a reasonable access standard or provides a substantial share of the total units of a particular service

utilized by Medicaid members within the region during the last three (3) years, and the combined capacity of other service providers in the region is insufficient to meet the total needs of the Medicaid members,

o. a pharmacy or pharmacist, or

p. any provider not otherwise mentioned in this paragraph that meets the definition of "essential community provider" under 45 C.F.R., Section 156.235;

~~11. "Material change" includes, but is not limited to, any change in overall business operations such as policy, process or protocol which affects, or can reasonably be expected to affect, more than five percent (5%) of enrollees or participating providers of the contracted entity;~~

12. "Governing body" means a group of individuals appointed by the contracted entity who approve policies, operations, profit/loss ratios, executive employment decisions, and who have overall responsibility for the operations of the contracted entity of which they are appointed;

13. "Health care service" means any service provided by a participating provider, or by an individual working for or under the supervision of the participating provider, that relates to the diagnosis, assessment, prevention, treatment, or care of any human illness, disease, injury, or condition. Unless the context clearly indicates otherwise, health care service includes the provision of

mental health and substance use disorder services and the provision of durable medical equipment;

14. "Local Oklahoma provider organization" means any state provider association, accountable care organization, Certified Community Behavioral Health Clinic, Federally Qualified Health Center, Native American tribe or tribal association, hospital or health system, academic medical institution, currently practicing licensed provider, or other local Oklahoma provider organization as approved by the Authority;

~~14. "Medical necessity" has the same meaning as "medically~~

15. "Material change" includes, but is not limited to, any change in overall business operations such as policy, process, or protocol which affects, or can reasonably be expected to affect, more than five percent (5%) of members or participating providers of the contracted entity;

16. "Medically necessary" ~~in Section 6592 of Title 36 of the Oklahoma Statutes~~ means services or supplies provided by a participating provider that are:

a. appropriate for the symptoms and diagnosis or treatment of a member's condition, illness, disease, or injury,

b. in accordance with standards of good medical practice,

c. not primarily for the convenience of the member or the member's health care provider, and

d. the most appropriate supply or level of service that can safely be provided to the member as determined by the Authority;

~~15.~~ 17. "Participating provider" means a provider who has a contract with or is employed by a contracted entity to provide services to Medicaid members as authorized by the Ensuring Access to Medicaid Act;

18. "Prior authorization" means the process by which a contracted entity or its designee utilization review entity determines the medical necessity and medical appropriateness of otherwise covered health care services prior to the rendering of such health care services;

~~16.~~ 19. "Provider" means a health care or dental provider licensed or certified in this state or a provider that meets the Authority's provider enrollment criteria to contract with the Authority as a SoonerCare provider;

~~17.~~ 20. "Provider-led entity" means an organization or entity, a majority of whose governing body is composed of individuals who:

a. have experience serving Medicaid members and:

(1) are licensed in this state as physicians, physician assistants, or Advanced Practice Registered Nurses,

(2) at least one board member is a licensed behavioral health provider, or

(3) are employed by:

(a) a hospital or other medical facility licensed by this state and operating in this state, or

(b) an inpatient or outpatient mental health or substance abuse treatment facility or program licensed or certified by this state and operating in this state,

b. represent the providers or facilities described in subparagraph a of this paragraph including, but not limited to, individuals who are employed by a statewide provider association, or

c. are nonclinical administrators of clinical practices serving Medicaid members;

~~18.~~ 21. "Provider-owned entity" means an organization or entity, a majority of whose ownership is held by Medicaid providers in this state or is held by an entity that directly or indirectly owns or is under common ownership with Medicaid providers in this state;

~~19.~~ 22. "Statewide" means all counties of this state including the urban region; ~~and~~

~~20.~~ 23. "Urban region" means:

a. all counties of this state with a county population of not less than five hundred thousand (500,000) according to the latest Federal Decennial Census, and

b. all counties that are contiguous to the counties described in subparagraph a of this paragraph, combined into one region; and

24. "Urgent health care service" means, with respect to the application of the time period for making a prior authorization determination under Section 4002.6 of this title, a health care service which, in the opinion of a physician with knowledge of the member's medical condition:

a. could seriously jeopardize the life or health of the member or the ability of the member to regain maximum function, or

b. in the opinion of a physician with knowledge of the member's medical condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the prior authorization.

SECTION 2. AMENDATORY 56 O.S. 2021, Section 4002.6, as last amended by Section 5, Chapter 448, O.S.L. 2024 (56 O.S. Supp. 2024, Section 4002.6), is amended to read as follows:

Section 4002.6. A. A contracted entity shall meet all requirements established by ~~the Oklahoma Health Care Authority~~ this

section pertaining to prior authorizations. ~~The Authority shall establish requirements that ensure timely determinations by contracted entities when prior authorizations are required including expedited review in urgent and emergent cases that at a minimum meet the criteria of this section.~~

~~B. A contracted entity shall make a determination on a request for an authorization of the transfer of a hospital inpatient to a post-acute care or long-term acute care facility within twenty-four (24) hours of receipt of the request.~~

~~C. A contracted entity shall make a determination on a request for any member who is not hospitalized at the time of the request within seventy-two (72) hours of receipt of the request; provided, that if the request does not include sufficient or adequate documentation, the review and determination shall occur within a time frame and in accordance with a process established by the Authority. The process established by the Authority pursuant to this subsection shall include a time frame of at least forty-eight (48) hours within which a provider may submit the necessary documentation.~~

~~D. A contracted entity shall make a determination on a request for services for a hospitalized member including, but not limited to, acute care inpatient services or equipment necessary to discharge the member from an inpatient facility within twenty-four (24) hours of receipt of the request.~~

~~E. Notwithstanding the provisions of subsection C of this section, a contracted entity shall make a determination on a request as expeditiously as necessary and, in any event, within twenty-four (24) hours of receipt of the request for service if adhering to the provisions of subsection C or D of this section could jeopardize the member's life, health or ability to attain, maintain or regain maximum function. In the event of a medically emergent matter, the contracted entity shall not impose limitations on providers in coordination of post-emergent stabilization health care including pre-certification or prior authorization.~~

~~F. Notwithstanding any other provision of this section, a contracted entity shall make a determination on a request for inpatient behavioral health services within twenty-four (24) hours of receipt of the request.~~

~~G. A~~ To the extent a contracted entity uses a third-party utilization review entity to administer prior authorizations on its behalf, the utilization review entity shall comply with the provisions of this section applicable to contracted entities.

B. 1. A contracted entity shall make any current prior authorization requirements and restrictions, including written clinical criteria, readily accessible on its website to members and participating providers. Such requirements and restrictions shall be described in detail but also in easily understandable language.

2. If a contracted entity intends either to implement a new prior authorization requirement or restriction or to amend an existing requirement or restriction, the contracted entity shall:

a. ensure that the new or amended requirement or restriction is not implemented until the contracted entity's website has been updated to reflect the new or amended requirement or restriction, and

b. provide participating providers credentialed to perform the service, and members who have a chronic condition and are already receiving the service which the prior authorization changes will impact, notice of the new or amended requirement or restriction no less than sixty (60) days before the requirement or restriction is implemented.

C. A contracted entity shall ensure that all adverse determinations are made by a licensed physician or, if appropriate for the requested service, a licensed mental health professional. The physician or mental health professional shall:

1. Possess a current and valid nonrestricted license in any United States jurisdiction;

2. Have the appropriate training, knowledge, or expertise to apply appropriate clinical guidelines to the health care service being requested; and

3. Make the adverse determination under the clinical direction of a medical director of the contracted entity who is responsible for reviewing health care services to members. Any such medical director shall be a physician licensed in any United States jurisdiction.

D. 1. Not later than January 1, 2027, each contracted entity shall implement and maintain a Prior Authorization Application Programming Interface (API), as described in 45 C.F.R., Part 156.

2. Not later than July 1, 2027, all participating providers shall have electronic health records or practice management systems that are compatible with the API, subject to such exceptions as may be authorized by the Oklahoma Health Care Authority Board through rule.

E. 1. If a contracted entity or the Authority requires prior authorization of a health care service, the contracted entity shall make a prior authorization or adverse determination ~~on a request~~ in accordance with the following time periods:

a. for urgent health care services, within seventy-two (72) hours of obtaining all necessary information to make the prior authorization or adverse determination,

b. for non-urgent health care services, within seven (7) days of obtaining all necessary information to make the prior authorization or adverse determination,

c. for covered prescription drugs ~~that are required to be prior authorized by the Authority~~, within twenty-four (24) hours of ~~receipt of the request~~ obtaining all necessary information to make the prior authorization or adverse determination. The contracted entity shall not require prior authorization on any covered prescription drug for which the Authority does not require prior authorization~~.~~

~~H. A contracted entity shall make a determination on a request~~, and

d. for coverage of biomarker testing, in accordance with Section 4003 of this title.

~~I. Upon issuance of an adverse determination on a prior authorization request under subsection B of this section, the contracted entity shall provide the requesting provider, within seventy-two (72) hours of receipt of such issuance, with reasonable opportunity to participate in a peer-to-peer review process with a provider who practices in the same specialty, but not necessarily the same sub-specialty, and who has experience treating the same population as the patient on whose behalf the request is submitted; provided, however, if the requesting provider determines the services to be clinically urgent, the contracted entity shall provide such opportunity within twenty-four (24) hours of receipt of such issuance. Services not covered under the state Medicaid~~

~~program for the particular patient shall not be subject to peer-to-peer review.~~

~~J. The Authority shall ensure that a provider offers to provide to a member in a timely manner services authorized by a contracted entity.~~

~~K. The Authority shall establish requirements for both internal and external reviews and appeals of adverse determinations on prior authorization requests or claims that, at a minimum:~~

~~1. Require contracted entities to provide a detailed explanation of denials to Medicaid providers and members;~~

~~2. Require contracted entities to provide an opportunity for peer-to-peer conversations with Oklahoma-licensed clinical staff of the same or similar specialty within twenty-four (24) hours of the adverse determination; and~~

~~3. Establish uniform rules for Medicaid provider or member appeals across all contracted entities.~~

2. If a participating provider submits all necessary information through the contracted entity's authorized prior authorization system, and if the contracted entity fails to comply with the deadlines specified in this subsection, such health care services are deemed authorized.

3. For the purposes of this subsection, "necessary information" includes, but is not limited to, the results of any face-to-face clinical evaluation or second opinion that may be required.

F. 1. If a member needs emergency health care services, the member's contracted entity shall not require prior authorization for pre-hospital transportation, for the provision of emergency health care services, or for transfers between facilities as required by the federal Emergency Medical Treatment and Labor Act.

2. A contracted entity shall allow a member and the member's provider a minimum of twenty-four (24) hours following an emergency admission or provision of emergency health care services for the member or provider to notify the contracted entity of the admission or provision of health care services. If the admission or health care service occurs on a holiday or weekend, the contracted entity shall not require notification until the next business day after the admission or provision of the health care services.

G. 1. In the notification to the provider that a prior authorization has been approved, the contracted entity shall include in such notification the duration of the prior authorization or the date by which the prior authorization will expire.

2. A contracted entity shall not revoke, limit, condition, or restrict a prior authorization if the authorized service is provided within forty-five (45) business days from the date the provider received the prior authorization unless the member was no longer eligible for the service on the date it was provided.

3. On receipt of information documenting a prior authorization from the member or from the member's provider, a contracted entity

shall honor a prior authorization granted to a member from a previous contracted entity for at least the initial sixty (60) days of a member's coverage under a new contracted entity. During the time period described in this subsection, a contracted entity may perform its own review to grant a prior authorization or make an adverse determination.

H. A contracted entity shall provide participating providers with the following opportunities for communication during the prior authorization process:

1. Make staff available at least eight (8) hours each day during normal business hours for inbound telephone calls regarding prior authorization issues;

2. Allow staff to receive inbound communication regarding prior authorization issues after normal business hours; and

3. Provide a participating provider with the opportunity to discuss a prior authorization denial with an appropriate reviewer.

I. A contracted entity shall reimburse a participating provider at the contracted payment rate for a health care service provided by the provider per a prior authorization, subject to any applicable reimbursement requirements provided by Section 4002.12 of this title, unless:

1. The provider knowingly and materially misrepresented the health care service in the prior authorization request with the

specific intent to deceive and obtain an unlawful payment from a contracted entity;

2. The health care service was no longer a covered benefit on the day it was provided;

3. The provider was no longer contracted with the member's contracted entity on the date the service was provided;

4. The provider failed to meet the contracted entity's timely filing requirements; or

5. The member was no longer eligible for health care coverage on the date the service was provided.

SECTION 3. AMENDATORY 56 O.S. 2021, Section 4002.8, as amended by Section 12, Chapter 395, O.S.L. 2022 (56 O.S. Supp. 2024, Section 4002.8), is amended to read as follows:

Section 4002.8. A. A contracted entity shall utilize uniform procedures established by the Authority under subsection B of this section for the review and appeal of any adverse determination by the contracted entity sought by any ~~enrollee~~ member or provider adversely affected by such determination.

B. The Authority shall develop procedures for ~~enrollees~~ members or providers to seek review by the contracted entity of any adverse determination made by the contracted entity.

C. A provider shall have six (6) months from the receipt of a claim denial to file an appeal. ~~With respect to~~

D. A contracted entity shall ensure that all appeals of adverse determinations made by ~~a~~ the contracted entity ~~on the basis of medical necessity, the following requirements shall apply:~~

~~1. Medical review staff of the contracted entity shall be licensed or credentialed health care clinicians with relevant clinical training or experience; and~~

~~2. All contracted entities shall use medical review staff for such appeals and~~ are reviewed by a licensed physician or, if appropriate for the requested service, a licensed mental health professional. The contracted entity shall not use any automated claim review software or other automated functionality for such appeals.

E. The physician or mental health professional who reviews the appeal shall:

1. Possess a current and valid unrestricted license in any United States jurisdiction;

2. Be of the same or similar specialty as a physician or mental health professional who typically manages the medical condition or disease. This requirement shall be considered met:

a. for a physician, if:

(1) the physician maintains board certification for the same or similar specialty as the medical condition in question, or

(2) the physician's training and experience:

(a) includes treatment of the condition,

(b) includes treatment of complications that may result from the service or procedure, and

(c) is sufficient for the physician to determine if the service or procedure is medically necessary or clinically appropriate, or

b. for a mental health professional, if the mental health professional's training and experience:

(1) includes treatment of the condition, and

(2) is sufficient for the mental health professional to determine if the service is medically necessary or clinically appropriate;

3. Not have been directly involved in making the adverse determination;

4. Not have any financial interest in the outcome of the appeal; and

5. Consider all known clinical aspects of the health care service under review including, but not limited to, a review of any medical records pertinent to the active condition that are provided to the contracted entity by the member's provider, or a health care facility, and any pertinent medical literature provided to the contracted entity by the provider.

~~C.~~ F. Upon receipt of notice from the contracted entity that the adverse determination has been upheld on appeal, the ~~enrollee~~

member or provider may request a fair hearing from the Authority. The Authority shall develop procedures for fair hearings in accordance with 42 C.F.R., Part 431.

SECTION 4. REPEALER 56 O.S. 2021, Section 4002.2, as last amended by Section 1, Chapter 206, O.S.L. 2024 (56 O.S. Supp. 2024, Section 4002.2), is hereby repealed.

SECTION 5. Sections 1, 2, and 3 of this act shall become effective November 1, 2025.

SECTION 6. It being immediately necessary for the preservation of the public peace, health or safety, an emergency is hereby declared to exist, by reason whereof this act shall take effect and be in full force from and after its passage and approval.

60-1-1998 DC 4/21/2025 4:42:01 PM