HB1810 FA1 NewtonCa-TJ(Untimely Filed)
3/25/2025 10:14:52 am

FLOOR AMENDMENT

HOUSE OF REPRESENTATIVES
State of Oklahoma

SPEAKER:

CHAIR:

I move to amend HB1810
Of the printed Bill

Page _____ Section _____ Lines _____
Of the Engrossed Bill

By deleting the content of the entire measure, and by inserting in lieu thereof the following language:

AMEND TITLE TO CONFORM TO AMENDMENTS

Amendment submitted by: Carl Newton

Adopted: _____

_____
Reading Clerk

STATE OF OKLAHOMA

1st Session of the 60th Legislature (2025)

FLOOR SUBSTITUTE
FOR
HOUSE BILL NO. 1810 By: Newton

FLOOR SUBSTITUTE

An Act relating to prior authorization; amending Section 2, Chapter 303, O.S.L. 2024 (36 O.S. Supp. 2024, Section 6570.1), which relates to definitions; modifying a definition; 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 ensuring access to Medicaid Act; clarifying definition; 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, other authorization requests, and requirements; modifying standard for requirements; removing certain requirements; and providing effective dates.

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

SECTION 1. AMENDATORY Section 2, Chapter 303, O.S.L. 2024 (36 O.S. Supp. 2024, Section 6570.1), is amended to read as follows:

Section 6570.1. As used in this act:

1. "Adverse determination" means a determination by a health carrier or its designee utilization review entity 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 as defined by Section 6475.3 of Title 36 of the Oklahoma Statutes;

2. "Chronic condition" means a condition that lasts one (1) year or more and requires ongoing medical attention or limits activities of daily living or both;

3. "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 the utilization review entity to determine the necessity and appropriateness of health care services;

4. "Emergency health care services", with respect to an emergency medical condition as defined in 42 U.S.C.A., Section 300gg-111, means:

a. a medical screening examination, as required under Section 1867 of the Social Security Act, 42 U.S.C., Section 1395dd, or as would be required under such section if such section applied to an independent, freestanding emergency department, that is within the capability of the emergency department of a hospital

or of an independent, freestanding emergency department, as applicable, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition, and

b. within the capabilities of the staff and facilities available at the hospital or the independent, freestanding emergency department, as applicable, such further medical examination and treatment as are required under Section 1395dd of the Social Security Act, or as would be required under such section if such section applied to an independent, freestanding emergency department, to stabilize the patient, regardless of the department of the hospital in which such further examination or treatment is furnished, as defined by 42 U.S.C.A., Section 300gg-111;

5. "Emergency Medical Treatment and Active Labor Act" or "EMTALA" means Section 1867 of the Social Security Act and associated regulations;

6. "Enrollee" means an individual who is enrolled in a health care plan, including covered dependents, as defined by Section ~~6592.1~~ 6592 of Title 36 of the Oklahoma Statutes;

7. "Health care provider" means any person or other entity who is licensed pursuant to the provisions of Title 59 or Title 63 of

the Oklahoma Statutes, or pursuant to the definition in Section 1-1708.1C of Title 63 of the Oklahoma Statutes;

8. "Health care services" means any services provided by a health care provider, or by an individual working for or under the supervision of a health care provider, that relate to the diagnosis, assessment, prevention, treatment, or care of any human illness, disease, injury, or condition, as defined by paragraph 2 of Section 1-1708.1C of Title 63 of the Oklahoma Statutes.

The term also includes the provision of mental health and substance use disorder services, as defined by Section 6060.10 of Title 36 of the Oklahoma Statutes, and the provision of durable medical equipment. The term does not include the provision, administration, or prescription of pharmaceutical products or services;

9. "Licensed mental health professional" means:

a. a psychiatrist who is a diplomate of the American Board of Psychiatry and Neurology,

b. a psychiatrist who is a diplomate of the American Osteopathic Board of Neurology and Psychiatry,

c. a physician licensed pursuant to the Oklahoma Allopathic Medical and Surgical Licensure and Supervision Act or the Oklahoma Osteopathic Medicine Act,

d. a clinical psychologist who is duly licensed to practice by the State Board of Examiners of Psychologists,

e. a professional counselor licensed pursuant to the Licensed Professional Counselors Act,

f. a person licensed as a clinical social worker pursuant to the provisions of the Social Worker's Licensing Act,

g. a licensed marital and family therapist as defined in the Marital and Family Therapist Licensure Act,

h. a licensed behavioral practitioner as defined in the Licensed Behavioral Practitioner Act,

i. an advanced practice nurse as defined in the Oklahoma Nursing Practice Act,

j. a physician assistant who is licensed in good standing in this state, or

k. a licensed alcohol and drug counselor/mental health (LADC/MH) as defined in the Licensed Alcohol and Drug Counselors Act;

10. "Medically necessary" means services or supplies provided by a health care provider that are:

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

b. in accordance with standards of good medical practice,

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

d. the most appropriate supply or level of service that can safely be provided to the enrollee as defined by Section 6592 of Title 36 of the Oklahoma Statutes;

11. "Notice" means communication delivered either electronically or through the United States Postal Service or common carrier;

12. "Physician" means an allopathic or osteopathic physician licensed by the State of Oklahoma or another state to practice medicine;

13. "Prior authorization" means the process by which utilization review entities determine the medical necessity and medical appropriateness of otherwise covered health care services prior to the rendering of such health care services. The term shall include "authorization", "pre-certification", and any other term that would be a reliable determination by a health benefit plan. The term shall not be construed to include or refer to such processes as they may pertain to pharmaceutical services;

14. "Urgent health care service" means a health care service with respect to which the application of the time periods for making an urgent care determination, which, in the opinion of a physician with knowledge of the enrollee's medical condition:

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

b. in the opinion of a physician with knowledge of the claimant's medical condition, would subject the enrollee to severe pain that cannot be adequately managed without the care or treatment that is the subject of the utilization review; and

15. "Utilization review entity" means an individual or entity that performs prior authorization for a health benefit plan as defined by Section 6060.4 of Title 36 of the Oklahoma Statutes, but shall not include any ~~health plan offered by a contracted entity defined in Section 4002.2 of Title 56 of the Oklahoma Statutes that provides coverage to members of the state Medicaid program or other~~ insurance subject to the Long-Term Care Insurance Act.

SECTION 2. 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;

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,

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

f. children in the custody of the Department of Human Services and placed at home under court supervision,

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

h. 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 Manual of the Oklahoma Health Care Authority, as defined in 42 C.F.R., Section 447.45(b);

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

10. "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. "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 necessary" in Section 6592 of Title 36 of the Oklahoma Statutes;

15. "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;

16. "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. "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. "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. "Statewide" means all counties of this state including the urban region; and

20. "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.

SECTION 3. 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 pertaining to prior authorizations, the requirements shall align with the provisions of 6570.1 (excluding the definition of "chronic

condition"), 6570.2, 6570.3, 6570.4, 6570.5, 6570.6, 6570.7, 6570.8, and 6570.10 of the Ensuring Transparency in Prior Authorization Act of Title 36 of the Oklahoma Statutes. 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, and the Ensuring Transparency in Prior Authorization Act.

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

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

SECTION 4. Sections 1 and 3 shall become effective November 1, 2025.

SECTION 5. Section 2 shall become effective July 1, 2026.

60-1-13362 TJ 03/24/25