STATE OF OKLAHOMA

2nd Session of the 60th Legislature (2026)

HOUSE BILL 3626 By: Lawson

AS INTRODUCED

An Act relating to Medicaid; amending 56 O.S. 2021, Section 4002.8, as last amended by Section 3, Chapter 372, O.S.L. 2025 (56 O.S. Supp. 2025, Section 4002.8), which relates to adverse determinations and procedures; adding to who can review the appeal; stating the requirements for a psychologist; amending 56 O.S. 2021, Section 4002.12, as last amended by Section 7, Chapter 448, O.S.L. 2024 (56 O.S. Supp. 2025, Section 4002.12), which relates to minimum rates of reimbursement, value-based payment arrangements, and payment methodologies; directing the Oklahoma Health Care Authority to establish a reimbursement rate for psychologists upon appeal; and providing an effective date.

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

SECTION 1. AMENDATORY 56 O.S. 2021, Section 4002.8, as last amended by Section 3, Chapter 372, O.S.L. 2025 (56 O.S. Supp. 2025, 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 member or provider adversely affected by such determination.

B. The Authority shall develop procedures for 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.

D. A contracted entity shall ensure that all appeals of adverse determinations made by the contracted entity 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<u>, psychologist,</u> 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 psychologist, if:

(1) the psychologist is currently licensed in accordance with the Psychologists Licensing Act in Title 59 of the Oklahoma Statutes,

(2) the psychologist has training and experience in the testing for and treatment of the condition, or

(3) the psychologist's training and experience is sufficient to determine if the service is medically necessary or clinically appropriate, or

c. for ~~a~~ other mental health ~~professional~~ professionals, 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.

F. Upon receipt of notice from the contracted entity that the adverse determination has been upheld on appeal, the 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 2. AMENDATORY 56 O.S. 2021, Section 4002.12, as last amended by Section 7, Chapter 448, O.S.L. 2024 (56 O.S. Supp. 2025, Section 4002.12), is amended to read as follows:

Section 4002.12. A. Until July 1, 2027, the Oklahoma Health Care Authority shall establish minimum rates of reimbursement from contracted entities to providers who elect not to enter into value-

based payment arrangements under subsection B of this section or other alternative payment agreements for health care items and services furnished by such providers to enrollees of the state Medicaid program. Except as provided by subsection I of this section, until July 1, 2027, such reimbursement rates shall be equal to or greater than:

1. For an item or service provided by a participating provider who is in the network of the contracted entity, one hundred percent (100%) of the reimbursement rate for the applicable service in the applicable fee schedule of the Authority; or

2. For an item or service provided by a non-participating provider or a provider who is not in the network of the contracted entity, ninety percent (90%) of the reimbursement rate for the applicable service in the applicable fee schedule of the Authority as of January 1, 2021.

B. A contracted entity shall offer value-based payment arrangements to all providers in its network capable of entering into value-based payment arrangements. Such arrangements shall be optional for the provider but shall be tied to reimbursement incentives when quality metrics are met. The quality measures used by a contracted entity to determine reimbursement amounts to providers in value-based payment arrangements shall align with the quality measures of the Authority for contracted entities.

C. Notwithstanding any other provision of this section, the Authority shall comply with payment methodologies required by federal law or regulation for specific types of providers, including, but not limited to, Federally Qualified Health Centers, rural health clinics, pharmacies, Indian Health Care Providers, and emergency services.

D. A contracted entity shall offer all rural health clinics (RHCs) contracts that reimburse RHCs using the methodology in place for each specific RHC prior to January 1, 2023, including any and all annual rate updates. The contracted entity shall comply with all federal program rules and requirements, and the transformed Medicaid delivery system shall not interfere with the program as designed.

E. The Oklahoma Health Care Authority shall establish minimum rates of reimbursement from contracted entities to Certified Community Behavioral Health Clinic (CCBHC) providers who elect alternative payment arrangements equal to the prospective payment system rate under the Medicaid State Plan.

F. The Authority shall establish an incentive payment under the Supplemental Hospital Offset Payment Program that is determined by value-based outcomes for providers other than hospitals.

G. 1. Psychologist reimbursement shall reflect outcomes. Reimbursement shall not be limited to therapy and shall include, but

not be limited to, patient intake administration, testing, and assessment.

2. The Authority shall establish a reimbursement rate for psychologists who are successful upon appeal pursuant to section 4002.8 of this title that compensates them for the hours spent by the psychologist on the appeal. Such reimbursement shall take into account the hours spent on the administration of the appeal that would have otherwise been spent on providing services to patients.

H. Coverage for Medicaid ground transportation services by licensed Oklahoma emergency medical services shall be reimbursed at no less than the published Medicaid rates as set by the Authority. All currently published Medicaid Healthcare Common Procedure Coding System (HCPCS) codes paid by the Authority shall continue to be paid by the contracted entity. The contracted entity shall comply with all reimbursement policies established by the Authority for the ambulance providers. Contracted entities shall accept the modifiers established by the Centers for Medicare and Medicaid Services currently in use by Medicare at the time of the transport of a member ~~that~~ who is dually eligible for Medicare and Medicaid.

I. 1. The rate paid to participating pharmacy providers is independent of subsection A of this section and shall be the same as the fee-for-service rate employed by the Authority for the Medicaid program as stated in the payment methodology in OAC 317:30-5-78,

unless the participating pharmacy provider elects to enter into other alternative payment agreements.

2. A pharmacy or pharmacist shall receive direct payment or reimbursement from the Authority or contracted entity when providing a health care service to the Medicaid member at a rate no less than that of other health care providers for providing the same service.

J. Notwithstanding any other provision of this section, anesthesia shall continue to be reimbursed equal to or greater than the anesthesia fee schedule established by the Authority as of January 1, 2021. Anesthesia providers may also enter into value-based payment arrangements under this section or alternative payment arrangements for services furnished to Medicaid members.

K. The Authority shall specify in the requests for proposals a reasonable time frame in which a contracted entity shall have entered into a certain percentage, as determined by the Authority, of value-based contracts with providers.

L. Capitation rates established by the Oklahoma Health Care Authority and paid to contracted entities under capitated contracts shall be updated annually and in accordance with 42 C.F.R., Section 438.3. Capitation rates shall be approved as actuarially sound as determined by the Centers for Medicare and Medicaid Services in accordance with 42 C.F.R., Section 438.4 and the following:

1. Actuarial calculations must include utilization and expenditure assumptions consistent with industry and local standards; and

2. Capitation rates shall be risk-adjusted and shall include a portion that is at risk for achievement of quality and outcomes measures.

M. The Authority may establish a symmetric risk corridor for contracted entities.

N. The Authority shall establish a process for annual recovery of funds from, or assessment of penalties on, contracted entities that do not meet the medical loss ratio standards stipulated in Section 4002.5 of this title.

O. 1. The Authority shall, through the financial reporting required under subsection G of Section 4002.12b of this title, determine the percentage of health care expenses by each contracted entity on primary care services.

2. Not later than the end of the fourth year of the initial contracting period, each contracted entity shall be currently spending not less than eleven percent (11%) of its total health care expenses on primary care services.

3. The Authority shall monitor the primary care spending of each contracted entity and require each contracted entity to maintain the level of spending on primary care services stipulated in paragraph 2 of this subsection.

SECTION 3. This act shall become effective November 1, 2026.

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