BILL SUMMARY
1st Session of the 60th Legislature

Bill No.:	**HB1810**
Version:	**SAHB**
Request Number:	
Author:	**Rep. Newton**
Date:	**5/15/2025**
Impact:	**$0**

Research Analysis

The Senate Amendments for HB 1810 adds more detail in Section 4002.2 to the definition of *adverse determination.* The Senate Amendments also expands who a "children's specialty plan" applies to on and after July 1, 2026. A definition of *clinical criteria* is added to the measure, which means criteria used by a contracted entity to determine the necessity and appropriateness of health care services. A definition of *health care service* is also added, which means any service provided by a participating provider or by an individual working for or under supervision of the participating provider and includes the provision of mental health and substance use disorder services and the provision of durable medical equipment unless the context clearly indicates otherwise. The measure also adds a definition of *medically necessary* which outlines criterion to meet this definition as well as adds a definition for *prior authorization* and one for *urgent health care service.*

The measure requires that a contracted entity meet all requirements pertaining to prior authorization and requires the utilization review entity to comply with the provisions of this section applicable to contracted entities. A contracted entity must make any current prior authorization requirements and restrictions readily accessible on its website in a detailed but easily understandable manner. If a contracted entity intends to implement a new prior authorization requirement or restriction or amend one, the contracted entity must do the listed actions. A contracted entity must ensure that all adverse determinations are made by a licensed physical or a licensed mental health professional who must have the qualifications listed in the measure and follow the actions listed. Each contracted entity must implement and maintain a Prior Authorization Application Programming Interface (API) no later than January 1, 2027. All participating providers must have electronic health records or practice management systems that are compatible with the API no later than July 1, 2027. If a contracted entity or OHCA requires prior authorization of a health care service, the contracted entity must make a prior authorization or adverse determination in accordance with the time periods listed in the measure.

The measure provides that if a participating provider submits all necessary information through the contracted entity's authorized prior authorization system and the contracted entity fails to comply with the deadlines specified in this subsection then such health care services will be deemed authorized. The measure provides that if a member needs emergency health care services, the contracted entity will not require prior authorization for pre-hospital transportation, the provision of emergency health care services, or for transfers between facilities. A contracted entity must allow a member or their provider at least 24 hours for notification following an emergency admission or provision of emergency health care services.

In the notification that a prior authorization is approved, a contracted entity must provide the date by which the prior authorization will expire. A contracted entity must no revoke, limit, condition, or restrict a prior authorization if the service is provided by 45 business days from the date the

provider received prior authorization unless the member is no longer eligible on the date provided. A contracted entity must honor a previously granted prior authorization for at least the first 60 days of the member's new coverage. A contracted entity must provide participating providers with the opportunities for communication listed during the prior authorization process. A contracted entity must reimburse a participating provider at the contracted payment rate for a health care service provided per a prior authorization unless certain situations listed in the measure occur. The measure provides that a contracted entity must ensure that all appeals of adverse determinations are reviewed by a licensed physician or mental health professional. The reviewer must possess a current and valid unrestricted license from any United State jurisdiction, be of the same or similar specialty as an individual who typically manages the medical condition or disease, not have been directly involved in making the adverse determination, not have any financial interest in the outcome, and consider all known aspects of the health care service under review.

Last the measure repeals 56 O.S. 2021, Section 4002.2 which relates to definitions in the Ensuring Access to Medicaid Act.

Prepared By: Suzie Nahach, House Research Staff

Fiscal Analysis

HB 1810 modifies the requirements for utilization review entities contracted with the Oklahoma Health Care Authority (OHCA), requiring their prior authorization processes to align with the requirements of the Ensuring Transparency in Prior Authorization Act. In its current form, OHCA does not anticipate that the measure will impact the Medicaid program, thus having no direct fiscal impact on the state budget or appropriations.

The Senate amendments do not change the fiscal impact from the previous House analysis.

Prepared By: Alexandra Ladner, House Fiscal Staff

Other Considerations

None.