

1 ENGROSSED SENATE AMENDMENT
TO

2 ENGROSSED HOUSE
3 BILL NO. 1810

By: Newton of the House

and

Gillespie of the Senate

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6
7 An Act relating to prior authorization; amending
8 Section 2, Chapter 303, O.S.L. 2024 (36 O.S. Supp.
9 2024, Section 6570.1), which relates to definitions;
10 modifying a definition; amending 56 O.S. 2021,
11 Section 4002.2, as last amended by Section 1, Chapter
12 448, O.S.L. 2024 (56 O.S. Supp. 2024, Section
13 4002.2), which relates to Ensuring Access to Medicaid
14 Act; clarifying definition; amending 56 O.S. 2021,
15 Section 4002.6, as last amended by Section 5, Chapter
16 448, O.S.L. 2024 (56 O.S. Supp. 2024, Section
17 4002.6), which relates to prior authorizations, other
18 authorization requests, and requirements; modifying
19 standard for requirements; removing certain
20 requirements; and providing effective dates.

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23 AMENDMENT NO. 1. Page 1, strike the title, enacting clause and
24 entire bill and insert

“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;

1 specifying qualifications for review of adverse
2 determinations; requiring implementation of certain
3 application programming interface; stipulating
4 certain time periods for prior authorization
5 determinations; deeming requested services authorized
6 under certain conditions; defining term; prohibiting
7 prior authorization and stipulating certain
8 procedures for emergency services; requiring and
9 prohibiting certain acts related to duration of prior
10 authorizations; requiring certain opportunity for
11 communication; directing certain reimbursement except
12 under specified conditions; amending 56 O.S. 2021,
13 Section 4002.8, as amended by Section 12, Chapter
14 395, O.S.L. 2022 (56 O.S. Supp. 2024, Section
15 4002.8), which relates to appeals of adverse
16 determinations; modifying qualifications for review
17 of appeals; updating statutory language; repealing 56
18 O.S. 2021, Section 4002.2, as last amended by Section
19 1, Chapter 206, O.S.L. 2024 (56 O.S. Supp. 2024,
20 Section 4002.2), which relates to definitions;
21 providing an effective date; and declaring an
22 emergency.

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

24 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,

1 does not meet the contracted entity's or the Oklahoma Health Care
2 Authority's requirements for medical necessity, appropriateness,
3 health care setting, level of care, or effectiveness, and the
4 requested service or payment for the service is therefore denied,
5 reduced, or terminated;

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

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

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

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

- 18 a. children in foster care,
- 19 b. former foster care children up to twenty-five (25)
20 years of age,
- 21 c. juvenile-justice-involved children, ~~and~~
- 22 d. children receiving adoption assistance, and
- 23 e. on and after July 1, 2026:

24

- 1 (1) children involved in a Family Centered Services
2 (FCS) case through the Child Welfare Services
3 division of the Department of Human Services,
4 (2) children in the custody of the Department of
5 Human Services and placed at home under court
6 supervision,
7 (3) children who are placed at home in a trial
8 reunification plan administered by the Department
9 of Human Services, and
10 (4) Medicaid enrolled parents and guardians whose
11 children are in an FCS case, are in trial
12 reunification, or are in the custody of the
13 Department of Human Services in foster care or
14 under court supervision;

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

23 7. "Clinical criteria" means the written policies, written
24 screening procedures, determination rules, determination abstracts,

1 clinical protocols, practice guidelines, medical protocols, and any
2 other criteria or rationale used by a contracted entity to determine
3 the necessity and appropriateness of health care services;

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

8 ~~8.~~ 9. "Contracted entity" means an organization or entity that
9 enters into or will enter into a capitated contract with the
10 Oklahoma Health Care Authority for the delivery of services
11 specified in the Ensuring Access to Medicaid Act that will assume
12 financial risk, operational accountability, and statewide or
13 regional functionality as defined in the Ensuring Access to Medicaid
14 Act in managing comprehensive health outcomes of Medicaid members.
15 For purposes of the Ensuring Access to Medicaid Act, the term
16 contracted entity includes an accountable care organization, a
17 provider-led entity, a commercial plan, a dental benefit manager, or
18 any other entity as determined by the Authority;

19 ~~9.~~ 10. "Dental benefit manager" means an entity that handles
20 claims payment and prior authorizations and coordinates dental care
21 with participating providers and Medicaid members;

22 ~~10.~~ 11. "Essential community provider" means:

- 23 a. a Federally Qualified Health Center,
24 b. a community mental health center,

- 1 c. an Indian Health Care Provider,
- 2 d. a rural health clinic,
- 3 e. a state-operated mental health hospital,
- 4 f. a long-term care hospital serving children (LTCH-C),
- 5 g. a teaching hospital owned, jointly owned, or
- 6 affiliated with and designated by the University
- 7 Hospitals Authority, University Hospitals Trust,
- 8 Oklahoma State University Medical Authority, or
- 9 Oklahoma State University Medical Trust,
- 10 h. a provider employed by or contracted with, or
- 11 otherwise a member of the faculty practice plan of:
- 12 (1) a public, accredited medical school in this
- 13 state, or
- 14 (2) a hospital or health care entity directly or
- 15 indirectly owned or operated by the University
- 16 Hospitals Trust or the Oklahoma State University
- 17 Medical Trust,
- 18 i. a county department of health or city-county health
- 19 department,
- 20 j. a comprehensive community addiction recovery center,
- 21 k. a hospital licensed by this state including all
- 22 hospitals participating in the Supplemental Hospital
- 23 Offset Payment Program,
- 24

- 1 l. a Certified Community Behavioral Health Clinic
2 (CCBHC),
- 3 m. a provider employed by or contracted with a primary
4 care residency program accredited by the Accreditation
5 Council for Graduate Medical Education,
- 6 n. any additional Medicaid provider as approved by the
7 Authority if the provider either offers services that
8 are not available from any other provider within a
9 reasonable access standard or provides a substantial
10 share of the total units of a particular service
11 utilized by Medicaid members within the region during
12 the last three (3) years, and the combined capacity of
13 other service providers in the region is insufficient
14 to meet the total needs of the Medicaid members,
- 15 o. a pharmacy or pharmacist, or
- 16 p. any provider not otherwise mentioned in this paragraph
17 that meets the definition of "essential community
18 provider" under 45 C.F.R., Section 156.235;

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

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

6 13. "Health care service" means any service provided by a
7 participating provider, or by an individual working for or under the
8 supervision of the participating provider, that relates to the
9 diagnosis, assessment, prevention, treatment, or care of any human
10 illness, disease, injury, or condition. Unless the context clearly
11 indicates otherwise, health care service includes the provision of
12 mental health and substance use disorder services and the provision
13 of durable medical equipment;

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

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

22 15. "Material change" includes, but is not limited to, any
23 change in overall business operations such as policy, process, or
24 protocol which affects, or can reasonably be expected to affect,

1 more than five percent (5%) of members or participating providers of
2 the contracted entity;

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

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

9 b. in accordance with standards of good medical practice,

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

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

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

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

24

1 ~~16.~~ 19. "Provider" means a health care or dental provider
2 licensed or certified in this state or a provider that meets the
3 Authority's provider enrollment criteria to contract with the
4 Authority as a SoonerCare provider;

5 ~~17.~~ 20. "Provider-led entity" means an organization or entity,
6 a majority of whose governing body is composed of individuals who:

7 a. have experience serving Medicaid members and:

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

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

13 (3) are employed by:

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

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

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

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

3 ~~18.~~ 21. "Provider-owned entity" means an organization or
4 entity, a majority of whose ownership is held by Medicaid providers
5 in this state or is held by an entity that directly or indirectly
6 owns or is under common ownership with Medicaid providers in this
7 state;

8 ~~19.~~ 22. "Statewide" means all counties of this state including
9 the urban region; ~~and~~

10 ~~20.~~ 23. "Urban region" means:

- 11 a. all counties of this state with a county population of
12 not less than five hundred thousand (500,000)
13 according to the latest Federal Decennial Census, and
14 b. all counties that are contiguous to the counties
15 described in subparagraph a of this paragraph,
16 combined into one region; and

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

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

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

6 SECTION 2. AMENDATORY 56 O.S. 2021, Section 4002.6, as
7 last amended by Section 5, Chapter 448, O.S.L. 2024 (56 O.S. Supp.
8 2024, Section 4002.6), is amended to read as follows:

9 Section 4002.6. A. A contracted entity shall meet all
10 requirements established by ~~the Oklahoma Health Care Authority~~ this
11 section pertaining to prior authorizations. ~~The Authority shall~~
12 ~~establish requirements that ensure timely determinations by~~
13 ~~contracted entities when prior authorizations are required including~~
14 ~~expedited review in urgent and emergent cases that at a minimum meet~~
15 ~~the criteria of this section.~~

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

20 ~~C. A contracted entity shall make a determination on a request~~
21 ~~for any member who is not hospitalized at the time of the request~~
22 ~~within seventy-two (72) hours of receipt of the request; provided,~~
23 ~~that if the request does not include sufficient or adequate~~
24 ~~documentation, the review and determination shall occur within a~~

1 ~~time frame and in accordance with a process established by the~~
2 ~~Authority. The process established by the Authority pursuant to~~
3 ~~this subsection shall include a time frame of at least forty eight~~
4 ~~(48) hours within which a provider may submit the necessary~~
5 ~~documentation.~~

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

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

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

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

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

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

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

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

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

4 The physician or mental health professional shall:

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

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

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

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

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

23 E. 1. If a contracted entity or the Authority requires prior
24 authorization of a health care service, the contracted entity shall

1 make a prior authorization or adverse determination on a request in
2 accordance with the following time periods:

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

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

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

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

18 and

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

21 ~~I. Upon issuance of an adverse determination on a prior~~
22 ~~authorization request under subsection B of this section, the~~
23 ~~contracted entity shall provide the requesting provider, within~~
24 ~~seventy two (72) hours of receipt of such issuance, with reasonable~~

1 ~~opportunity to participate in a peer-to-peer review process with a~~
2 ~~provider who practices in the same specialty, but not necessarily~~
3 ~~the same sub-specialty, and who has experience treating the same~~
4 ~~population as the patient on whose behalf the request is submitted;~~
5 ~~provided, however, if the requesting provider determines the~~
6 ~~services to be clinically urgent, the contracted entity shall~~
7 ~~provide such opportunity within twenty-four (24) hours of receipt of~~
8 ~~such issuance. Services not covered under the state Medicaid~~
9 ~~program for the particular patient shall not be subject to peer-to-~~
10 ~~peer review.~~

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

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

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

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

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

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

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

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

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

22 G. 1. In the notification to the provider that a prior
23 authorization has been approved, the contracted entity shall include
24

1 in such notification the duration of the prior authorization or the
2 date by which the prior authorization will expire.

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

8 3. On receipt of information documenting a prior authorization
9 from the member or from the member's provider, a contracted entity
10 shall honor a prior authorization granted to a member from a
11 previous contracted entity for at least the initial sixty (60) days
12 of a member's coverage under a new contracted entity. During the
13 time period described in this subsection, a contracted entity may
14 perform its own review to grant a prior authorization or make an
15 adverse determination.

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

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

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

24

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

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

8 1. The provider knowingly and materially misrepresented the
9 health care service in the prior authorization request with the
10 specific intent to deceive and obtain an unlawful payment from a
11 contracted entity;

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

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

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

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

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

23 Section 4002.8. A. A contracted entity shall utilize uniform
24 procedures established by the Authority under subsection B of this

1 section for the review and appeal of any adverse determination by
2 the contracted entity sought by any enrollee member or provider
3 adversely affected by such determination.

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

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

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

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

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

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

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

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

4 a. for a physician, if:

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

8 (2) the physician's training and experience:

9 (a) includes treatment of the condition,

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

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

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

17 (1) includes treatment of the condition, and

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

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

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

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

7 ~~E.~~ F. Upon receipt of notice from the contracted entity that
8 the adverse determination has been upheld on appeal, the enrollee
9 member or provider may request a fair hearing from the Authority.
10 The Authority shall develop procedures for fair hearings in
11 accordance with 42 C.F.R., Part 431.

12 SECTION 4. REPEALER 56 O.S. 2021, Section 4002.2, as
13 last amended by Section 1, Chapter 206, O.S.L. 2024 (56 O.S. Supp.
14 2024, Section 4002.2), is hereby repealed.

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

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

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1 Passed the Senate the 7th day of May, 2025.

2
3 _____
4 Presiding Officer of the Senate

5 Passed the House of Representatives the ____ day of _____,
6 2025.

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8 _____
9 Presiding Officer of the House
10 of Representatives

1 ENGROSSED HOUSE
2 BILL NO. 1810

By: Newton of the House

and

Gillespie of the Senate

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6
7 An Act relating to prior authorization; amending
8 Section 2, Chapter 303, O.S.L. 2024 (36 O.S. Supp.
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20 requirements; and providing effective dates.

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

22 SECTION 7. AMENDATORY Section 2, Chapter 303, O.S.L.
23 2024 (36 O.S. Supp. 2024, Section 6570.1), is amended to read as
24 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

1 information provided, does not meet the health carrier's
2 requirements for medical necessity, appropriateness, health care
3 setting, level of care, or effectiveness, and the requested service
4 or payment for the service is therefore denied, reduced, or
5 terminated as defined by Section 6475.3 of Title 36 of the Oklahoma
6 Statutes;

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

10 3. "Clinical criteria" means the written policies, written
11 screening procedures, determination rules, determination abstracts,
12 clinical protocols, practice guidelines, medical protocols, and any
13 other criteria or rationale used by the utilization review entity to
14 determine the necessity and appropriateness of health care services;

15 4. "Emergency health care services", with respect to an
16 emergency medical condition as defined in 42 U.S.C.A., Section
17 300gg-111, means:

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

1 department, as applicable, including ancillary
2 services routinely available to the emergency
3 department to evaluate such emergency medical
4 condition, and

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

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

19 6. "Enrollee" means an individual who is enrolled in a health
20 care plan, including covered dependents, as defined by Section
21 ~~6592.1~~ 6592 of Title 36 of the Oklahoma Statutes;

22 7. "Health care provider" means any person or other entity who
23 is licensed pursuant to the provisions of Title 59 or Title 63 of
24

1 the Oklahoma Statutes, or pursuant to the definition in Section 1-
2 1708.1C of Title 63 of the Oklahoma Statutes;

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

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

14 9. "Licensed mental health professional" means:

- 15 a. a psychiatrist who is a diplomate of the American
16 Board of Psychiatry and Neurology,
- 17 b. a psychiatrist who is a diplomate of the American
18 Osteopathic Board of Neurology and Psychiatry,
- 19 c. a physician licensed pursuant to the Oklahoma
20 Allopathic Medical and Surgical Licensure and
21 Supervision Act or the Oklahoma Osteopathic Medicine
22 Act,

23

24

- 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,

- 1 b. in accordance with standards of good medical practice,
2 c. not primarily for the convenience of the enrollee or
3 the enrollee's health care provider, and
4 d. the most appropriate supply or level of service that
5 can safely be provided to the enrollee as defined by
6 Section 6592 of Title 36 of the Oklahoma Statutes;

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

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

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

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

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

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

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

16 SECTION 8. AMENDATORY 56 O.S. 2021, Section 4002.2, as
17 last amended by Section 1, Chapter 448, O.S.L. 2024 (56 O.S. Supp.
18 2024, Section 4002.2), is amended to read as follows:

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

20 1. "Adverse determination" has the same meaning as provided by
21 Section 6475.3 of Title 36 of the Oklahoma Statutes;

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

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

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

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

- 10 a. children in foster care,
- 11 b. former foster care children up to twenty-five (25)
12 years of age,
- 13 c. juvenile-justice-involved children, ~~and~~
- 14 d. children receiving adoption assistance,
- 15 e. children involved in a Family Centered Services (FCS)
16 case through the Child Welfare Services division of
17 the Department of Human Services,
- 18 f. children in the custody of the Department of Human
19 Services and placed at home under court supervision,
- 20 g. children who are placed at home in a trial
21 reunification plan administered by the Department of
22 Human Services, and
- 23 h. Medicaid enrolled parents and guardians whose children
24 are in an FCS case, are in trial reunification, or are

1 in the custody of the Department of Human Services in
2 foster care or under court supervision;

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

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

15 8. "Contracted entity" means an organization or entity that
16 enters into or will enter into a capitated contract with the
17 Oklahoma Health Care Authority for the delivery of services
18 specified in the Ensuring Access to Medicaid Act that will assume
19 financial risk, operational accountability, and statewide or
20 regional functionality as defined in the Ensuring Access to Medicaid
21 Act in managing comprehensive health outcomes of Medicaid members.
22 For purposes of the Ensuring Access to Medicaid Act, the term
23 contracted entity includes an accountable care organization, a
24

1 provider-led entity, a commercial plan, a dental benefit manager, or
2 any other entity as determined by the Authority;

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

6 10. "Essential community provider" means:

7 a. a Federally Qualified Health Center,

8 b. a community mental health center,

9 c. an Indian Health Care Provider,

10 d. a rural health clinic,

11 e. a state-operated mental health hospital,

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

13 g. a teaching hospital owned, jointly owned, or

14 affiliated with and designated by the University

15 Hospitals Authority, University Hospitals Trust,

16 Oklahoma State University Medical Authority, or

17 Oklahoma State University Medical Trust,

18 h. a provider employed by or contracted with, or

19 otherwise a member of the faculty practice plan of:

20 (1) a public, accredited medical school in this

21 state, or

22 (2) a hospital or health care entity directly or

23 indirectly owned or operated by the University

24

1 Hospitals Trust or the Oklahoma State University
2 Medical Trust,

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

5 j. a comprehensive community addiction recovery center,

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

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

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

14 n. any additional Medicaid provider as approved by the
15 Authority if the provider either offers services that
16 are not available from any other provider within a
17 reasonable access standard or provides a substantial
18 share of the total units of a particular service
19 utilized by Medicaid members within the region during
20 the last three (3) years, and the combined capacity of
21 other service providers in the region is insufficient
22 to meet the total needs of the Medicaid members,

23 o. a pharmacy or pharmacist, or
24

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

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

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

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

21 14. "Medical necessity" has the same meaning as "medically
22 necessary" in Section 6592 of Title 36 of the Oklahoma Statutes;

23 15. "Participating provider" means a provider who has a
24 contract with or is employed by a contracted entity to provide

1 services to Medicaid members as authorized by the Ensuring Access to
2 Medicaid Act;

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

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

9 a. have experience serving Medicaid members and:

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

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

15 (3) are employed by:

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

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

23 b. represent the providers or facilities described in
24 subparagraph a of this paragraph including, but not

1 limited to, individuals who are employed by a
2 statewide provider association, or

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

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

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

11 20. "Urban region" means:

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

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

18 SECTION 9. AMENDATORY 56 O.S. 2021, Section 4002.6, as
19 last amended by Section 5, Chapter 448, O.S.L. 2024 (56 O.S. Supp.
20 2024, Section 4002.6), is amended to read as follows:

21 Section 4002.6. A. A contracted entity shall meet all
22 requirements established by the Oklahoma Health Care Authority
23 pertaining to prior authorizations, the requirements shall align
24 with the provisions of 6570.1 (excluding the definition of "chronic

1 condition"), 6570.2, 6570.3, 6570.4, 6570.5, 6570.6, 6570.7, 6570.8,
2 and 6570.10 of the Ensuring Transparency in Prior Authorization Act
3 of Title 36 of the Oklahoma Statutes. The Authority shall establish
4 requirements that ensure timely determinations by contracted
5 entities when prior authorizations are required including expedited
6 review in urgent and emergent cases that at a minimum meet the
7 criteria of this section and the Ensuring Transparency in Prior
8 Authorization Act.

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

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

23 ~~D. A contracted entity shall make a determination on a request~~
24 ~~for services for a hospitalized member including, but not limited~~

1 ~~to, acute care inpatient services or equipment necessary to~~
2 ~~discharge the member from an inpatient facility within twenty-four~~
3 ~~(24) hours of receipt of the request.~~

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

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

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

24

1 ~~H. C.~~ A contracted entity shall make a determination on a
2 request for coverage of biomarker testing in accordance with Section
3 4003 of this title.

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

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

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

