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COMMITTEE SUBSTITUTE
FOR ENGROSSED
HOUSE BILL NO. 1810

By: Newton of the House

and

Gillespie of the Senate

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

1 1, Chapter 206, O.S.L. 2024 (56 O.S. Supp. 2024,
2 Section 4002.2), which relates to definitions;
3 providing an effective date; and declaring an
4 emergency.

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

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

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

10 1. "Adverse determination" ~~has the same meaning as provided by~~
11 ~~Section 6475.3 of Title 36 of the Oklahoma Statutes~~ means a
12 determination by a contracted entity or its designee utilization
13 review entity that an admission, availability of care, continued
14 stay, or other health care service that is a covered Medicaid
15 benefit has been reviewed and, based upon the information provided,
16 does not meet the contracted entity's or the Oklahoma Health Care
17 Authority's requirements for medical necessity, appropriateness,
18 health care setting, level of care, or effectiveness, and the
19 requested service or payment for the service is therefore denied,
20 reduced, or terminated;

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

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, and
15 e. on and after July 1, 2026:

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

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

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

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

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

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

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

23 ~~8.~~ 9. "Contracted entity" means an organization or entity that
24 enters into or will enter into a capitated contract with the

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

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

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

- a. a Federally Qualified Health Center,
- b. a community mental health center,
- c. an Indian Health Care Provider,
- d. a rural health clinic,
- e. a state-operated mental health hospital,
- f. a long-term care hospital serving children (LTCH-C),
- g. a teaching hospital owned, jointly owned, or affiliated with and designated by the University Hospitals Authority, University Hospitals Trust, Oklahoma State University Medical Authority, or Oklahoma State University Medical Trust,

- 1 h. a provider employed by or contracted with, or
2 otherwise a member of the faculty practice plan of:
3 (1) a public, accredited medical school in this
4 state, or
5 (2) a hospital or health care entity directly or
6 indirectly owned or operated by the University
7 Hospitals Trust or the Oklahoma State University
8 Medical Trust,
9 i. a county department of health or city-county health
10 department,
11 j. a comprehensive community addiction recovery center,
12 k. a hospital licensed by this state including all
13 hospitals participating in the Supplemental Hospital
14 Offset Payment Program,
15 l. a Certified Community Behavioral Health Clinic
16 (CCBHC) ,
17 m. a provider employed by or contracted with a primary
18 care residency program accredited by the Accreditation
19 Council for Graduate Medical Education,
20 n. any additional Medicaid provider as approved by the
21 Authority if the provider either offers services that
22 are not available from any other provider within a
23 reasonable access standard or provides a substantial
24 share of the total units of a particular service

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4 ~~15.~~ 17. "Participating provider" means a provider who has a
5 contract with or is employed by a contracted entity to provide
6 services to Medicaid members as authorized by the Ensuring Access to
7 Medicaid Act;

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

13 ~~16.~~ 19. "Provider" means a health care or dental provider
14 licensed or certified in this state or a provider that meets the
15 Authority's provider enrollment criteria to contract with the
16 Authority as a SoonerCare provider;

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

- 19 a. have experience serving Medicaid members and:
- 20 (1) are licensed in this state as physicians,
- 21 physician assistants, or Advanced Practice
- 22 Registered Nurses,
- 23 (2) at least one board member is a licensed
- 24 behavioral health provider, or

1 (3) are employed by:

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

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

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

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

15 ~~18.~~ 21. "Provider-owned entity" means an organization or
16 entity, a majority of whose ownership is held by Medicaid providers
17 in this state or is held by an entity that directly or indirectly
18 owns or is under common ownership with Medicaid providers in this
19 state;

20 ~~19.~~ 22. "Statewide" means all counties of this state including
21 the urban region; and

22 ~~20.~~ 23. "Urban region" means:
23
24

- 1 a. all counties of this state with a county population of
2 not less than five hundred thousand (500,000)
3 according to the latest Federal Decennial Census, and
4 b. all counties that are contiguous to the counties
5 described in subparagraph a of this paragraph,
6 combined into one region; and

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

- 12 a. could seriously jeopardize the life or health of the
13 member or the ability of the member to regain maximum
14 function, or
15 b. in the opinion of a physician with knowledge of the
16 member's medical condition, would subject the member
17 to severe pain that cannot be adequately managed
18 without the care or treatment that is the subject of
19 the prior authorization.

20 SECTION 2. AMENDATORY 56 O.S. 2021, Section 4002.6, as
21 last amended by Section 5, Chapter 448, O.S.L. 2024 (56 O.S. Supp.
22 2024, Section 4002.6), is amended to read as follows:

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

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

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

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

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

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

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

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

19 B. 1. A contracted entity shall make any current prior
20 authorization requirements and restrictions, including written
21 clinical criteria, readily accessible on its website to members and
22 participating providers. Such requirements and restrictions shall
23 be described in detail but also in easily understandable language.
24

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

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

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

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

18 The physician or mental health professional shall:

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

21 2. Have the appropriate training, knowledge, or expertise to
22 apply appropriate clinical guidelines to the health care service
23 being requested; and
24

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

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

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

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

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

21 b. for non-urgent health care services, within seven (7)
22 days of obtaining all necessary information to make
23 the prior authorization or adverse determination,
24

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22 1. The provider knowingly and materially misrepresented the
23 health care service in the prior authorization request with the
24

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

20 a. for a physician, if:

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

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

- 1 (a) includes treatment of the condition,
2 (b) includes treatment of complications that may
3 result from the service or procedure, and
4 (c) is sufficient for the physician to determine
5 if the service or procedure is medically
6 necessary or clinically appropriate, or

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

- 9 (1) includes treatment of the condition, and
10 (2) is sufficient for the mental health professional
11 to determine if the service is medically
12 necessary or clinically appropriate;

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

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

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

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

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

4 SECTION 4. REPEALER 56 O.S. 2021, Section 4002.2, as
5 last amended by Section 1, Chapter 206, O.S.L. 2024 (56 O.S. Supp.
6 2024, Section 4002.2), is hereby repealed.

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

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

13 COMMITTEE REPORT BY: COMMITTEE ON HEALTH AND HUMAN SERVICES
14 April 21, 2025 - DO PASS AS AMENDED BY CS
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