House _____ **Amendment NO.**____

Offered By

_____ _____

AMEND House Committee Substitute for Senate Substitute for Senate Bill No. 7, Page 88, Section 376.1280, Line 26, by inserting after said section and line the following:

"376.2100. 1. Except as otherwise provided in subsection 1 of section 376.2108, as used in sections 376.2100 to 376.2108, terms shall have the same meanings as are ascribed to them under section 376.1350.

2. As used in sections 376.2100 to 376.2108, the following terms mean:

(1) "Evaluation period", any consecutive twelve months;

(2) "Value-based care agreement", a contractual agreement between a health care provider, either directly or indirectly through a health care provider group or organization, and a health carrier that:

(a) Incentivizes or rewards providers based on one or more of the following:

a. Quality of care;

b. Safety;

c. Patient outcomes;

d. Efficiency;

e. Cost reduction; or

f. Other factors; and

(b) May, but is not required to, include shared financial risk and rewards based on performance metrics.

376.2102. 1. Except as otherwise provided in this section, beginning January 1, 2026, a health carrier or utilization review entity shall not require a health care provider to obtain prior authorization for a health care service unless the health carrier or utilization review entity makes a determination that in the most recent evaluation period the health carrier or utilization review entity has approved or would have approved less than ninety percent of the prior authorization requests submitted by that provider for that health care service.

2. Beginning January 1, 2026, a health carrier or utilization review entity shall not require a health care provider to obtain prior authorization for any health care services unless the health carrier or utilization review entity makes a determination that in the most recent evaluation period

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the health carrier or utilization review entity has approved or would have approved less than ninety percent of all prior authorization requests submitted by that provider for health care services.

3. (1) Beginning January 1, 2026, a health carrier or utilization review entity may elect to have a hospital, as that term is defined in section 197.020, determine which of the following conditions that such hospital will comply with to obtain an exemption from prior authorization requirements under subsections 1 and 2 of this section:

(a) The hospital entering into, either directly or indirectly through a health care provider group or organization a value-based care agreement with the health carrier;

(b) The hospital's score of three or higher on the Center for Medicare and Medicaid Services Five-Star Quality Rating System, 42 CFR § 412.190, or its successor rating system; or

(c) At least ninety-one percent of the hospital's prior authorization requests submitted for purposes of eligibility for subsections 1 or 2 of this section were approved or would have been approved by the health carrier or utilization review entity.

(2) Critical access hospitals and hospitals that do not participate in the Center for Medicare and Medicaid Services Five-Star Quality Rating System, or its successor rating system, shall be exempt from the provisions of this subsection.

4. The exemption from prior authorization requirements described in subsections 1, 2, and 3 of this section shall not include:

(1) Pharmacy services, not to exceed the amount of one hundred thousand dollars;

(2) Imaging services, not to exceed the amount of one hundred thousand dollars;

(3) Cosmetic procedures that are not medically necessary; or

(4) Investigative or experimental treatments.

5. The amount of the limitations described in subdivisions (1) and (2) of subsection 4 of this section shall be increased every year, rounded to the nearest thousand dollars, beginning January 1, 2027, based on the Consumer Price Index for All Urban Consumers for the United States (CPI-U), or its successor index, as such index is defined and officially reported by the United States Department of Labor, or its successor agency.

6. In making a determination under this section, the health carrier or utilization review entity shall not count:

(1) Any prior authorization requests denied by a health carrier or utilization review entity and being appealed by the health care provider; or

(2) Any request made by a health care provider for a service that is not included in the health carrier's benefit plan

but shall count as approved any prior authorization request that was denied by a health carrier or utilization review entity but that was subsequently authorized.

7. In making a determination under this section, the health carrier or utilization review entity shall use either the provider's national provider identifier or a taxpayer identification number. Such designation shall remain unless requested to be changed by the provider.

8. The exemption from prior authorization requirements described in subsections 1, 2, and 3 of this section may be subject to internal auditing of the most recent consecutive six months, up to a maximum of two times per year, by the health carrier or utilization review entity and may be rescinded if:

(1) Such carrier or utilization review entity determines that the carrier or utilization review entity would have approved less than ninety percent of prior authorization requests for a health care service that the provider was exempt from the prior authorization requirement under subsection 1 of this section;

(2) Such carrier or utilization review entity determines that the carrier or utilization review entity would have approved less than ninety percent of all prior authorization requests if the provider was exempt from the prior authorization requirement under subsection 2 of this section; or

(3) There has been an increase in the provision of exempt procedures by a health care provider of more than fifty percent or more than twenty procedures, whichever amount is greater.

9. The exemption described in subsections 1, 2, and 3 of this section shall be null and void upon a determination that the health care provider has been found by a court of law to have civilly or criminally engaged in any fraud or abuse after the exemption is granted by a health carrier or utilization review entity.

10. A health carrier or utilization review entity may require health care providers in the health carrier's or utilization review entity's network to use an online portal to submit requests for prior authorization.

11. No adverse determination shall be finalized under subsections 1, 2, 3, or 8 unless reviewed by a clinical peer.

12. Any patient who has received prior authorization for the coverage of a ninety-day supply of medication whose health coverage plan changes following such authorization shall be permitted a ninety-day grace period from the date of such change in order to determine whether such patient's new plan covers the previously authorized medication or whether prior authorization is required.

376.2104. 1. The health carrier or utilization review entity shall notify the health care provider no later than twenty-five days after any determination made under section 376.2102. The notification shall include the statistics, data, and any supporting documentation for making the determination for the relevant evaluation period.

2. The health carrier or utilization review entity shall establish a process for health care providers to appeal any determinations made under section 376.2102.

3. The health carrier or utilization review entity shall maintain an online portal to allow health care providers to access all prior authorization decisions, including determinations made under section 376.2102. For health care providers subject to prior authorizations, the portal shall include the status of each prior authorization request, all notifications to the health care provider, the dates the health care provider received such notifications, and any other information relevant to the determination.

376.2106. No health carrier or utilization review entity shall deny or reduce payment to a health care provider for a health care service for which the provider has a prior authorization unless the provider:

(1) Knowingly and materially misrepresented the health care service in a request for payment submitted to the health carrier or utilization review entity with the specific intent to deceive and obtain an unlawful payment from the carrier or entity; or

(2) Failed to substantially perform the health care service.

376.2108. 1. The provisions of sections 376.2100 to 376.2108 shall not apply to MO HealthNet, except that a Medicaid managed care organization as defined in section 208.431 shall be considered a health carrier for purposes of sections 376.2100 to 376.2108.

2. The provisions of sections 376.2100 to 376.2108 shall not apply to health care providers who have not participated in a health benefit plan offered by the health carrier for at least one full evaluation period.

3. Nothing in sections 376.2100 to 376.2108 shall be construed to:

(1) Authorize a health care provider to provide a health care service outside the scope of his or her applicable license; or

(2) Require a health carrier or utilization review entity to pay for a health care service described in subdivision (1) of this subsection."; and

Further amend said bill by amending the title, enacting clause, and intersectional references accordingly.