House _____ **Amendment NO.**____

Offered By

_____ _____

AMEND House Bill No. 618, Page 1, Section 376.2100, Lines 4-6, by deleting said lines and inserting in lieu thereof the following:

"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."; and

Further amend said bill and page, Section 376.2102, Line 1, by inserting after the number "1." the following:

"Except as otherwise provided in this section, beginning January 1, 2026,"; and

Further amend said bill, page, and section, Line 7, by inserting after the number "2." the following:

"Beginning January 1, 2026,"; and

Further amend said bill and section, Page 2, Lines 13-17, by deleting said lines and inserting in lieu thereof the following:

"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;

Action Taken_____ Date _____

(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."; and

Further amend said bill and page, Section 376.2104, Lines 2-3, by deleting the words "the conclusion of the relevant evaluation period of"; and

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