

SECOND REGULAR SESSION

HOUSE BILL NO. 3010

103RD GENERAL ASSEMBLY

INTRODUCED BY REPRESENTATIVE STINNETT.

6673H.011

JOSEPH ENGLER, Chief Clerk

AN ACT

To repeal sections 376.1363 and 376.1364, RSMo, and to enact in lieu thereof eight new sections relating to prior authorization of health care services.

Be it enacted by the General Assembly of the state of Missouri, as follows:

Section A. Sections 376.1363 and 376.1364, RSMo, are repealed and eight new
2 sections enacted in lieu thereof, to be known as sections 376.1363, 376.1364, 376.1366,
3 376.2100, 376.2102, 376.2104, 376.2106, and 376.2108, to read as follows:

376.1363. 1. A health carrier shall maintain written procedures for making utilization
2 review decisions and for notifying enrollees and providers acting on behalf of enrollees of its
3 decisions. For purposes of this section, "enrollee" includes the representative of an enrollee.
4 2. For determinations, a health carrier shall make the determination within thirty-six
5 hours, which shall include one working day, of obtaining all necessary information regarding
6 a proposed admission, procedure or service requiring a review determination. For purposes
7 of this section, "necessary information" includes the results of any face-to-face clinical
8 evaluation or second opinion that may be required:

9 (1) In the case of a determination to certify an admission, procedure or service, the
10 carrier shall notify the provider rendering the service by telephone or electronically within
11 twenty-four hours of making the certification, and provide written or electronic confirmation
12 of a telephone or electronic notification to the enrollee and the provider within two working
13 days of making the certification;

14 (2) In the case of an adverse determination, the carrier shall notify the provider
15 rendering the service by telephone or electronically within twenty-four hours of making the
16 adverse determination; and shall provide written or electronic confirmation of a telephone or

EXPLANATION — Matter enclosed in bold-faced brackets ~~thus~~ in the above bill is not enacted and is intended to be omitted from the law. Matter in **bold-face** type in the above bill is proposed language.

17 electronic notification to the enrollee and the provider within one working day of making the
18 adverse determination.

19 3. For concurrent review determinations, a health carrier shall make the determination
20 within one working day of obtaining all necessary information:

21 (1) In the case of a determination to certify an extended stay or additional services,
22 the carrier shall notify by telephone or electronically the provider rendering the service within
23 one working day of making the certification, and provide written or electronic confirmation to
24 the enrollee and the provider within one working day after telephone or electronic
25 notification. The written notification shall include the number of extended days or next
26 review date, the new total number of days or services approved, and the date of admission or
27 initiation of services;

28 (2) In the case of an adverse determination, the carrier shall notify by telephone or
29 electronically the provider rendering the service within twenty-four hours of making the
30 adverse determination, and provide written or electronic notification to the enrollee and the
31 provider within one working day of a telephone or electronic notification. The service shall
32 be continued without liability to the enrollee until the enrollee has been notified of the
33 determination.

34 4. For retrospective review determinations, a health carrier shall make the
35 determination within thirty working days of receiving all necessary information. A carrier
36 shall provide notice in writing of the carrier's determination to an enrollee within ten working
37 days of making the determination.

38 5. A written notification of an adverse determination shall include the principal reason
39 or reasons for the determination, including the clinical rationale, and the instructions for
40 initiating an appeal or reconsideration of the determination. A health carrier shall provide the
41 clinical rationale in writing for an adverse determination, including the clinical review criteria
42 used to make that determination, to the health care provider and to any party who received
43 notice of the adverse determination.

44 6. A health carrier shall have written procedures to address the failure or inability of a
45 provider or an enrollee to provide all necessary information for review. These procedures
46 shall be made available to health care providers on the health carrier's website or provider
47 portal. In cases where the provider or an enrollee will not release necessary information, the
48 health carrier may deny certification of an admission, procedure or service.

49 7. **(1)** Provided the patient is an enrollee of the health benefit plan, no utilization
50 review entity shall revoke, limit, condition, or otherwise restrict a prior authorization within
51 ~~[forty five working days of the date the health care provider receives the prior authorization]~~
52 **the lesser of six months after the date the health care provider receives the prior**

53 **authorization approval or the length of treatment as determined by the patient's health**
54 **care provider.**

55 **(2) If a health carrier requires a prior authorization for a recurring health care**
56 **service or maintenance medication for the treatment of a chronic or long-term condition**
57 **as defined by the United States Centers for Disease Control and Prevention, including,**
58 **but not limited to, chemotherapy for the treatment of cancer, the approval shall remain**
59 **valid for the lesser of twelve months from the date the health care professional or health**
60 **care provider receives the prior authorization approval or the length of the treatment as**
61 **determined by the patient's health care provider. A health carrier and an enrollee or his**
62 **or her health care provider may extend a prior authorization approval for a longer**
63 **period by mutual agreement.**

64 8. Provided the patient is an enrollee of the health benefit plan at the time the service
65 is provided, no health carrier, utilization review entity, or health care provider shall bill an
66 enrollee for any health care service for which a prior authorization was in effect at the time
67 the health care service was provided, except as consistent with cost-sharing requirements
68 applicable to a covered benefit under the enrollee's health benefit plan. Such cost-sharing
69 shall be subject to and applied toward any in-network deductible or out-of-pocket maximum
70 applicable to the enrollee's health benefit plan.

71 **9. The failure of a health carrier to comply with the deadlines and requirements**
72 **of this section shall result in any health care services subject to prior authorization to be**
73 **automatically deemed authorized by the health carrier for a duration of time of at least**
74 **the time frames set forth in subsection 7 of this section.**

376.1364. 1. Any utilization review entity performing prior authorization review
2 shall provide a unique confirmation number **and timestamp** to a provider upon receipt from
3 that provider of a request for prior authorization. Except as otherwise requested by the
4 provider in writing, unique confirmation numbers shall be transmitted or otherwise
5 communicated through the same medium through which the requests for prior
6 authorization were made.

7 2. No later than January 1, 2021, utilization review entities shall accept and respond
8 to requests for prior authorization of drug benefits through a secure electronic transmission
9 using the National Council for Prescription Drugs SCRIPT Standard Version 2017071 or a
10 backwards-compatible successor adopted by the United States Department of Health and
11 Human Services. For purposes of this subsection, facsimile, proprietary payer portals, and
12 electronic forms shall not be considered electronic transmission.

13 3. No later than January 1, 2021, utilization review entities shall accept and respond
14 to requests for prior authorization of health care services and mental health services

15 electronically. For purposes of this subsection, facsimile, proprietary payer portals, and
16 electronic forms shall not be considered electronic transmission.

17 4. ~~[No later than January 1, 2021, each health carrier utilizing prior authorization~~
18 ~~review shall develop a single secure electronic prior authorization cover page for all of its~~
19 ~~health benefit plans utilizing prior authorization review, which the carrier or its utilization~~
20 ~~review entity shall use to accept and respond to, and which providers shall use to submit,~~
21 ~~requests for prior authorization. Such cover page shall include, but not be limited to, fields~~
22 ~~for patient or enrollee information, referring or requesting provider information, rendering or~~
23 ~~attending provider information, and required clinical information, and shall be supplemented~~
24 ~~by additional clinical information as required by the health carrier or utilization review~~
25 ~~entity.]~~ For plan years beginning on or after January 1, 2027, a health carrier or its
26 utilization review entity shall implement and maintain a prior authorization application
27 programming interface (API) that conforms with 45 CFR 156.221(c)(2) through (4), (d),
28 and (e) and the standards in 45 CFR 170.215(a)(1), (b)(1)(i), and (c)(1) to respond to
29 requests for prior authorization for health care services, excluding prescription drugs.
30 If a health carrier cannot implement the prior authorization API by January 1, 2027,
31 the health carrier shall provide written notice to the department requesting an
32 extension, accompanied by a documented plan to come into compliance.

33 5. An enrollee's health care provider shall use the prior authorization API, as
34 described in subsection 4 of this section, to submit requests for prior authorization for
35 health care services, excluding prescription drugs.

36 6. For contracts between health carriers and participating health care providers
37 entered into or renewed on or after January 1, 2027, a health carrier shall include a
38 provision that requires health care providers to submit prior authorization requests
39 using the application programming interface described in subsection 4 of this section. If
40 a participating health care provider fails to utilize the prior authorization API to submit
41 requests, the enrollee shall not be subject to cost sharing in excess of the in-network
42 cost-sharing amount.

43 7. For plan years beginning on or after January 1, 2027, a health carrier using
44 prior authorization shall make statistics available regarding prior authorization
45 approvals and denials for health care services, excluding drugs, on its website in a
46 readily accessible format. Health carriers shall submit the uniform resource locator
47 (URL) for the website location where such statistics are posted to the department, and
48 the department shall publish the website locations in a central location on the
49 department's website. The statistics shall be updated each year thereafter, no later than
50 March thirty-first, and shall include all the following information:

51 **(1) The percentage of standard prior authorization requests that were approved,**
52 **aggregated for all health care services;**

53 **(2) The percentage of standard prior authorization requests that were denied,**
54 **aggregated for all health care services;**

55 **(3) The percentage of prior authorization requests that were approved after**
56 **appeal, aggregated for all health care services;**

57 **(4) The percentage of prior authorization requests for which the time frame for**
58 **review was extended, and the request was approved, aggregated for all health care**
59 **services;**

60 **(5) The percentage of expedited prior authorization requests that were**
61 **approved, aggregated for all health care services;**

62 **(6) The percentage of expedited prior authorization requests that were denied,**
63 **aggregated for all health care services;**

64 **(7) The average and median time that elapsed between the submission of a**
65 **request and a determination by the health carrier for standard prior authorization,**
66 **aggregated for all health care services;**

67 **(8) The average and median time that elapsed between the submission of a**
68 **request and a decision by the health carrier for expedited prior authorizations,**
69 **aggregated for all health care services; and**

70 **(9) Any other information as the department determines appropriate.**

71 **8. Every health carrier in this state offering a health benefit plan with a**
72 **managed care component shall report annually to the department, in a manner specified**
73 **by the department, a complete list of the health care services, excluding drugs, for which**
74 **prior authorization is required, including for services where prior authorization is**
75 **performed by the health carrier's utilization review entity.**

76 **9. Health carriers shall reduce the scope of claims subject to prior**
77 **authorizations. To promote consistency among carriers, the department shall review**
78 **the reports submitted under subsection 8 of this section and compile an annual report to**
79 **be published on the department's website no later than October first of each year.**

80 **10. No later than May 31, 2028, and annually thereafter, every health carrier in**
81 **this state offering a health benefit plan with a managed care component shall report to**
82 **the department, in a manner specified by the department, aggregated data related to the**
83 **following practices and experience of the health carrier for the prior plan year for**
84 **health care services submitted for payment, excluding drugs:**

85 **(1) The number of prior authorization requests;**

86 **(2) The number of prior authorization requests approved;**

87 **(3) The number of prior authorization requests denied;**

88 (4) The number of prior authorization requests for mental health services,
89 behavioral health benefits, and substance use disorders;

90 (5) The number of prior authorization requests for mental health services,
91 behavioral health benefits, and substance use disorders denied;

92 (6) The number of prior authorization requests for mental health services,
93 behavioral health benefits, and substance use disorders approved;

94 (7) The number of prior authorization appeals received;

95 (8) The number of adverse determinations reversed on appeal;

96 (9) The ten health care services or mental health services that were most
97 frequently denied through prior authorization;

98 (10) The ten reasons prior authorization requests were most frequently denied;

99 (11) The number of claims for health care services or mental health services that
100 were examined through a post-service utilization review process;

101 (12) The number and percentage of claims for health care services or mental
102 health services denied through post-service utilization review; and

103 (13) The ten health care services or mental health services that were most
104 frequently denied as a result of post-service utilization reviews.

376.1366. 1. Contracts between health carriers and health care providers shall
2 include a provision for the continuation of prior authorization approvals for enrollees
3 from a previous health carrier for at least one hundred eighty days from the effective
4 date of the enrollee's coverage under the new health benefit plan, subject to the terms of
5 the certificate of coverage.

6 2. At any time during the one-hundred-eighty-day period described in
7 subsection 1 of this section, the new health carrier may perform its own review to
8 grant a prior authorization approval subject to the terms of the certificate of coverage.

9 3. If there is a change in coverage of, or approval criteria for, a previously
10 authorized health care service, the change in coverage or approval criteria shall not
11 affect an enrollee who received prior authorization approval before the effective date of
12 the change through the remainder of the enrollee's plan year.

13 4. Except to the extent required by medical exceptions processes for prescription
14 drugs, nothing in this section shall require a health benefit plan to cover any care,
15 treatment, or services for any health condition that the certificate of coverage otherwise
16 completely excludes from the health benefit plan's covered benefits without regard for
17 whether the care, treatment, or services are medically necessary.

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

4 2. As used in sections 376.2100 to 376.2108, the term "evaluation period" means
5 any consecutive twelve months.

 376.2102. 1. Except as otherwise provided in this section, beginning January 1,
2 2027, a health carrier or utilization review entity shall not require a health care provider
3 to obtain prior authorization for a health care service unless the health carrier or
4 utilization review entity makes a determination that in the most recent evaluation period
5 the health carrier or utilization review entity has approved or would have approved less
6 than ninety percent of the prior authorization requests submitted by that provider for
7 that health care service.

8 2. Beginning January 1, 2027, a health carrier or utilization review entity shall
9 not require a health care provider to obtain prior authorization for any health care
10 services unless the health carrier or utilization review entity makes a determination that
11 in the most recent evaluation period the health carrier or utilization review entity has
12 approved or would have approved less than ninety percent of all prior authorization
13 requests submitted by that provider for health care services.

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

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

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

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

23 4. In making a determination under this section, the health carrier or utilization
24 review entity shall use either the provider's National Provider Identifier or a taxpayer
25 identification number. Such designation shall remain unless requested to be changed by
26 the provider.

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

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

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

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

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

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

49 8. No adverse determination shall be finalized under subsection 1, 2, or 5 of this
50 section unless reviewed by a clinical peer.

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

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

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

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

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

7 (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
2 MO HealthNet, except that a Medicaid managed care organization as defined in section

3 **208.431 shall be considered a health carrier for purposes of sections 376.2100 to**
4 **376.2108.**

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

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

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

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

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