SECOND REGULAR SESSION

[PERFECTED]

HOUSE COMMITTEE SUBSTITUTE FOR

HOUSE BILL NO. 3010

103RD GENERAL ASSEMBLY

6673H.02P 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Section A. Sections 376.1363 and 376.1364, RSMo, are repealed and eight new sections enacted in lieu thereof, to be known as sections 376.1363, 376.1364, 376.1366, 376.2100, 376.2102, 376.2104, 376.2106, and 376.2108, to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 review decisions and for notifying enrollees and providers acting on behalf of enrollees of its decisions. For purposes of this section, "enrollee" includes the representative of an enrollee.

2. For determinations, a health carrier shall make the determination within thirty-six hours, which shall include one working day, of obtaining all necessary information regarding a proposed admission, procedure or service requiring a review determination. For purposes of this section, "necessary information" includes the results of any face-to-face clinical evaluation or second opinion that may be required:

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

(2) In the case of an adverse determination, the carrier shall notify the provider rendering the service by telephone or electronically within twenty-four hours of making the 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.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) The number of prior authorization requests;

(2) The number of prior authorization requests approved;

(3) The number of prior authorization requests denied;

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

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

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

(7) The number of prior authorization appeals received;

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

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

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

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

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

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

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

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

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

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

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 term "evaluation period" means any consecutive twelve months.

376.2102. 1. Except as otherwise provided in this section, beginning January 1, 2027, 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, 2027, 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 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. 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.

4. 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.

5. The exemption from prior authorization requirements described in subsections 1 and 2 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 for which the provider was exempt from the prior authorization requirement under subsection 1 of this section; or

(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.

6. The exemption described in subsections 1 and 2 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.

7. 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.

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

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.

✓