HB 3010 -- PRIOR AUTHORIZATION OF HEALTH CARE SERVICES

SPONSOR: Stinnett

Currently, provided a patient is an enrollee of a health benefit plan, a utilization review entity is prohibited from revoking, limiting, conditioning, or otherwise restricting a prior authorization for a health care service within 45 working days of the date the health care provider receives the prior authorization. This bill changes the time frame to be 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.

Additionally, 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, the approval will remain valid for the lesser of 12 months from 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.

Failure of a health carrier to comply with these provisions will 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 described above.

Currently, any utilization review entity performing prior authorization review must provide a unique confirmation number to a provider upon receipt from that provider of a request for prior authorization. This bill requires a timestamp to be provided to a provider as well.

Prior to January 1, 2021, health carriers utilizing prior authorization review were required to develop a single secure electronic prior authorization cover page for all of its health benefit plans utilizing prior authorization review, which would be used by the carrier or its utilization review entity to accept and respond to, and which providers would use to submit, requests for prior authorization. This bill repeals that provision and instead provides that for plan years beginning on or after January 1, 2027, health carriers or utilization review entities are required to implement and maintain a prior authorization application programming interface (API) to respond to requests for prior authorization for health care services, excluding prescription drugs. If the API cannot be implemented in time, the carrier must notify the Department of Commerce and Insurance

requesting an extension. Health care providers must use the API to submit requests for prior authorization for health care services, excluding prescription drugs.

The bill requires contracts between health carriers and participating health care providers entered into or renewed on or after January 1, 2027, to include a provision requiring health care providers to submit prior authorization requests via the API; failure to do so will result in the enrollee not being subject to cost sharing in excess of the in-network cost-sharing amount.

Additionally, the bill requires that health carriers utilizing prior authorization make available statistics regarding prior authorization approvals and denials for health care services in a readily available format. Carriers must submit the URL to the Department, which must publish the website locations in a central location on the Department's website. The bill specifies what information must be included.

This bill requires that health carriers offering health benefit plans with a managed care component report to the Department a complete list of the health care services for which prior authorization is required. The bill requires health carriers to reduce the scope of claims subject to prior authorizations. To promote consistency among carriers, the Department is required to review the submitted reports and compile an annual report to be published on the Department’s website. The bill also requires the reporting by health carriers to the Department of aggregated data related to certain practices, including, but not limited to, the number of prior authorization requests, the number of requests approved or denied, and the number of requests for mental health services, behavioral health benefits, and substance use disorders. The bill lists the data required to be reported.

The bill requires that contracts between health carriers and health care providers include a provision for the continuation of prior authorization approvals for enrollees from a previous health carrier for at least 180 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. At any time during this 180-day period, the new health carrier can perform its own review to grant a prior authorization approval subject to the terms of the certificate of coverage. Additionally, 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 must 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.

Beginning January 1, 2027, prior authorization is not required unless a determination is made that less than 90% of prior authorization requests submitted by the health care provider in the previous evaluation period, as defined in the bill, were or would have been approved.

Entities exempt from these prior authorization requirements may be audited, up to a maximum of two times per year, and exemption may be revoked under specific conditions, such as approval rates dropping below 90% or a significant increase in exempt procedures. Additionally, exemptions are void if providers are found guilty of fraud or abuse.

Online portals may be required for prior authorization submissions, and no adverse determinations are to be finalized unless reviewed by a clinical peer.

The bill specifies requirements for notifying the provider of determinations in the bill, requires carriers and utilization review entities to maintain an online portal giving providers access to certain information, and provides that a health carrier or utilization review entity must notify the health care provider no later than 25 days after a determination has been made.

Lastly, no health carrier or utilization review entity can deny or reduce payments to a health care provider who had a prior authorization, unless the provider made a knowing and material misrepresentation with the intent to deceive the carrier or utilization review entity, or unless the health care service was not substantially performed.

This bill does not apply to MO HealthNet, except with regard to a Medicaid managed care organization as defined by law. The bill also does not apply to providers who have not participated in a health benefit plan offered by the carrier for at least one full evaluation period.

This bill should not be construed to authorize providers to provide services outside the scope of their licenses, nor to require health carriers or utilization review entities to pay for care provided outside the scope of a provider's license.