

SENATE AMENDMENT NO. _____

Offered by _____ Of _____

Amend SS/SCS/Senate Bill No. 841, Page 129, Section 376.1280, Line 45,

2 by inserting after all of said line the following:

3 "376.1364. 1. Any utilization review entity
 4 performing prior authorization review shall provide a unique
 5 confirmation number and timestamp or similar indicator that
 6 documents the time of receipt acknowledgment of the request
 7 for prior authorization to a provider upon receipt from that
 8 provider of a request for prior authorization. Such
 9 timestamp or similar indicator shall be referenced to the
 10 specific prior authorization request. Except as otherwise
 11 requested by the provider in writing, unique confirmation
 12 numbers shall be transmitted or otherwise communicated
 13 through the same medium through which the requests for prior
 14 authorization were made.

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

25 3. No later than January 1, 2021, utilization review
26 entities shall accept and respond to requests for prior
27 authorization of health care services and mental health
28 services electronically. For purposes of this subsection,
29 facsimile, proprietary payer portals, and electronic forms
30 shall not be considered electronic transmission.

31 4. [No later than January 1, 2021, each health carrier
32 utilizing prior authorization review shall develop a single
33 secure electronic prior authorization cover page for all of
34 its health benefit plans utilizing prior authorization
35 review, which the carrier or its utilization review entity
36 shall use to accept and respond to, and which providers
37 shall use to submit, requests for prior authorization. Such
38 cover page shall include, but not be limited to, fields for
39 patient or enrollee information, referring or requesting
40 provider information, rendering or attending provider
41 information, and required clinical information, and shall be
42 supplemented by additional clinical information as required
43 by the health carrier or utilization review entity.] By
44 January 1, 2028, health carriers and utilization review
45 entities shall implement and maintain a prior authorization
46 application programming interface (API) that conforms with
47 45 CFR 156.221(c) (2) through (4), (d), and (e) and the
48 standards in 45 CFR 170.215(a) (1), (b) (1) (i), and (c) (1) to
49 respond to requests for prior authorization for health care
50 services, excluding prescription drugs. If a health carrier
51 cannot implement the prior authorization API by January 1,
52 2028, the health carrier shall provide written notice to the
53 department requesting an extension, accompanied by a
54 documented plan to come into compliance.

55 5. By January 1, 2028, an enrollee's health care
56 provider shall use the prior authorization API, as described
57 in subsection 4 of this section, to submit requests for

58 prior authorization for health care services, excluding
59 prescription drugs.

60 6. For contracts between health carriers and
61 participating health care providers entered into or renewed
62 on or after January 1, 2028, a health carrier shall include
63 a provision that requires health care providers to submit
64 prior authorization requests using the application
65 programming interface described in subsection 4 of this
66 section. If a participating health care provider fails to
67 utilize the prior authorization API to submit requests, the
68 enrollee shall not be subject to cost sharing in excess of
69 the in-network cost-sharing amount.

70 7. (1) For plan years beginning on or after January
71 1, 2027, a health carrier using prior authorization shall
72 make statistics available regarding prior authorization
73 approvals and denials for health care services, excluding
74 drugs, on its website in a readily accessible format.
75 Health carriers shall submit the uniform resource locator
76 (URL) for the website location where such statistics are
77 posted to the department, and the department shall publish
78 the website locations in a central location on the
79 department's website. The statistics shall be updated each
80 year thereafter, no later than March thirty-first, and shall
81 include all the following information:

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

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

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

91 (d) The percentage of prior authorization requests for
92 which the time frame for review was extended by the health
93 carrier, and the request was approved, aggregated for all
94 health care services;

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

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

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

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

109 (i) Any other information as the department determines
110 appropriate that does not create an unreasonable burden on
111 the health carrier.

112 (2) Any information required to be made available by a
113 health carrier under this subsection that is contained in a
114 health benefit plan file with the department may satisfy any
115 reporting requirement under this subsection; provided, that
116 such information shall be made available in a readily
117 accessible format in accordance with the provisions of this
118 subsection.

119 8. Every health carrier in this state offering a
120 health benefit plan with a managed care component shall
121 report annually to the department, in a manner specified by
122 the department, a complete list of the health care services,
123 excluding drugs, for which prior authorization is required,

124 including for services where prior authorization is
125 performed by the health carrier's utilization review entity.

126 9. Health carriers shall reduce the scope of claims
127 subject to prior authorizations. For transparency, the
128 department shall review the reports submitted under
129 subsection 8 of this section and compile an annual report to
130 be published on the department's website no later than
131 October first of each year.

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

140 (1) The number of prior authorization requests;

141 (2) The number of prior authorization requests
142 approved;

143 (3) The number of prior authorization requests denied;

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

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

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

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

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

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

159 (10) The most frequent reasons prior authorization
160 requests are denied;

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

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

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

170 Further amend the title and enacting clause accordingly.