COMMITTEE ON LEGISLATIVE RESEARCH
OVERSIGHT DIVISION

FISCAL NOTE

L.R. No.: 4302S.01I
Bill No.: SB 947
Subject: Commerce and Insurance, Department of; Health Care; Health Care Professionals; Insurance - Health; Medical Procedures and Personnel
Type: Original
Date: March 31, 2022

Bill Summary: This proposal enacts provisions relating to prior authorization of health care services.

FISCAL SUMMARY

ESTIMATED NET EFFECT ON GENERAL REVENUE FUND			
FUND AFFECTED	FY 2023	FY 2024	FY 2025
General Revenue Fund*	(Unknown)	(Unknown)	(Unknown)
Total Estimated Net Effect on General Revenue	**(Unknown)**	**(Unknown)**	**(Unknown)**

*Oversight assumes the cost could exceed the $250,000 threshold.

ESTIMATED NET EFFECT ON OTHER STATE FUNDS			
FUND AFFECTED	FY 2023	FY 2024	FY 2025
Other State Funds	(Unknown)	(Unknown)	(Unknown)
Total Estimated Net Effect on Other State Funds	**(Unknown)**	**(Unknown)**	**(Unknown)**

Numbers within parentheses: () indicate costs or losses.

ESTIMATED NET EFFECT ON FEDERAL FUNDS			
FUND AFFECTED	FY 2023	FY 2024	FY 2025
Federal Funds	(Unknown)	(Unknown)	(Unknown)
Total Estimated Net Effect on <u>All</u> Federal Funds	**(Unknown)**	**(Unknown)**	**(Unknown)**

ESTIMATED NET EFFECT ON FULL TIME EQUIVALENT (FTE)			
FUND AFFECTED	FY 2023	FY 2024	FY 2025
Total Estimated Net Effect on FTE	**0**	**0**	**0**

☒ Estimated Net Effect (expenditures or reduced revenues) expected to exceed $250,000 in any of the three fiscal years after implementation of the act or at full implementation of the act.

☐ Estimated Net Effect (savings or increased revenues) expected to exceed $250,000 in any of the three fiscal years after implementation of the act or at full implementation of the act.

ESTIMATED NET EFFECT ON LOCAL FUNDS			
FUND AFFECTED	FY 2023	FY 2024	FY 2025
Local Government	**(Unknown)**	**(Unknown)**	**(Unknown)**

FISCAL ANALYSIS

ASSUMPTION

Sections 376.2100 - 376.2114 - Prior Authorization Exemption

Officials from the **Missouri Consolidated Health Care Plan (MCHCP)** assume SB 947 creates a prior authorization exemption, which would allow providers to skip prior authorization requirements if they qualify by meeting a 90% approval threshold in the 6 months prior. Once this exemption is applied, payment can only be withheld for limited reasons that does not include the service being later found not medically necessary in whole or in part.

It is unknown how many providers serving MCHCP members would qualify for this exemption. It is also unknown how many cases would be authorized under the exemption that would otherwise be deemed not medically necessary in whole or in part. SB 947 would have an unknown, possibly exceeding $250,000, impact on MCHCP.

Oversight does not have any information to the contrary. Therefore, Oversight will reflect an unknown cost to the General Revenue, Federal Funds and Other State Funds. Oversight assumes the cost could exceed the $250,000 threshold each year. Oversight assumes this legislation could have a fiscal impact on local health insurance programs and will also reflect an unknown cost to local political subdivisions.

Officials from the **Department of Commerce and Insurance**, the **Department of Social Services**, the **Missouri Department of Conservation**, the **Missouri Department of Transportation**, **Kansas City** and the **City of Springfield** each assume the proposal will have no fiscal impact on their respective organizations. **Oversight** does not have any information to the contrary. Therefore, Oversight will reflect a zero impact in the fiscal note for these agencies.

Officials from the **Department of Public Safety - Missouri Highway Patrol** defer to the Missouri Department of Transportation for the potential fiscal impact of this proposal.

Oversight only reflects the responses received from state agencies and political subdivisions; however, other cities were requested to respond to this proposed legislation but did not. A listing of political subdivisions included in the Missouri Legislative Information System database is available upon request.

FISCAL IMPACT – State Government	FY 2023 (10 Mo.)	FY 2024	FY 2025
GENERAL REVENUE FUND			
Cost – MCHCP Prior Authorization Exemptions p.3	(Unknown)	(Unknown)	(Unknown)
ESTIMATED NET EFFECT TO THE GENERAL REVENUE FUND	**(Unknown)**	**(Unknown)**	**(Unknown)**
FEDERAL FUNDS			
Cost – MCHCP Prior Authorization Exemptions p.3	(Unknown)	(Unknown)	(Unknown)
ESTIMATED NET EFFECT TO FEDERAL FUNDS	**(Unknown)**	**(Unknown)**	**(Unknown)**
OTHER STATE FUNDS			
Cost – MCHCP Prior Authorization Exemptions p.3	(Unknown)	(Unknown)	(Unknown)
ESTIMATED NET EFFECT TO OTHER STATE FUNDS	**(Unknown)**	**(Unknown)**	**(Unknown)**

FISCAL IMPACT – Local Government	FY 2023 (10 Mo.)	FY 2024	FY 2025
LOCAL POLITICAL SUBDIVISIONS			
Cost – MCHCP Prior Authorization Exemptions p.3	(Unknown)	(Unknown)	(Unknown)
ESTIMATED NET EFFECT TO LOCAL POLITICAL SUBDIVISIONS	**(Unknown)**	**(Unknown)**	**(Unknown)**

FISCAL IMPACT – Small Business

No direct fiscal impact to small businesses would be expected as a result of this proposal.

FISCAL DESCRIPTION

Under this act, no health carrier or utilization review entity shall require a health care provider to obtain prior authorization for a particular health care service if, in the most recent six-month evaluation period as described in the act, the health carrier or utilization review entity has approved not less than 90% of the prior authorization requests submitted by that provider for that particular health care service. Carriers or utilization review entities shall evaluate whether a provider qualifies for this exemption (a "prior authorization provider exemption" or "exemption") under this act once every six months, or may continue an existing exemption without evaluation. (Section 376.2102)

An exemption under this act shall remain in effect until: the 30th day after the health carrier or utilization review entity notifies the provider of its decision to rescind the exemption as provided in the act, if the provider does not request a review of the decision as specified in the act; or the 5th day after the independent review organization affirms the determination to rescind the exemption, if the provider requests a review of the decision as specified in the act. If a health carrier or utilization review entity does not finalize a rescission determination in one of these manners, the provider shall be considered to have met the criteria for an exemption, and the exemption shall remain in effect. (Section 376.2104)

A health carrier or utilization review entity shall rescind a prior authorization provider exemption only during January or July of each year, if the carrier or utilization review entity makes a determination that less than 90% of a random sample of 5 to 20 claims for the particular health care service met the medical necessity criteria used for prior authorization review, if the carrier or utilization review entity notifies the provider not less than 25 days before the proposed rescission is to take effect, and if the carrier or utilization review entity provides along with this notice both the sample information used to make the determination and a plain language explanation of how the provider may request an independent review of the determination. (Section 376.2106.1).

A rescission determination must be made by an individual licensed to practice medicine in this state. A rescission determination made with regard to a physician must be made by an individual licensed to practice medicine in this state who has the same or similar specialty as that physician. (Section 376.2106.2).

A health carrier or utilization review entity shall deny a prior authorization provider exemption only if the provider does not have an exemption at the time of the relevant evaluation period, and the carrier or utilization review entity provides the provider with data and information for the relevant evaluation period sufficient to demonstrate that the provider does not meet the criteria for the exemption. (Section 376.2106.3)

Providers shall have the right to a review of an adverse determination regarding a prior authorization provider exemption, which shall be conducted by an independent review organization. No health carrier or utilization review entity shall require a provider to engage in an internal appeals process before requesting a review by an independent review organization. (Section 376.2108.1).

A health carrier or utilization review entity shall pay for any appeal or independent review of an adverse determination regarding an exemption under this act, and shall pay a reasonable fee for any copies of medical records or other documents requested from a provider during an independent review requested under the act. (Section 376.2108.2).

An independent review organization shall complete a review of an adverse determination regarding an exemption under this act not later than the 30th day after the provider files the request for an independent review. (Section 376.2108.3).

A provider may request that the independent review organization consider another random sample of 5 to 20 claims submitted by the provider during the relevant evaluation period for the relevant health care service, as specified in the act. If the provider makes this request, the independent review organization shall base its determination on both the claims initially reviewed by the health carrier or utilization review entity and the claims included in the additional random sample requested by the provider. (Section 376.2108.4)

A health carrier or utilization review entity shall be bound by an independent review determination under the act which does not affirm the determination made by the carrier or entity to deny or rescind a prior authorization provider exemption. (Section 376.2110.1).

No health carrier or utilization review entity shall retroactively deny coverage for a health care service on the basis of a rescission of a prior authorization provider exemption, even if the carrier's or entity's determination to rescind the exemption is affirmed by an independent review organization. (Section 376.2110.2).

If a health carrier's or utilization review entity's determination of a prior authorization provider exemption is overturned on review by an independent review organization, the carrier or utilization review entity shall not attempt to rescind the exemption before the end of the next evaluation period that occurs, and shall only rescind the exemption thereafter in compliance with the act. (Section 376.2110.3)

After a final determination or review affirming the rescission or denial of a prior authorization provider exemption, a provider shall be eligible for consideration for an exemption for the same health care service after the evaluation period that follows the evaluation period which formed the basis of the rescission or denial. (Section 376.2112)

No health carrier or utilization review entity shall deny or reduce payment to a provider for a health care service for which the provider has a prior authorization provider exemption in effect based on medical necessity or appropriateness of care, unless the provider knowingly and materially misrepresented the health care service in a request for payment with the specific intent to deceive and obtain an unlawful payment, or failed to substantially perform the health care service. (Section 376.2114.1).

No health carrier or utilization review entity shall conduct a retrospective review of a health care service subject to a prior authorization provider exemption, except to determine whether the provider still qualifies for the exemption, or if the health carrier or utilization review entity has reasonable cause to suspect there has been a knowing material misrepresentation or a failure to perform the health care service, as specified in the act. (Section 376.2114.2).

For retrospective reviews subject to a prior authorization provider exemption, nothing in the act shall be construed to modify existing utilization review procedures or timelines, or any other applicable law except to prescribe when a retrospective utilization review may occur as specified in the act, or when payment may be denied or reduced as specified in the act. (Section 376.2114.3).

No later than 5 days after a provider qualifies for a prior authorization provider exemption, a health carrier or utilization review entity shall provide to the provider a notice that includes a statement that the provider qualifies for the exemption, a list of the health care services and health benefit plans to which the exemption applies, and a statement of the duration of the exemption.

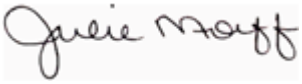
(Section 376.2114.4). If a provider submits a prior authorization request for a health care service for which the provider qualifies for an exemption, the health carrier or utilization review entity shall include in its response a notice to the provider which includes the information provided to providers when they qualify for an exemption, and a notification of the health carrier's or utilization review entity's payment requirements. (Section 376.2114.5).

Nothing in this act shall be construed to authorize provision of health care services outside the scope of providers' applicable licenses, or to require a health carrier or utilization review entity to pay for such services performed outside the scope of a providers' licenses. (Section 376.2114.6)

This legislation is not federally mandated, would not duplicate any other program and would not require additional capital improvements or rental space.

SOURCES OF INFORMATION

Department of Commerce and Insurance
Department of Public Safety
Missouri Highway Patrol
Department of Social Services
Missouri Department of Conservation
Missouri Department of Transportation
Missouri Consolidated Health Care Plan
Kansas City
City of Springfield



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