State of Arkansas
94th General Assembly
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A Bill

HOUSE BILL 1271

By: Representative L. Johnson
By: Senator Irvin

For An Act To Be Entitled

AN ACT TO AMEND THE PRIOR AUTHORIZATION TRANSPARENCY ACT; TO EXEMPT CERTAIN HEALTHCARE PROVIDERS THAT PROVIDE CERTAIN HEALTHCARE SERVICES FROM PRIOR AUTHORIZATION REQUIREMENTS; AND FOR OTHER PURPOSES.

Subtitle

TO AMEND THE PRIOR AUTHORIZATION TRANSPARENCY ACT; AND TO EXEMPT CERTAIN HEALTHCARE PROVIDERS THAT PROVIDE CERTAIN HEALTHCARE SERVICES FROM PRIOR AUTHORIZATION REQUIREMENTS.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF ARKANSAS:

SECTION 1. Arkansas Code § 23-99-1103(8), concerning the definition of "healthcare insurer" under the Prior Authorization Transparency Act, is amended to read as follows:

(8)(A)(i) "Healthcare insurer" means an entity that is subject to state insurance regulation, including an insurance company, a health maintenance organization, a hospital and medical service corporation, a risk-based provider organization, and a sponsor of a nonfederal self-funded governmental plan.

(ii) "Healthcare insurer" includes Medicaid where specifically referenced in §§ 23-99-1119 – 23-99-1126.

(B) "Healthcare insurer" does not include:

(i) A workers' compensation plan;

(ii) Medicaid, except as provided under §§ 23-99-1119 – 23-99-1126 or when Medicaid services are managed or reimbursed by a healthcare insurer; or

(iii) An entity that provides only dental benefits or eye and vision care benefits;

SECTION 2. Arkansas Code § 23-99-1103, concerning definitions used under the Prior Authorization Transparency Act, is amended to add additional subdivisions to read as follows:

(22) "Random sample" means at least five (5) claims but no more than twenty (20) claims for a particular healthcare service that are selected without method or conscious decision; and

(23) "Value-based reimbursement" means reimbursement that:

(A) Ties a payment for the provision of healthcare services to the quality of health care provided;

(B) Rewards a healthcare provider for efficiency and effectiveness; and

(C) May impose a risk-sharing requirement on a healthcare provider for healthcare services that do not meet the healthcare insurer's requirements for quality, effectiveness, and efficiency.

SECTION 3. Arkansas Code § 23-99-1104(a)(1), concerning disclosure required under the Prior Authorization Transparency Act, is amended to read as follows:

(a)(1)(A) A utilization review entity shall disclose all of its prior authorization requirements and restrictions~~, including any written clinical criteria,~~ in a publicly accessible manner on its website.

(B) The disclosure under subdivision (a)(1)(A) of this section shall include:

(i) A list of any healthcare services that require prior authorization; and

(ii) Any written clinical criteria.

SECTION 4. Arkansas Code § 23-99-1111 is amended to read as follows:

23-99-1111. Requests for prior authorization — Qualified persons authorized to review and approve — Adverse determinations to be made only by

Arkansas-licensed physicians — Opportunity to discuss treatment before adverse determination.

(a) The initial review of information submitted in support of a request for prior authorization may be conducted by a qualified person employed or contracted by a utilization review entity.

(b) A request for prior authorization may be approved by a qualified person employed or contracted by a utilization review entity.

(c)(1) An adverse determination regarding a request for prior authorization shall be made by a physician who possesses a current and unrestricted license to practice medicine in the State of Arkansas issued by the Arkansas State Medical Board.

(2)(A) A utilization review entity shall provide a method by which a physician may request that a prior authorization request be reviewed by a physician in the same specialty as the physician making the request, by a physician in another appropriate specialty, or by a pharmacologist.

(B) If a request is made under subdivision (c)(2)(A) of this section, the reviewing physician or pharmacologist is not required to meet the requirements of subdivision (c)(1) of this section.

(3)(A) Subject to this subdivision (c)(3)(A), before an adverse determination is issued by a utilization review entity that questions the medical necessity, the appropriateness, or the experimental or investigational nature of a healthcare service, the utilization review entity shall provide the healthcare provider that ordered, requested, provided, or is to provide the healthcare service a reasonable opportunity to discuss with a physician who possesses a current and unrestricted license to practice medicine in this state the patient's treatment plan and the clinical basis for the utilization review entity's determination.

(B)(i) If a healthcare service described in subdivision (c)(3)(A) of this section is ordered, requested, or provided, or is to be provided, by a physician, then before an adverse determination is made, the utilization review entity shall provide the healthcare provider with the opportunity described under subdivision (c)(3)(A) of this section.

(ii) The opportunity described under subdivision (c)(3)(A) of this section shall be with a physician who:

(a) Possesses a current and unrestricted license to practice medicine in this state; and

(b) Has the same or similar specialty as the healthcare provider.

SECTION 5. Arkansas Code Title 23, Chapter 99, Subchapter 11, is amended to add additional sections to read as follows:

23-99-1120. Initial exemption from prior authorization requirements for healthcare providers providing certain healthcare services.

(a)(1) Except as provided under subdivision (a)(2) of this section, beginning on and after January 1, 2024, a healthcare provider shall not be required to obtain prior authorization for a particular healthcare service and shall be considered exempt from prior authorization requirements through June 30, 2024.

(2) If a healthcare provider's use for a particular healthcare service increases by twenty-five percent (25%) or more during the initial period under subdivision (a)(1) of this section, based on a review of the healthcare provider's utilization of the particular healthcare service from January 1, 2022, through June 30, 2022, then the healthcare insurer may disallow the exemption from prior authorization requirements for the healthcare provider for the particular healthcare service.

(b)(1) A healthcare insurer shall conduct an evaluation of the initial six-month exemption period based on claims submitted between January 1, 2024, through June 30, 2024, to determine whether to grant or deny an exemption for each particular healthcare service that requires a prior authorization by the healthcare insurer.

(2) The evaluation by the healthcare insurer shall be conducted by using the retrospective review process under § 23-99-1122(c) and applying the criteria under subsection (d) of this section.

(3) A healthcare insurer shall submit to a healthcare provider a written statement of:

(A) The total number of payable claims submitted by or in connection with the healthcare provider; and

(B) The total number of denied and approved prior authorizations between January 1, 2022, through June 30, 2022.

(c)(1) No later than October 1, 2024, a healthcare insurer shall issue a notice to each healthcare provider that is credentialed by the healthcare insurer under § 23-99-411 that either grants or denies a prior authorization

exemption to the healthcare provider for each particular healthcare service.

(2) An exemption granted under this subdivision (c)(1) shall be valid for at least twelve (12) months.

(d) Except as provided under subsection (f) of this section or § 23-99-1125, a healthcare insurer that uses a prior authorization process for healthcare services shall not require a healthcare provider to obtain prior authorization for a particular healthcare service that a healthcare provider has previously been subject to a prior authorization requirement if, in the most recent six-month evaluation period as described under subsection (e) of this section, the healthcare insurer has approved or would have approved no less than ninety percent (90%) of the prior authorization requests submitted by the healthcare provider for that particular healthcare service.

(e)(1) Except as provided under subsection (f) of this section, a healthcare insurer shall evaluate whether or not a healthcare provider qualifies for an exemption from prior authorization requirements under subsection (d) of this section one (1) time every twelve (12) months.

(2) The six-month period for the evaluation period described under subsection (d) of this section shall be any consecutive six (6) month period during the twelve (12) months following the effective date of the exemption.

(3) The healthcare insurer shall choose a six-month evaluation period that allows time for:

(A) The evaluation under subsection (b) of this section;

(B) Notice to the healthcare provider of the decision; and

(C) Appeal of the decision for an independent review in arbitration to be completed by the end of the twelve-month period of the exemption.

(f) A healthcare insurer may continue an exemption under subsection (d) of this section without evaluating whether or not the healthcare provider qualifies for the exemption under subsection (d) of this section for a particular evaluation period.

(g) A healthcare provider is not required to request an exemption under subsection (d) of this section to qualify for the exemption.

23-99-1121. Duration of prior authorization exemption.

(a) Unless a prior authorization exemption is continued for a longer

period of time by a healthcare insurer under § 23-99-1120(f), a healthcare provider's exemption from prior authorization requirements under § 23-99-1120 remains in effect until the later of:

(1) The thirtieth day after the date the healthcare insurer notifies the healthcare provider of the healthcare insurer's determination to rescind the exemption as described under § 23-99-1122, if the healthcare provider does not appeal the healthcare insurer's determination;

(2) If the healthcare provider appeals the determination, the fifth day after the date an independent review organization affirms the healthcare insurer's determination to rescind the exemption; or

(3) Twelve (12) months after the effective date of the exemption.

(b) If a healthcare insurer does not finalize a rescission determination as specified in subsection (a) of this section, then the healthcare provider is considered to have met the criteria under § 23-99-1120 to continue to qualify for the exemption.

(c) A healthcare provider shall not rely on another healthcare provider's exemption except when the healthcare provider with an exemption is the healthcare provider that orders healthcare services that are rendered by a healthcare provider without an exemption.

23-99-1122. Denial or rescission of prior authorization exemption.

(a) A healthcare insurer may rescind an exemption from prior authorization requirements of a healthcare provider under § 23-99-1120 only if:

(1) The healthcare insurer makes a determination that, on the basis of a retrospective review of a random sample that is submitted by the healthcare provider during the most recent evaluation period described by § 23-99-1120(e), less than ninety percent (90%) of the claims for the particular healthcare service met the medical necessity criteria that would have been used by the healthcare insurer when conducting prior authorization review for the particular healthcare service during the relevant evaluation period; and

(2) The healthcare insurer complies with other applicable requirements specified in this section, including without limitation:

(A) Notifying the healthcare provider no less than twenty-

five (25) days before the proposed rescission is to take effect; and

(B) Providing:

(i) An identification of the healthcare service that an exemption is being rescinded, the date the notice is issued, and the effective date of the rescission;

(ii) A plain-language explanation of how the healthcare provider may appeal and seek an independent review of the determination, the date the notice is issued, and the company's address and contact information for returning the form by mail or email to request an appeal;

(iii) A statement of the total number of payable claims submitted by or in connection with the healthcare provider during the most recent evaluation period that were eligible to be evaluated with respect to the healthcare service subject to rescission, the number of claims included in the random sample, and the sample information used to make the determination, including without limitation:

(a) Identification of each claim included in the random sample;

(b) The healthcare insurer's determination of whether each claim met the healthcare insurer's screening criteria; and

(c) For any claim determined to not have met the healthcare insurer's screening criteria:

(1) The principal reasons for the determination that the claim did not meet the healthcare insurer's screening criteria, including, if applicable, a statement that the determination was based on a failure to submit specified medical records;

(2) The clinical basis for the determination that the claim did not meet the healthcare insurer's screening criteria;

(3) A description of the sources of the screening criteria that were used as guidelines in making the determination; and

(4) The professional specialty of the healthcare provider who made the determination;

(iv) A space to be filled out by the healthcare provider that includes:

(a) The name, address, contact information, and identification number of the healthcare provider requesting an independent review;

(b) An indication of whether or not the healthcare provider is requesting that the entity performing the independent review examine the same random sample or a different random sample of claims, if available; and

(c) The date the appeal is being requested; and

(v) An instruction to the healthcare provider to return the form to the healthcare insurer before the date the rescission becomes effective.

(b) A determination made under subdivision (a)(1) of this section shall be made by a physician who:

(1) Possesses a current and unrestricted license to practice medicine in this state; and

(2) Has the same or similar specialty as the healthcare provider.

(c)(1) A healthcare insurer that is conducting an evaluation under subsection (a) of this section to determine whether or not a healthcare provider still qualifies for a prior authorization exemption may request medical records and documents required for the retrospective review, limited to no more than twenty (20) claims for a particular healthcare service.

(2) A healthcare insurer shall provide a healthcare provider at least thirty (30) days to provide the medical records requested under subdivision (c)(1) of this section.

(d) A healthcare insurer may deny an exemption from prior authorization requirements under § 23-99-1120 only if:

(1) The healthcare provider does not have an exemption at the time of the relevant evaluation period; and

(2) The healthcare insurer provides the healthcare provider with:

(A) Actual data for the relevant prior authorization request evaluation period; and

(B) Detailed information sufficient to demonstrate that the healthcare provider does not meet the criteria for an exemption from

prior authorization requirements for the particular healthcare service under § 23-99-1120.

(e) A healthcare insurer shall:

(1) Allow a healthcare provider to designate an email address or a mailing address for communications regarding exemptions, denials, and rescissions;

(2) Provide an option for a healthcare provider to submit a request for an appeal by mail, by email, or by other electronic method; and

(3) Include an explanation of how a healthcare provider may update his or her preferred contact information and delivery method on the healthcare insurer's website and for all communications issued under this section.

23-99-1123. Independent review of exemption determination.

(a)(1) A healthcare provider has a right to a review of an adverse determination regarding a prior authorization exemption to be conducted by an independent review organization.

(2) A healthcare insurer shall not require a healthcare provider to engage in an internal appeal process before requesting a review by an independent review organization under this section.

(3) A healthcare provider who has an exemption rescinded due to a failure to provide medical records within sixty (60) days of a record request for a retrospective review shall not be eligible for review of that rescission by an independent review entity.

(b) A healthcare insurer shall pay:

(1) For any appeal or independent review of an adverse determination regarding a prior authorization exemption requested under this section; and

(2) A reasonable fee determined by the Arkansas State Medical Board for any copies of medical records or other documents requested from a healthcare provider during an exemption rescission review requested under this section.

(c) An independent review organization shall complete an expedited review of an adverse determination regarding a prior authorization exemption no later than the thirtieth day after the date a healthcare provider files the request for a review under this section.

(d)(1) A healthcare provider may request that the independent review organization consider another random sample of no fewer than five (5) and no more than twenty (20) claims submitted to the healthcare insurer by the healthcare provider during the relevant evaluation period for the relevant healthcare service as part of the review under this section.

(2) If a healthcare provider makes a request under subdivision (d)(1) of this section, the independent review organization shall base its determination on the medical necessity of claims reviewed:

(A) By the healthcare insurer under § 23-99-1122; and

(B) By the independent review organization under subdivision (d)(1) of this section.

23-99-1124. Effect of appeal of independent review organization determination.

(a) A healthcare insurer is bound by an appeal or independent review organization determination that does not affirm the determination made by the healthcare insurer to rescind a prior authorization exemption.

(b) A healthcare insurer shall not retroactively deny a healthcare service on the basis of a rescission of an exemption, even if the healthcare insurer's determination to rescind the prior authorization exemption is affirmed by an independent review organization.

(c) If a determination of a prior authorization exemption made by the healthcare insurer is overturned on review by an independent review organization, the healthcare insurer:

(1) Shall not attempt to rescind the exemption before the end of the next evaluation period; and

(2) May only rescind the exemption if the healthcare insurer complies with §§ 23-99-1122 and 23-99-1123.

23-99-1125. Eligibility for prior authorization exemption following finalized exemption rescission or denial.

(a) After a final determination or review affirming the rescission or denial of an exemption for a specific healthcare service under § 23-99-1120, a healthcare insurer shall conduct another evaluation to determine whether or not the exemption should be granted or reinstated based on the six-month evaluation period that follows the evaluation period that formed the basis of

the rescission or denial of an exemption.

(b) A time period that is included in a previous evaluation or determination period shall not be included in a subsequent evaluation period.

23-99-1126. Effect of prior authorization exemption.

(a) A healthcare insurer shall not deny or reduce payment to a healthcare provider for a healthcare service for which the healthcare provider has qualified for an exemption from prior authorization requirements under § 23-99-1120 based on medical necessity or appropriateness of care unless the healthcare provider:

(1) Knowingly and materially misrepresented the healthcare service in a request for payment submitted to the healthcare insurer with the specific intent to deceive the healthcare insurer and obtain an unlawful payment from the healthcare insurer; or

(2) Substantially failed to perform the healthcare service.

(b) A healthcare insurer shall not conduct a retrospective review of a healthcare service subject to an exemption except to determine if:

(1) The healthcare provider still qualifies for an exemption under § 23-99-1120; or

(2) The healthcare insurer has a reasonable cause to suspect a basis for denial exists under subsection (a) of this section.

(c) For a retrospective review described by subdivision (b)(2) of this section, §§ 23-99-1120 — 23-99-1125 shall not modify or otherwise affect:

(1) The requirements under or application of § 23-99-1115, including without limitation any time frames; or

(2) Any other applicable law, except to prescribe the only circumstances under which:

(A) A retrospective review may occur as specified by subdivision (b)(2) of this section; or

(B) Payment may be denied or reduced as specified by subsection (a) of this section.

(d) Beginning on January 1, 2024, a healthcare insurer shall provide to a healthcare provider a notice that includes a:

(1) Statement that the healthcare provider has an exemption from prior authorization requirements under § 23-99-1120;

(2) List of the healthcare services and health benefit plans to

which the exemption applies; and

(3) Statement of the duration of the exemption.

(e) If a healthcare provider submits a prior authorization request for a healthcare service for which the healthcare provider has an exemption from prior authorization requirements under § 23-99-1120, the healthcare insurer shall promptly provide a notice to the healthcare provider that includes:

(1) The information described in subsection (d) of this section; and

(2) A notification of the healthcare insurer's payment requirements.

(f) This section and §§ 23-99-1120 – 23-99-1125 shall not be construed to:

(1) Authorize a healthcare provider to provide a healthcare service outside the scope of the healthcare provider's applicable license; or

(2) Require a healthcare insurer to pay for a healthcare service described by subdivision (f)(1) of this section that is performed in violation of the laws of this state.

(g) A healthcare insurer that offers multiple health benefit plans or that utilizes multiple healthcare provider networks shall not determine a healthcare provider's eligibility for an exemption from prior authorization for each specific health benefit plan or each specific healthcare provider network but rather shall determine the healthcare provider's eligibility for an exemption applicable to all health benefit plans and healthcare provider networks.

(h) If a healthcare insurer and a healthcare provider are engaged in a value-based reimbursement arrangement for particular healthcare services or subscribers, the healthcare insurer shall not impose any prior authorization requirements for any particular healthcare service that is included in that value-based reimbursement arrangement.