House File 2635

H-8080

Amend House File 2635 as follows:

1. By striking everything after the enacting clause and inserting:

<DIVISION I

HEALTH INSURANCE TRADE PRACTICES

Section 1. Section 514F.8, Code 2026, is amended by adding the following new subsection:

NEW SUBSECTION. 2A. A utilization review organization may use an artificial intelligence-based algorithm or system to provide an initial review of a request for prior authorization, except that, for a prior authorization request for a health care service based on medical necessity, a utilization review organization shall not use an artificial intelligence-based algorithm or system as the sole basis for the utilization review organization's decision to deny, delay, or downgrade the prior authorization request.

Sec. 2. NEW SECTION. **514F.8C Utilization review organizations — audits.**

1. As used in this section, unless the context otherwise requires:

a. "Audit" means a review, investigation, or request for additional documentation by a utilization review organization before or after issuing payment on a claim to a health care provider.

b. "Commissioner" means the commissioner of insurance.

c. "Health care provider" means the same as defined in section 514F.8.

d. "Health carrier" means the same as defined in Section 514F.8.

e. "Utilization review organization" means the same as defined in section 514F.8.

2. *a.* A utilization review organization that conducts an audit shall notify the health care provider that submitted the claim of the initiation of the audit no later than fifteen calendar days after the date the utilization review

organization selects the claim for audit.

b. A utilization review organization shall complete an audit of a claim and issue a determination on the claim to the health care provider that submitted the claim no later than forty-five calendar days after the date that the utilization review organization receives all requested documentation regarding the claim from the health care provider.

c. A health care provider that submitted a claim that is the subject of an audit by a utilization review organization that receives an adverse determination regarding the claim may appeal the adverse determination no later than thirty calendar days after the date the health care provider receives the audit determination.

d. A utilization review organization shall consider an appeal under paragraph "*c*" and issue a final determination on the claim that is the subject of the appeal no later than thirty calendar days after the date the utilization review organization receives notice of the appeal.

e. If, after a hearing, the commissioner finds that a utilization review organization has violated this subsection, the claim shall be approved by the utilization review organization and promptly paid, including interest at the rate of ten percent per annum.

3. *a.* This section applies to the following classes of third-party payment provider contracts, policies, or plans delivered, issued for delivery, continued, or renewed in this state on or after January 1, 2027:

(1) Individual or group accident and sickness insurance providing coverage on an expense-incurred basis.

(2) An individual or group hospital or medical service contract issued pursuant to chapter 509, 514, or 514A.

(3) An individual or group health maintenance organization contract regulated under chapter 514B.

(4) A plan established for public employees pursuant to chapter 509A.

b. This section shall not apply to accident-only, specified disease, short-term hospital or medical, hospital confinement indemnity, credit, dental, vision, Medicare supplement, long-term care, basic hospital and medical-surgical expense coverage as defined by the commissioner of insurance, disability income insurance coverage, coverage issued as a supplement to liability insurance, workers' compensation or similar insurance, or automobile medical payment insurance.

4. The commissioner may adopt rules pursuant to chapter 17A to administer and enforce this section.

5. *a.* This section shall apply to an audit initiated on or after January 1, 2027.

b. This section shall not apply to a claim that is under active fraud investigation by a state or federal authority.

c. This section shall not apply to a federal program where audits are mandated by federal law.

Sec. 3. NEW SECTION. **514F.8D Health carriers —— standards of conduct.**

1. As used in this section, unless the context otherwise requires:

a. "*Health care provider*" means the same as defined in section 514J.102.

b. "*Health carrier*" means the same as defined in section 514F.8.

2. A health carrier shall not impose on a health care provider, directly or indirectly, any financial penalty, reimbursement reduction, or administrative fee, or terminate a health care provider's participation in the health carrier's network, based on the health care provider's referral to, or affiliation with, an out-of-network health care provider.

3. A health carrier shall not interfere with, or participate in any capacity in, a health care provider's decisions regarding staffing and referrals, except as otherwise provided by law.

4. A health carrier shall not offer, attempt to enforce,

or enforce an agreement, or an amendment to an agreement, with a health care provider without providing an opportunity for negotiation. A decision of the commissioner enforcing this subsection is final agency action for purposes of chapter 17A.

5. The commissioner may adopt rules pursuant to chapter 17A to administer and enforce this section.

DIVISION II

PRIOR AUTHORIZATIONS

Sec. 4. NEW SECTION. **514F.8A Prior authorizations — peer review.**

1. For purposes of this section, unless the context otherwise requires:

a. "Clinical peer" means a health care professional that meets all of the following requirements:

(1) The health care professional practices in the same or similar specialty as the health care provider that requested a prior authorization.

(2) The health care professional has experience managing the specific medical condition or administering the health care service that is the subject of the prior authorization request.

(3) The health care professional is employed by or contracted with the utilization review organization or health carrier to which a health care provider submitted a request for prior authorization.

b. "Covered person" means the same as defined in section 514F.8.

c. "Downgrade" means a decision by a utilization review organization to change an expedited or urgent request for prior authorization to a standard determination, or otherwise modify a health care service that is the subject of a request for prior authorization to a lower-level health care service.

d. "Health care professional" means the same as defined in section 514J.102.

e. "Health care provider" means the same as defined in section 514F.8.

f. *"Health care services"* means the same as defined in section 514F.8.

g. *"Health carrier"* means the same as defined in section 514F.8.

h. *"Physician"* means a doctor of medicine and surgery, or a doctor of osteopathic medicine and surgery, licensed under chapter 148.

i. *"Prior authorization"* means the same as defined in section 514F.8.

j. *"Qualified reviewer"* means a physician that meets all of the following requirements:

(1) The physician practices in the same or a similar specialty as the health care provider that requested a prior authorization.

(2) The physician has the training and expertise to treat the specific medical condition that is the subject of a request for prior authorization, including sufficient knowledge to determine whether the health care service that is the subject of the request is medically necessary or clinically appropriate.

(3) The physician is employed by or contracted with the utilization review organization to which a health care provider submitted a request for prior authorization.

k. *"Utilization review organization"* means the same as defined in section 514F.8.

2. A utilization review organization shall not deny or downgrade a request for prior authorization unless all of the following requirements are met:

a. The decision to deny or downgrade the request is made by either of the following:

(1) A qualified reviewer, if the health care provider requesting prior authorization is a physician.

(2) A clinical peer, if the health care provider requesting prior authorization is not a physician.

b. The utilization review organization provides the health

care provider that requested the prior authorization all of the following:

(1) A written statement that cites the specific reasons for the denial or downgrade, including any coverage criteria or limits, or clinical criteria, that the utilization review organization considered or that was the basis for the denial or downgrade. The written statement must be signed by either of the following:

(a) The qualified reviewer that made the denial or downgrade determination if the health care provider that requested prior authorization is a physician.

(b) The clinical peer that made the denial or downgrade determination if the health care provider that requested prior authorization is not a physician.

(2) A written explanation of the utilization review organization's appeals process. The utilization review organization shall also provide the written explanation to the covered person for whom prior authorization was requested.

(3) A written attestation that is either of the following:

(a) If the health care provider that requested prior authorization is a physician, a written attestation that the qualified reviewer who made the denial or downgrade determination practices in the same or a similar specialty as the health care provider, and has the requisite training and expertise to treat the medical condition that is the subject of the request for prior authorization, including sufficient knowledge to determine whether the health care service is medically necessary or clinically appropriate. The attestation shall include the qualified reviewer's name, national provider identifier, state medical license number, board certifications, specialty expertise, and educational background.

(b) If the health care provider that requested prior authorization is not a physician, a written attestation that the clinical peer who made the denial or downgrade determination practices in the same or a similar specialty as

the health care provider, and the clinical peer has experience managing the specific medical condition or administering the health care service that is the subject of the request for prior authorization. The attestation shall include the clinical peer's name, national provider identifier, state medical license number, board certifications, specialty expertise, and educational background.

3. At the request of the requesting health care provider, a utilization review organization that denies a request for prior authorization shall, no later than seven business days after the date that the utilization review organization notifies the requesting health care provider of the denial, conduct a consultation either in person or remotely, as follows:

a. Between the health care provider and a qualified reviewer if the health care provider requesting prior authorization is a physician.

b. Between the health care provider and a clinical peer if the health care provider requesting prior authorization is not a physician.

4. *a.* If a utilization review organization's decision to deny or downgrade a request for prior authorization is appealed by the requesting health care provider or covered person, the appeal shall be conducted by either of the following:

(1) A qualified reviewer if the health care provider requesting prior authorization is a physician.

(2) A clinical peer if the health care provider requesting prior authorization is not a physician.

b. A qualified reviewer or clinical peer involved in the initial denial or downgrade determination of a request for prior authorization that is the subject of an appeal shall not conduct the appeal.

c. When conducting an appeal of a request for prior authorization, the qualified reviewer or clinical peer shall consider the known clinical aspects of the health care services under review, including but not limited to medical records

relevant to the covered person's medical condition who is the subject of the health care services for which prior authorization is requested, and any relevant medical literature submitted by the health care provider as part of the appeal.

5. This section applies to requests for prior authorization made on or after January 1, 2027.

6. *a.* This section applies to the following classes of third-party payment provider contracts, policies, or plans delivered, issued for delivery, continued, or renewed in this state on or after January 1, 2027:

(1) Individual or group accident and sickness insurance providing coverage on an expense-incurred basis.

(2) An individual or group hospital or medical service contract issued pursuant to chapter 509, 514, or 514A.

(3) An individual or group health maintenance organization contract regulated under chapter 514B.

(4) A plan established for public employees pursuant to chapter 509A.

b. This section shall not apply to accident-only, specified disease, short-term hospital or medical, hospital confinement indemnity, credit, dental, vision, Medicare supplement, long-term care, basic hospital and medical-surgical expense coverage as defined by the commissioner of insurance, disability income insurance coverage, coverage issued as a supplement to liability insurance, workers' compensation or similar insurance, or automobile medical payment insurance.

7. The commissioner of insurance may adopt rules pursuant to chapter 17A to administer this section.

Sec. 5. NEW SECTION. **514F.8B Prior authorizations — exemptions.**

1. For purposes of this section:

a. *"Covered person"* means the same as defined in section 514F.8.

b. *"Health benefit plan"* means the same as defined in section 514J.102.

c. *"Health care professional"* means the same as defined in section 514J.102.

d. *"Health carrier"* means the same as defined in section 514F.8.

e. *"Prior authorization"* means the same as defined in section 514F.8.

f. *"Utilization review"* means the same as defined in section 514F.4, subsection 3.

2. A health carrier shall not require prior authorization for, or impose additional utilization review requirements on, a covered person for any of the following:

a. A cancer-related screening if the cancer-related screening is recommended by the covered person's health care professional based on the most recently updated national comprehensive cancer network clinical practice guidelines in oncology which are designated as category 2A or lower.

b. Diagnosis and treatment of an emergency medical condition that develops or becomes evident in a covered person while the covered person is receiving inpatient care that meets inpatient care standards, if the emergency medical condition is reasonably determined by a health care professional to be a life-threatening condition unless the covered person receives immediate assessment and treatment.

3. This section applies to all of the following:

a. Health benefit plans delivered, issued for delivery, continued, or renewed in this state on or after January 1, 2027.

b. Requests for prior authorization for a cancer-related screening, if the screening is recommended by the covered person's health care professional based on the most recently updated national comprehensive cancer network clinical practice guidelines in oncology designated as category 2A or lower, and is made on or after January 1, 2027.

c. Requests for prior authorization for the diagnosis and treatment of an emergency medical condition that develops or

becomes evident in a covered person while the covered person is receiving inpatient care that meets inpatient care standards, if the emergency medical condition is reasonably determined by a health care professional to be a life-threatening condition unless the covered person receives immediate assessment and treatment if the request is made on or after January 1, 2027.

4. *a.* This section applies to the following classes of third-party payment provider contracts, policies, or plans delivered, issued for delivery, continued, or renewed in this state on or after January 1, 2027:

(1) Individual or group accident and sickness insurance providing coverage on an expense-incurred basis.

(2) An individual or group hospital or medical service contract issued pursuant to chapter 509, 514, or 514A.

(3) An individual or group health maintenance organization contract regulated under chapter 514B.

(4) A plan established for public employees pursuant to chapter 509A.

b. This section shall not apply to accident-only, specified disease, short-term hospital or medical, hospital confinement indemnity, credit, dental, vision, Medicare supplement, long-term care, basic hospital and medical-surgical expense coverage as defined by the commissioner of insurance, disability income insurance coverage, coverage issued as a supplement to liability insurance, workers' compensation or similar insurance, or automobile medical payment insurance.

5. The commissioner of insurance may adopt rules pursuant to chapter 17A to administer this section.

Sec. 6. NEW SECTION. **514F.8E Enforcement.**

The remedy for noncompliance with section 514F.8, 514F.8A, 514F.8B, 514F.8C, or 514F.8D shall be those remedies authorized by chapters 505 and 507B pursuant to the procedures set forth in sections 507B.6, 507B.7, and 507B.8. Upon a finding of a pattern or practice of noncompliance with sections 514F.8, 514F.8A, 514F.8B, 514F.8C, or 514F.8D, the commissioner of

insurance may also suspend a utilization review organization's authority to conduct utilization review.

DIVISION III

PRIOR AUTHORIZATIONS —— MEDICAL ASSISTANCE PROGRAM

Sec. 7. NEW SECTION. **249A.5 Prior authorization —— exemptions.**

1. For purposes of this section, unless the context otherwise requires:

a. "Emergency medical condition" means the same as defined in 42 C.F.R. §438.114.

b. "Managed care organization" means an entity acting pursuant to a contract with the department to administer the medical assistance program.

c. "Prior authorization" means any process used by the department or a managed care organization to determine if, before a health care service is furnished to a recipient, the service is covered or medically necessary.

d. "Utilization review" means a set of formal techniques used to monitor or evaluate the medical necessity, appropriateness, or efficiency of a health care service.

2. The department, or a managed care organization, shall not require prior authorization for, or impose additional utilization review requirements on, a recipient for any of the following:

a. A cancer-related screening recommended for the recipient by the recipient's provider in accordance with the most recently updated national comprehensive cancer network clinical practice guidelines in oncology which are designated as category 2A or lower.

b. The diagnosis and treatment of an emergency medical condition that develops or becomes evident in a recipient while the recipient is receiving inpatient care that meets inpatient care standards, if the emergency medical condition is reasonably determined by a provider to present a life-threatening risk unless the recipient receives immediate

assessment and treatment.

3. This section applies to all of the following:

a. All contracts between the department and a managed care organization that are delivered, issued for delivery, continued, extended, or renewed on or after January 1, 2027.

b. All requests for prior authorization made on or after January 1, 2027.

4. The department may adopt rules pursuant to chapter 17A to administer this section.

Sec. 8. NEW SECTION. **514I.13 Prior authorizations — exemptions.**

1. For purposes of this section:

a. *"Emergency medical condition"* means the same as defined in 42 C.F.R. §438.114.

b. *"Health care professional"* means a person licensed or certified under the laws of this state to provide health care services to an eligible child.

c. *"Managed care organization"* means an entity acting pursuant to a contract with the department to administer the Hawki program.

d. *"Prior authorization"* means any process used by the department or a managed care organization to determine if, before a health care service is furnished to an eligible child, the service is covered or medically necessary.

e. *"Utilization review"* means a set of formal techniques used to monitor or evaluate the medical necessity, appropriateness, or efficiency of a health care service.

2. The department, or a managed care organization, shall not require prior authorization for, or impose additional utilization review requirements on, an eligible child for any of the following:

a. A cancer-related screening recommended for the eligible child by the eligible child's health care professional in accordance with the most recently updated national comprehensive cancer network clinical practice guidelines in

oncology which are designated as category 2A or lower.

b. The diagnosis and treatment of an emergency medical condition that develops or becomes evident in an eligible child while the eligible child is receiving inpatient care that meets inpatient care standards, if the emergency medical condition is reasonably determined by a health care professional to present a life-threatening risk unless the eligible child receives immediate assessment and treatment.

3. This section applies to all of the following:

a. All contracts between the department and a managed care organization that are delivered, issued for delivery, continued, extended, or renewed on or after January 1, 2027.

b. All requests for prior authorizations made on or after January 1, 2027.

4. The department may adopt rules pursuant to chapter 17A to administer this section.

DIVISION IV

CERTIFICATES OF NEED

Sec. 9. Section 135.61, subsection 1, paragraphs d and f, Code 2026, are amended by striking the paragraphs.

Sec. 10. Section 135.61, subsection 12, paragraph e, Code 2026, is amended by striking the paragraph.

Sec. 11. Section 135.61, subsection 16, Code 2026, is amended to read as follows:

16. *"New institutional health service"* or *"changed institutional health service"* means any of the following:

a. (1) The construction, development, or other establishment of a new institutional health facility regardless of ownership if completing the construction, development, or other establishment requires more than the following amount:

(a) Beginning on or after January 1, 2027, and before December 31, 2031, four million dollars.

(b) Beginning on or after January 1, 2032, and before December 31, 2036, four million five hundred thousand dollars.

(c) Beginning on or after January 1, 2037, five million

dollars.

(2) If the new institutional health facility involves the use of a leased building, the market value of the leased building shall be used when calculating the value of completing construction, development, or other establishment under subparagraph (1).

b. Relocation of an institutional health facility.

c. ~~Any~~ A capital expenditure, lease, or donation by ~~or on behalf of~~ an institutional health facility in excess of ~~one million five hundred thousand dollars~~ the following amount within a consecutive twelve-month period:

(1) Beginning on or after January 1, 2027, and before December 31, 2031, four million dollars.

(2) Beginning on or after January 1, 2032, and before December 31, 2036, four million five hundred thousand dollars.

(3) Beginning on or after January 1, 2037, five million dollars.

d. A permanent change in the bed capacity, as determined by the department, of an institutional health facility. For purposes of this paragraph, a change is permanent if it is intended to be effective for one year or more.

~~*e.* Any expenditure in excess of five hundred thousand dollars by or on behalf of an institutional health facility for health services which are or will be offered in or through an institutional health facility at a specific time but which were not offered on a regular basis in or through that institutional health facility within the twelve-month period prior to that time.~~

~~*f.* The deletion of one or more health services, previously offered on a regular basis by an institutional health facility or health maintenance organization or the relocation of one or more health services from one physical facility to another.~~

~~*g.* Any acquisition by or on behalf of a health care provider or a group of health care providers of any piece of replacement equipment with a value in excess of one million five hundred~~

~~thousand dollars, whether acquired by purchase, lease, or donation.~~

~~*h.*~~ *e.* (1) Any acquisition by or on behalf of a health care provider or group of health care providers of any piece of equipment ~~with a value in excess of one million five hundred thousand dollars~~, whether acquired by purchase, lease, or donation, which results in the offering or development of a health service not previously provided that has a value in excess of the following amount:

(a) Beginning on or after January 1, 2027, and before December 31, 2031, four million dollars.

(b) Beginning on or after January 1, 2032, and before December 31, 2036, four million five hundred thousand dollars.

(c) Beginning on or after January 1, 2037, five million dollars.

(2) A mobile health service provided on a contract basis is not considered to have been previously provided by a health care provider or group of health care providers.

~~*i. Any acquisition by or on behalf of an institutional health facility or a health maintenance organization of any piece of replacement equipment with a value in excess of one million five hundred thousand dollars, whether acquired by purchase, lease, or donation.*~~

~~*j.*~~ *f.* (1) Any acquisition by or on behalf of an institutional health facility or health maintenance organization of any piece of equipment ~~with a value in excess of one million five hundred thousand dollars~~, whether acquired by purchase, lease, or donation, which results in the offering or development of a health service not previously provided that has a value in excess of the following amount:

(a) Beginning on or after January 1, 2027, and before December 31, 2031, four million dollars.

(b) Beginning on or after January 1, 2032, and before December 31, 2036, four million five hundred thousand dollars.

(c) Beginning on or after January 1, 2037, five million

dollars.

(2) A mobile health service provided on a contract basis is not considered to have been previously provided by an institutional health facility.

~~*k. Any air transportation service for transportation of patients or medical personnel offered through an institutional health facility at a specific time but which was not offered on a regular basis in or through that institutional health facility within the twelve-month period prior to the specific time.*~~

~~*l.*~~ *g.* ~~Any~~ A mobile health service with a value in excess of ~~one~~ four million ~~five hundred thousand~~ dollars.

~~*m. Any of the following:*~~

~~(1) Cardiac catheterization service.~~

~~(2) Open heart surgical service.~~

~~(3) Organ transplantation service.~~

~~(4) Radiation therapy service applying ionizing radiation for the treatment of malignant disease using megavoltage external beam equipment.~~

Sec. 12. Section 135.62, subsection 1, Code 2026, is amended to read as follows:

1. *a.* A new institutional health service or changed institutional health service shall not be offered or developed in this state without prior application to the department for, and receipt of, a certificate of need, pursuant to this subchapter.

b. The application shall be made ~~upon~~ on forms furnished or prescribed by the department and shall contain ~~such~~ information as required by the department ~~may require under this subchapter~~ by rule adopted pursuant to chapter 17A.

c. (1) The application shall be accompanied by a fee equivalent to three-tenths of one percent of the anticipated cost of the project with a minimum fee of six hundred dollars and a maximum fee of twenty-one thousand dollars. The fee shall be remitted by the department to the treasurer of state~~,~~

~~who shall place it~~ for deposit in the general fund of the state. An applicant for a new institutional health service or a changed institutional health service offered or developed by an intermediate care facility for persons with an intellectual disability or an intermediate care facility for persons with mental illness, as each of those terms are defined in section 135C.1, shall not be required to pay the application fee.

(2) If an application is voluntarily withdrawn within thirty calendar days after submission, seventy-five percent of the application fee shall be refunded~~; if the application is voluntarily withdrawn more than thirty but within sixty days after submission, fifty percent of the application fee shall be refunded; if the application is withdrawn voluntarily more than sixty days after submission, twenty-five percent of the application fee shall be refunded. Notwithstanding the required payment of an application fee under this subsection, an applicant for a new institutional health service or a changed institutional health service offered or developed by an intermediate care facility for persons with an intellectual disability or an intermediate care facility for persons with mental illness as defined pursuant to section 135C.1 is exempt from payment of the application fee.~~

Sec. 13. Section 135.62, subsection 2, paragraphs a and e, Code 2026, are amended to read as follows:

a. Private offices and private clinics of an individual physician, dentist, or other practitioner or group of health care providers, except as provided by section 135.61, subsection 16, ~~paragraphs "*g*", "*h*", and "*m*"~~ paragraph "*e*", and section 135.61, subsections 2 and 18.

e. A health maintenance organization or combination of health maintenance organizations or an institutional health facility controlled directly or indirectly by a health maintenance organization or combination of health maintenance organizations, except when the health maintenance organization or combination of health maintenance organizations does any of

the following:

(1) Constructs, develops, renovates, relocates, or otherwise establishes an institutional health facility.

(2) Acquires major medical equipment as provided by section 135.61, subsection 16, ~~paragraphs "i" and "j"~~ paragraph "f".

Sec. 14. Section 135.62, subsection 2, paragraph h, subparagraph (2), Code 2026, is amended to read as follows:

(2) If these conditions are not met, the institutional health facility or health maintenance organization is subject to ~~review as a "new institutional health service" or "changed institutional health service" under section 135.61, subsection 16, paragraph "f", and is subject to~~ sanctions under section 135.72.

Sec. 15. Section 135.62, subsection 2, Code 2026, is amended by adding the following new paragraphs:

NEW PARAGRAPH. *r.* An organized outpatient health facility that provides behavioral health services as defined by the department by rule, including but not limited to substitution-based treatment centers for opiate addiction.

NEW PARAGRAPH. *s.* Open heart surgical services.

NEW PARAGRAPH. *t.* Organ transplantation services.

NEW PARAGRAPH. *u.* Radiation therapy services.

NEW PARAGRAPH. *v.* Cardiac catheterization services.

Sec. 16. Section 135.63, subsection 2, paragraph b, Code 2026, is amended by striking the paragraph.

Sec. 17. Section 135.65, subsections 1 and 2, Code 2026, are amended to read as follows:

1. *a.* Within fifteen business days ~~after receipt~~ of the date the department receives an application for a certificate of need, the department shall examine the application for form and completeness and accept or reject it. An application shall be rejected only if it fails to provide all information required by the department pursuant to section 135.62, subsection 1. The department shall ~~promptly~~ return ~~to the applicant any~~ a rejected application~~,~~ to the applicant with an

explanation of the reasons for its rejection.

b. Within thirty calendar days of the date the department sends a rejected application to an applicant, the applicant may revise and resubmit the application once for review without submitting another application fee under section 135.62.

2. Upon acceptance of an application for a certificate of need, the department shall ~~promptly undertake to~~ notify all affected persons ~~in writing~~ through electronic means that formal review of the application has been initiated. Notification to ~~those~~ affected persons who are consumers ~~or third-party payers or other payers for health services~~ may be provided by electronic distribution of the pertinent information ~~to the news media~~.

Sec. 18. Section 135.65, subsection 3, paragraph b, Code 2026, is amended to read as follows:

b. A period for the submission of written public ~~hearing~~ comments from affected persons on the application, to be ~~held~~ scheduled prior to completion of the evaluation required by paragraph *"a"*.

Sec. 19. Section 135.65, subsection 4, Code 2026, is amended by striking the subsection.

Sec. 20. Section 135.66, subsection 1, Code 2026, is amended to read as follows:

1. The department may ~~waive the letter of intent procedures prescribed by section 135.64 and substitute~~ conduct a summary review procedure, ~~which shall be~~ established by rules ~~of~~ adopted by the department, when ~~it~~ the department accepts an application for a certificate of need for a project ~~which~~ that meets any of the following criteria ~~in paragraphs "a" through "e"~~:

a. A project which is limited to repair or replacement of a facility or equipment damaged or destroyed by a disaster, and which will not expand the facility nor increase the services provided beyond the level existing prior to the disaster.

b. A project necessary to enable the facility or service to

achieve or maintain compliance with federal, state, or other appropriate licensing, certification, or safety requirements.

c. A project which will not change the existing bed capacity of the applicant's facility or service, as determined by the department, by more than ten percent or ten beds, whichever is less, over a two-year period.

~~*d. A project the total cost of which will not exceed one hundred fifty thousand dollars.*~~

~~*e.*~~ *d.* Any other project for which the applicant proposes and the department agrees to summary review.

Sec. 21. Section 135.70, subsection 2, Code 2026, is amended to read as follows:

2. Upon expiration of a certificate of need, and prior to extension of the certificate of need, any affected person shall have the right to submit to the department information which may be relevant to the question of granting an extension. ~~The department may call a public hearing for this purpose.~~

Sec. 22. Section 135.71, subsection 4, Code 2026, is amended to read as follows:

4. Criteria for determining when it is not feasible to complete formal review of an application for a certificate of need within the time ~~limits~~ limit specified in section 135.68. The rules adopted under this subsection shall include criteria for determining whether an application proposes introduction of technologically innovative equipment, and if so, procedures to be followed in reviewing the application. However, a rule adopted under this subsection shall not permit a deferral of more than ~~sixty~~ thirty calendar days beyond the time when a decision is required under section 135.68, unless both the applicant and the department agree to a longer deferment.

Sec. 23. Section 135P.1, subsection 3, Code 2026, is amended to read as follows:

3. *"Health facility"* means ~~an~~ any of the following:

a. An institutional health facility ~~as defined in section 135.61, a~~.

b. A birth center as defined in section 135.131~~, a~~.

c. A hospice licensed under chapter 135J~~, a~~.

d. A home health agency as defined in section 144D.1~~, an~~.

e. An assisted living program certified under chapter 231C~~,~~ ~~a~~.

f. A clinic~~, a~~.

g. A community health center~~, or the~~.

h. The university of Iowa hospitals and clinics~~, and includes any~~.

i. A corporation, professional corporation, partnership, limited liability company, limited liability partnership, or other entity comprised of ~~such~~ health facilities.

Sec. 24. Section 135P.1, Code 2026, is amended by adding the following new subsection:

NEW SUBSECTION. 3A. "*Institutional health facility*" means any of the following without regard to whether the facility is publicly or privately owned, organized for profit, or is part of or sponsored by a health maintenance organization:

a. A hospital as defined in section 135B.1.

b. A health care facility as defined in section 135C.1.

c. An organized outpatient health facility as defined in section 135.61.

d. An ambulatory surgical center as defined in section 135.61.

e. A community mental health center as defined in section 225A.1.

Sec. 25. REPEAL. Section 135.64, Code 2026, is repealed.>

2. Title page, by striking lines 1 through 4 and inserting <An Act relating to health carriers standards of conduct; utilization review organizations, artificial intelligence, audits, and prior authorizations; certificate of need processes; and including applicability provisions.>

HARRIS of Appanoose