Senate Study Bill 1100 - Introduced

SENATE FILE _____
BY (PROPOSED COMMITTEE
ON COMMERCE BILL BY
CHAIRPERSON BROWN)

A BILL FOR

An Act relating to prior authorization exemptions for certain health care providers for specific health care services.

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

Section 1. NEW SECTION. **514F.9 Prior authorization exemption — health care providers.**

1. *Definitions.* For purposes of this section:

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

b. "Evaluation" means either of the following:

(1) A review of the outcomes of preauthorization requests submitted by a health care provider during the most recent evaluation period to determine the percentage of the preauthorization requests that were approved, and that is conducted to determine whether to grant the health care provider an exemption for a specific health care service for which the provider does not have an exemption.

(2) A retrospective review of a random sample of claims submitted by a health care provider during the most recent evaluation period to determine the percentage of claims that would have been approved, based on meeting the health carrier's applicable medical necessity criteria at the time the health care service was provided, and that is conducted to determine whether to rescind the health care provider's exemption, consistent with subsection 5, for a specific health care service.

c. "Evaluation period" means the six-month period immediately preceding an evaluation, including all of the following:

(1) For an initial exemption determination, the evaluation period shall be the six-month period beginning on January 1, 2024, then each subsequent six-month period beginning on July 1 and ending December 31, and beginning on January 1 and ending June 30.

(2) After an exemption denial or an exemption rescission for a specific health care service, the subsequent six-month evaluation period shall begin on the first day immediately after the last day of the evaluation period that formed the basis for the exemption denial or exemption rescission.

(3) For a retrospective review conducted pursuant to subsection 5, paragraph *"a"*, subparagraph (2), the evaluation period shall be any six-month period selected by the health carrier.

d. "Exemption" means an exception to a health carrier's requirement that a health care provider obtain prior authorization for a specific health care service.

e. "Facility" means the same as defined in section 514J.102.

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

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

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

i. "Health care services" means the same as defined in section 514J.102.

j. "Health carrier" means the same as defined in section 514F.108.

k. "Independent review organization" means an entity that conducts an independent external review of an adverse determination.

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

m. "Random sample" means between five and twenty claims for a specific health care service submitted by a health care provider during the most recent evaluation period.

2. *Exemption.*

a. A health carrier that requires prior authorization for certain health care services shall grant a health care provider an exemption for a specific health care service, if, in the most recent evaluation period, the health carrier has approved not less than eighty percent of the health care provider's prior authorization requests for the specific health care service.

b. A health carrier shall conduct an evaluation of each

health care provider that is contracted with the health carrier to provide health care services to the health carrier's covered persons a minimum of once every six months to determine if the health care provider qualifies for an exemption under paragraph *"a"*. A health carrier may continue a health care provider's exemption granted under paragraph *"a"* without conducting an evaluation for a specific evaluation period.

c. A health care provider shall not be required to request an exemption from a health carrier to qualify for an exemption under paragraph *"a"*.

d. No later than five calendar days after a health care provider qualifies for an exemption, the health carrier shall provide a notice to the health care provider that includes all of the following:

(1) A statement that the health care provider qualifies for an exemption under paragraph *"a"*.

(2) A complete list of all health benefit plans and health care services to which the exemption applies.

(3) The duration of the exemption.

e. If a health care provider submits a prior authorization request for a health care service for which the health care provider qualifies for an exemption under paragraph *"a"*, the health carrier shall promptly provide the notice under paragraph *"d"* to the health care provider and an explanation of the health carrier's claim submission requirements.

3. *Duration of exemption.* A health care provider's exemption granted under subsection 2, paragraph *"a"*, shall remain in effect until either of the following occurs:

a. The health carrier notifies the health care provider of the health carrier's decision to rescind the health care provider's exemption, and the health care provider fails to appeal the health carrier's decision within thirty calendar days, at which time the health provider's exemption shall be rescinded effective thirty-one calendar days after the date of the health carrier's rescission notice.

b. If a health care provider appeals a health carrier's decision to rescind the health care provider's exemption within the thirty-day appeal period and the decision is upheld on appeal, the health provider's exemption shall be rescinded effective five calendar days after the date the rescission decision is upheld.

4. *Denial of exemption.* A health carrier may deny an exemption for a health care provider for a specific health care service if the health carrier provides the health care provider with sufficient statistics and documentation for the relevant evaluation period to demonstrate that the health care provider does not meet the health carrier's criteria for exemption. The health carrier shall notify the health care provider not more than five calendar days after the date of the health carrier's decision to deny the exemption. At the same time as the notice, the health carrier must provide the health care provider with a plain-language explanation of the health care provider's right to an appeal of, or to an independent review of, the health carrier's decision, and of the process for the health care provider to file an appeal or to request an independent review.

5. *Rescission of exemption.*

a. A health carrier may rescind a health care provider's exemption for a specific health care service granted under subsection 2, paragraph *"a"*, at any of the following times:

(1) During January or June of each calendar year.

(2) If, during a retrospective review of a random sample of the health care provider's claims, the health carrier determines that less than eighty percent of the claims for the specific health care service met the medical necessity and appropriateness criteria used by the health carrier for conducting a prior authorization review for the specific health care service during the relevant evaluation period. A determination made under this subsection must be made by a health care professional licensed to practice medicine in this

state. If a determination is made with respect to a health care professional who is a physician, the determination must be made by a physician licensed in this state who has either the same or a similar medical specialty as the health care professional.

b. The health carrier must notify the health care provider not less than thirty calendar days before the date that the rescission is effective. At the same time as the notice, the health carrier must provide the health care provider with all of the following:

(1) Sufficient statistics and documentation from the health carrier's retrospective review under paragraph "*a*", subparagraph (2), to substantiate the health carrier's decision to rescind the health care provider's exemption.

(2) A plain-language explanation of the health care provider's right to an appeal of, or to an independent review of, the health carrier's decision to rescind the health care provider's exemption, and of the process for the health care provider to file an appeal or to request an independent review.

6. *Appeal or independent review.*

a. A health care provider shall have the right to appeal an adverse exemption determination, and have the right to a review of the determination by an independent review organization. A health carrier shall not require a health care provider to participate in the health carrier's internal appeal process prior to requesting an independent review.

b. The health carrier shall pay the cost of an appeal and the cost of an independent review requested by a health care provider under this subsection. The costs shall include reasonable fees for copies of applicable medical records or other documents requested from the health care provider during the internal appeal or the independent review.

c. (1) An independent review organization shall complete an independent review requested by a health care provider under this section no later than thirty calendar days after the date

of the health care provider's request.

(2) A health care provider may request that the independent review organization evaluate an additional random sample from the relevant evaluation period as part of the independent review organization's review. If the health care provider requests that the independent review organization evaluate an additional random sample, the independent review organization shall base its determination on the medical necessity and appropriateness of both the random samples reviewed under subsection 5, paragraph *"a"*, subparagraph (2), and the random samples reviewed under this subparagraph.

d. The health carrier and the health care provider shall be bound by the appeal decision or by the independent review organization's determination.

e. If a health carrier's adverse exemption determination is overturned on appeal or by an independent review organization, the health carrier shall not attempt to rescind the health care provider's exemption prior to the end of the next-occurring evaluation period. After the date on which the next-occurring evaluation period ends, the health carrier may rescind the health care provider's exemption if the health carrier complies with subsection 5 and this subsection.

f. A health carrier shall not retroactively deny a health care service for a covered person on the basis of the health carrier's rescission of the health care provider's exemption, even if the health carrier's rescission decision is affirmed on appeal or by an independent review organization.

7. *Exemption eligibility after rescission or denial.* If an appeal or an independent review organization affirms a rescission or a denial of a health care provider's exemption for a specific health care service, the health care provider shall be eligible for an exemption for the same health care service after the last day of the six-month evaluation period immediately following the evaluation period that was the basis for the denial or rescission.

8. *Effect of exemption.*

a. A health carrier shall not deny or reduce payment on a health care provider's claim based on the medical necessity or medical appropriateness of care for a health care service for which the health care provider qualified for an exemption under subsection 2, unless the health care provider knowingly and materially misrepresented the health care service in the claim with the specific intent to deceive the health carrier and to obtain an unlawful claim payment.

b. A health carrier shall not conduct a retrospective review of a health care service provided by a health care provider who has been allowed an exemption for the health care service under subsection 2, except in the following circumstances:

(1) Pursuant to subsection 5, paragraph *"a"*, subparagraph (2).

(2) The health carrier has reasonable cause to suspect a basis for denial of a claim under paragraph *"a"*.

9. *Scope of practice.* This section shall not be construed to permit a health care provider to provide a health care service outside the scope of the health care provider's license, or to require a health carrier to pay a claim submitted by a health care provider for a health care service outside the scope of the health care provider's license.

10. *Applicability.* This section applies to all health benefit plans delivered, issued for delivery, continued, or renewed in this state on or after January 1, 2024.

EXPLANATION

The inclusion of this explanation does not constitute agreement with the explanation's substance by the members of the general assembly.

This bill relates to prior authorization exemptions for certain health care providers for certain health care services.

The bill requires health carriers (carrier) that require prior authorization for certain health care services (services) to grant a health care provider (provider) an exemption, if, in the most recent evaluation period (period), the

carrier has approved not less than 80 percent of the prior authorization requests submitted by that provider for the specific service. "Exemption" is defined in the bill as an exception to a carrier's requirement that a provider obtain prior authorization for a specific service. "Evaluation period" is defined in the bill.

A carrier shall conduct an evaluation of each health provider that is contracted with the carrier to provide services to the carrier's covered persons a minimum of once every six months to determine if the provider qualifies for an exemption. "Evaluation" is defined in the bill. A carrier may continue an exemption without conducting an evaluation for a specific evaluation period. A provider is not required to request a provider's exemption from a carrier to qualify for an exemption. No later than five calendar days after a provider qualifies for an exemption, the carrier shall provide a notice to the provider that includes a statement that the provider qualifies for an exemption, a complete list of all health benefit plans and services to which the exemption applies, and the duration of the exemption. If a provider submits a prior authorization request for a service for which the provider qualifies for an exemption, the carrier shall promptly provide the provider with the same notice.

If a carrier notifies a provider of the carrier's decision to rescind the provider's exemption and the provider fails to appeal the decision within 30 calendar days, the provider's exemption is rescinded effective 31 calendar days after the date of the carrier's notice. If the provider appeals the carrier's decision within the 30-day appeal period and the decision is upheld on appeal, the provider's exemption shall be rescinded five calendar days after the date the decision is upheld.

A carrier may deny an exemption for a provider for a specific service if the carrier provides the provider with sufficient statistics and documentation for the relevant

period to demonstrate that the provider does not meet the carrier's criteria for exemption. The carrier must satisfy the notification requirements detailed in the bill.

A carrier may rescind a provider's exemption during January or June of each year, or if a retrospective review of a random sample of the provider's claims show that less than 80 percent of the claims for the specific service met the medical necessity and appropriateness criteria used by the carrier for conducting a prior authorization review for the specific service during the relevant period. "Random sample" is defined in the bill. The determination must be made by a health care professional licensed to practice medicine in this state, and if the determination is made with respect to a health care professional who is a physician, the determination must be made by a physician licensed in this state who has either the same or a similar medical specialty as the health care professional. The carrier must notify the provider not less than 30 days before the date the rescission is effective. The carrier must provide the provider with documentation, as detailed in the bill, with the notice.

A provider shall have the right to appeal an adverse exemption determination as detailed in the bill, and the carrier and provider are bound by the appeal decision or the independent review organization's (organization) determination. If a carrier's adverse exemption determination is overturned by an organization, the carrier shall not attempt to rescind the provider's exemption prior to the end of the next occurring period. A carrier shall not retroactively deny a service on the basis of the carrier's rescission of the provider's exemption, even if the carrier's decision is affirmed on appeal or by an organization's determination. If an appeal or an organization's determination affirms the rescission or denial of a provider's exemption for a specific service, the provider shall be eligible for an exemption for the same service after the last day of the six-month period immediately following the

period that was the basis for the denial or rescission.

A carrier shall not deny or reduce payment on a provider's claim based on the medical necessity or appropriateness of care for a service for which the provider qualified for an exemption, unless the provider knowingly and materially misrepresented the service in the claim with the specific intent to deceive the carrier and to obtain an unlawful claim payment on the claim. A carrier shall not conduct a retrospective review of a service provided by a provider who has been granted an exemption for the service except in the circumstances detailed in the bill.

The bill shall not be construed to permit a provider to provide a service outside the scope of the provider's license, or to require a carrier to pay a claim submitted by a provider for a service outside the scope of the provider's license.

The bill applies to all health benefit plans delivered, issued for delivery, continued, or renewed in this state on or after January 1, 2024.