

**304.17A-606 Definitions for section -- Prior authorization exemption program --
Program requirements and options. (Effective January 1, 2028)**

- (1) As used in this section:
- (a) "Covered health care service" means a health care service furnished or proposed to be furnished to a covered person that is specifically available or included as a covered benefit in the covered person's health benefit plan;
 - (b) "Electronic health record" has the same meaning as in 42 U.S.C. sec. 17921, as amended;
 - (c) "Evaluation period" means a twelve (12) month period of time for which a health care provider's prior authorization experience is evaluated by an insurer or private review agent;
 - (d) "Health care provider" has the same meaning as in KRS 304.17A-005, except for purposes of this section the term includes, if practicing independently, any:
 - 1. Licensed clinical alcohol and drug counselor licensed under KRS Chapter 309;
 - 2. Licensed psychologist, licensed psychological practitioner, or certified psychologist with autonomous functioning licensed or certified under the provisions of KRS Chapter 319;
 - 3. Licensed professional clinical counselor licensed under KRS Chapter 335;
 - 4. Licensed marriage and family therapist licensed under KRS Chapter 335;
 - 5. Licensed professional art therapist licensed under KRS Chapter 309; and
 - 6. Licensed clinical social worker licensed under KRS Chapter 335;
 - (e) "Health care provider group" means two (2) or more health care providers that provide health care services within an entity that shares a common:
 - 1. Group provider number; or
 - 2. Tax identification number;
 - (f) "Health care service" has the same meaning as in KRS 304.17A-005, except for purposes of this section the term:
 - 1. Includes procedures, treatments, and services rendered by a health care provider as defined in this section; and
 - 2. Does not include the provision of prescription drugs;
 - (g) "Interoperability standards" means the technical standards set forth in 45 C.F.R. sec. 170.215, as amended;
 - (h) "Participating provider":
 - 1. Means a health care provider that has entered into a participating provider contract; and
 - 2. Includes a health care provider group if the insurer has elected to offer an exemption to the health care provider group under subsection (4)(b)2. of this section;

- (i) "Participating provider contract" means a contract between a health care provider, either directly or through a health care provider group, and an insurer for the provision of health care services under a health benefit plan;
 - (j) "Utilization" means the number of claims submitted for a particular health care service under a health benefit plan by a participating provider; and
 - (k) "Value-based care agreement" means a contractual agreement between a health care provider, either directly or through a health care provider group, and an insurer that:
 - 1. Incentivizes or rewards the provider based on one (1) or more of the following:
 - a. Quality of care;
 - b. Safety;
 - c. Patient outcomes;
 - d. Efficiency;
 - e. Cost reduction; or
 - f. Other factors; and
 - 2. May, but is not required to, include shared financial risk and rewards based on performance metrics.
- (2) An insurer or its private review agent shall not require a covered person, authorized person, or participating provider to obtain a prior authorization for a particular health care service under a health benefit plan if, at the time the health care service was provided, the provider had a prior authorization exemption for that particular health care service under a program offered under subsection (3) of this section.
- (3) Every insurer shall offer a program under which a participating provider may qualify for an exemption from the requirement to obtain prior authorization for any covered health care service that requires prior authorization.
- (4) The program offered under subsection (3) of this section:
- (a) Shall:
 - 1. Provide that a participating provider, for an evaluation period established by the insurer or private review agent, receive a prior authorization exemption for a particular health care service if, during the previous evaluation period, the provider met program terms and conditions established by the insurer or private review agent that are not in violation of this section;
 - 2. Not condition a prior authorization exemption upon the provider exceeding a ninety-three percent (93%) approval rate for prior authorization requests submitted by the provider for that health care service during an evaluation period;
 - 3. Require the insurer or its private review agent to evaluate, on an annual basis, whether a participating provider qualifies to receive a prior authorization exemption for each covered health care service for which the insurer requires prior authorization;
 - 4. Require each annual evaluation required under subparagraph 3. of this

paragraph to be conducted on:

- a. For participating provider contracts that have a performance period of one (1) year, the contract's renewal date; or
 - b. For participating provider contracts that have a performance period of greater than one (1) year, the annual anniversary date of the contract renewal;
5. Require an insurer or its private review agent to notify each participating provider that qualifies for a prior authorization exemption within thirty (30) days after conducting the annual evaluation required under subparagraph 3. of this paragraph;
 6. Require an insurer or its private review agent to make available to a health care provider during the contracting process the requirements that the provider must meet to participate in the program; and
 7. Comply with any administrative regulation promulgated under KRS 304.2-110 for or as an aid to the effectuation of this section; and
- (b) May:
1. Offer a prior authorization exemption for any prescription drug;
 2. Offer a prior authorization exemption to a health care provider group in lieu of each participating provider practicing within a health care provider group;
 3. Condition a participating provider's eligibility to participate in the program on the provider satisfying one (1) or more of the following:
 - a. The provider has entered into, either directly or through a health care provider group, a value-based care agreement with the insurer;
 - b. The provider has been a participating provider for a minimum period of time established by the insurer or private review agent, except an established minimum period of time shall not be more than one (1) year; or
 - c. The provider:
 - i. Complies with interoperability standards; and
 - ii. Has entered into, either directly or through a health care provider group, an electronic health record access agreement with the insurer or private review agent;
 4. Provide that a participating provider shall not qualify for a prior authorization exemption for any particular health care service unless the provider's utilization for that health care service during the previous evaluation period meets any utilization requirement established by the insurer or private review agent, except an established utilization requirement shall not:
 - a. Require a minimum utilization of more than twenty-four (24); or
 - b. Impose a maximum utilization of less than one hundred ten percent (110%) of the participating provider's utilization for that

particular health care service during the previous evaluation period; and

5. Provide that an insurer or its private review agent may revoke a participating provider's prior authorization exemption for any particular health care service, or suspend or revoke a participating provider's participation in the program, if:
 - a. The insurer or private review agent has evidence that the provider has engaged in fraud or abuse; or
 - b. The provider's utilization meets or exceeds a maximum utilization imposed under subparagraph 4.b. of this paragraph.
- (5) If an insurer or its private review agent determines that a participating provider is eligible to participate in the program offered under subsection (3) of this section, the insurer or private review agent shall send a notice to the provider that includes:
 - (a) A statement that the provider is eligible to participate in the program; and
 - (b) A list of each health care service that is subject to the elimination of prior authorization requirements under the program.
- (6) For all forms and notices sent to a participating provider in accordance with this section, or any administrative regulations promulgated under KRS 304.2-110 for or as an aid to the effectuation of this section, the insurer or its private review agent shall:
 - (a) Provide a process for the provider to designate and update the provider's preferred manner for receiving the forms and notices; and
 - (b) Send the forms and notices to the provider in the manner designated under paragraph (a) of this subsection.
- (7) This section shall not be construed to:
 - (a) Prevent an insurer or its private review agent from requesting a health care provider to provide additional information about a health care service rendered to a covered person; or
 - (b) Require coverage of a noncovered health care service under a covered person's health benefit plan.

Effective: January 1, 2028

History: Created 2026 Ky. Acts ch. 102, sec. 1, effective January 1, 2028.

Legislative Research Commission Note (1/1/2028). 2026 Ky. Acts ch. 102, sec. 7, provides that this statute shall apply to contracts delivered, entered, renewed, extended, or amended on or after January 1, 2028.