AN ACT relating to prior authorization.

Be it enacted by the General Assembly of the Commonwealth of Kentucky:

➔SECTION 1. A NEW SECTION OF KRS 304.17A-600 TO 304.17A-633 IS CREATED TO READ AS FOLLOWS:

(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.

➔SECTION 2. A NEW SECTION OF KRS 304.17A-600 TO 304.17A-633 IS CREATED TO READ AS FOLLOWS:

The commissioner shall:

(1) (a) Submit a written report not later than September 30 of each year to the Legislative Research Commission for referral to the Interim Joint Committees on Banking and Insurance and Health Services relating to prior authorization in the provision of health care benefits under this chapter.

(b) The report required under paragraph (a) of this subsection shall include:

1. Information relating to the implementation and effectuation of Section 1 of this Act;

2. The number of insurers and private review agents offering a program required under Section 1 of this Act;

3. The number of providers, by provider group, specialty, and county, participating in one (1) or more programs offered under Section 1 of this Act;

4. A list of health care services, which shall include a description and Current Procedural Terminology code for each service, for which exemptions have been granted under the programs required under Section 1 of this Act;

5. The number of programs offered under Section 1 of this Act, which shall include:

a. The number of programs that grant exemptions for one (1) or more prescription drugs; and

b. A list of the drugs for which exemptions are granted under a program reported under subdivision a. of this subparagraph; and

6. With respect to any health insurance policy, certificate, plan, or contract required to comply with KRS 304.17A-600 to 304.17A-633:

a. A list of all services, procedures, and other treatments, including prescription drugs, that require prior authorization;

b. The percentage of prior authorization requests for nonurgent health care services in aggregate and by specific service, procedure, prescription drug, and other treatment:

i. That were approved without an extension;

ii. For which the review was extended and the request approved; and

iii. That were denied, which may include the reason or reasons for the denials;

c. The percentage of prior authorization requests for urgent health care services that were:

i. Approved; and

ii. Denied, which may include the reason or reasons for the denials; and

d. The average and median time between submission of a prior authorization request and the prior authorization decision for:

i. Nonurgent health care services; and

ii. Urgent health care services;

(2) Provide the Interim Joint Committees on Banking and Insurance and Health Services with a detailed briefing, upon request, to discuss and explain any report submitted under subsection (1) of this section; and

(3) Promulgate any administrative regulation, including an emergency administrative regulation, in accordance with KRS Chapter 13A that the commissioner deems necessary to implement this section.

➔Section 3. KRS 304.17A-605 is amended to read as follows:

(1) ***(a) Except as provided in paragraph (b) of this subsection,*** KRS 304.17A-600, 304.17A-603, 304.17A-605, 304.17A-607, 304.17A-609, 304.17A-611, 304.17A-613, and 304.17A-615 set forth the requirements and procedures regarding utilization review and shall apply to:

1. ~~[(a)]~~ Any insurer or its private review agent that provides or performs utilization review in connection with a health benefit plan or a limited health service benefit plan; and

2. ~~[(b)]~~ Any private review agent that performs utilization review functions on behalf of any person providing or administering health benefit plans or limited health service benefit plans.

(b) Section 1 of this Act sets forth additional requirements for prior authorization and shall apply to:

1. Any insurer or its private review agent that provides or performs utilization review in connection with a health benefit plan; and

2. Any private review agent that performs utilization review functions on behalf of any person providing and administering health benefit plans.

(2) Where an insurer or its agent provides or performs utilization review, and in all instances where internal appeals as set forth in KRS 304.17A-617 are involved, the insurer or its agent shall be responsible for:

(a) Monitoring all utilization reviews and internal appeals carried out by or on behalf of the insurer;

(b) Ensuring that all requirements of KRS 304.17A-600 to 304.17A-633 are met;

(c) Ensuring that all administrative regulations promulgated in accordance with KRS 304.17A-609, 304.17A-613, and 304.17A-629 are complied with; and

(d) Ensuring that appropriate personnel have operational responsibility for the performance of the insurer's utilization review plan.

(3) A private review agent that operates solely under contract with the federal government for utilization review or patients eligible for hospital services under Title XVIII of the Social Security Act shall not be subject to the registration requirements set forth in KRS 304.17A-607, 304.17A-609, and 304.17A-613.

➔Section 4. KRS 304.17A-611 is amended to read as follows:

(1) A utilization review decision shall not retrospectively deny coverage for health care services provided to a covered person when prior approval has been obtained from the insurer or its designee for those services, unless the approval was based upon fraudulent, materially inaccurate, or misrepresented information submitted by the covered person, authorized person, or the provider.

(2) An insurer of a health benefit plan shall not require or conduct a prospective or concurrent review for a prescription drug:

(a) That:

1. Is used in the treatment of alcohol or opioid use disorder; and

2. Contains Methadone, Buprenorphine, an opioid antagonist, or Naltrexone; or

(b) That was approved before January 1, 2022, by the United States Food and Drug Administration for the mitigation of opioid withdrawal symptoms.

(3) Notwithstanding any other law to the contrary:

(a) An insurer or its private review agent shall not conduct a retrospective review that is based solely on a participating provider having a prior authorization exemption under a program offered under subsection (3) of Section 1 of this Act except to determine if the provider continues to qualify for the exemption; and

(b) The timeframes for rendering a utilization review decision under KRS 304.17A-607 shall not apply to a retrospective review conducted for the purpose of determining if a participating provider qualifies for an initial or

continuing prior authorization exemption under a program offered under subsection (3) of Section 1 of this Act.

➔SECTION 5. A NEW SECTION OF KRS CHAPTER 205 IS CREATED TO READ AS FOLLOWS:

The commissioner of the Department for Medicaid Services shall:

(1) (a) Submit a written report not later than September 30 of each year to the Legislative Research Commission for referral to the Interim Joint Committees on Banking and Insurance and Health Services relating to prior authorization in the provision of Medicaid benefits in Kentucky.

(b) The report required under paragraph (a) of this subsection shall include the following, categorized by Medicaid managed care organization and fee for service:

1. A list of all services, procedures, and other treatments, including prescription drugs, that require prior authorization;

2. The percentage of prior authorization requests for nonurgent health care services in aggregate and by specific service, procedure, prescription drug, and other treatment:

a. That were approved without an extension;

b. For which the review was extended and the request approved; and

c. That were denied, which may include the reason or reasons for the denials;

3. The percentage of prior authorization requests for urgent health care services that were:

a. Approved; and

b. Denied, which may include the reason or reasons for the denials; and

4. The average and median time between submission of a prior authorization request and a prior authorization decision for:

a. Nonurgent health care services; and

b. Urgent health care services;

(2) Provide the Interim Joint Committees on Banking and Insurance and Health Services with a detailed briefing, upon request, to discuss and explain any report submitted under subsection (1) of this section; and

(3) Promulgate any administrative regulation, including an emergency administrative regulation, in accordance with KRS Chapter 13A that the commissioner deems necessary to implement this section.

➔Section 6. KRS 205.536 is amended to read as follows:

(1) ***Except as provided in subsection (4) of this section,*** a Medicaid managed care organization shall have a utilization review plan, as defined in KRS 304.17A-600, that meets the requirements established in 42 C.F.R. pts. 431, 438, and 456. If the Medicaid managed care organization utilizes a private review agent, as defined in KRS 304.17A-600, the agent shall comply with all applicable requirements of KRS 304.17A-600 to 304.17A-633.

(2) In conducting utilization reviews for Medicaid benefits, each Medicaid managed care organization shall use the medical necessity criteria selected by the Department of Insurance pursuant to KRS 304.38-240, for making determinations of medical necessity and clinical appropriateness pursuant to the utilization review plan required by subsection (1) of this section.

(3) To the extent consistent with the federal regulations referenced in subsection (1) of this section, the Department for Medicaid Services or any managed care organization contracted to provide Medicaid benefits pursuant to KRS Chapter 205 shall not require or conduct a prospective or concurrent review, as defined in KRS 304.17A-600, for a prescription drug:

(a) That:

1. Is used in the treatment of alcohol or opioid use disorder; and

2. Contains Methadone, Buprenorphine, an opioid antagonist, or Naltrexone; or

(b) That was approved before January 1, 2022, by the United States Food and Drug Administration for the mitigation of opioid withdrawal symptoms.

(4) This chapter shall not be construed to require, with respect to the administration and provision of Medicaid benefits pursuant to this chapter, the Department for Medicaid Services, any managed care organization contracted to provide Medicaid benefits pursuant to this chapter, including any private review agent utilized by the Medicaid managed care organization, or the state's medical assistance program to comply with Section 1 of this Act.

➔Section 7. Sections 1 to 4 of this Act apply to contracts delivered, entered, renewed, extended, or amended on or after January 1, 2028.

➔Section 8. Section 5 of this Act takes effect January 1, 2027.

➔Section 9. Sections 1, 2, 3, 4, 6, and 7 of this Act take effect January 1, 2028.