HB 751 -- PAYMENTS FOR HEALTH CARE SERVICES

SPONSOR: Grier

This bill enacts provisions relating to payments for health care services.

METHODS OF REIMBURSEMENT

This bill prohibits health carriers from restricting methods of reimbursement which require health care providers to pay a fee to redeem the amount of their claim for reimbursement.

Health carriers changing the reimbursement method used shall notify health care providers whether any fee is required to receive reimbursement through the new or different method. For health benefit plans issued, delivered, or renewed on or after August 28, 2019, the provider will be able to select an alternative method of reimbursement which does not require a fee.

Violation of these provisions shall be deemed an unfair trade practice under the Unfair Trade Practice Act (Section 376.1345, RSMo).

These provisions are similar to HB 492 (2019).

UTILIZATION REVIEWS

This bill replaces "utilization review organization" with "utilization review entity," and "prospective review" with "prior authorization review" throughout the statutes relating to utilization reviews (Sections 374.500 and 376.1350).

This bill adds health care services that are denied under a utilization review to the definition of "adverse determination," including with regard to the reconsideration process. The definition of "certification" is modified to refer to only those health care services approved for coverage which the health carrier or utilization review entity, as defined in the bill, has also determined it will pay for. The definitions of "adverse determination" and "certification" are modified to refer to decisions made by "a utilization review entity" rather than a health carrier's "designee utilization review entity." "Clinical review criteria" is modified to include several specific policies and rules, as well as any other criteria or rationale used by a health carrier or utilization review entity to determine appropriateness or necessity of health care services. "Health care service" is modified to specifically include the provision of drugs or durable medical equipment (Section 376.1350).

This bill prohibits health carriers and utilization review entities from requiring providers to follow a step therapy protocol when the provider determines the step therapy protocol is not in the enrollee's best interest. The bill also prohibits carriers and review entities from requiring providers to obtain a waiver, exception, or other override when determining a step therapy protocol to not be in the enrollee's best interest. No carrier or review entity shall sanction or otherwise penalize any provider for recommending or performing a health care service that may conflict with a step therapy protocol (Section 376.1362).

This bill shortens the time period health carriers have to make initial decisions in a utilization review, from 36 hours to 24 hours and then must notify providers immediately upon the carrier making its initial and concurrent review decisions, instead of within 24 hours. This bill repeals the requirement that written notice to enrollees of an adverse coverage determination include instructions for requesting a statement of the clinical rationale and review criteria used to make the determination. Written procedures to address a failure or inability of a provider or enrollee to provide all information necessary to make a decision shall be made available on the health carrier's website or provider portal. A utilization review entity shall not revoke, limit, condition, or otherwise restrict a prior authorization within 45 working days of its receipt by a health care provider. The prior authorization shall be valid for one year from the date received unless revoked or restricted in writing in accordance with these provisions. Any failure by a utilization review entity to comply with these provisions shall be deemed authorization of the health care services being reviewed (Section 376.1363.1-8).

For purposes of utilization reviews, a health care service shall be considered medically necessary if it is provided in a manner that is in accordance with generally accepted standards of health care practices; clinically appropriate in terms of the type, frequency, extent, and duration; and not primarily for the economic benefit of the health carrier, nor the convenience of the patient, treating physician, or other health care provider (Section 376.1363.9).

No later than January 1, 2020, utilization review entities shall accept and respond to requests for prior authorization of drug benefits through a secure electronic transmission using the National Council for Prescription Drugs SCRIPT Standard Version 201310 or a backwards-compatible successor adopted by the United States Department of Health and Human Services (Section 376.1364.1).

No later than January 1, 2020, the Department of Insurance,

Financial Institutions, and Professional Registration shall develop a standard prior authorization form, which all health carriers shall use beginning January 1, 2021 (Section 376.1364).

The bill requires health carriers and utilization review entities to make available on its web site any current prior authorization requirements or restrictions, including written clinical criteria. A health carrier or utilization review entity shall not amend or implement a new prior authorization requirement or restriction prior to the change being reflected on the carrier or review entity's website. Health carriers and utilization review entities shall provide in-network health care providers with written notice of the new or amended requirement not less than 60 days prior to implementing the requirement or restriction. A carrier utilizing prior authorization review shall make statistics regarding approvals and denials available on its website in a readily accessible format, including categories for provider type or physician specialty, medication or diagnostic test or procedure, indication offered, and reason for denial (Section 376.1372).

This bill modifies the panel for a second-level grievance review for an adverse determination to require a majority of persons that are "actively practicing clinical peers licensed to practice medicine" rather than "appropriate clinical peers" in the same or similar specialty as would typically manage the case being reviewed (Section 376.1385).

The bill specifies that if an independent review organization reviews an adverse determination appeal and reverses the adverse determination, the health carrier shall reimburse the department for any and all fees charged by the independent review organization (Section 376.1387).

This bill is similar to SB 298 (2019).