ARKANSAS SENATE

94th General Assembly - Regular Session, 2023

Amendment Form

Subtitle of House Bill No. 1271

TO AMEND THE PRIOR AUTHORIZATION TRANSPARENCY ACT; AND TO EXEMPT CERTAIN HEALTHCARE PROVIDERS THAT PROVIDE CERTAIN HEALTHCARE SERVICES FROM PRIOR AUTHORIZATION REQUIREMENTS.

Amendment No. 1 to House Bill 1271

Amend House Bill No. 1271 as engrossed H3/9/23 (version: 3/9/2023 9:46:28 AM):

Page 3, delete line 23, and substitute the following:
"(3)(A) Subject to this subdivision (c)(3), when an adverse"

AND

Page 3, delete lines 27 through 36, and substitute the following:
"shall provide in the notice of adverse determination the name and telephone number of a physician who possesses a current and unrestricted license in this state with whom the requesting healthcare provider may have a reasonable opportunity to discuss the patient's treatment plan and the clinical basis for the intervention.

(B) The requesting healthcare provider may contact the reviewing physician at the telephone number provided with the adverse determination under subdivision (c)(3)(A) of this section within one (1) business day of receipt of the adverse determination for an urgent service, or within two (2) business days of receipt of the adverse determination for a nonurgent service, to engage in the discussion of the patient's treatment plan and the clinical basis for the intervention under subdivision (c)(3)(A) of this section.

(C)(i) Following any discussion under subdivision (c)(3)(B) of this section, the utilization review entity shall notify the healthcare provider whether or not the adverse determination decision remains the same or the service is approved.

(ii) The notice under subdivision (c)(3)(C)(i) of this section shall be provided:

(a) Within one (1) business day of the discussion under subdivision (c)(3)(B) of this section between the provider and physician for an urgent service; or

(b) Within two (2) business days of the discussion under subdivision (c)(3)(B) of this section between the provider

and physician for a nonurgent service.

(D) A discussion under subdivision (c)(3)(A) of this section shall not replace or eliminate the opportunity for any internal grievance or appeal process provided by the utilization review entity.

(E) If a requesting healthcare provider is a physician, then the reviewing physician with whom the requesting physician is given an opportunity to discuss the treatment plan and clinical basis for the intervention under subdivision (c)(3)(B) of this section shall be a physician who:"

AND

Page 4 delete lines 1 and 2

AND

Page 4, line 3, delete "(a)" and substitute "(i)"

AND

Page 4, line 5, delete "(b)" and substitute "(ii)"

AND

Page 4, delete lines 21 and 22, and substitute the following:
"service increases by twenty-five percent (25%) or more during the period between January 1, 2024, and June 30, 2024, based on a review of the"

AND

Page 5, delete lines 6 and 7, and substitute the following:
"a notice to each healthcare provider that either grants or denies a prior authorization"

AND

Page 5, line 30, delete "subsection (b)" and substitute "subsection (d)"

AND

Page 5, delete lines 32 and 33, and substitute the following:
"(C) Appeal of the decision for an independent review to be completed by the end of the twelve-month period of the"

AND

Page 6, delete lines 8 and 9, and substitute the following:
"(1) A healthcare provider with an ownership interest in the entity to which the tax identification number is assigned does not object; or"

AND

Page 6, delete lines 22 and 23, and substitute the following:
"provider does not appeal the healthcare insurer's determination within thirty (30) days of notification of the determination;

(2) If the healthcare provider appeals the determination within thirty (30) days of notification of the determination, the"

AND

Page 6, delete line 27, and substitute the following:
"exemption.

(b) If a healthcare provider appeals the determination to rescind the exemption more than thirty (30) days after notification of the determination and the independent review organization overturns the rescission, the healthcare provider's exemption is restored the fifth day after the date of the independent review organization's decision, and the exemption remains in effect for twelve (12) months after restoration unless rescinded under § 23-99-1122."

AND

Page 6, line 28, delete "(b)" and substitute "(c)"

AND

Page 6, line 32, delete "(c)" and substitute "(d)"

AND

Page 12, delete lines 6 through 9, and substitute the following:
"healthcare service subject to an exemption except:

(1) To determine if the healthcare provider still qualifies for an exemption under § 23-99-1120; or

(2) If the healthcare insurer has a reasonable cause to suspect a"

AND

Page 13, line 21, delete "(a) An" and substitute "(a)(1) An"

AND

Page 13, line 28, delete "(b) The" and substitute "(2) The"

AND

Page 13, delete line 34, and substitute the following:
"authorizations for a healthcare provider on or before January 1, 2025.

(3) A qualified health plan that is a health benefit plan under the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, and

purchased on the Arkansas Health Insurance Marketplace created under the Arkansas Health Insurance Marketplace Act, § 23-61-801 et seq., for an individual up to four hundred percent (400%) of the federal poverty level, operating in this state is exempt from §§ 23-99-1120 — 23-99-1126 if the qualified health plan, without limiting the program's application to any other plan or program, develops a program to reduce or eliminate prior authorizations for a healthcare provider on or before January 1, 2025.

(b)(1) The programs under subsection (a) of this section to reduce or eliminate prior authorization shall be:

(A) Submitted to the State Insurance Department; and

(B) Subject to approval by the Legislative Council.

(2) If a program is not submitted to the department and approved by the Legislative Council on or before January 1, 2025, the Medicaid-managed care program operating in this state, the Arkansas Health and Opportunity for Me Program established by the Arkansas Health and Opportunity for Me Act of 2021, § 23-61-1001 et seq., or its successor program, and qualified health plans under the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, and purchased on the Arkansas Health Insurance Marketplace created under the Arkansas Health Insurance Marketplace Act, § 23-61-801 et seq., for an individual up to four hundred percent (400%) of the federal poverty level, operating in this state shall be subject to §§ 23-99-1120 — 23-99-1126 and § 23-99-1128 as of January 1, 2025."

AND

Page 14, delete lines 8 through 11, and substitute the following:

"(2)(A) As of January 1, 2025, the provisions of §§ 23-99-1120 — 23-99-1126 shall apply to prescription drugs, medicines, biological products, pharmaceuticals, or pharmaceutical services that have not been approved for continuation of prior authorization under § 23-99-1128.

(B) For the products in subdivision (e)(2)(A) of this section that have not been approved for continuation of prior authorization, for purposes of § 23-99-1120, then:

(i) Provisions regarding time periods specified during the calendar year 2022 shall instead apply to the same months during calendar year 2023; and

(ii) Provisions regarding time periods specified during the calendar year 2024 shall instead apply to the same months during calendar year 2025."

AND

Page 14, delete lines 15 through 36, and substitute the following:

"(a)(1) Beginning on January 1, 2024, a healthcare insurer or pharmacy benefits manager shall submit a written request to the Arkansas State Board of Pharmacy for any prescription drug, medicine, biological product, pharmaceutical, or pharmaceutical service to be reviewed for a continuation of prior authorization by a specified health benefit plan whether or not a healthcare provider has met the criteria for an exemption from prior authorization under §§ 23-99-1120 — 23-99-1126.

(2) The request under subdivision (a)(1) of this section shall state the reason the request is being made for each prescription drug, medicine, biological product, pharmaceutical, or pharmaceutical service for the specified health benefit plan.

(b) The Arkansas State Board of Pharmacy and the Arkansas State Medical Board, jointly, may establish criteria and procedures to review whether a request made under subdivision (a)(1) of this section should be granted for the requesting party and specified health benefit plan.

(c)(1) The Arkansas State Board of Pharmacy and the Arkansas State Medical Board, jointly, may determine whether or not a prescription drug, medicine, biological product, pharmaceutical, or pharmaceutical service may be subject to prior authorization by a health benefit plan under the criteria and procedures under subsection (b) of this section.

(2) The Arkansas State Board of Pharmacy shall promptly notify the entity that made the request of the joint decision made by the Arkansas State Board of Pharmacy and the Arkansas State Medical Board."

AND

Page 15, delete lines 1 through 4

AND

Page 15, line 6, delete "it, a list of" and substitute "it, a list for any health benefit plan of"

AND

Page 15, delete lines 9 and 10

AND

Page 15, delete lines 13 and 14, and substitute with the following:

"(a) If the Arkansas State Board of Pharmacy and the Arkansas State Medical Board, jointly, disallow a prior authorization of a"

The Amendment was read the first time, rules suspended and read the second time and _____

By: Senator Irvin

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ANS340 **Secretary**