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HB 187: Prior Auth Exempt for Health Providers Sectional Analysis

Section 1: AS 21.07.005(a) is amended to insert the following language into sub-section (1) under (a) so it reads "the structure and operation of utilization review and benefit determination processes, including processes for utilization review entities under AS 21.07.100".

Sec. 2. AS 21.07 is amended by adding a new section called Sec. 21.07.100. Utilization Review Entities to implement the following:

A utilization review entity may not require a health care provider to complete a prior authorization for a health care service for a covered person to receive coverage for the health care service if, during the most recent 12 month period, the utilization review entity has approved or would have approved at least 0 percent of the prior authorization requests submitted by the health care provider for that health care service.

A utilization review entity may evaluate whether a health care provider continues to qualify for an exemption not more than once every 12 months. A utilization review entity is not required to evaluate an existing exemption, and nothing prevents a utilization review entity from establishing a longer exemption period. A health care provider is not required to request an exemption to qualify for an exemption.

If a health care provider does not receive an exemption, the health care provider may, once every 12 months of providing health care services, request the utilization review entity to provide a determination to deny a prior authorization exemption under (a) of this section. The utilization review entity shall provide to the health care provider an explanation of how to appeal the determination.

A utilization review entity may revoke an exemption after 12 months if the utilization review entity does the following:

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- Decides that the health care provider would not have met the 80% approval criteria based on a retrospective review of the claims for the health care service for which the exemption applies for the previous three months or the period needed to reach a minimum of 10 claims for review.
- Provides the health care provider with the information used by the utilization review entity to make the determination to revoke the exemption.
- Provides an explanation to the health car provider on how to appeal the determination.

The exemption remains in effect until the 30th day after the date the utilization review entity notifies the health care provider of its determination to revoke the exemption or, if the health care provider appeals the determination, the fifth day after the revocation is upheld on appeal.

A determination to revoke or deny an exemption by a utilization review entity must be made by a health care provider licensed in Alaska with the same or similar specialty as the health care provider being consider for an exemption and must have experience in the health care service, they are providing for which the requested exemption applies.

A utilization review entity must provide a health care provider who receives an exemption of this section with a notice that includes the following:

- A statement that the health care provider qualifies for an exemption from a prior authorization requirement and the duration of the exemption.
- A list of health care services for which the exemption applies.

A utilization review entity may not deny or reduce payment for a health care service exempted from a prior authorization requirement, including a health care service performed or supervised by another health care provider when the health care provider who ordered the service received a prior authorization exemption, unless the health care provider providing the health care service does the following:

- Knowingly and materially misrepresented the health care service in a quest for payment submitted by the utilization review entity with the specific intent to deceive and obtain an unlawful payment form a utilization review entity.
- Failed to substantially perform the health care service(s)

In this sectional analysis, the following are defined:

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- "Health care services" means the following:

    - The provision of pharmaceutical products, services, or durable medical equipment
    - A health care procedure, treatment, or service provided in a health care facility licensed in Alaska or by a Doctor of Medicine, Doctor of Osteopathy, or within the scope of practice of a health care professional who is licensed in Alaska.

- "Health maintenance organization" has the meaning given in AS 21.86.900.
- "Prior authorization" means the process used by a utilization review entity to determine the medical necessity or medical appropriateness of a covered entity to determine the medical necessity or medical appropriateness of a covered health care service before the health care service is provided or a requirement that a covered person or health care provider notify a health care insurer or utilization review entity before providing a health care service.
- "Utilization review entity" means an individual or entity that performs prior authorization for the following:
    - An employer in Alaska with employees covered under a health benefit plan or health insurance policy.
    - A health care insurer
    - A preferred provider organization
    - A health maintenance organization
    - An individual or entity that provides, offers to provide, or administers hospital, outpatient, medical, prescription drug, or other health care benefits to a person treated by a health care provider licensed in Alaska under a health care policy, plan, or contract.

Sec. 3. This Act takes effect immediately under AS 01.10.070(c)