## **EXHIBIT D1**

## Stricken language would be deleted from and underlined language would be added to present law. Act 575 of the Regular Session

1	State of Arkansas
2	94th General Assembly A Bill
3	Regular Session, 2023 HOUSE BILL 127
4	
5	By: Representatives L. Johnson, Achor, F. Allen, Bentley, Breaux, K. Brown, M. Brown, Joey Carr,
6	Cavenaugh, Duffield, Ennett, Eubanks, D. Ferguson, V. Flowers, D. Garner, Gramlich, Hawk, G.
7	Hodges, Hollowell, Ladyman, Long, J. Mayberry, McAlindon, McGrew, B. McKenzie, S. Meeks, J.
8	Moore, Painter, Pilkington, J. Richardson, R. Scott Richardson, Richmond, Rye, Underwood, Vaught,
9	Wardlaw, D. Whitaker, Womack, Wooten
10	By: Senators Irvin, J. Boyd
11	
12	For An Act To Be Entitled
13	AN ACT TO AMEND THE PRIOR AUTHORIZATION TRANSPARENCY
14	ACT; TO EXEMPT CERTAIN HEALTHCARE PROVIDERS THAT
15	PROVIDE CERTAIN HEALTHCARE SERVICES FROM PRIOR
16	AUTHORIZATION REQUIREMENTS; AND FOR OTHER PURPOSES.
17	
18	
19	Subtitle
20	TO AMEND THE PRIOR AUTHORIZATION
21	TRANSPARENCY ACT; AND TO EXEMPT CERTAIN
22	HEALTHCARE PROVIDERS THAT PROVIDE CERTAIN
23	HEALTHCARE SERVICES FROM PRIOR
24	AUTHORIZATION REQUIREMENTS.
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26	
27	BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF ARKANSAS:
28	
29	SECTION 1. Arkansas Code § 23-99-1103(8), concerning the definition of
30	"healthcare insurer" under the Prior Authorization Transparency Act, is
31	amended to read as follows:
32	(8)(A)(i) "Healthcare insurer" means an entity that is subject
33	to state insurance regulation, including an insurance company, a health
34	maintenance organization, a hospital and medical service corporation, a risk-
35	based provider organization, and a sponsor of a nonfederal self-funded
36	governmental plan.

1	(ii) "Healthcare insurer" includes Medicaid where
2	specifically referenced in §§ 23-99-1119 $-23-99-1126$ .
3	(B) "Healthcare insurer" does not include:
4	(i) A workers' compensation plan;
5	(ii) Medicaid, except as provided under §§ 23-99-
6	1119 - 23-99-1126 or when Medicaid services are managed or reimbursed by a
7	healthcare insurer; or
8	(iii) An entity that provides only dental benefits
9	or eye and vision care benefits;
10	
11	SECTION 2. Arkansas Code § 23-99-1103, concerning definitions used
12	under the Prior Authorization Transparency Act, is amended to add additional
13	subdivisions to read as follows:
14	(22) "Random sample" means at least five (5) claims but no more
15	than twenty (20) claims for a particular healthcare service that are selected
16	without method or conscious decision; and
17	(23) "Value-based reimbursement" means reimbursement that:
18	(A) Ties a payment for the provision of healthcare
19	services to the quality of health care provided;
20	(B) Rewards a healthcare provider for efficiency and
21	effectiveness; and
22	(C) May impose a risk-sharing requirement on a healthcare
23	provider for healthcare services that do not meet the healthcare insurer's
24	requirements for quality, effectiveness, and efficiency.
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26	SECTION 3. Arkansas Code § 23-99-1104(a)(1), concerning disclosure
27	required under the Prior Authorization Transparency Act, is amended to read
28	as follows:
29	(a)(1) $\underline{(A)}$ A utilization review entity shall disclose all of its prior
30	authorization requirements and restrictions, including any written clinical
31	criteria, in a publicly accessible manner on its website.
32	(B) The disclosure under subdivision (a)(1)(A) of this
33	section shall include:
34	(i) A list of any healthcare services that require
35	prior authorization; and
36	(ii) Any written clinical criteria.

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2 SECTION 4. Arkansas Code § 23-99-1111 is amended to read as follows: 3 23-99-1111. Requests for prior authorization — Qualified persons

4 authorized to review and approve — Adverse determinations to be made only by

5 Arkansas-licensed physicians — Opportunity to discuss treatment before 6 adverse determination.

- (a) The initial review of information submitted in support of a request for prior authorization may be conducted by a qualified person employed or contracted by a utilization review entity.
- (b) A request for prior authorization may be approved by a qualified person employed or contracted by a utilization review entity.
- (c)(1) An adverse determination regarding a request for prior authorization shall be made by a physician who possesses a current and unrestricted license to practice medicine in the State of Arkansas issued by the Arkansas State Medical Board.
- (2)(A) A utilization review entity shall provide a method by which a physician may request that a prior authorization request be reviewed by a physician in the same specialty as the physician making the request, by a physician in another appropriate specialty, or by a pharmacologist.
- (B) If a request is made under subdivision (c)(2)(A) of this section, the reviewing physician or pharmacologist is not required to meet the requirements of subdivision (c)(1) of this section.
- 23 (3)(A) Subject to this subdivision (c)(3), when an adverse 24 determination is issued by a utilization review entity that questions the 25 medical necessity, the appropriateness, or the experimental or 26 investigational nature of a healthcare service, the utilization review entity 27 shall provide in the notice of adverse determination the name and telephone number of a physician who possesses a current and unrestricted license in 28 29 this state with whom the requesting healthcare provider may have a reasonable 30 opportunity to discuss the patient's treatment plan and the clinical basis for the intervention. 31
- 32 (B) The requesting healthcare provider may contact the
  33 reviewing physician at the telephone number provided with the adverse
  34 determination under subdivision (c)(3)(A) of this section within one (1)
  35 business day of receipt of the adverse determination for an urgent service,
  36 or within two (2) business days of receipt of the adverse determination for a

1	nonurgent service, to engage in the discussion of the patient's treatment
2	plan and the clinical basis for the intervention under subdivision $(c)(3)(A)$
3	of this section.
4	(C)(i) Following any discussion under subdivision
5	(c)(3)(B) of this section, the utilization review entity shall notify the
6	healthcare provider whether or not the adverse determination decision remains
7	the same or the service is approved.
8	(ii) The notice under subdivision $(c)(3)(C)(i)$ of
9	this section shall be provided:
10	(a) Within one (1) business day of the
11	discussion under subdivision (c)(3)(B) of this section between the provider
12	and physician for an urgent service; or
13	(b) Within two (2) business days of the
14	discussion under subdivision (c)(3)(B) of this section between the provider
15	and physician for a nonurgent service.
16	(D) A discussion under subdivision (c)(3)(A) of this
17	section shall not replace or eliminate the opportunity for any internal
18	grievance or appeal process provided by the utilization review entity.
19	(E) If a requesting healthcare provider is a physician,
20	then the reviewing physician with whom the requesting physician is given an
21	opportunity to discuss the treatment plan and clinical basis for the
22	intervention under subdivision (c)(3)(B) of this section shall be a physician
23	<u>who:</u>
24	(i) Possesses a current and unrestricted
25	license to practice medicine in this state; and
26	(ii) Has the same or similar specialty as the
27	healthcare provider.
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29	SECTION 5. Arkansas Code Title 23, Chapter 99, Subchapter 11, is
30	amended to add additional sections to read as follows:
31	23-99-1120. Initial exemption from prior authorization requirements
32	for healthcare providers providing certain healthcare services.
33	(a)(1) Except as provided under subdivision (a)(2) of this section,
34	beginning on and after January 1, 2024, a healthcare provider that received
35	approval for ninety percent (90%) or more of the healthcare provider's prior
36	authorization requests based on a review of the healthcare provider's

- 1 utilization of the particular healthcare services from January 1, 2022,
- 2 through June 30, 2022, shall not be required to obtain prior authorization
- 3 for a particular healthcare service and shall be considered exempt from prior
- 4 <u>authorization requirements through September 30, 2024.</u>
- 5 (2) If a healthcare provider's use for a particular healthcare
- 6 <u>service increases by twenty-five percent (25%) or more during the period</u>
- 7 between January 1, 2024, and June 30, 2024, based on a review of the
- 8 <u>healthcare provider's utilization of the particular healthcare service from</u>
- 9 January 1, 2022, through June 30, 2022, then the healthcare insurer may
- 10 disallow the exemption from prior authorization requirements for the
- 11 healthcare provider for the particular healthcare service.
- 12 (b)(1) A healthcare insurer shall conduct an evaluation of the initial
- 13 <u>six-month exemption period based on claims submitted between January 1, 2024,</u>
- 14 through June 30, 2024, to determine whether to grant or deny an exemption for
- 15 <u>each particular healthcare service that requires a prior authorization by the</u>
- 16 healthcare insurer.
- 17 (2) The evaluation by the healthcare insurer shall be conducted
- by using the retrospective review process under § 23-99-1122(c) and applying
- 19 the criteria under subsection (d) of this section.
- 20 <u>(3) A healthcare insurer shall submit to a healthcare provider a</u>
- 21 <u>written statement of:</u>
- 22 (A) The total number of payable claims submitted by or in
- 23 connection with the healthcare provider; and
- 24 (B) The total number of denied and approved prior
- 25 <u>authorizations between January 1, 2022, through June 30, 2022.</u>
- 26 (c)(1) No later than October 1, 2024, a healthcare insurer shall issue
- 27 a notice to each healthcare provider that either grants or denies a prior
- 28 authorization exemption to the healthcare provider for each particular
- 29 healthcare service.
- 30 (2) An exemption granted under this subdivision (c)(1) shall be
- 31 <u>valid for at least twelve (12) months.</u>
- 32 (d) Except as provided under subsection (f) of this section or § 23-
- 33 99-1125, a healthcare insurer that uses a prior authorization process for
- 34 healthcare services shall not require a healthcare provider to obtain prior
- 35 authorization for a particular healthcare service that a healthcare provider
- 36 has previously been subject to a prior authorization requirement if, in the

1	most recent six-month evaluation period as described under subsection (e) of
2	this section, the healthcare insurer has approved or would have approved no
3	less than ninety percent (90%) of the prior authorization requests submitted
4	by the healthcare provider for that particular healthcare service.
5	(e)(1) Except as provided under subsection (f) of this section, a
6	healthcare insurer shall evaluate whether or not a healthcare provider
7	qualifies for an exemption from prior authorization requirements under
8	subsection (d) of this section one (1) time every twelve (12) months.
9	(2) The six-month period for the evaluation period described
10	under subsection (d) of this section shall be any consecutive six (6) month
11	period during the twelve (12) months following the effective date of the
12	exemption.
13	(3) The healthcare insurer shall choose a six-month evaluation
14	period that allows time for:
15	(A) The evaluation under subsection (d) of this section;
16	(B) Notice to the healthcare provider of the decision; and
17	(C) Appeal of the decision for an independent review to be
18	completed by the end of the twelve-month period of the exemption.
19	(f) A healthcare insurer may continue an exemption under subsection
20	(d) of this section without evaluating whether or not the healthcare provider
21	qualifies for the exemption under subsection (d) of this section for a
22	particular evaluation period.
23	(g) A healthcare provider is not required to request an exemption
24	under subsection (d) of this section to quality for the exemption.
25	(h) A healthcare insurer may extend an exemption under subsection (d)
26	of this section to a group of healthcare providers under the same tax
27	<u>identification number if:</u>
28	(1) A healthcare provider with an ownership interest in the
29	entity to which the tax identification number is assigned does not object; or
30	(2) The tax identification number is associated with a hospital
31	licensed in this state and the chief executive officer of the hospital agrees
32	to the exemption.
33	
34	23-99-1121. Duration of prior authorization exemption.
35	(a) Unless a prior authorization exemption is continued for a longer
36	period of time by a healthcare insurer under § 23-99-1120(f), a healthcare

1	provider's exemption from prior authorization requirements under § 23-99-1120
2	remains in effect until the later of:
3	(1) The thirtieth day after the date the healthcare insurer
4	notifies the healthcare provider of the healthcare insurer's determination to
5	rescind the exemption as described under § 23-99-1122, if the healthcare
6	provider does not appeal the healthcare insurer's determination within thirty
7	(30) days of notification of the determination;
8	(2) If the healthcare provider appeals the determination within
9	thirty (30) days of notification of the determination, the fifth day after
10	the date an independent review organization affirms the healthcare insurer's
11	determination to rescind the exemption; or
12	(3) Twelve (12) months after the effective date of the
13	exemption.
14	(b) If a healthcare provider appeals the determination to rescind the
15	exemption more than thirty (30) days after notification of the determination
16	and the independent review organization overturns the rescission, the
17	healthcare provider's exemption is restored the fifth day after the date of
18	the independent review organization's decision, and the exemption remains in
19	effect for twelve (12) months after restoration unless rescinded under § 23-
20	<u>99-1122.</u>
21	(c) If a healthcare insurer does not finalize a rescission
22	determination as specified in subsection (a) of this section, then the
23	healthcare provider is considered to have met the criteria under § 23-99-1120
24	to continue to qualify for the exemption.
25	(d) A healthcare provider shall not rely on another healthcare
26	provider's exemption except when the healthcare provider with an exemption is
27	the healthcare provider that orders healthcare services that are rendered by
28	a healthcare provider without an exemption.
29	
30	23-99-1122. Denial or rescission of prior authorization exemption.
31	(a) A healthcare insurer may rescind an exemption from prior
32	authorization requirements of a healthcare provider under § 23-99-1120 only
33	<u>if:</u>
34	(1) The healthcare insurer makes a determination that, on the
35	basis of a retrospective review of a random sample of claims selected by the
36	healthcare insurer during the most recent evaluation period described by §

1	23-99-1120(e), less than ninety percent (90%) of the claims for the
2	particular healthcare service met the medical necessity criteria that would
3	have been used by the healthcare insurer when conducting prior authorization
4	review for the particular healthcare service during the relevant evaluation
5	period;
6	(2) The healthcare insurer complies with other applicable
7	requirements specified in this section, including without limitation:
8	(A) Notifying the healthcare provider no less than twenty-
9	five (25) days before the proposed rescission is to take effect; and
10	(B) Providing:
11	(i) An identification of the healthcare service that
12	an exemption is being rescinded, the date the notice is issued, and the
13	effective date of the rescission;
14	(ii) A plain-language explanation of how the
15	healthcare provider may appeal and seek an independent review of the
16	determination, the date the notice is issued, and the company's address and
17	contact information for returning the form by mail or email to request an
18	appeal;
19	(iii) A statement of the total number of payable
20	claims submitted by or in connection with the healthcare provider during the
21	most recent evaluation period that were eligible to be evaluated with respect
22	to the healthcare service subject to rescission, the number of claims
23	included in the random sample, and the sample information used to make the
24	determination, including without limitation:
25	(a) Identification of each claim included in
26	the random sample;
27	(b) The healthcare insurer's determination of
28	whether each claim met the healthcare insurer's screening criteria; and
29	(c) For any claim determined to not have met
30	the healthcare insurer's screening criteria:
31	(1) The principal reasons for the
32	determination that the claim did not meet the healthcare insurer's screening
33	criteria, including, if applicable, a statement that the determination was
34	based on a failure to submit specified medical records;
35	(2) The clinical basis for the
36	determination that the claim did not meet the healthcare insurer's screening

1	<u>criteria;</u>
2	(3) A description of the sources of the
3	screening criteria that were used as guidelines in making the determination;
4	<u>and</u>
5	(4) The professional specialty of the
6	healthcare provider who made the determination;
7	(iv) A space to be filled out by the healthcare
8	provider that includes:
9	(a) The name, address, contact information,
10	and identification number of the healthcare provider requesting an
11	independent review;
12	(b) An indication of whether or not the
13	healthcare provider is requesting that the entity performing the independent
14	review examine the same random sample or a different random sample of claims,
15	if available; and
16	(c) The date the appeal is being requested;
17	<u>and</u>
18	(v) An instruction to the healthcare provider to
19	return the form to the healthcare insurer before the date the rescission
20	becomes effective; and
21	(3) The healthcare provider performs five (5) or fewer of a
22	particular healthcare service in the most recent six-month evaluation period
23	<u>under § 23-99-1120(e).</u>
24	(b) A determination made under subdivision (a)(1) of this section
25	shall be made by a physician who:
26	(1) Possesses a current and unrestricted license to practice
27	medicine in this state; and
28	(2) Has the same or similar specialty as the healthcare
29	provider.
30	(c)(1) A healthcare insurer that is conducting an evaluation under
31	subsection (a) of this section to determine whether or not a healthcare
32	provider still qualifies for a prior authorization exemption may request
33	medical records and documents required for the retrospective review, limited
34	to no more than twenty (20) claims for a particular healthcare service.
35	(2) A healthcare insurer shall provide a healthcare provider at
36	least thirty (30) days to provide the medical records requested under

T	subdivision (c)(1) of this section.
2	(d) A healthcare insurer may deny an exemption from prior
3	authorization requirements under § 23-99-1120 only if:
4	(1) The healthcare provider does not have an exemption at the
5	time of the relevant evaluation period; and
6	(2) The healthcare insurer provides the healthcare provider
7	with:
8	(A) Actual data for the relevant prior authorization
9	request evaluation period; and
10	(B) Detailed information sufficient to demonstrate that
11	the healthcare provider does not meet the criteria for an exemption from
12	prior authorization requirements for the particular healthcare service under
13	<u>§ 23-99-1120.</u>
14	(e) A healthcare insurer shall:
15	(1) Allow a healthcare provider to designate an email address or
16	a mailing address for communications regarding exemptions, denials, and
17	rescissions;
18	(2) Provide an option for a healthcare provider to submit a
19	request for an appeal by mail, by email, or by other electronic method; and
20	(3) Include an explanation of how a healthcare provider may
21	update his or her preferred contact information and delivery method on the
22	healthcare insurer's website and for all communications issued under this
23	section.
24	
25	23-99-1123. Independent review of exemption determination.
26	(a)(l) A healthcare provider has a right to a review of an adverse
27	determination regarding a prior authorization exemption within twelve (12)
28	months of receiving proper notice of recission from a healthcare insurer to
29	be conducted by an independent review organization.
30	(2) A healthcare insurer shall not require a healthcare provider
31	to engage in an internal appeal process before requesting a review by an
32	independent review organization under this section.
33	(3) A healthcare provider who has an exemption rescinded due to
34	a failure to provide medical records within sixty (60) days of a record
35	request for a retrospective review shall not be eligible for review of that
36	rescission by an independent review entity.

1	(b) A healthcare insurer shall pay:
2	(1) For any appeal or independent review of an adverse
3	determination regarding a prior authorization exemption requested under this
4	section; and
5	(2) A reasonable fee determined by the Arkansas State Medical
6	Board for any copies of medical records or other documents requested from a
7	healthcare provider during an exemption rescission review requested under
8	this section.
9	(c) An independent review organization shall complete an expedited
10	review of an adverse determination regarding a prior authorization exemption
11	no later than the thirtieth day after the date a healthcare provider files
12	the request for a review under this section.
13	(d)(1) A healthcare provider may request that the independent review
14	organization consider another random sample of no fewer than five (5) and no
15	more than twenty (20) claims submitted to the healthcare insurer by the
16	healthcare provider during the relevant evaluation period for the relevant
17	healthcare service as part of the review under this section.
18	(2) If a healthcare provider makes a request under subdivision
19	(d)(l) of this section, the independent review organization shall base its
20	determination on the medical necessity of claims reviewed:
21	(A) By the healthcare insurer under § 23-99-1122; and
22	(B) By the independent review organization under
23	subdivision (d)(1) of this section.
24	(e) The Insurance Commissioner may refuse, suspend, revoke, or not
25	renew a license or certificate of authority of a healthcare insurer that has
26	fifty percent (50%) of healthcare provider appeals overturned in a twelve-
27	month period by an independent review organization under this section.
28	
29	23-99-1124. Effect of appeal of independent review organization
30	determination.
31	(a) A healthcare insurer is bound by an appeal or independent review
32	organization determination that does not affirm the determination made by the
33	healthcare insurer to rescind a prior authorization exemption.
34	(b) A healthcare insurer shall not retroactively deny a healthcare
35	service on the basis of a rescission of an exemption, even if the healthcare
36	insurer's determination to rescind the prior authorization exemption is

1 affirmed by an independent review organization.

2	(c) If a determination of a prior authorization exemption made by the
3	healthcare insurer is overturned on review by an independent review
4	organization, the healthcare insurer:
5	(1) Shall not attempt to rescind the exemption before the end of
6	the next evaluation period; and
7	(2) May only rescind the exemption if the healthcare insurer
8	complies with §§ 23-99-1122 and 23-99-1123.
9	
10	23-99-1125. Eligibility for prior authorization exemption following
11	finalized exemption rescission or denial.
12	(a) After a final determination or review affirming the rescission or
13	denial of an exemption for a specific healthcare service under § 23-99-1120,
14	a healthcare insurer shall conduct another evaluation to determine whether or
15	not the exemption should be granted or reinstated based on the six-month
16	evaluation period that follows the evaluation period that formed the basis of
17	the rescission or denial of an exemption.
18	(b) A time period that is included in a previous evaluation or
19	determination period shall not be included in a subsequent evaluation period.
20	
21	23-99-1126. Effect of prior authorization exemption.
22	(a) A healthcare insurer shall not deny or reduce payment to a
23	healthcare provider for a healthcare service for which the healthcare
24	provider has qualified for an exemption from prior authorization requirements
25	under § 23-99-1120, including a healthcare service performed or supervised by
26	another healthcare provider, if the healthcare provider who ordered the
27	healthcare service received a prior authorization exemption based on medical
28	necessity or appropriateness of care unless the healthcare provider:
29	(1) Knowingly and materially misrepresented the healthcare
30	service in a request for payment submitted to the healthcare insurer with the
31	specific intent to deceive the healthcare insurer and obtain an unlawful
32	payment from the healthcare insurer; or
33	(2) Substantially failed to perform the healthcare service.
34	(b) A healthcare insurer shall not conduct a retrospective review of a
35	healthcare service subject to an exemption except:
36	(1) To determine if the healthcare provider still qualifies for

1	an exemption under § 23-99-1120; or
2	(2) If the healthcare insurer has a reasonable cause to suspect
3	a basis for denial exists under subsection (a) of this section.
4	(c) For a retrospective review described by subdivision (b)(2) of this
5	section, $\S\S 23-99-1120-23-99-1125$ shall not modify or otherwise affect:
6	(1) The requirements under or application of § 23-99-1115,
7	including without limitation any time frames; or
8	(2) Any other applicable law, except to prescribe the only
9	circumstances under which:
10	(A) A retrospective review may occur as specified by
11	subdivision (b)(2) of this section; or
12	(B) Payment may be denied or reduced as specified by
13	subsection (a) of this section.
14	(d) Beginning on January 1, 2024, a healthcare insurer shall provide
15	to a healthcare provider a notice that includes a:
16	(1) Statement that the healthcare provider has an exemption from
17	prior authorization requirements under § 23-99-1120;
18	(2) List of the healthcare services and health benefit plans to
19	which the exemption applies; and
20	(3) Statement of the duration of the exemption.
21	(e) If a healthcare provider submits a prior authorization request for
22	a healthcare service for which the healthcare provider has an exemption from
23	prior authorization requirements under § 23-99-1120, the healthcare insurer
24	shall promptly provide a notice to the healthcare provider that includes:
25	(1) The information described in subsection (d) of this section;
26	<u>and</u>
27	(2) A notification of the healthcare insurer's payment
28	requirements.
29	(f) This section and §§ 23-99-1120 — 23-99-1125 shall not be construed
30	to:
31	(1) Authorize a healthcare provider to provide a healthcare
32	service outside the scope of the healthcare provider's applicable license; or
33	(2) Require a healthcare insurer to pay for a healthcare service
34	described by subdivision (f)(l) of this section that is performed in
35	violation of the laws of this state.
36	(g) A healthcare insurer that offers multiple health benefit plans or

- that utilizes multiple healthcare provider networks shall not determine a
  healthcare provider's eligibility for an exemption from prior authorization
- 3 for each specific health benefit plan or each specific healthcare provider
- 4 network but rather shall determine the healthcare provider's eligibility for
- 5 <u>an exemption applicable to all health benefit plans and healthcare provider</u>
- 6 <u>networks</u>.
- 7 (h) If a healthcare insurer and a healthcare provider are engaged in a
- 8 value-based reimbursement arrangement for particular healthcare services or
- 9 <u>subscribers</u>, the healthcare insurer shall not impose any prior authorization
- 10 requirements for any particular healthcare service that is included in that
- 11 value-based reimbursement arrangement.

12 13

- 23-99-1127. Applicability.
- (a) (1) An organization or entity directly or indirectly providing a
- 15 plan or services to patients under the Medicaid Provider-Led Organized Care
- 16 Act, § 20-77-2701 et seq., or any other Medicaid-managed care program
- 17 operating in this state is exempt from §§ 23-99-1120 23-99-1126 if the
- 18 program, without limiting the program's application to any other plan or
- 19 program, develops a program to reduce or eliminate prior authorizations for a
- 20 <u>healthcare provider on or before January 1, 2025.</u>
- 21 <u>(2) The Arkansas Health and Opportunity for Me Program established by</u>
- 22 the Arkansas Health and Opportunity for Me Act of 2021, § 23-61-1001 et seq.,
- 23 or its successor program is exempt from  $\S\S 23-99-1120-23-99-1126$ , provided
- 24 that the Arkansas Health and Opportunity for Me Program, without limiting the
- 25 Arkansas Health and Opportunity for Me Program's application to any other
- 26 plan or program, develops a program to reduce or eliminate prior
- 27 authorizations for a healthcare provider on or before January 1, 2025.
- 28 (3) A qualified health plan that is a health benefit plan under
- 29 the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, and
- 30 <u>purchased on the Arkansas Health Insurance Marketplace created under the</u>
- 31 Arkansas Health Insurance Marketplace Act, § 23-61-801 et seq., for an
- 32 individual up to four hundred percent (400%) of the federal poverty level,
- 33 operating in this state is exempt from §§ 23-99-1120 23-99-1126 if the
- 34 qualified health plan, without limiting the program's application to any
- 35 other plan or program, develops a program to reduce or eliminate prior
- 36 <u>authorizations for a healthcare provider on or before January 1, 2025.</u>

1	(b)(1) The programs under subsection (a) of this section to reduce or
2	eliminate prior authorization shall be:
3	(A) Submitted to the State Insurance Department; and
4	(B) Subject to approval by the Legislative Council.
5	(2) If a program is not submitted to the department and approved
6	by the Legislative Council on or before January 1, 2025, the Medicaid-managed
7	care program operating in this state, the Arkansas Health and Opportunity for
8	Me Program established by the Arkansas Health and Opportunity for Me Act of
9	2021, § 23-61-1001 et seq., or its successor program, and qualified health
10	plans under the Patient Protection and Affordable Care Act, Pub. L. No. 111-
11	148, and purchased on the Arkansas Health Insurance Marketplace created under
12	the Arkansas Health Insurance Marketplace Act, § 23-61-801 et seq., for an
13	individual up to four hundred percent (400%) of the federal poverty level,
14	operating in this state shall be subject to §§ 23-99-1120 $-$ 23-99-1126 and §
15	23-99-1128 as of January 1, 2025.
16	(c) Any state or local governmental employee plan is exempt from §§
17	<u>23-99-1120 - 23-99-1126 and § 23-99-1128.</u>
18	(d) A health benefit plan provided by a trust established under §§ 14-
19	54-101 and 25-20-104 to provide benefits, including accident and health
20	benefits, death benefits, dental benefits, and disability income benefits, is
21	exempt from §§ 23-99-1120 - 23-99-1126.
22	(e)(l) Prescription drugs, medicines, biological products,
23	pharmaceuticals, or pharmaceutical services are exempt as a healthcare
24	service for purposes of §§ 23-99-1120 - 23-99-1126 until December 31, 2024.
25	(2)(A) As of January 1, 2025, the provisions of §§ 23-99-1120 -
26	23-99-1126 shall apply to prescription drugs, medicines, biological products,
27	pharmaceuticals, or pharmaceutical services that have not been approved for
28	continuation of prior authorization under § 23-99-1128.
29	(B) For the products in subdivision (e)(2)(A) of this
30	section that have not been approved for continuation of prior authorization,
31	for purposes of § 23-99-1120, then:
32	(i) Provisions regarding time periods specified
33	during the calendar year 2022 shall instead apply to the same months during
34	calendar year 2023; and
35	(ii) Provisions regarding time periods specified
36	during the calendar year 2024 shall instead apply to the same months during

1	calendar year 2025.
2	
3	23-99-1128. Prescription drugs, medicines, biological products,
4	pharmaceuticals, or pharmaceutical services.
5	(a)(1) Beginning on January 1, 2024, a healthcare insurer or pharmacy
6	benefits manager shall submit a written request to the Arkansas State Board
7	of Pharmacy for any prescription drug, medicine, biological product,
8	pharmaceutical, or pharmaceutical service to be reviewed for a continuation
9	of prior authorization by a specified health benefit plan whether or not a
10	healthcare provider has met the criteria for an exemption from prior
11	authorization under §§ 23-99-1120 — 23-99-1126.
12	(2) The request under subdivision (a)(1) of this section shall
13	state the reason the request is being made for each prescription drug,
14	medicine, biological product, pharmaceutical, or pharmaceutical service for
15	the specified health benefit plan.
16	(b) The Arkansas State Board of Pharmacy and the Arkansas State
17	Medical Board, jointly, may establish criteria and procedures to review
18	whether a request made under subdivision (a)(1) of this section should be
19	granted for the requesting party and specified health benefit plan.
20	(c)(1) The Arkansas State Board of Pharmacy and the Arkansas State
21	Medical Board, jointly, may determine whether or not a prescription drug,
22	medicine, biological product, pharmaceutical, or pharmaceutical service may
23	be subject to prior authorization by a health benefit plan under the criteria
24	and procedures under subsection (b) of this section.
25	(2) The Arkansas State Board of Pharmacy shall promptly notify
26	the entity that made the request of the joint decision made by the Arkansas
27	State Board of Pharmacy and the Arkansas State Medical Board.
28	(d) The Arkansas State Board of Pharmacy shall make available to any
29	person who requests it, a list for any health benefit plan of prescription
30	drugs, medicines, biological products, pharmaceuticals, or pharmaceutical
31	services that require a prior authorization under this section.
32	
33	23-99-1129. Appeals process for disallowance of prior authorization.
34	(a) If the Arkansas State Board of Pharmacy and the Arkansas State
35	Medical Board, jointly, disallow a prior authorization of a prescription
36	drug, medicine, biological product, pharmaceutical, or pharmaceutical service

1	requested under § 23-99-1128, a healthcare insurer, pharmacy benefits
2	manager, or other interested party may file an appeal to the State Insurance
3	Department within ninety (90) days of the disallowance of the prior
4	authorization.
5	(b) No later than the thirtieth day after the date a healthcare
6	insurer, pharmacy benefits manager, or other interested party files an appear
7	under subsection (a) of this section, the Insurance Commissioner shall
8	appoint an independent review organization to review the appeal.
9	(c) A healthcare insurer, pharmacy benefits manager, or other
10	interested party that files an appeal under subsection (a) of this section
11	shall pay for the independent review organization appointed under subsection
12	(b) of this section to review the appeal.
13	(d) A healthcare insurer, pharmacy benefits manager, or other
14	interested party is bound by the independent review organization's
15	determination of the appeal under this section.
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17	/s/L. Johnson
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20	APPROVED: 4/11/23
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