SB 284

Telehealth matters. Consolidates Medicaid telehealth language. Provides that “health care services” does not include certain case management services, care management services, service coordination services, or care coordination services for purposes of telehealth. Adds occupational therapist assistants, school psychologists, specified developmental therapists, peers, clinical fellows, students and graduates of certain professional programs, physical therapist assistants, and certain community mental health center providers to the definition of “practitioner” for purposes of practicing telehealth. Allows behavior health analysts to temporarily perform telehealth during the time when the professional licensing agency is preparing to implement licensure for the profession.

HB 1230

Telemedicine services. Expands the application of the telehealth statute to additional practitioners.

HB 1284

Telehealth services. Requires a health care provider who provides telehealth services to obtain written health care consent for the provision of telehealth services. Requires a prescriber who provides telehealth services to a patient to conduct certain components of a physical examination and document the results in the patient’s medical record. Allows a prescriber to issue a prescription for a controlled substance to a patient: (1) who is receiving services through the use of telehealth; and (2) who has been previously examined by the prescriber in person. Creates an exception by allowing a prescriber who specializes in psychiatry to issue a prescription for a controlled substance to a patient who is receiving psychiatric services through the use of telehealth.

SB 88

Prescription drug rebates and pricing. Provides that, for individual health insurance coverage, the defined cost sharing for a prescription drug be calculated at the point of sale and based on a price that is reduced by an amount equal to at least 85% of all rebates received by the insurer in connection with the dispensing or administration of the prescription drug. Requires that, for group health insurance coverage, an insurer: (1) pass through to a plan sponsor 100% of all rebates received or estimated to be received by the insurer concerning the dispensing or administration of prescription drugs to the covered individuals of the plan sponsor; (2) provide a plan sponsor, at the time of contracting, the option of calculating defined cost sharing for covered individuals of the plan sponsor at the point of sale based on a price that is reduced by some or all of the rebates received or estimated to be received by the insurer concerning the dispensing or administration of the prescription drug; and (3) disclose specified information to the plan sponsor. Allows the department of insurance to enforce the provisions and impose a civil penalty.

SB 407

Medicaid risk based managed care. Requires review by the budget committee before a request for proposal for the procurement of a covered population in a risk based managed care program or a capitated managed care program (program) is issued. Sets forth requirements that the office of the secretary (office) must ensure are met before the office may contract with an entity to operate a program. Sets forth provisions that must be included in a contract with an entity to operate the program. Requires the office to do the following: (1) determine all eligibility requirements; and (2) determine the base reimbursement rate structure, methodology, and reimbursement rates that are sufficient to provide an adequate number of providers to provide home and community based services. Requires a managed care organization to contract with any providers that meet specified requirements for the program. Prohibits a managed care organization from delegating or subcontracting specified functions within the program unless certain conditions are met. Requires the office to apply to amend the aged and disabled waiver to ensure that an individual in need of waiver services is authorized for reimbursable services within 72 hours of determining the individual would

qualify for Medicaid and the waiver services. Expires the program on July 1, 2027. Requires the office to annually provide the budget committee information concerning the number of Medicaid recipients in certain categories and reimbursement rates for home and community based services. Allows the office of the attorney general to investigate and prosecute complaints concerning employment agencies. Provides that the division of consumer protection is responsible for the investigation of complaints concerning employment agencies.

HB 1046

Health insurance matters. Requires the commissioner of the department of insurance to provide an order directing the discontinuance of an illegal, unauthorized, or unsafe practice of an insurance company. Provides that a health plan may not require a participating provider to seek prior authorization for a particular health service if the health plan approved at least 90% of the prior authorization requests for the particular health service in the previous six month period. Requires a health plan to post notice of a technical issue with its claims submission system on the health plan's Internet web site. Requires a health plan to post on its Internet web site not later than February 1 of each year: (1) the 30 most frequently submitted CPT codes in the previous calendar year; and (2) the percentage of the 30 most frequently submitted CPT codes that were approved in the previous calendar year. Requires a health plan to provide annual and quarterly financial statements to the department of insurance. Establishes an approval process for a health plan's proposed premium rate increase of 5% or greater as compared to the previous calendar year. Requires an insurer and a health maintenance organization to provide a contracted provider with a current reimbursement rate schedule: (1) every two years; and (2) when three or more CPT code rates change in a 12 month period. Requires an insurer and a health maintenance organization to provide a contracted provider with notice of a proposed material change to the agreement between the insurer or health maintenance organization and the contracted provider at least 90 days prior to the proposed effective date. Establishes requirements for the contents of a notice of a proposed material change. Requires an insurer or health maintenance organization to provide a contracted provider with notice at least 15 days prior to a change to an existing prior authorization, precertification, notification, referral program, edit program, or specific edits.

HB 1383

Withdrawal from Medicare advantage networks. Provides that a hospital, physician, or physician group: (1) may not withdraw from a Medicare advantage network for any part of a calendar year after the calendar year has begun; (2) may withdraw from a Medicare advantage network only for an entire calendar year; and (3) may withdraw for an entire calendar year only by giving notice of the withdrawal to the insurer that operates the Medicare advantage plan not later than September 1 immediately preceding the calendar year. Provides that an insurer operating a Medicare advantage plan: (1) may not remove a hospital, physician, or physician group from the Medicare advantage plan's Medicare advantage network for any part of a calendar year after the calendar year has begun; (2) may remove a hospital, physician, or physician group from the Medicare advantage network only for an entire calendar year; and (2) may remove a hospital, physician, or physician group from the Medicare advantage network for a calendar year only by giving notice of the removal to the hospital, physician, or physician group not later than September 1 immediately preceding the calendar year. Makes certain exceptions. Provides that notice of the withdrawal or removal of a hospital, physician, or physician group from a Medicare advantage network must be given by letter, telephone message, or electronic mail message at least 60 days before the withdrawal or removal to each individual who is covered by the Medicare advantage plan and who, not more than two years before the date of the withdrawal or removal, was seen or treated by the physician or a physician of the physician group or was an inpatient in or received medical treatment in the hospital. Empowers the insurance commissioner to impose penalties for violations and authorizes the insurance commissioner to adopt administrative rules.

HB 1271

Health care prior authorization. Provides that when a health plan makes an adverse determination in response to a health care provider's request for prior authorization of a health care service: (1) the health plan is required to provide the health care provider with an opportunity to have a peer to peer conversation with a clinical peer concerning the adverse determination; and (2) the peer to peer conversation opportunity must be provided not more than seven business days after the health plan receives the health care provider's request for the peer to peer conversation. Provides that after December 31, 2023: (1) if a health plan,

during a six month evaluation period, approves at least 90% of a health care provider's requests for prior authorization for a particular type of health care service, the health plan may not require the health care provider to obtain prior authorization for that type of health care service for the entire duration of an exemption period of six calendar months immediately following the evaluation period; and (2) at the conclusion of the initial exemption period, the health plan shall continue a health care provider's exemption for consecutive periods of six months unless the health plan rescinds the health care provider's exemption; (3) a health plan's rescission of a health care provider's exemption must be based on: (A) a determination by a physician that, in cases randomly selected for review, less than 90% of the health care services provided by the health care provider met the health plan's medical necessity criteria; or (B) the health care provider committing health care provider fraud or the health care provider's license or legal authorization to provide health care services being suspended or revoked; (4) a health care provider whose exemption is rescinded may initiate a review of the rescission by an independent review panel; (5) the independent review panel is required to determine: (A) whether at least 90% of the health care services provided by the health care provider met the health plan's medical necessity criteria; or (B) whether the health care provider committed health care provider fraud or the health care provider's license or legal authorization to provide health care services is suspended or revoked; (6) the health plan is required to restore the health care provider's exemption if the independent review panel's determination is in favor of the health care provider; and (7) if a health care provider whose exemption is rescinded does not initiate a review or if the independent review panel's determination is not in favor of the health care provider, the health plan is not required to determine again whether the health care provider is entitled to an exemption until the first evaluation period beginning at least two years later. Requires the insurance commissioner to adopt rules.

HB 1194

Risk based managed care and integrated care. Requires the office of the secretary of family and social services (office of the secretary) to apply to the United States Department of Health and Human Services for a Medicaid waiver or state plan amendment to implement, not earlier than January 1, 2024, a fee for service integrated care model program for specified category of Medicaid recipients. Sets forth requirements of the program. Sets forth certain requirements, including contract requirements for any contract between the office of the secretary and specified entities, in the operation of a risk based managed care program or

integrated care model program for the specified covered population.

SB 405

Regulation of hospitals and nursing homes. Repeals provisions that allow a county or city hospital to withhold from disclosure the individual salaries of hospital employees. Sets forth financial reporting requirements for hospitals concerning revenue generated from the ownership, operation, or management of a nursing facility. Requires the state department of health to: (1) jointly with the office of the secretary of family and social services, develop and finalize before July 1, 2024, quality metrics to improve clinical, administrative, and quality of life care for health facility residents; and (2) post on the state department's Internet web site certain information concerning a health facility's inspection reports, survey reports, and ownership information. Requires a health facility to disclose a description of the services provided by the facility and the rates charged for the services to prospective residents. Requires a health facility to: (1) post personnel and licensure classification information for on duty personnel; (2) retain personnel and licensure information for employees for public inspection; and (3) maintain a record of every inspection report and final citation issued to the health facility for public inspection. Prohibits a health facility from taking retaliatory action against an employee because the employee: (1) discloses or threatens to disclose actions or practices implemented by the health facility that the employee reasonably believes is in violation of federal or state law, rule, or regulation; (2) provides information or testifies in investigations or hearings; or (3) assists or participates in proceedings to enforce state law. Provides for relief to the employee.