

SB 129 ANALYSIS**Governor Kasich Signs Prior Authorization Reform Bill**

On June 15, Ohio Governor John Kasich signed Senate Bill 129, legislation that reforms Ohio's current prior authorization system. Ohio becomes the third state to establish prior authorization standards either in statute or the administrative code. OHFAMA would like to thank **Senators Randy Gardner** and **Capri Cafaro** and former House Insurance Committee chairwoman **Barbara Sears** for their hard work on this bill.

The podiatric physician and surgeon community is grateful to Senator Gardner, who is a strong supporter of our organization and profession, for reaching out to representatives of our association throughout difficult negotiations to ensure that the interests of members were reflected in SB 129, especially regarding "clinical peer review" of PA requests and appeals.

Some provisions will be implemented by January 1, 2017 and others by January 1, 2018. The bill impacts Health Insuring Corporations (HICs—ORC 1751), tradition Indemnity Plans (ORC 3923) and Medicaid Managed Care Plans (ORC 5160). Certain time lines will not apply to Medicaid plans' requirements of state Medicaid plans through federal laws or federal Medicaid administrative requirements. A summary of SB 129 follows.

January 1, 2017

- Providers will have access to electronic PA forms and PA requests shall be accepted through secure electronic transmissions;
- Health plans must respond using NCPDP SCRIPT standard ePA transactions;
- A FAX is not considered to be an electronic transmission nor is a proprietary portal for prescription drug requests that does not use NCPDP SCRIPT standard;
- A provider and a plan may enter into an agreement to process a PA request that does not use electronic means due to certain factors;
- There will be a 48 hour response required for urgent care services (originally 24 hours);
- There will be a response required within 10 calendar days for non-urgent services

(originally 5 days was requested);

- The "PA clock" starts when receipt of all information necessary is received by the health plan from the practitioner;
- These time frames DO NOT apply to emergency services as defined in the bill;
- In these time frames, the plans must clearly state if the PA request has been approved, denied or is incomplete;
- A specific reason must be given for a denial and if the submission is incomplete, the plan must request and cite specific information needed;
- The provider must respond within 72 hours to this request for additional information upon receipt from the plan;
- Plans must provide an electronic receipt for this transaction.

PA Process For Prescribed Drugs — January 1, 2017

- The PA will be either 12 months or until the last day of the person's coverage eligibility, whichever is less;
- Plans can check with the provider no more than quarterly to check if the patient's chronic condition has changed. These consultations shall be done within medical or scientific evidence as defined in ORC 3922.01;
- The practitioner must respond within 5 days to the request for information by the plan or the PA can be terminated;
- A 12-month PA will no longer be valid or will be terminated if changes are made to state or federal laws or guidance regulations that say the prescribed drug is no longer approved or safe for its intended purpose;
- A 12-month PA is not required or apply to medications prescribed for non-maintenance conditions (not defined), medications for conditions that have a typical treatment plan of less than one year, medications that require an initial trial period to determine effectiveness or tolerability, medications where there is medical or scientific evidence under ORC 3922.01 that does not support a 12-month prior approval, medications that are Schedule I or II controlled substances or any opioid analgesic or benzodiazepine as defined under ORC 3719.01, or medications that are not prescribed by an in-network provider as part of a case management program;
- A 12-month PA MAY be granted but is not required for medications that are pre-

scribed for a rare disease (as defined as a disease impacting 200,000 or less per year in the US), medications that are controlled substances that are not opioids or benzodiazepines as defined in earlier section;

- The substitution of a drug by a pharmacist that is already allowed under current Ohio law will not be prevented nor will be impacted by the granting of a prior authorization. A similar provision on interchangeable biologics was attempted by the health plans to be added at the last minute but was not accepted by the bill sponsor and others;
- The bill also states specific conditions under which a retrospective review of a PA can be made by the plan;

Notice Requirements

- By January 1, 2017, plans must make available to all participating providers on its website or provider portal listing its PA requirements and needs for PA information (to make a submission complete) as well as listing of all services, devices or drugs to which a PA authorization requirement exists.

Appeals Process — by January 1, 2018

- Plans must establish PA process;
- Urgent care appeals shall be concluded within 48 hours of receipt;
- All others must be completed within 10 days of receipt;
- Appeals that are done are required to be done between submitting practitioner and a clinical peer;
- If the appealing party is not satisfied with the plan's appeal process or result, they may request an external appeal as allowed under ORC 3922.

Retroactive Denial of PA — January 1, 2017

- Absent fraud or materially incorrect information, plans shall not retroactively deny a granted PA when all the following apply: the practitioner has submitted a PA request to a plan, the plan has approved the PA after determinations made of allowed factors and the plan's standards have been met for PA and medical necessity.

Ohio Department Of Insurance

- The bill will allow ODI to adopt rules needed to implement requirements of this section.