Amend **SB 1096** (house committee report) by adding the following appropriately numbered SECTIONS to the bill and renumbering subsequent SECTIONS of the bill accordingly:

SECTION ____. Subchapter A, Chapter 533, Government Code, is amended by adding Sections 533.00282, 533.00283, and 533.00284 to read as follows:

Sec. 533.00282. UTILIZATION REVIEW AND PRIOR AUTHORIZATION PROCEDURES. In addition to the requirements of Section 533.005, a contract between a managed care organization and the commission described by that section must require that:

(1) before issuing an adverse determination on a prior authorization request, the organization provide the physician requesting the prior authorization with a reasonable opportunity to discuss the request with another physician who practices in the same or a similar specialty, but not necessarily the same subspecialty, and has experience in treating the same category of population as the recipient on whose behalf the request is submitted;

(2) the organization review and issue determinations on prior authorization requests according to the following time frames:

(A) with respect to a recipient who is hospitalized at the time of the request:

(i) within one business day after receiving the request, except as provided by Subparagraphs (ii) and (iii);

(ii) within 72 hours after receiving the request if the request is submitted by a provider of acute care inpatient services for services or equipment necessary to discharge the recipient from an inpatient facility; or

(iii) within one hour after receiving the request if the request is related to poststabilization care or a life-threatening condition; or

(B) with respect to a recipient who is not hospitalized at the time of the request, within three business days after receiving the request; and

(3) the organization:

(A) have appropriate personnel reasonably

available at a toll-free telephone number to respond to a prior authorization request between 6 a.m. and 6 p.m. central time Monday through Friday on each day that is not a legal holiday and between 9 a.m. and noon central time on Saturday, Sunday, and legal holidays;

(B) have a telephone system capable of receiving and recording incoming telephone calls for prior authorization requests after 6 p.m. central time Monday through Friday and after noon central time on Saturday, Sunday, and legal holidays; and

(C) have appropriate personnel to respond to each call described by Paragraph (B) not later than 24 hours after receiving the call.

Sec. 533.00283. ANNUAL REVIEW OF PRIOR AUTHORIZATION REQUIREMENTS. (a) Each managed care organization that contracts with the commission to provide health care services to recipients shall develop and implement a process to conduct an annual review of the organization's prior authorization requirements, other than a prior authorization requirement prescribed by or implemented under Section 531.073 for the vendor drug program. In conducting a review, the organization must:

(1) solicit, receive, and consider input from providers in the organization's provider network; and

(2) ensure that each prior authorization requirement is based on accurate, up-to-date, evidence-based, and peer-reviewed clinical criteria that distinguish, as appropriate, between categories, including age, of recipients for whom prior authorization requests are submitted.

(b) A managed care organization described by Subsection (a) may not impose a prior authorization requirement, other than a prior authorization requirement prescribed by or implemented under Section 531.073 for the vendor drug program, unless the organization has reviewed the requirement during the most recent annual review required under this section.

Sec. 533.00284. RECONSIDERATION FOLLOWING ADVERSE DETERMINATIONS ON CERTAIN PRIOR AUTHORIZATION REQUESTS. (a) In addition to the requirements of Section 533.005, a contract between a managed care organization and the commission for the organization

to provide health care services to recipients must include a requirement that the organization establish a process for reconsidering an adverse determination on a prior authorization request that resulted solely from the submission of insufficient or inadequate documentation.

(b) The process for reconsidering an adverse determination on a prior authorization request under this section must:

(1) allow a provider to, not later than the seventh business day following the date of the determination, submit any documentation that the managed care organization identified as insufficient or inadequate;

(2) allow the physician requesting the prior authorization to discuss the request with another physician who practices in the same or a similar specialty, but not necessarily the same subspecialty, and has experience in treating the same category of population as the recipient on whose behalf the request is submitted; and

(3) require the managed care organization to, not later than the first business day following the date the provider submits sufficient and adequate documentation under Subdivision (1), amend the determination to approve the prior authorization request.

(c) An adverse determination on a prior authorization request is considered a denial of services in an evaluation of the managed care organization only if the determination is not amended under Subsection (b)(3).

(d) The process for reconsidering an adverse determination on a prior authorization request under this section does not affect:

(1) any related timelines, including the timeline for an internal appeal or a Medicaid fair hearing; or

(2) any rights of a recipient to appeal a determination on a prior authorization request.

SECTION ____. (a) Sections 533.00282 and 533.00284, Government Code, as added by this Act, apply only to a contract between the Health and Human Services Commission and a managed care organization under Chapter 533, Government Code, that is entered

into or renewed on or after the effective date of this Act.

(b) The Health and Human Services Commission shall seek to amend contracts entered into with managed care organizations under Chapter 533, Government Code, before the effective date of this Act to include the provisions required by Sections 533.00282 and 533.00284, Government Code, as added by this Act.