SENATE APPROPRIATIONS COMMITTEE FISCAL NOTE

BILL NO. Senate Bill 225

PRINTER NO. 1809

AMOUNT

See Fiscal Impact

FUND

General Fund

DATE INTRODUCED

March 18, 2021

PRIME SPONSOR

Senator Phillips-Hill

DESCRIPTION

Senate Bill 225 Amends Article XXI (Quality Health Care Accountability and Protection) of the Insurance Company Law of 1921, which provides for managed care plan responsibilities, utilization review of health care services and complaints and grievances. The current article only applies to managed care plans which are Medicaid managed care organizations (MCOs) and gatekeeper commercial insurance plans. This act will expand applicability to Medicaid, the Children's Health Insurance Program and fully insured commercial plans.

Senate Bill 225 provides for the following:

- Prior authorization shall not be required for emergency services, including testing and other diagnostic services that are medically necessary to evaluate or treat an emergency medical condition prior to the point at which the condition is stabilized;
- Providers shall have a minimum of twenty-four (24) hours to notify an insurer, MCO, or contractor following an enrollee's admission to inpatient care;
- At least one FDA-approved prescription drug classified as medication assisted treatment shall be available without initial prior authorization. Nothing shall prohibit the designation of preferred medications nor prohibit prior authorization on subsequent requests for medication assisted treatment in accordance with clinical guidelines;
- Within 18 months following the effective date of this section, an insurer, MCO or contractor shall establish a provider portal for electronic submission of prior authorization, access to applicable medical policies and information necessary to request peer-to-peer review. Training on the use of provider portals shall also be made available;
- Within 18 months following establishment of the provider portals, prior authorization requests shall be submitted electronically;
- Medical policies and clinical review criteria shall be available on the insurer, MCO or contractor's publicly accessible internet website or provider portal and include references to third-party standards that are used. Policies shall be reviewed at least annually, and providers shall be notified of discretionary changes to medical policies 30 days prior to applicability. For policy changes

- required by state or federal law or changes that result in less restrictive coverage, providers shall be notified within 30 days after application;
- Clinical review criteria shall be based on nationally recognized medical standards, be consistent with governmental guidelines and reflect the current quality of medical and scientific evidence regarding emerging procedures and best practices as articulated in independent, peer-reviewed medical literature. Nothing shall require coverage for a health care service otherwise excluded from coverage;
- The bill streamlines the existing two levels of internal complaint review into a single review by a committee of three or more individuals to be completed within 30 days;
- Medical policies that incorporate step therapy for prescription drugs shall be reviewed in accordance with the standards set forth in prior authorization review. The review shall also take into consideration the enrollee's individualized clinical condition with respect to contraindications, clinical effectiveness or ineffectiveness of the required prerequisite prescription drugs, past clinical outcomes, expected clinical outcomes of the prescribed prescription drug and, for new enrollees, whether the enrollee has already satisfied a step therapy protocol with their previous health plan that required trials of drugs similar to those currently required in a step therapy protocol;
- Prior authorization shall be based upon medical policy, administrative policy and all medical information and evidence submitted by requesting providers. The review shall also verify the enrollee's eligibility for coverage under the terms of the insurance policy or contract. Appeals of administrative denials shall be subject to the complaint process;
- A list of all health services for which prior authorization is required shall be posted on the insurer, MCO or contractor's publicly accessible internet website;
- Prior authorization may only be denied upon review by a properly licensed medical professional in the same or similar specialty that manages or consults on the health care service in question. This may be satisfied through third-party medical professionals provided compensation is not contingent upon the outcome of the review;
- In the case of a denied prior authorization, the opportunity for a peer-to-peer review shall be made available and the reviewer shall have authority to modify or overturn the prior authorization decision. The procedure for requesting a peer-to-peer review shall be available on the insurer's, MCO's or contractor's publicly accessible internet website or provider portal. Peer-to-peer discussions shall occur during or outside normal business hours subject to reasonable limitations on the availability of qualified reviewers;
- Providers may designate another licensed member of the provider's affiliated or employed clinical staff with knowledge of the enrollee's condition and requested procedure as a qualified proxy for completing a peer-to-peer discussion. Peer-to-peers shall be available from the time of a prior authorization denial until the internal grievance process commences;

- Prior authorization shall be rendered within 72 hours for urgent requests and 14 days for non-urgent medical services. Prescription drug and step therapy determinations shall be made in not more than 24 hours for urgent requests and not more than 72 hours for non-urgent requests;
- If, after requesting prior authorization, a provider determines the enrollee's medical condition requires emergency services, such services may be provided under section 2116;
- If a prior authorization request is missing clinical information necessary to complete the review, an insurer, MCO or contractor shall notify the provider of missing clinical information within 24 hours for urgent requests or within 2 business days of all other types of requests and allow the provider or a member of the provider's clinical or administrative staff to submit such information. Complete prior authorization requests shall be determined in no longer than 48 hours;
- If a provider performs a closely related service, the insurer, MCO or contractor may not deny a claim for failure to obtain prior authorization provided the provider notifies the insurer, MCO or contractor of the closely related service no later than 72 hours following completion but prior to submission of the claim for payment. The notification shall include all relevant clinical information necessary to evaluate the medical necessity and appropriateness of the closely related service. Nothing shall limit the ability to determine medical necessity and appropriateness of the closely related service nor limit the need for verification of the enrollee's eligibility for coverage; and
- The bill streamlines the existing two levels of internal grievance review into a single review by a committee of three or more individuals to be completed within 30 days. Enrollee's and provider's shall have 4 months within receiving an adverse benefit determination to file a grievance and shall have the right to appear before the review committee.

This act shall take effect in 90 days.

FISCAL IMPACT:

Senate Bill 225 will not create additional services for Children's Health Insurance Program (CHIP) or Medical Assistance; however, the bill will change standards for the complaint and grievance process across CHIP and the HealthChoices programs. These changes could create increased administrative costs for CHIP insurers and Medical Assistance Managed Care Organizations. The Department of Human Services may have to increase rates during future negotiations to the extent that the CHIP and the HealthChoices programs are not able to accommodate the increased administrative tasks within their current workforce and budgets.