Bill Summary

H.F. 3578

As introduced

Subject	Prior authorization of health care services
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Date	February 14, 2024

Overview

Prior authorization is the evaluation by a person other than the attending health care professional, before the delivery of a health care service, of the service's necessity, appropriateness, and efficacy, to determine the medical necessity of the service for a patient. This bill modifies requirements for utilization review and prior authorization of health care services, including requiring utilization review organizations to automate elements of the prior authorization process, specifying additional services for which prior authorization cannot be conducted or required, and requiring the adoption of rules to establish requirements for a prior authorization exemption process. This bill also prohibits health carriers from retrospectively limiting coverage of a health care service in certain circumstances.

Summary

Section	Description
1	**Coverage of service; prior authorization.** Adds § 62A.59. Prohibits a health carrier from: ▪ retrospectively denying or limiting coverage of a service for which prior authorization was not required, unless there is evidence the service was provided based on fraud or misinformation; and ▪ denying or limiting coverage of a service the enrollee already received on the basis of lack of prior authorization, if the service would have been covered if prior authorization had been obtained.
2	**Scope.** Amends § 62M.01, subd. 3. Provides that chapter 62M, which governs utilization review of health care, applies to managed care plans and county-based purchasing plans covering medical assistance or MinnesotaCare enrollees. (Current law provides chapter 62M does not apply to managed care plans and county-based purchasing plans covering medical assistance or MinnesotaCare enrollees).

Section	Description
3	**Adverse determination.** Amends § 62M.02, subd. 1a. Amends the definition of adverse determination to provide adverse determination includes an authorization for a health care service that is less intensive than the health care service specified in the original authorization request.
4	**Standard review determination.** Amends § 62M.05, subd. 3a. Strikes obsolete language from a paragraph establishing timelines for communicating standard review determinations to providers and enrollees.
5	**Automated process.** Adds subd. 6 to § 62M.05. Requires utilization review organizations to establish a prior authorization application programming interface to automate certain steps of the prior authorization process and promote information exchange between providers and utilization review organizations. Lists functions the application programming interface must perform.
6	**Prior authorization of certain services prohibited.** Amends § 62M.07, subd. 2. Current law prohibits prior authorization from being conducted or required for emergency confinement or an emergency service. This section adds the following to the items for which prior authorization cannot be conducted or required: ▪ medication to treat a substance use disorder; ▪ a generic drug or multisource brand name drug rated as therapeutically equivalent, or a biologic drug rated as interchangeable; ▪ outpatient mental health or substance use disorder treatment; ▪ antineoplastic cancer treatment consistent with certain guidelines; ▪ certain preventive services, immunizations, and screenings; ▪ certain pediatric hospice services; ▪ treatment provided by a neonatal abstinence program; and ▪ services covered by a value-based payment arrangement that meet certain requirements.
7	**Treatment of a chronic condition.** Adds subd. 5 to § 62M.07. Provides an authorization for treatment of a health condition an enrollee is expected to have for longer than one year does not expire unless the treatment standard for that condition changes.

Section	Description
8	**Requirements for prior authorization exemption process; rulemaking.** Adds § 62M.075. By January 1, 2025, requires the commissioner of commerce to adopt rules establishing a process to exempt providers or groups of providers from prior authorization requirements. Lists criteria the exemption process must satisfy, and requires the commissioner to consult with at least the listed stakeholder groups in adopting rules. Allows the commissioner to use the expedited rulemaking process. Requires utilization review organizations, health plan companies, and claims administrators to provide the commissioner with any data needed to adopt these rules, and classifies this data as private data on individuals or nonpublic data. Requires utilization review organizations to implement a prior authorization exemption process that complies with the rules by January 1, 2026. This section is effective the day following final enactment.
9	**Effect of change in prior authorization clinical criteria.** Amends § 62M.17, subd. 2. Under current law, a utilization review organization's change to coverage of a health care service or to the clinical criteria used for prior authorizations does not apply until the next plan year, for enrollees who received prior authorization for that service using the prior coverage terms or clinical criteria. This general rule does not apply if the utilization review organization changed coverage terms or the clinical criteria when an independent source recommended the change for reasons related to patient harm. This section specifies the patient harm must be previously unknown and imminent, for the exception to apply.
10	**Annual report to commissioner of commerce; prior authorizations.** Adds § 62M.19. By September 1 each year, requires utilization review organizations to report to the commissioner of commerce, information on prior authorization requests for the previous calendar year. Lists data that must be included in each report, and requires this data to be sorted by the listed categories of services.
11	**Utilization review.** Amends § 147.091, subd. 1b. Modifies Board of Medical Practice authority to investigate and impose disciplinary action against physicians for utilization review activities, to allow investigations and imposition of disciplinary action if a physician performing utilization review: ▪ fails to apply current evidence when making a utilization review determination; or ▪ fails to exercise the required degree of care in making utilization review determinations (current law allows investigations and imposition of disciplinary action for a pattern of failing to exercise the required degree of care).

Section	Description
12	**Commissioner of commerce; analysis and report to the legislature.** Requires the commissioner of commerce to use the data submitted by utilization review organizations and other available data to analyze the use of utilization management tools in health care. Lists what the analysis must include, and requires the commissioner to develop recommendations on how to simplify prior authorization standards and processes. Requires the commissioner to submit the analysis and recommendations to the legislature by January 15, 2026.
13	**Initial reports to commissioner of commerce; utilization management tools.** Requires utilization review organizations to submit initial reports on prior authorizations during the previous calendar year by September 1, 2025.
14	**Repealer.** Repeals section 62D.12, subd. 19. This subdivision prohibits a health maintenance organization from denying or limiting coverage of a service the enrollee has already received on the basis of lack of prior authorization or second opinion, if the service would have been covered under the member contract had prior authorization or second opinion been obtained.