Chapter 848/Senate Bill 791 and Chapter 847/House Bill 932, *Health Insurance - Utilization Review - Revisions* (2024)

Findings from an Environmental Scan of the Prior Authorization Process and Recommendations

NOVEMBER 21, 2024

Prior Authorization Landscape

- Requirements for prior authorization vary across payors from lists of services and medications, approval criteria, and supporting documentation
- The process can be time-intensive for providers and payors and result in delayed or abandoned care
- Approaches at the federal and state level to reform prior authorization are focused on automating the process and improving transparency and timeframes for processing requests; some efforts aim to reduce the volume of prior authorizations

Background – MHCC's Role in Prior Authorization

- In 2012, Maryland became one of the first states to enact legislation (Chapter 534/Senate Bill 540 and Chapter 535/House Bill 470, *Maryland Health Care Commission – Preauthorization of Health Care Services – Benchmarks*) requiring payors and pharmacy benefits managers (PBMs) to establish online portals
  - The legislation aimed to reduce use of telephone, fax, and paper-based communications
- Staff worked with payors and PBMs to implement electronic prior authorization processes required by the law in a series of four benchmarks
- Staff reported annually to the Governor and General Assembly through 2016
  - In general, use of the online portals was found to be more common for medical items and services compared to prescription drugs that rely on existing e-prescribing workflows to initiate prior authorization requests

New Requirements –2024 Maryland Law

- During the 2024 session, the General Assembly passed Chapter 848/Senate Bill 791 and Chapter 847/House Bill 932, *Health Insurance – Utilization Review – Revisions*
  - Includes several provisions pertaining to health insurance utilization review, internal grievance and adverse decision procedures, payor reporting on adverse decisions, and the provision of patient benefit information
  - By July 1, 2026, payors are required to link to e-prescribing and electronic health record (EHR) systems, accept and timely review electronic prior authorization requests, and link to real-time patient out-of-pocket costs (copayment, deductible, and coinsurance) and more affordable medication alternatives
- The law requires MHCC and the Maryland Insurance Administration (MIA) to study the development of standards for modifying prior authorization requirements for prescription drugs, medical care, and other services, including state-level approaches
  - Findings and recommendations are due to the General Assembly by December 1, 2024

Environmental Scan

- A national environmental scan (scan) commenced in June centering on select policy and technical aspects related to the prior authorization process
- A literature review explored:
  - Approaches at the federal and state-level to reform prior authorization
  - Adverse decisions reported to the MIA
  - Policies to advance access to interoperable data between payors and providers
  - Implementation of "gold carding" programs and real-time benefit tools
  - Perspectives on prescription drug coupons
- Lewis and Ellis, LLC was competitively selected to support completion of the scan
- Findings provide a broad overview of the prior authorization landscape and informed development of three recommendations

Key Insights

Federal Activities

- Federal efforts are advancing to standardize the exchange of electronic health information
- On January 17, 2024, the Centers for Medicare & Medicaid Services (CMS) released the *Interoperability and Prior Authorization Final Rule*
  - Includes provisions for federally regulated payors to implement certain technology* that will allow providers to identify prior authorization requirements, retrieve necessary patient data, and exchange requests and responses within EHR workflows (effective January 2027)
  - Payors are required to: issue decisions on non-urgent prior authorization requests within seven calendar days and expedite urgent prior authorization requests within 72 hours; specify reasons for denying prior authorization requests; and publicly report certain prior authorization metrics (effective January 2026)

** Consist of establishing and maintaining API (application programming interface) communication standards*

State-Level Highlights

Electronic Prior Authorization

- About 28 states, including Maryland, require electronic processes for prior authorization, which typically include online portals and the use of certain data exchange standards
  - Maryland and approximately 11 other states (CO, DE, GA, IN, KY, ME, MN, NJ, OH, TN, VA) require payors to accept and respond to prior authorization requests for prescription drugs using data exchange standards established and maintained by the National Council for Prescription Drug Programs (NCPDP)*
  - California, Colorado, and Tennessee are among the first states to align with federal requirements to automate prior authorization for medical items and services

** NCPDP is an ANSI-accredited, not-for-profit membership organization using a consensus-based process for standards development to foster innovation; absent standards, trading partners would resort to proprietary means of exchanging data to conduct business*

Gold Carding – Implementation

- Since 2020, about five states (TX, WV, AR, LA, MI) mandate payors adopt gold carding programs that exempt eligible providers from prior authorization if certain conditions are met (e.g., approval rates and adherence to nationally recognized evidence-based guidelines)
  - West Virginia amended its law in 2023 to lower the approval threshold from 100 to 90 percent (no providers were found to be eligible)
  - Texas is exploring changes to its law after a "smaller than expected" impact with a 90 percent approval threshold (only three percent of providers received an exception for one or more services)
- In general, states have expressed some concern about the administrative burden with the implementation of gold carding programs and the potential impact on quality and patient safety

Gold Carding – Further Study

- A few states have commissioned pilot programs or studies to assess the impact of gold carding (VT, RI, IN)
  - Vermont concluded that lack of clear program requirements and guardrails made it difficult for providers to qualify or determine eligibility to participate (2020 pilots have concluded; legislation not yet enacted)
  - A Rhode Island workgroup (convened from October 2023 - March 2024) recommended (June 2024) that payors be required to reduce prior authorization volume by 20 percent with flexibility to decide how those reductions are achieved, noting the need to assess rates of prior authorizations per member to maintain fairness (legislation not yet enacted)
  - Indiana passed legislation in 2023 requiring a study on the impact of a pilot that exempts 49 commonly used CPT codes from prior authorization for state employee health plans (a report is due to the legislature in November 2025)

Other Requirements

Exceptions

- About 16 states (AZ, AR, CO, CT, DC, IL, MD, MO, MT, NH, NJ, NY, TN, TX, WA, WV), including Maryland, prohibit prior authorization for certain specialties, drugs, conditions, or circumstances

Response times

- Maryland is among the 40 states that require payors to respond to prior authorization requests within specified time periods (generally ranges from 24 hours to 15 days for pharmacy and medical items and services)

Reporting

- About 19 states mandate payors report certain data on prior authorizations (e.g., total number of prior authorization requests, denials, and approvals and response times)
- Effective January 1, 2025, Maryland law will require payors to report the number of adverse decisions that involved prior authorization or a step therapy protocol

**See Appendix for more information around state-level prior authorization requirements*

Maryland Insurance Administration

Appeals and Grievances

MEDICAL NECESSITY &
EMERGENCY APPEALS
1-800-492-6116

Maryland
INSURANCE ADMINISTRATION

insurance.maryland.gov

The Appeals and Grievance Law

Title 15, Subtitle 10A of the Insurance Article

- Enacted by the General Assembly to provide a full and fair process for resolving disputes regarding the medical necessity of a proposed or delivered health care service.
- Gives the Administration the authority to contract with an Independent Review Organization “IRO” to review these medical necessity complaints.

How the Appeals and Grievance Process Works

Step 1

- When an HMO or health insurer denies coverage for treatment, it must do so in writing. After an adverse decision or denial, the health plan must give the member (and the provider acting on behalf of the member) the details of its internal grievance process so that the member or provider can file an appeal with the health plan if they choose.

- If the member decides to file an appeal, the Maryland Attorney General's Health Education and Advocacy Unit will assist the member, free-of-charge, in filing the appeal. The Health Education and Advocacy Unit may be reached toll-free at 1-877-261-8807.

How the Appeals and Grievance Process Works

Step 2

- After the member or provider has exhausted the health plan's internal grievance process and if the member or provider is still not satisfied with the result, the member, the member’s authorized representative, or the provider may seek assistance from the Maryland Insurance Administration within four months after the health plan's grievance decision. In its written decision, the health plan must provide details on filing a complaint with the Insurance Administration.
- Once the Insurance Administration has concluded its investigation, the member or provider will be notified promptly of the final decision. In emergency cases, a decision must be provided within 24 hours.

The MIA and Carriers are Available 24/7 for Emergency Cases

- The MIA maintains a 24/7 Hotline to provide assistance to consumers and providers with emergency medical necessity appeals: 1-800-492-6116 .
- Maryland law (§15-10B-05(a)(4) of the Insurance Article) requires a carrier or its delegated private review agent to ensure that a representative is reasonably accessible to patients and health care providers 7 days a week, 24 hours a day. This representative must be available to assist with initial authorization requests as well as grievances.

Carrier Requirements to Report

The Appeals and Grievance Law also requires carriers to submit quarterly reports to the Commissioner about their adverse decisions and grievance decisions. Specifically, carriers must provide to the Administration:

- The number of adverse decisions issued by the carrier;
- The outcome of each grievance filed with the carrier;
- The number and outcomes of cases that were considered emergency cases;
- The time within which the carrier made a grievance decision on all other cases that were not considered emergency cases;
- The number of grievances filed with the carrier that resulted from an adverse decision involving length of stay for inpatient hospitalization as related to the medical procedure involved; and
- The number and outcome of all other cases that resulted from an adverse decision involving the length of stay for inpatient hospitalization.

HB0932/SB0791 Changes to the Appeals and Grievance Process

- Specifies the criteria for determining whether a grievance is considered an emergency case that qualifies for an expedited internal review procedure
- Amends the criteria for the required contents of a notice of adverse decision or notice of grievance decision
- Amends requirements for what carriers must include in their quarterly adverse decision and grievance reports to the Insurance Commissioner
- Imposes new requirements for the peer-to-peer reconsideration process under Maryland law, and change it from an optional process to a mandatory process.
- Amends the required qualifications for individuals rendering adverse decisions and grievance decisions to include a requirement that the individuals must have actual clinical experience related to the requested health care service or treatment.

Recommendations

Prior Authorization Reporting, Technology, and Monitoring

1. **Assess the impact of commercial payors including an indicator on claims that required prior authorization, in quarterly submissions to MHCC's All Payer Claims Database, starting in 2026.**

   - Reporting prior authorization metrics increases transparency and allows for a general measurement of spending to assess the impact of prior authorization on payors, provider specialties, and consumers

2. **Require EHR vendors to implement an electronic prior authorization application programming interface (API) in accordance with the CMS Interoperability and Prior Authorization Final Rule (January 1, 2027). Encourage commercial payors to use an API implementation guide specified by CMS.**

   - Stakeholders have expressed concern that absent a mandate on EHR vendors, providers may struggle to identify prior authorization requirements, retrieve necessary patient data, and exchange requests and responses with payors within their workflows.

3. **Monitor the implementation and impact of the 2024 law (Chapter 848/Senate Bill 791 and Chapter 847/House Bill 932) and any future amendments on providers and commercial payors and submit an annual report to the legislature through 2028.**

   - Continuous monitoring helps ensure implementation of new prior authorization requirements are reasonably progressing and provides opportunities to identify policies and practices that may need to be reviewed to inform future legislative considerations

Commission Action Items

- Staff proposes the Commission accept the draft prior authorization report as final

The End

Appendix

State Laws

State Prior Authorization Laws *As of January 2024**													
State	Electronic Prior Authorization	Response Times	PA Length	Retrospective Denials	Data Reporting	Clinical Criteria and Medical Necessity	Notice of New Requirements	Transparency	Qualifications of Reviewer	Exceptions	Gold Carding	Peer-to-Peer/ Appeal Process/Other	Total
AL		x							x			x	3
AK		x		x					x				3
AR	x	x	x	x	X	x	x	x	x	x	x	x	12
AZ		x		x		x							3
CA	x	x			X	x		x	x			x	7
CO	x	x				x		x	x			x	6
CT			x	x						x			3
DE	x	x	x		x	x	x	x					7
DC	x	x	x	x	x	x	x	x	x	x		x	11
FL													0
GA	x	x	x		x	x			x	x			7
HI													0
ID		x		x									2
IL		x	x	x	x	x	x	x	x		x	x	10
IN	x	x		x	x		x	x		x		x	8
IA	x	x		x				x					4
KS		x										x	2
KY	x	x	x	x		x	x	x	x	x			9
LA		x	x	x	x	x	x	x	x	x	x	x	11
ME	x	x		x		x				x			5
MD	x	x	x	x	x	x	x	x	x	x		x	11

State Laws *(continued)*

State Prior Authorization Laws *As of January 2024**													
State	Electronic Prior Authorization	Response Times	PA Length	Retrospective Denials	Data Reporting	Clinical Criteria and Medical Necessity	Notice of New Requirements	Transparency	Qualifications of Reviewer	Exceptions	Gold Carding	Peer-to-Peer/ Appeal Process/Other	Total
MA	x	x				x		x					4
MI	x	x	x		x	x	x	x	x		x		9
MN	x	x	x	x	x		x	x	x				8
MS		x											1
MO		x		x		x		x	x			x	6
MT		x	x			x	x	x	x	x			7
NE						x			x			x	3
NH	x	x			x	x				x		x	6
NM	x	x			x								3
NJ	x	x	x	x	x	x	x	x	x			x	10
NY	x	x		x		x		x	x	x		x	8
NC		x		x				x	x			x	5
ND	x											x	2
NV		x										x	2
OH	x	x	x	x			x	x	x			x	8
OK						x							1
OR	x	x	x	x	x	x	x	x	x		x	x	11
PA	x	x		x		x	x	x	x			x	8
RI		x		x				x	x		x	x	6
SC													0
SD								x					1
TN	x	x	x	x	x	x	x	x	x	x	x	x	12
TX	x	x			x		x	x	x	x	x	x	9
UT				x	x		x		x				4

State Laws *(continued)*

State Prior Authorization Laws
*As of January 2024**

State	Electronic Prior Authorization	Response Times	PA Length	Retrospective Denials	Data Reporting	Clinical Criteria and Medical Necessity	Notice of New Requirements	Transparency	Qualifications of Reviewer	Exceptions	Gold Carding	Peer-to-Peer/ Appeal Process/Other	Total
VT	x	x									x		3
VA	x	x	x	x				x		x		x	7
WA	x	x	x		x	x	x	x	x	x		x	10
WV	x	x			x	x		x	x	x	x	x	9
WI		x											1
WY													0
Total	28	41	18	24	19	25	19	29	28	16	10	27	

Source: American Medical Association, fixpriorauth.org/sites/default/files/2024-02/Updated%202024%20Prior%20Authorization%20State%20Law%20Chart.pdf
*Maryland reflects legislation enacted on May 16, 2024
Maryland and contiguous states are highlighted in yellow

Prior Authorization Benchmarks

Chapter 534/Senate Bill 540 and Chapter 535/House Bill 470, *Maryland Health Care Commission – Preauthorization of Health Care Services – Benchmarks* (2012)

1. By **October 1, 2012**, provide online access to a listing of all medical and pharmaceuticals that require preauthorization and the key criteria for making a preauthorization determination

2. By **March 1, 2013**, establish an online system to receive electronic preauthorization requests and assign a unique identification number to each request for tracking purposes

3. By **July 1, 2013**, process electronic preauthorizations for pharmaceuticals in real-time or within one business day of receiving all pertinent information, and process non-urgent medical requests within two business days of receiving all pertinent information

4. By **July 1, 2015**, establish an electronic override process for a step therapy or fail-first protocol for electronic preauthorizations for pharmaceuticals