B25-124 Section by section analysis – **updated 9/28/23 with mark-up version**

- Section ~~2~~ 101 – Definitions
  - Adverse determination – decision made by review entity to deny coverage because it is not medically necessary or an experimental/investigational drug.
  - Approval – the utilization review entity has determined a covered health service is medically necessary and appropriate.
  - Emergency health care services – service provided in an emergency facility for a condition a reasonable person would know could put a person in serious health jeopardy.
  - Enrollee – individual eligible to receive insurance benefits.
  - Long-term services and support – institutional and home and community-based services under DC Medicaid
  - Medication assisted treatment – medicine + counselling = comprehensive SUD treatment.
  - Prior authorization – how a "utilization review entity" (see below) determines the medical necessity of covered healthcare services, AND the requirement an enrollee or provider notify an insurer/utilization review entity prior to providing a requested service.
  - Representative – an enrollee's legally authorized representative, such as a lawyer
  - Urgent health care service – service that a physician deems necessary and expedited to prevent life threatening conditions or severe pain (higher threshold than emergency) OR Medication Assisted Treatment
  - Utilization review entity **(URE)** – an entity doing prior auths for:
    - A health insurer regulated by DC code
    - PPO or HMO
    - Medicaid MCO
    - DC Alliance Program
    - ~~An employer with employees in DC~~
    - ~~An insurer that writes insurance policies~~
    - ~~PPO or HMO~~
    - An entity or person offering a health benefit to a person treated by a DC located provider.
- Section 102~~3~~ – Prior authorization requirements and restrictions
  - Insurer/URE can only require prior auth for a covered service based on a medical determination that different care is necessary OR the care is experimental.
  - Insurers cannot require PAs solely for cost, except
    - Medicaid may require PAs based on a preferred drug list
    - Same for the Alliance
  - Insurers also cannot require PA for medication assisted treatment or hospital transportation or emergency healthcare services
  - URE must make prior auth requirements known through:
    - Website accessible to everyone
    - Email
    - Phone call

- Requirements must be easy to understand, include written clinical criteria, include all drugs requiring a PA, and include if applicable clinical guidelines for requiring a PA.
- No changes to prior auth requirements can become official until the website updates are made to reflect the change.

- Section 103~~4~~ – Prior authorization determinations in a non-emergency circumstance
  - When a prior auth is granted or denied, notification must be made within 24 hours of the determination for urgent services (or 30 days for long-term services and supports under Medicaid) and 3 business days for non-urgent, non-emergency treatments if submitted electronically/5 days for mail, telephone or fax requests
  - Failure to meet these time frames means the requests are automatically approved
  - Notifications will include the following about the person making the determination:
    - States licensed
    - Status of their medical license
    - Medical specialty
  - If an adverse determination:
    - Reason for adverse determination
    - Right and process to appeal
    - Information needed for a successful appeal
  - The URE needs to tell an enrollee if information is missing
  - Prior to an adverse determination, the insurer must give the provider an opportunity to provide more information.
  - For emergency health services, the enrollee or their provider has 24 hours during business days to notify the insurer of emergency medical care~~.~~ A provider then has 72 hours to confirm that the care was emergency medical care. If the emergency care was provided by an out-of-network provider, that fact cannot factor into a denial.
  - Required information = results of clinical evaluations
  - ~~Adverse determinations must include grounds for denial and appeals information.~~
  - ~~Prior auth considerations from the previous five years must be made available on the insurer's website.~~
- Section 104~~5~~ – Length of prior auth
  - Prior auths shall be valid for one year regardless of dosage changes within the law from the date of approval.
  - EXCEPTION – if the prior auth is for a long-term or chronic condition, the prior auth is valid for~~-~~ the length of treatment of a chronic condition as recommended by medical history and the treating provider. ~~the length of the treatment~~.
  - DHCF may need annual reauthorization for long-term services and supports
  - This session doesn't apply in cases of fraud.
- Section 105 – Appeals
  - An enrollee has 15 days from notice of denial to appeal
  - The URE needs to take all medical history of the patient and current medical knowledge into consideration in an appeal
  - The URE has 24 hours to let the enrollee know about the appeal's decision, including the qualifications of the physician reviewing the appeal (see Section 106) and grounds for previous denial.

- Section 106 – Personnel qualified to make adverse determinations
  - Adverse determinations must be made by a physician licensed in DC or Maryland or Virginia and of the same or similar specialty who would normally manage the condition being considered. ~~The~~ A DC medical director of the URE ~~(who also must be DC licensed)~~ oversees all adverse determinations.
  - The URE cannot provide financial incentives for the reviewers to deny appeals
  - The URE is responsible for ensuring reviewers are (1) licensed in the DMV, (2) of the same of similar specialty of a physician typically managing the service in question, (3) and has knowledge of, experience providing, the care in question.
  - The physician reviewing the appeal cannot have a financial incentive for an adverse denial and cannot have been involved in or work for the physician involved in the initial denial.
- ~~Section 7 – Consultation prior to an adverse determination~~
  - ~~A URE must tell a provider their decision is being reviewed. If an adverse decision is made, the provider must have access to a telephone consult with the physician making the adverse determination (see above).~~
- ~~Section 8 – Appeals~~
  - ~~An enrollee is allowed to appeal an adverse determination.~~
  - ~~Appeals can be submitted via website or paper.~~
  - ~~24-hour window to share determination of an appeal and URE must provide name of physician doing review as well as medical grounds for determination~~
- ~~Section 9 – Personnel qualified to review appeals~~
  - ~~Only physicians can review appeals.~~
    - ~~That physician must be DC licensed, be in the same type of specialty that treats condition in question for at least 5 years, be knowledgeable of the treatment in question, and not be employed by the URE except via arrangement to handle appeals and was not involved in original decision.~~
  - ~~Reviews are based on medical facts of the case.~~
- ~~Section 10 – Utilization review entities' obligations with respect to prior authorizations in non-urgent, urgent, and emergency situations~~
  - ~~A URE must decide on a prior auth once the needed materials are obtained within 3 days, otherwise it is automatically approved.~~
  - ~~Urgent care services reduce this window to 24 hours.~~
  - ~~Prior auths are prohibited for pre-hospital transport or emergency health care services (see above). The enrollee/provider has a 24-hour grace period before needing to notify an insurer of the emergency services~~
  - ~~Determining appropriateness of services cannot be based on in-network status of provider.~~
- ~~Section 11 - Prior authorization limitations~~
  - ~~Prior auth based solely on cost is prohibited.~~
  - ~~Prior auth is only required for experimental treatments or "determination of medical necessity for different care".~~
  - ~~Prior auth cannot be required for MAT for OUD treatment.~~
- ~~Section 12 – Retrospective denial~~

    - ~~Not allowed if care is provided within 45 days of prior auth being received.~~
- Section 107~~13~~ – Continuity of care for enrollees
    - When an enrollee changes insurance, the prior auths from previous insurer must be honored for 60 days if documentation is provided.
    - Change in coverage will not impact prior auth status.
    - If an enrollee changes plans but keeps the same insurer, previous prior approvals must be honored.
- Section 108~~14~~ – ~~Health care services deemed authorized if a utilization review entity fails to comply with the requirements of this Act~~Failure to comply and penalties.
    - If a URE/insurer doesn't comply with requirements, the prior auth in question is deemed approved.
    - If an insurer continues to violate this law, as determined by DISB, they're in trouble.
- Section 109~~5~~ – Data transparency~~collection~~
    - Entities requiring prior auths must make data publicly available on their website, including compliance with this law's requirements, beginning in January 2025 for prior authorizations from the past five years.
    - Enrollees shall be provided all materials from their provider and insurer involved in a prior authorization determination.
    - Publicly available prior authorization data includes:
        - Specialty of reviewing physician
        - Types of medicines and treatments triggering prior auths
        - Medical indication for each prior auth request
        - Reasons for adverse determinations
        - Number of appeals, with amount of those denied and approved
        - Time between submission of request and determination
    - None of this applies to long-term services and supports.
- Section 110 – Rulemaking
    - The Mayor (read: DISB) May wrote rules to clear up anything in this bill.
- Section 201~~16~~ – Uniform Health Insurance Claim Forms Act changes
    - URE must ~~use~~ accept an NCPDP SCRIPT Standard ePA transaction-based system to issue prior auths.
    - ~~Secure transmissions must be integrated with a physician's HER to be considered legal transmissions.~~
- Section 17 – HIPAA Conformity Act and No-Fault Motor Vehicle Insurance Act amendments
    - If an employer has a negotiated health care plan, they are required to notify participants of the difference in coverage between their plan and the standard plan.
- Section 301 – Applicability
    - Medicaid and Alliance programs only qualify under this bill if budget pays for implementation.
- Section 302~~18~~ – FIS
    - ~~No fiscal impact~~See Section 301
- Section ~~19~~ 303 – Effective date
    - The effective date is once the bill goes through the District and Congressional approval process and is published in the DC Register.