Health and Human Services
February 7, 2024
2024-0560s
05/08

Amendment to SB 561-FN

Amend the bill by replacing all after the enacting clause with the following:

1 Clinical Review Criteria. Amend RSA 420-J:3, VII to read as follows:

VII. "Clinical review criteria" means the written ***policies,*** screening procedures, decision abstracts, clinical protocols, [~~and~~] practice guidelines***, medical protocols, and any other written decision-making standards*** used by [~~the~~] ***a*** health carrier ***or utilization review entity*** to determine the ***medical*** necessity and appropriateness of health care services.

2 Definitions of Prior Authorization and Prior Authorization Determination Added. Amend RSA 420-J:3, XXVIII-b to read as follows:

XXVIII-b. [~~"Pre-service claim" means any claim for a benefit under a health plan with respect to which the terms of the plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care. "Pre-service claim" shall not include a request for reimbursement made by a provider pursuant to the terms of an agreement between the provider and the health carrier.~~] ***"Prior authorization" means the approval from a health carrier or utilization review entity that may be required before a particular health care service, item, or prescription drug is received by the covered person in order for that service, item or prescription drug to be covered under the covered person's plan.***

XXVIII-c. "Prior authorization determination" means a determination by a health carrier or a utilization review entity that a health care service, item or prescription drug has been reviewed pursuant to a request for prior authorization and, based on the information provided, satisfies or does not satisfy the health carrier's or the utilization review entity's requirements for coverage.

3 New Paragraph; Definition of Urgent Care. Amend RSA 420-J:3 by inserting after paragraph XXXIV the following new paragraph:

XXXIV-a. "Urgent care" means a medical or behavioral health care service available to a covered person which, if delayed:

(a) Could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function; or

(b) In the opinion of a provider with knowledge of the covered person's medical condition, would subject the covered person to severe pain that cannot be adequately managed without the available health care service.

4 Definitions of Utilization Review and Utilization Review Entity. RSA 420-J:3, XXXIV and XXXV are amended to read as follows:

XXXIV. "Utilization review" means a set of formal techniques designed to monitor the use of or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of health care services procedures, providers, or facilities. Techniques and methods may include, ***but are not limited to*** ambulatory care review, case management, concurrent hospital review, discharge planning, pre-hospital admission certification, pre-inpatient service eligibility certification, prospective review, ***prior authorization,*** second opinion, or retrospective review.

XXXV. "Utilization review entity" means an entity[~~, subject to licensure pursuant to RSA 420-E, that conducts utilization review, other than a health carrier performing review for its own health plans~~] ***described in RSA 420-E:2 as being subject to licensure pursuant to RSA 420-E***.

5 Managed Care Law; Utilization Review; Prior Authorization. RSA 420-J:6 is repealed and reenacted to read as follows:

420-J:6 Utilization Review.

I. Written standards and procedures.

(a) Each health carrier conducting utilization review directly or indirectly through a contracted utilization review entity shall have written procedures for carrying out its utilization review processes and shall file such procedures with the commissioner on or before April 1 of each year. Health carriers shall conform to the standards of either the Utilization Review Accreditation Commission or the National Committee for Quality Assurances and are subject to all applicable rules issued pursuant to RSA 420-E:7.

(b) The written procedures shall describe the categories of health care personnel that perform utilization review activities and whether or not such individuals are licensed in this state, and shall address at a minimum, prior authorization requirements, second opinion programs; pre-hospital admission certification; pre-inpatient service eligibility certification; and concurrent hospital review to determine appropriate length of stay; as well as the process used by the health carrier to preserve confidentiality of medical information.

(c) The clinical review criteria used by a health carrier or its contracted utilization review entity shall be in writing and:

(1) Developed with input from appropriate actively practicing practitioners in the health carrier's service area;

(2) Updated at least biennially and as new treatments, applications, and technologies emerge;

(3) Developed in accordance with the standards of national accreditation entities;

(4) Based on current, nationally accepted standards of medical practice; and

(5) If practicable, evidence-based.

(d) All contracts that health carriers make with a utilization review entity shall be available to the commissioner upon request.

II. Disclosure of prior authorization requirements and publication of prior authorization performance indicators.

(a) A health carrier conducting utilization review directly, or indirectly through a contracted utilization review entity, shall make any current prior authorization requirements and restrictions readily accessible on its website to enrollees, health care professionals, and the general public. This includes the written clinical criteria. Requirements shall be described in detail, but also in easily understandable language.

(b) If a health carrier or its contracted utilization review entity intends either to implement a new prior authorization requirement or restriction, or amend an existing requirement or restriction, the health carrier shall:

(1) Ensure that the new or amended requirement is not implemented unless the health carrier's website has been updated to reflect the new or amended requirement or restriction.

(2) Provide contracted health care providers of enrollees written notice of the new or amended requirement or amendment no less than 60 days before the requirement or restriction is implemented.

(c) Effective March 31, 2026, health carriers conducting utilization review directly, or indirectly through a contracted utilization review entity, shall make prior authorization metrics as specified in 45 C.F.R section 156.223 available to the commissioner, and the commissioner shall display relevant corresponding data, in a carrier specific format, on a website maintained by the insurance department in a readily accessible format.

III. Qualifications of reviewers making medical necessity determinations. A health carrier conducting utilization review directly, or indirectly through a contracted utilization review entity, shall ensure that all medical necessity determinations are made by a qualified health care provider. A reviewing provider shall:

(a) Have appropriate medical and professional expertise and credentials to competently apply the health carrier’s clinical review criteria.

(b) Make the medical necessity determination under the clinical direction of one of the health carrier’s own medical directors or one of the contracted utilization review entity’s medical directors who is responsible for the review of health care services provided to covered persons who are residents of New Hampshire.

IV. Medical directors. Each health carrier that conducts utilization review shall employ one or more medical directors who shall have responsibility for all utilization review techniques and methods and their administration and implementation and who shall be licensed in New Hampshire under RSA 329. Nothing in this section shall be construed to preclude a medical director from consulting with or relying on the advice of a physician licensed in this state or any other state.

Nothing in this section shall be construed as creating any civil liability to the medical director for the medical director's alleged negligent performance of the aforementioned responsibilities for utilization review.

V. Timeliness standards for processing prior authorization requests submitted electronically. Health carriers conducting utilization review directly, or indirectly through a contracted utilization review entity, shall meet the following time frames for prior authorization determinations requested by participating providers or facilities that submit the prior authorization request through an electronic prior authorization process as designated by the health carrier:

(a) In non-urgent circumstances, health carriers requiring prior authorization of a health care service shall approve or deny authorization and notify the covered person and the covered person's health care provider of the determination within 7 calendar days of obtaining all information necessary to make the determination. Any request that the health carrier makes for additional information necessary to make the determination shall be made within 7 calendar days of the prior authorization request date.

(b) In urgent circumstances, health carriers requiring prior authorization of a health care service shall approve or deny authorization and notify the covered person and the covered person's health care provider of the determination as expeditiously as the covered person's medical condition requires, and not later than 72 hours after obtaining all information necessary to make the determination. Any request that the health carrier makes for additional information necessary to make the determination shall be made as expeditiously as required to meet the 72 hour timeline, assuming a timely response from the treating provider.

VI. Timeliness standards for processing prior authorization requests submitted non-electronically. Health carriers conducting utilization review directly, or indirectly through a contracted utilization review entity, shall meet the following time frames for prior authorization determinations requested by participating providers or facilities that submit the prior authorization request through a non-electronic prior authorization process:

(a) In non-urgent circumstances, health carriers requiring prior authorization of a health care service shall approve or deny authorization and notify the covered person and the covered person's health care provider of the determination within 14 calendar days of obtaining all information necessary to make the determination. Any request that the health carrier makes for additional information necessary to make the determination shall be made within 7 calendar days of the prior authorization request date.

(b) In urgent circumstances, health carriers requiring prior authorization of a health care service shall approve or deny authorization and notify the covered person and the covered person's health care provider of the determination as expeditiously as the covered person's medical condition requires, and not later than 72 hours after obtaining all information necessary to make the determination. Any request that the health carrier makes for additional information necessary to

make the determination shall be made as expeditiously as required to meet the 72 hour timeline, assuming a timely response from the treating provider.

VII. In paragraphs V and VI, "all information necessary to make the determination" shall include any information that may have been provided through a peer-to-peer review.

VIII. A prior authorization request shall be considered approved if the health carrier fails to notify the covered person and the covered person's health care provider of the prior authorization determination within the timeliness standards for making a determination after obtaining all necessary information.

IX. Duration of an approval of a prior authorization request.

(a) Health carriers conducting utilization review directly, or indirectly through a contracted utilization review entity, shall not revoke, limit, condition, or restrict a prior authorization if care is provided within 60 business days from the date the health care provider received approval of the prior authorization request.

(b) A health carrier conducting utilization review directly, or indirectly through a contracted utilization review entity, shall pay a participating health care provider at the contracted payment rate for a health care service provided by the health care provider pursuant to a prior authorization determination that coverage is available unless:

(1) The health care provider materially misrepresented the health care service in the prior authorization request;

(2) The health care service was no longer a covered benefit on the day it was provided;

(3) The health care provider was no longer contracted with the covered person's health carrier on the date the care was provided;

(4) The health care provider failed to meet the health carrier's timely filing requirements;

(5) The patient was no longer eligible for health care coverage on the day the care was provided; or

(6) The health carrier does not have liability for the claim or for a part of the claim for any reason under the covered person's coverage policy, the provider contract between the health carrier and the participating provider, or any other reason applicable at law or in equity.

X. Option to request a peer-to-peer review. When a health carrier requires prior authorization for an item or service, the carrier shall offer the provider the opportunity to request a peer-to-peer review of a prior authorization request in which the provider is able to have a direct conversational exchange with a medical director or a designated provider who is a clinical peer about the basis for the prior authorization request. A "clinical peer" in this context shall be a health care professional who has demonstrable expertise to review a case, whether or not the reviewing professional is in the same or a similar specialty as the provider. The peer-to-peer review may be

requested before the carrier's prior authorization determination or after a prior authorization denial and before a formal grievance request has been made. The peer-to-peer review shall be made available by the health carrier within 2 business days of the request. If the peer-to-peer review is requested after a prior authorization denial, the heath carrier shall treat the review request as a request for reconsideration that is external to the grievance process and shall provide the provider and the covered person a written determination containing a statement of the specific reasons for the reconsideration determination with reference to the information provided in the peer-to-peer review. The written reconsideration determination shall be provided within 7 business days of the peer-to-peer review.

XI. Nothing in this section shall be construed to contravene a covered person's right to external review under RSA 420-J:5-a. Unless otherwise required by law, the prior authorization requirements set out in this chapter shall apply to all medical services and items.

6 Managed Care Law; Grievance Procedures. RSA 420-J:5, I(b) is repealed and reenacted to read as follows:

(b) For medical necessity appeals, the health carrier conducting utilization review directly, or indirectly through a contracted utilization review entity, shall ensure that all reviews are conducted by or in consultation with a health care professional. The health care professional shall:

(1) Be a practitioner in the same or similar specialty who typically treats the medical condition, performs the procedure, or provides the treatment at issue in the appeal. A practitioner is considered of the same specialty if he or she has similar credentials and licensure as those who typically treat the condition or health problem in question in the appeal. A practitioner is considered of a similar specialty if he or she has experience treating the same problems as those in question in the appeal, in addition to expertise treating similar complications of those problems; and

(2) Consider all known clinical aspects of the health care service under review, including, but not limited to, a review of all pertinent medical records and medical literature provided to the health carrier or the contracted utilization review entity by the covered person's health care provider and any relevant records provided to the health carrier or the contracted utilization review entity by a health care facility.

7 Managed Care Law; Grievance Procedures. Amend RSA 420-J:5, IV(a) to read as follows:

(a) In the case of nonexpedited appeal of a [~~pre-service claim~~] ***prior authorization determination*** or post-service claim, the determination on appeal shall be made within a reasonable time appropriate to the medical circumstances, but in no event more than 30 days after receipt by the carrier or other licensed entity of the claimant's appeal.

8 New Paragraph; Licensure of Medical Utilization Review Entities; Definitions. Amend RSA 420-E:1 by inserting after paragraph I-a the following new paragraph:

I-b. "Clinical review criteria" means the written policies, screening procedures, decision abstracts, clinical or medical protocols, practice guidelines, and any other written decision-making

standards used by a utilization review entity to determine the medical necessity and appropriateness of health care services.

9 Licensure of Medical Utilization Review Entities; Definitions. RSA 420-E:1, III-a and IV are repealed and reenacted to read as follows:

IV. "Medical necessity" means health care services or products provided to an enrollee for the purpose of preventing, stabilizing, diagnosing, or treating an illness, injury, or disease or the symptoms of an illness, injury, or disease in a manner that is:

(a) Consistent with generally accepted standards of medical practice;

(b) Clinically appropriate in terms of type, frequency, extent, site, and duration;

(c) Demonstrated through scientific evidence to be effective in improving health outcomes;

(d) Representative of "best practices" in the medical profession; and

(e) Not primarily for the convenience of the enrollee or physician or other health care provider.

V. "Pre-service claim" means a request for prior authorization.

VI. "Prior authorization" means the approval from a health carrier or utilization review entity that may be required before a particular health care service, item, or prescription drug is received by the covered person in order for that service, item, or prescription drug to be covered under the covered person's plan.

VII. "Prior authorization determination" means a determination by a health carrier or utilization review entity that a health care service, item or prescription drug has been reviewed pursuant to a pre-service request for prior authorization and, based on the information provided, satisfies or does not satisfy the health carrier's or utilization review entity's requirements for coverage.

VIII. "Utilization review" means a set of formal techniques designed to monitor the use of or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of health care services procedures, providers, or facilities, for the purpose of recommending or determining whether such services should be covered or provided by an insurer, nonprofit service organization, health maintenance organization, third-party administrator, or employer. Techniques and methods may include, but are not limited to, ambulatory care review, case management, concurrent hospital review, discharge planning, pre-hospital admission certification, pre-inpatient service eligibility certification, prospective review, prior authorization, second opinion, or retrospective review.

10 Licensure of Medical Utilization Review Entities; Medical Director. Amend RSA 420-E:2-a to read as follows:

420-E:2-a Medical Director. Every medical utilization review entity licensed by the department under this chapter shall employ [~~a medical director~~] ***one or more medical directors*** licensed under RSA 329 or, in the case of a dental utilization review entity, a dentist licensed under RSA 317-A.

11 New Section; Licensure of Medical Utilization Review Entities; Minimum Standards; Prior Authorization. Amend RSA 420-E by inserting after section 4-a the following new section:

420-E:4-b Prior Authorization Standards for Managed Care Plans. The following prior authorization requirements apply to utilization review entities conducting prior authorization review determinations for managed care plans operating subject to RSA 420-J.

I. Timeliness standards for processing prior authorization requests submitted electronically. Utilization review entities administering fully insured coverage for managed care plans subject to RSA 420-J shall meet the following time frames for prior authorization determinations requested by participating providers or facilities that submit the prior authorization request through an electronic prior authorization process as designated by the utilization review entity:

(a) In non-urgent circumstances, utilization review entities requiring prior authorization of a health care service shall approve or deny authorization and notify the covered person and the covered person's health care provider of the determination within 7 calendar days of obtaining all information necessary to make the determination. Any request that the utilization review entity makes for additional information necessary to make the determination shall be made within 7 calendar days of the prior authorization request date.

(b) In urgent circumstances, utilization review entities requiring prior authorization of a health care service shall approve or deny authorization and notify the covered person and the covered person's health care provider of the determination as expeditiously as the covered person's medical condition requires, and not later than 72 hours after obtaining all information necessary to make the determination. Any request that the utilization review entity makes for additional information necessary to make the determination shall be made as expeditiously as required to meet the 72 hour timeline, assuming a timely response from the treating provider.

II. Timeliness standards for processing prior authorization requests submitted non-electronically. Utilization review entities shall meet the following time frames for prior authorization determinations requested by participating providers or facilities that submit the prior authorization request through a non-electronic prior authorization process as designated by the utilization review entity:

(a) In non-urgent circumstances, utilization review entities requiring prior authorization of a health care service shall approve or deny authorization and notify the covered person and the covered person's health care provider of the determination within 14 calendar days of obtaining all information necessary to make the determination. Any request that the utilization review entity makes for additional information necessary to make the determination shall be made within 7 calendar days of the prior authorization request date.

(b) In urgent circumstances, utilization review entities requiring prior authorization of a health care service shall approve or deny authorization and notify the covered person and the covered person's health care provider of the determination as expeditiously as the covered person's

medical condition requires, and not later than 72 hours after obtaining all information necessary to make the determination. Any request that the utilization review entity makes for additional information necessary to make the determination shall be made as expeditiously as required to meet the 72 hour timeline, assuming a timely response from the treating provider.

III. In paragraphs I and II, "all information necessary to make the determination" shall include the information provided through a peer-to-peer review.

IV. A prior authorization request shall be considered approved if the utilization review entity fails to notify the covered person and the covered person's health care provider of the prior authorization determination within the timeliness standards for making a determination after obtaining all necessary information.

V. Duration of an approval of a prior authorization request. Utilization review entities shall not revoke, limit, condition, or restrict a prior authorization if care is provided within 60 business days from the date the health care provider received approval of the prior authorization request.

VI. A utilization review entity conducting utilization review directly, or indirectly through a contracted utilization review entity, shall pay a participating health care provider at the contracted payment rate for a health care service provided by the health care provider pursuant to a prior authorization determination that coverage is available unless:

(a) The health care provider materially misrepresented the health care service in the prior authorization request;

(b) The health care service was no longer a covered benefit on the day it was provided;

(c) The health care provider was no longer contracted with the covered person's utilization review entity on the date the care was provided;

(d) The health care provider failed to meet the utilization review entity's timely filing requirements;

(e) The patient was no longer eligible for health care coverage on the day the care was provided; or

(f) The utilization review entity does not have liability for the claim or for a part of the claim for any reason under the covered person's coverage policy, the provider contract between the utilization review entity and the participating provider, or any other reason applicable at law or in equity.

VII. Option to request a peer-to-peer review. When a utilization review entity requires prior authorization for an item or service, the utilization review entity shall offer the provider the opportunity to request a peer-to-peer review of a prior authorization request in which the provider is able to have a direct conversational exchange with a medical director or a designated provider who is a clinical peer about the basis for the prior authorization request. A "clinical peer" in this context shall be a health care professional who has demonstrable expertise to review a case, whether or not

the reviewing professional is in the same or a similar specialty as the provider. The peer-to-peer review may be requested before the utilization review entity's prior authorization determination or after a prior authorization denial and before a formal grievance request has been made. The peer-to-peer review shall be made available by the utilization review entity within 2 business days of the request. If the peer-to-peer review is requested after a prior authorization denial, the utilization review entity shall treat the review request as a request for reconsideration that is external to the grievance process and shall provide the provider and the covered person a written determination containing a statement of the specific reasons for the reconsideration determination with reference to the information provided in the peer-to-peer review. The written reconsideration determination shall be provided within 7 business days of the peer-to-peer review.

VIII. Nothing in this section shall be construed to contravene a covered person's right to external review under RSA 420-J:5-a. Unless otherwise required by law, the prior authorization requirements set out in this chapter shall apply to all medical services and items.

12 Effective Date. This act shall take effect January 1, 2025.