SENATE
STATE OF MINNESOTA
NINETY-FIRST SESSION

S.F. No. 3204

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DATE	D-PG	OFFICIAL STATUS
02/17/2020	4778	Introduction and first reading Referred to Health and Human Services Finance and Policy
05/07/2020	6399a	Comm report: To pass as amended and re-refer to Commerce and Consumer Protection Finance and Policy Joint rule 2.03, referred to Rules and Administration
	6425	Comm report: Adopt previous comm report Jt. rule 2.03 suspended
05/12/2020	6862a	Comm report: To pass as amended
	6865	Second reading
05/13/2020		Special Order: Amended Third reading Passed

A bill for an act

relating to health care coverage; modifying requirements governing utilization review and prior authorization of health care services; making conforming changes; requiring a report; amending Minnesota Statutes 2018, sections 62M.01, subdivisions 2, 3; 62M.02, subdivisions 2, 5, 8, 20, 21, by adding subdivisions; 62M.04, subdivisions 1, 2, 3, 4; 62M.05, subdivisions 3, 3a, 3b, 4, 5; 62M.06, subdivisions 1, 2, 3, 4; 62M.07; 62M.09, subdivisions 3, 3a, 4, 4a, 5; 62M.10, subdivision 7, by adding a subdivision; 62M.11; 62M.12; 62Q.71; 62Q.73, subdivision 1; 256B.692, subdivision 2; proposing coding for new law in Minnesota Statutes, chapter 62M; repealing Minnesota Statutes 2018, section 62M.02, subdivision 19; Minnesota Rules, part 4685.0100, subpart 9b.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

ARTICLE 1

UTILIZATION REVIEW AND PRIOR AUTHORIZATION OF HEALTH CARE SERVICES

Section 1. Minnesota Statutes 2018, section 62M.01, subdivision 2, is amended to read:

Subd. 2. **Jurisdiction.** ~~Sections 62M.01 to 62M.16 apply~~ This chapter applies to any insurance company licensed under chapter 60A to offer, sell, or issue a policy of accident and sickness insurance as defined in section 62A.01; a health service plan licensed under chapter 62C; a health maintenance organization licensed under chapter 62D; the Minnesota Comprehensive Health Association created under chapter 62E; a community integrated service network licensed under chapter 62N; an accountable provider network operating under chapter 62T; a fraternal benefit society operating under chapter 64B; a joint self-insurance employee health plan operating under chapter 62H; a multiple employer welfare arrangement, as defined in section 3 of the Employee Retirement Income Security Act of 1974 (ERISA), United States Code, title 29, section 1103, as amended; a third-party

administrator licensed under section 60A.23, subdivision 8, that provides utilization review services for the administration of benefits under a health benefit plan as defined in section 62M.02; any other entity that provides, offers, or administers hospital, outpatient, medical, prescription drug, or other health benefits to individuals treated by a health professional under a policy, plan, or contract; or any entity performing utilization review on behalf of a business entity in this state pursuant to a health benefit plan covering a Minnesota resident.

EFFECTIVE DATE. This section is effective January 1, 2021, and applies to health plans offered, sold, issued, or renewed on or after that date.

Sec. 2. Minnesota Statutes 2018, section 62M.01, subdivision 3, is amended to read:

Subd. 3. **Scope.** (a) Nothing in sections 62M.01 to 62M.16 applies to review of claims after submission to determine eligibility for benefits under a health benefit plan. The appeal procedure described in section 62M.06 applies to any complaint as defined under section 62Q.68, subdivision 2, that requires a medical determination in its resolution.

(b) This chapter does not apply to managed care plans or county-based purchasing plans when the plan is providing coverage to state public health care program enrollees under chapter 256B or 256L.

Sec. 3. Minnesota Statutes 2018, section 62M.02, is amended by adding a subdivision to read:

Subd. 1a. **Adverse determination.** "Adverse determination" means a decision by a utilization review organization relating to an admission, extension of stay, or health care service that is partially or wholly adverse to the enrollee, including a decision to deny an admission, extension of stay, or health care service on the basis that it is not medically necessary.

EFFECTIVE DATE. This section is effective January 1, 2021, and applies to health plans offered, sold, issued, or renewed on or after that date.

Sec. 4. Minnesota Statutes 2018, section 62M.02, subdivision 5, is amended to read:

Subd. 5. ~~**Certification**~~ **Authorization.** ~~"Certification"~~ "Authorization" means a determination by a utilization review organization that an admission, extension of stay, or other health care service has been reviewed and that ~~it~~, based on the information provided, ~~meets~~ it satisfies the utilization review requirements of the applicable health plan and the health plan company will then pay for the covered benefit, provided the preexisting limitation

provisions, the general exclusion provisions, and any deductible, co-payment, coinsurance, or other policy requirements have been met.

EFFECTIVE DATE. This section is effective January 1, 2021, and applies to health plans offered, sold, issued, or renewed on or after that date.

Sec. 5. Minnesota Statutes 2018, section 62M.02, subdivision 8, is amended to read:

Subd. 8. **Clinical criteria.** "Clinical criteria" means the written policies, ~~decision~~ rules, clinical protocols, medical protocols, or ~~guidelines~~ any other criteria or rationale used by the utilization review organization to determine ~~certification~~ whether a health care service is authorized.

EFFECTIVE DATE. This section is effective January 1, 2021, and applies to health plans offered, sold, issued, or renewed on or after that date.

Sec. 6. Minnesota Statutes 2018, section 62M.02, is amended by adding a subdivision to read:

Subd. 10a. **Emergency services.** "Emergency services" has the meaning given in section 62Q.55, subdivision 3.

EFFECTIVE DATE. This section is effective January 1, 2021, and applies to health plans offered, sold, issued, or renewed on or after that date.

Sec. 7. Minnesota Statutes 2018, section 62M.02, is amended by adding a subdivision to read:

Subd. 13a. **Medically necessary care.** "Medically necessary care" has the meaning given in section 62Q.53.

EFFECTIVE DATE. This section is effective January 1, 2021, and applies to health plans offered, sold, issued, or renewed on or after that date.

Sec. 8. Minnesota Statutes 2018, section 62M.02, subdivision 20, is amended to read:

Subd. 20. **Utilization review.** "Utilization review" means the evaluation of the necessity, appropriateness, and efficacy of the use of health care services, procedures, and facilities, by a person or entity other than the attending health care professional, for the purpose of determining the medical necessity of the service or admission. Utilization review also includes prior authorization and review conducted after the admission of the enrollee. It includes situations where the enrollee is unconscious or otherwise unable to provide advance

notification. Utilization review does not include a referral or participation in a referral process by a participating provider unless the provider is acting as a utilization review organization.

EFFECTIVE DATE. This section is effective January 1, 2021, and applies to health plans offered, sold, issued, or renewed on or after that date.

Sec. 9. Minnesota Statutes 2018, section 62M.02, subdivision 21, is amended to read:

Subd. 21. **Utilization review organization.** "Utilization review organization" means an entity including but not limited to an insurance company licensed under chapter 60A to offer, sell, or issue a policy of accident and sickness insurance as defined in section 62A.01; a prepaid limited health service organization issued a certificate of authority and operating under sections 62A.451 to 62A.4528; a health service plan licensed under chapter 62C; a health maintenance organization licensed under chapter 62D; a community integrated service network licensed under chapter 62N; an accountable provider network operating under chapter 62T; a fraternal benefit society operating under chapter 64B; a joint self-insurance employee health plan operating under chapter 62H; a multiple employer welfare arrangement, as defined in section 3 of the Employee Retirement Income Security Act of 1974 (ERISA), United States Code, title 29, section 1103, as amended; a third-party administrator licensed under section 60A.23, subdivision 8, which conducts utilization review and ~~determines certification of~~ authorizes or makes adverse determinations regarding an admission, extension of stay, or other health care services for a Minnesota resident; any other entity that provides, offers, or administers hospital, outpatient, medical, prescription drug, or other health benefits to individuals treated by a health professional under a policy, plan, or contract; or any entity performing utilization review that is affiliated with, under contract with, or conducting utilization review on behalf of, a business entity in this state. Utilization review organization does not include a clinic or health care system acting pursuant to a written delegation agreement with an otherwise regulated utilization review organization that contracts with the clinic or health care system. The regulated utilization review organization is accountable for the delegated utilization review activities of the clinic or health care system.

EFFECTIVE DATE. This section is effective January 1, 2021, and applies to health plans offered, sold, issued, or renewed on or after that date.

Sec. 10. Minnesota Statutes 2018, section 62M.05, subdivision 3a, is amended to read:

Subd. 3a. **Standard review determination.** (a) Notwithstanding subdivision 3b, ~~an initial~~ a standard review determination on all requests for utilization review must be

communicated to the provider and enrollee in accordance with this subdivision within ~~ten~~ five business days ~~of~~ after receiving the request if the request is received electronically, or within six business days if received through nonelectronic means, provided that all information reasonably necessary to make a determination on the request has been made available to the utilization review organization. Effective January 1, 2022, a standard review determination on all requests for utilization review must be communicated to the provider and enrollee in accordance with this subdivision within five business days after receiving the request, regardless of how the request was received, provided that all information reasonably necessary to make a determination on the request has been made available to the utilization review organization.

(b) When ~~an initial~~ a determination is made to ~~certify~~ authorize, notification must be provided promptly by telephone to the provider. The utilization review organization shall send written notification to the provider or shall maintain an audit trail of the determination and telephone notification. For purposes of this subdivision, "audit trail" includes documentation of the telephone notification, including the date; the name of the person spoken to; the enrollee; the service, procedure, or admission ~~certified~~ authorized; and the date of the service, procedure, or admission. If the utilization review organization indicates ~~certification~~ authorization by use of a number, the number must be called the "~~certification~~ authorization number." For purposes of this subdivision, notification may also be made by facsimile to a verified number or by electronic mail to a secure electronic mailbox. These electronic forms of notification satisfy the "audit trail" requirement of this paragraph.

(c) When an ~~initial~~ adverse determination is made ~~not to certify~~, notification must be provided within the time periods specified in paragraph (a) by telephone, by facsimile to a verified number, or by electronic mail to a secure electronic mailbox ~~within one working day after making the determination~~ to the attending health care professional and hospital or physician office as applicable. Written notification must also be sent to the hospital or physician office as applicable and attending health care professional if notification occurred by telephone. For purposes of this subdivision, notification may be made by facsimile to a verified number or by electronic mail to a secure electronic mailbox. Written notification must be sent to the enrollee and may be sent by United States mail, facsimile to a verified number, or by electronic mail to a secure mailbox. The written notification must include ~~the principal reason or~~ all reasons relied on by the utilization review organization for the determination and the process for initiating an appeal of the determination. Upon request, the utilization review organization shall provide the provider or enrollee with the criteria used to determine the necessity, appropriateness, and efficacy of the health care service and

identify the database, professional treatment parameter, or other basis for the criteria. Reasons for ~~a~~ an adverse determination ~~not to certify~~ may include, among other things, the lack of adequate information to ~~certify~~ authorize after a reasonable attempt has been made to contact the provider or enrollee.

(d) When an ~~initial~~ adverse determination is made ~~not to certify~~, the written notification must inform the enrollee and the attending health care professional of the right to submit an appeal to the internal appeal process described in section 62M.06 and the procedure for initiating the internal appeal. The written notice shall be provided in a culturally and linguistically appropriate manner consistent with the provisions of the Affordable Care Act as defined under section 62A.011, subdivision 1a.

EFFECTIVE DATE. This section is effective January 1, 2021, and applies to health plans offered, sold, issued, or renewed on or after that date.

Sec. 11. Minnesota Statutes 2018, section 62M.05, subdivision 3b, is amended to read:

Subd. 3b. **Expedited review determination.** (a) An expedited ~~initial~~ determination must be utilized if the attending health care professional believes that an expedited determination is warranted.

(b) Notification of an expedited ~~initial~~ determination to ~~either certify or not to certify~~ authorize or an expedited adverse determination must be provided to the hospital, the attending health care professional, and the enrollee as expeditiously as the enrollee's medical condition requires, but no later than ~~72~~ 48 hours ~~from~~ and must include at least one business day after the initial request. When an expedited ~~initial~~ adverse determination is made ~~not to certify~~, the utilization review organization must also notify the enrollee and the attending health care professional of the right to submit an appeal to the expedited internal appeal as described in section 62M.06 and the procedure for initiating an expedited internal ~~expedited~~ appeal.

EFFECTIVE DATE. This section is effective January 1, 2021, and applies to health plans offered, sold, issued, or renewed on or after that date.

Sec. 12. Minnesota Statutes 2018, section 62M.05, subdivision 4, is amended to read:

Subd. 4. **Failure to provide necessary information.** A utilization review organization must have written procedures to address the failure of a provider or enrollee to provide the ~~necessary~~ information ~~for review~~ necessary to make a determination on the request. If the enrollee or provider will not release the necessary information to the utilization review

organization, the utilization review organization may ~~deny certification~~ make an adverse determination in accordance with its own policy or the policy described in the health benefit plan.

EFFECTIVE DATE. This section is effective January 1, 2021, and applies to health plans offered, sold, issued, or renewed on or after that date.

Sec. 13. Minnesota Statutes 2018, section 62M.06, subdivision 1, is amended to read:

Subdivision 1. **Procedures for appeal.** (a) A utilization review organization must have written procedures for appeals of determinations not to certify. The right to appeal must be available to the enrollee and to the attending health care professional.

(b) The enrollee shall be allowed to review the information relied upon in the course of the appeal, present evidence and testimony as part of the appeals process, and receive continued coverage pending the outcome of the appeals process. This paragraph does not apply to ~~managed care plans or county-based purchasing plans serving state public health care program enrollees under section 256B.69, 256B.692, or chapter 256L, or to~~ grandfathered plans as defined under section 62A.011, subdivision 1c. Nothing in this paragraph shall be construed to limit or restrict the appeal rights of state public health care program enrollees provided under section 256.045 and Code of Federal Regulations, title 42, section 438.420(d).

Sec. 14. Minnesota Statutes 2018, section 62M.06, subdivision 3, is amended to read:

Subd. 3. **Standard appeal.** (a) The utilization review organization must establish procedures for appeals to be made either in writing or by telephone.

(b) A utilization review organization shall notify in writing the enrollee, attending health care professional, and claims administrator of its determination on the appeal within ~~30 days upon~~ 15 days after receipt of the notice of appeal. If the utilization review organization cannot make a determination within ~~30~~ 15 days due to circumstances outside the control of the utilization review organization, the utilization review organization may take up to ~~14~~ four additional days to notify the enrollee, attending health care professional, and claims administrator of its determination. If the utilization review organization takes any additional days beyond the initial ~~30-day~~ 15-day period to make its determination, it must inform the enrollee, attending health care professional, and claims administrator, in advance, of the extension and the reasons for the extension.

(c) The documentation required by the utilization review organization may include copies of part or all of the medical record and a written statement from the attending health care professional.

(d) Prior to upholding the ~~initial~~ adverse determination ~~not to certify~~ for clinical reasons, the utilization review organization shall conduct a review of the documentation by a physician who did not make the ~~initial~~ adverse determination ~~not to certify~~.

(e) The process established by a utilization review organization may include defining a period within which an appeal must be filed to be considered. The time period must be communicated to the enrollee and attending health care professional when the ~~initial~~ adverse determination is made.

(f) An attending health care professional or enrollee who has been unsuccessful in an attempt to reverse ~~a~~ an adverse determination ~~not to certify~~ shall, consistent with section 72A.285, be provided the following:

(1) a complete summary of the review findings;

(2) qualifications of the reviewers, including any license, certification, or specialty designation; and

(3) the relationship between the enrollee's diagnosis and the review criteria used as the basis for the decision, including the specific rationale for the reviewer's decision.

(g) In cases of appeal to reverse ~~a~~ an adverse determination ~~not to certify~~ for clinical reasons, the utilization review organization must ensure that a physician of the utilization review organization's choice in the same or a similar specialty as typically manages the medical condition, procedure, or treatment under discussion is reasonably available to review the case.

(h) If the ~~initial~~ adverse determination is not reversed on appeal, the utilization review organization must include in its notification the right to submit the appeal to the external review process described in section 62Q.73 and the procedure for initiating an appeal under the external process.

EFFECTIVE DATE. This section is effective January 1, 2021, and applies to health plans offered, sold, issued, or renewed on or after that date.

Sec. 15. Minnesota Statutes 2018, section 62M.07, is amended to read:

62M.07 PRIOR AUTHORIZATION OF SERVICES.

Subdivision 1. **Written standards.** ~~(a)~~ Utilization review organizations conducting prior authorization of services must have written standards that meet at a minimum the following requirements:

(1) written procedures and criteria used to determine whether care is appropriate, reasonable, or medically necessary;

(2) a system for providing prompt notification of its determinations to enrollees and providers and for notifying the provider, enrollee, or enrollee's designee of appeal procedures under clause (4);

(3) compliance with section 62M.05, subdivisions 3a and 3b, regarding time frames for ~~approving and disapproving~~ authorizing and making adverse determinations regarding prior authorization requests;

(4) written procedures ~~for appeals of denials~~ to appeal adverse determinations of prior authorization requests which specify the responsibilities of the enrollee and provider, and which meet the requirements of sections 62M.06 and 72A.285, regarding release of summary review findings; and

(5) procedures to ensure confidentiality of patient-specific information, consistent with applicable law.

Subd. 2. **Prior authorization of emergency services prohibited.** ~~(b)~~ No utilization review organization, health plan company, or claims administrator may conduct or require prior authorization of emergency confinement or an emergency ~~treatment~~ service. The enrollee or the enrollee's authorized representative may be required to notify the health plan company, claims administrator, or utilization review organization as soon as reasonably possible after the beginning of the emergency confinement or emergency ~~treatment as reasonably possible~~ service.

Subd. 3. **Retrospective revocation or limitation of prior authorization.** No utilization review organization, health plan company, or claims administrator may revoke, limit, condition, or restrict a prior authorization that has been authorized unless there is evidence that the prior authorization was authorized based on fraud or misinformation or a previously approved prior authorization conflicts with state or federal law. Application of a deductible, coinsurance, or other cost-sharing requirement does not constitute a limit, condition, or restriction under this subdivision.

Subd. 4. **Submission of prior authorization requests.** ~~(c)~~ If prior authorization for a health care service is required, the utilization review organization, health plan company, or claim administrator must allow providers to submit requests for prior authorization of the health care services without unreasonable delay by telephone, facsimile, or voice mail or through an electronic mechanism 24 hours a day, seven days a week. This ~~paragraph~~ subdivision does not apply to dental service covered under MinnesotaCare or medical assistance.

EFFECTIVE DATE. This section is effective January 1, 2021, and applies to health plans offered, sold, issued, or renewed on or after that date.

Sec. 16. Minnesota Statutes 2018, section 62M.09, subdivision 3, is amended to read:

Subd. 3. **Physician reviewer ~~involvement~~; adverse determinations.** (a) A physician must review and make the adverse determination under section 62M.05 in all cases in which the utilization review organization has concluded that ~~a~~ an adverse determination ~~not to certify~~ for clinical reasons is appropriate.

(b) The physician conducting the review and making the adverse determination must ~~be licensed~~:

(1) hold a current, unrestricted license to practice medicine in this state~~.~~; and

(2) have the same or similar medical specialty as a provider that typically treats or manages the condition for which the health care service has been requested.

This paragraph does not apply to reviews conducted in connection with policies issued by a health plan company that is assessed less than three percent of the total amount assessed by the Minnesota Comprehensive Health Association.

(c) The physician should be reasonably available by telephone to discuss the determination with the attending health care professional.

(d) Notwithstanding paragraph (a), a review of an adverse determination involving a prescription drug must be conducted by a licensed pharmacist or physician who is competent to evaluate the specific clinical issues presented in the review.

(e) This subdivision does not apply to outpatient mental health or substance abuse services governed by subdivision 3a.

EFFECTIVE DATE. This section is effective January 1, 2021, and applies to health plans offered, sold, issued, or renewed on or after that date.

Sec. 17. Minnesota Statutes 2018, section 62M.10, subdivision 7, is amended to read:

Subd. 7. **Availability of criteria.** ~~Upon request,~~ (a) For utilization review determinations other than prior authorization, a utilization review organization shall, upon request, provide to an enrollee, a provider, and the commissioner of commerce the criteria used to determine the medical necessity, appropriateness, and efficacy of a procedure or service and identify the database, professional treatment guideline, or other basis for the criteria.

(b) For prior authorization determinations, a utilization review organization must submit the organization's current prior authorization requirements and restrictions, including written, evidence-based, clinical criteria used to make an authorization or adverse determination, to all health plan companies for which the organization performs utilization review. A health plan company must post on its public website the prior authorization requirements and restrictions of any utilization review organization that performs utilization review for the health plan company. These prior authorization requirements and restrictions must be detailed and written in language that is easily understandable to providers.

EFFECTIVE DATE. This section is effective January 1, 2021, and applies to health plans offered, sold, issued, or renewed on or after that date.

Sec. 18. Minnesota Statutes 2018, section 62M.10, is amended by adding a subdivision to read:

Subd. 8. **Notice; new prior authorization requirements or restrictions; change to existing requirement or restriction.** (a) Before a utilization review organization may implement a new prior authorization requirement or restriction or amend an existing prior authorization requirement or restriction, the utilization review organization must submit the new or amended requirement or restriction to all health plan companies for which the organization performs utilization review. A health plan company must post on its website the new or amended requirement or restriction.

(b) At least 45 days before a new prior authorization requirement or restriction or an amended existing prior authorization requirement or restriction is implemented, the utilization review organization, health plan company, or claims administrator must provide written or electronic notice of the new or amended requirement or restriction to all Minnesota-based, in-network attending health care professionals who are subject to the prior authorization requirements and restrictions.

EFFECTIVE DATE. This section is effective January 1, 2021, and applies to health plans offered, sold, issued, or renewed on or after that date.

Sec. 19. **[62M.17] CONTINUITY OF CARE; PRIOR AUTHORIZATIONS.**

Subdivision 1. **Compliance with prior authorization approved by previous utilization review organization; change in health plan company.** If an enrollee obtains coverage from a new health plan company and the health plan company for the enrollee's new health benefit plan uses a different utilization review organization from the enrollee's previous health benefit plan to conduct utilization review, the health plan company for the enrollee's new health benefit plan shall comply with a prior authorization for health care services approved by the utilization review organization used by the enrollee's previous health benefit plan for at least the first 60 days that the enrollee is covered under the new health benefit plan. In order to obtain coverage for this 60-day time period, the enrollee or the enrollee's attending health care professional must submit documentation of the previous prior authorization to the enrollee's new health plan company according to procedures in the enrollee's new health benefit plan. During this 60-day time period, the utilization review organization used by the enrollee's new health plan company may conduct its own utilization review of these health care services.

Subd. 2. **Effect of change in prior authorization clinical criteria.** (a) If, during a plan year, a utilization review organization changes coverage terms for a health care service or the clinical criteria used to conduct prior authorizations for a health care service, the change in coverage terms or change in clinical criteria shall not apply until the next plan year for any enrollee who received prior authorization for a health care service using the coverage terms or clinical criteria in effect before the effective date of the change.

(b) Paragraph (a) does not apply if a utilization review organization changes coverage terms for a drug or device that has been deemed unsafe by the United States Food and Drug Administration (FDA); that has been withdrawn by either the FDA or the product manufacturer; or when an independent source of research, clinical guidelines, or evidence-based standards has issued drug- or device-specific warnings or recommended changes in drug or device usage.

(c) Paragraph (a) does not apply if a utilization review organization changes coverage terms for a service or the clinical criteria used to conduct prior authorizations for a service when an independent source of research, clinical guidelines, or evidence-based standards has recommended changes in usage of the service for reasons related to patient harm.

(d) Paragraph (a) does not apply if a utilization review organization removes a brand name drug from its formulary or places a brand name drug in a benefit category that increases the enrollee's cost, provided the utilization review organization (1) adds to its formulary a

generic or multisource brand name drug rated as therapeutically equivalent according to the FDA Orange Book, or a biologic drug rated as interchangeable according to the FDA Purple Book, at a lower cost to the enrollee, and (2) provides at least a 60-day notice to prescribers, pharmacists, and affected enrollees.

EFFECTIVE DATE. This section is effective January 1, 2021, and applies to health plans offered, sold, issued, or renewed on or after that date.

Sec. 20. **[62M.18] ANNUAL POSTING ON WEBSITE; PRIOR AUTHORIZATIONS.**

(a) By April 1, 2022, and each April 1 thereafter, a health plan company must post on the health plan company's public website the following data for the immediately preceding calendar year for each commercial product:

(1) the number of prior authorization requests for which an authorization was issued;

(2) the number of prior authorization requests for which an adverse determination was issued and sorted by: (i) health care service; (ii) whether the adverse determination was appealed; and (iii) whether the adverse determination was upheld or reversed on appeal;

(3) the number of prior authorization requests that were submitted electronically and not by facsimile or e-mail or other method pursuant to section 62J.497; and

(4) the reasons for prior authorization denial including but not limited to:

(i) patient did not meet prior authorization criteria;

(ii) incomplete information submitted by the provider to the utilization review organization;

(iii) change in treatment program; and

(iv) the patient is no longer covered by the plan.

(b) All information posted under this section must be written in easily understandable language.

EFFECTIVE DATE. This section is effective January 1, 2021, and applies to health plans offered, sold, issued, or renewed on or after that date.

Sec. 21. **COMPLIANCE REPORT ON DRUG PRIOR AUTHORIZATION.**

By February 1, 2021, the commissioner of health shall submit to the chairs and ranking minority members of the legislative committees with jurisdiction over health care policy and finance a report on compliance with the requirements for providers in Minnesota Statutes,

section 62J.497, subdivision 5. The report must include the following information from health plans offered in the commercial fully insured and self-insured health insurance markets:

(1) the total number of drug prior authorization requests;

(2) the frequency with which drug prior authorization requests are submitted electronically. Electronic submission does not include facsimile or e-mail requests;

(3) the turnaround times for health plans when drug prior authorizations are submitted electronically;

(4) the turnaround times for health plans when drug prior authorizations are not submitted electronically;

(5) the reasons electronic drug prior authorizations are denied;

(6) the reasons nonelectronic drug prior authorizations are denied;

(7) the anticipated effect on denials and turnaround times if all providers in Minnesota were to submit drug prior authorizations electronically;

(8) the differences between the commercial fully insured and self-insured markets for clauses (1) to (7); and

(9) the reasons providers are not able to comply with Minnesota Statutes, section 62J.497, subdivision 5.

Sec. 22. **REPEALER.**

(a) Minnesota Statutes 2018, section 62M.02, subdivision 19, is repealed effective January 1, 2021.

(b) Minnesota Rules, part 4685.0100, subpart 9b, is repealed effective January 1, 2021.

ARTICLE 2
CONFORMING CHANGES

Section 1. Minnesota Statutes 2018, section 62M.02, subdivision 2, is amended to read:

Subd. 2. **Appeal.** "Appeal" means a formal request, either orally or in writing, to reconsider ~~a~~ an adverse determination ~~not to certify~~ regarding an admission, extension of stay, or other health care service.

EFFECTIVE DATE. This section is effective January 1, 2021, and applies to health plans offered, sold, issued, or renewed on or after that date.

Sec. 2. Minnesota Statutes 2018, section 62M.04, subdivision 1, is amended to read:

Subdivision 1. **Responsibility for obtaining ~~certification~~ authorization.** A health benefit plan that includes utilization review requirements must specify the process for notifying the utilization review organization in a timely manner and obtaining ~~certification~~ authorization for health care services. Each health plan company must provide a clear and concise description of this process to an enrollee as part of the policy, subscriber contract, or certificate of coverage. In addition to the enrollee, the utilization review organization must allow any provider or provider's designee, or responsible patient representative, including a family member, to fulfill the obligations under the health plan.

A claims administrator that contracts directly with providers for the provision of health care services to enrollees may, through contract, require the provider to notify the review organization in a timely manner and obtain ~~certification~~ authorization for health care services.

EFFECTIVE DATE. This section is effective January 1, 2021, and applies to health plans offered, sold, issued, or renewed on or after that date.

Sec. 3. Minnesota Statutes 2018, section 62M.04, subdivision 2, is amended to read:

Subd. 2. **Information upon which utilization review is conducted.** (a) If the utilization review organization is conducting routine prospective and concurrent utilization review, utilization review organizations must collect only the information necessary to ~~certify~~ authorize the admission, procedure of treatment, and length of stay.

(b) Utilization review organizations may request, but may not require providers to supply, numerically encoded diagnoses or procedures as part of the ~~certification~~ authorization process.

(c) Utilization review organizations must not routinely request copies of medical records for all patients reviewed. In performing prospective and concurrent review, copies of the pertinent portion of the medical record should be required only when a difficulty develops in ~~certifying~~ authorizing the medical necessity or appropriateness of the admission or extension of stay.

(d) Utilization review organizations may request copies of medical records retrospectively for a number of purposes, including auditing the services provided, quality assurance review, ensuring compliance with the terms of either the health benefit plan or the provider contract, and compliance with utilization review activities. Except for reviewing medical records associated with an appeal or with an investigation or audit of data discrepancies, providers must be reimbursed for the reasonable costs of duplicating records requested by the utilization

review organization for retrospective review unless otherwise provided under the terms of the provider contract.

EFFECTIVE DATE. This section is effective January 1, 2021, and applies to health plans offered, sold, issued, or renewed on or after that date.

Sec. 4. Minnesota Statutes 2018, section 62M.04, subdivision 3, is amended to read:

Subd. 3. **Data elements.** (a) Except as otherwise provided in ~~sections 62M.01 to 62M.16~~ this chapter, for purposes of ~~certification~~ authorization a utilization review organization must limit its data requirements to the following elements:

(b) Patient information that includes the following:

(1) name;

(2) address;

(3) date of birth;

(4) sex;

(5) Social Security number or patient identification number;

(6) name of health plan company or health plan; and

(7) plan identification number.

(c) Enrollee information that includes the following:

(1) name;

(2) address;

(3) Social Security number or employee identification number;

(4) relation to patient;

(5) employer;

(6) health benefit plan;

(7) group number or plan identification number; and

(8) availability of other coverage.

(d) Attending health care professional information that includes the following:

(1) name;

(2) address;

(3) telephone numbers;

(4) degree and license;

(5) specialty or board certification status; and

(6) tax identification number or other identification number.

(e) Diagnosis and treatment information that includes the following:

(1) primary diagnosis with associated ICD or DSM coding, if available;

(2) secondary diagnosis with associated ICD or DSM coding, if available;

(3) tertiary diagnoses with associated ICD or DSM coding, if available;

(4) proposed procedures or treatments with ICD or associated CPT codes, if available;

(5) surgical assistant requirement;

(6) anesthesia requirement;

(7) proposed admission or service dates;

(8) proposed procedure date; and

(9) proposed length of stay.

(f) Clinical information that includes the following:

(1) support and documentation of appropriateness and level of service proposed; and

(2) identification of contact person for detailed clinical information.

(g) Facility information that includes the following:

(1) type;

(2) licensure and certification status and DRG exempt status;

(3) name;

(4) address;

(5) telephone number; and

(6) tax identification number or other identification number.

(h) Concurrent or continued stay review information that includes the following:

(1) additional days, services, or procedures proposed;

(2) reasons for extension, including clinical information sufficient for support of appropriateness and level of service proposed; and

(3) diagnosis status.

(i) For admissions to facilities other than acute medical or surgical hospitals, additional information that includes the following:

(1) history of present illness;

(2) patient treatment plan and goals;

(3) prognosis;

(4) staff qualifications; and

(5) 24-hour availability of staff.

Additional information may be required for other specific review functions such as discharge planning or catastrophic case management. Second opinion information may also be required, when applicable, to support benefit plan requirements.

EFFECTIVE DATE. This section is effective January 1, 2021, and applies to health plans offered, sold, issued, or renewed on or after that date.

Sec. 5. Minnesota Statutes 2018, section 62M.04, subdivision 4, is amended to read:

Subd. 4. **Additional information.** A utilization review organization may request information in addition to that described in subdivision 3 when there is significant lack of agreement between the utilization review organization and the provider regarding the appropriateness of ~~certification~~ authorization during the review or appeal process. For purposes of this subdivision, "significant lack of agreement" means that the utilization review organization has:

(1) tentatively determined through its professional staff that a service cannot be ~~certified~~ authorized;

(2) referred the case to a physician for review; and

(3) talked to or attempted to talk to the attending health care professional for further information.

Nothing in ~~sections 62M.01 to 62M.16~~ this chapter prohibits a utilization review organization from requiring submission of data necessary to comply with the quality assurance and utilization review requirements of chapter 62D or other appropriate data or outcome analyses.

EFFECTIVE DATE. This section is effective January 1, 2021, and applies to health plans offered, sold, issued, or renewed on or after that date.

Sec. 6. Minnesota Statutes 2018, section 62M.05, subdivision 3, is amended to read:

Subd. 3. **Notification of adverse determinations and authorizations.** A utilization review organization must have written procedures for providing notification of ~~its determinations on~~ all ~~certifications~~ its adverse determinations and authorizations in accordance with this section.

EFFECTIVE DATE. This section is effective January 1, 2021, and applies to health plans offered, sold, issued, or renewed on or after that date.

Sec. 7. Minnesota Statutes 2018, section 62M.05, subdivision 5, is amended to read:

Subd. 5. **Notification to claims administrator.** If the utilization review organization and the claims administrator are separate entities, the utilization review organization must forward, electronically or in writing, a notification of ~~certification or determination not to certify~~ an authorization or adverse determination to the appropriate claims administrator for the health benefit plan. If it is determined by the claims administrator that the ~~certified~~ authorized health care service is not covered by the health benefit plan, the claims administrator must promptly notify the claimant and provider of this information.

EFFECTIVE DATE. This section is effective January 1, 2021, and applies to health plans offered, sold, issued, or renewed on or after that date.

Sec. 8. Minnesota Statutes 2018, section 62M.06, subdivision 1, is amended to read:

Subdivision 1. **Procedures for appeal.** (a) A utilization review organization must have written procedures for appeals of adverse determinations ~~not to certify~~. The right to appeal must be available to the enrollee and to the attending health care professional.

(b) The enrollee shall be allowed to review the information relied upon in the course of the appeal, present evidence and testimony as part of the appeals process, and receive continued coverage pending the outcome of the appeals process. This paragraph does not apply to managed care plans or county-based purchasing plans serving state public health care program enrollees under section 256B.69, 256B.692, or chapter 256L, or to grandfathered plans as defined under section 62A.011, subdivision 1c. Nothing in this paragraph shall be construed to limit or restrict the appeal rights of state public health care program enrollees provided under section 256.045 and Code of Federal Regulations, title 42, section 438.420(d).

EFFECTIVE DATE. This section is effective January 1, 2021, and applies to health plans offered, sold, issued, or renewed on or after that date.

Sec. 9. Minnesota Statutes 2018, section 62M.06, subdivision 2, is amended to read:

Subd. 2. **Expedited appeal.** (a) When an ~~initial~~ adverse determination ~~not to certify~~ for a health care service is made prior to or during an ongoing service requiring review and the attending health care professional believes that the determination warrants an expedited appeal, the utilization review organization must ensure that the enrollee and the attending health care professional have an opportunity to appeal the determination over the telephone on an expedited basis. In such an appeal, the utilization review organization must ensure reasonable access to its consulting physician or health care provider.

(b) The utilization review organization shall notify the enrollee and attending health care professional by telephone of its determination on the expedited appeal as expeditiously as the enrollee's medical condition requires, but no later than 72 hours after receiving the expedited appeal.

(c) If the adverse determination ~~not to certify~~ is not reversed through the expedited appeal, the utilization review organization must include in its notification the right to submit the appeal to the external appeal process described in section 62Q.73 and the procedure for initiating the process. This information must be provided in writing to the enrollee and the attending health care professional as soon as practical.

EFFECTIVE DATE. This section is effective January 1, 2021, and applies to health plans offered, sold, issued, or renewed on or after that date.

Sec. 10. Minnesota Statutes 2018, section 62M.06, subdivision 4, is amended to read:

Subd. 4. **Notification to claims administrator.** If the utilization review organization and the claims administrator are separate entities, the utilization review organization must notify, either electronically or in writing, the appropriate claims administrator for the health benefit plan of any adverse determination ~~not to certify~~ that is reversed on appeal.

EFFECTIVE DATE. This section is effective January 1, 2021, and applies to health plans offered, sold, issued, or renewed on or after that date.

Sec. 11. Minnesota Statutes 2018, section 62M.09, subdivision 3a, is amended to read:

Subd. 3a. **Mental health and substance abuse reviews.** (a) A peer of the treating mental health or substance abuse provider, a doctoral-level psychologist, or a physician must review

requests for outpatient services in which the utilization review organization has concluded that ~~a~~ an adverse determination ~~not to certify~~ for a mental health or substance abuse service for clinical reasons is appropriate, provided that any final adverse determination ~~not to certify~~ issued under section 62M.05 for a treatment is made by a psychiatrist certified by the American Board of Psychiatry and Neurology and appropriately licensed in this state or by a doctoral-level psychologist licensed in this state.

(b) Notwithstanding paragraph (a), a doctoral-level psychologist shall not review any request or final adverse determination ~~not to certify~~ for a mental health or substance abuse service or treatment if the treating provider is a psychiatrist.

(c) Notwithstanding the notification requirements of section 62M.05, a utilization review organization that has made ~~an initial decision~~ an adverse determination to ~~certify~~ authorize in accordance with the requirements of section 62M.05 may elect to provide notification of a determination to continue coverage through facsimile or mail.

(d) This subdivision does not apply to determinations made in connection with policies issued by a health plan company that is assessed less than three percent of the total amount assessed by the Minnesota Comprehensive Health Association.

EFFECTIVE DATE. This section is effective January 1, 2021, and applies to health plans offered, sold, issued, or renewed on or after that date.

Sec. 12. Minnesota Statutes 2018, section 62M.09, subdivision 4, is amended to read:

Subd. 4. **Dentist plan reviews.** A dentist must review all cases in which the utilization review organization has concluded that ~~a~~ an adverse determination ~~not to certify~~ for a dental service or procedure for clinical reasons is appropriate and an appeal has been made by the attending dentist, enrollee, or designee.

EFFECTIVE DATE. This section is effective January 1, 2021, and applies to health plans offered, sold, issued, or renewed on or after that date.

Sec. 13. Minnesota Statutes 2018, section 62M.09, subdivision 4a, is amended to read:

Subd. 4a. **Chiropractic review.** A chiropractor must review all cases in which the utilization review organization has concluded that ~~a~~ an adverse determination ~~not to certify~~ for a chiropractic service or procedure for clinical reasons is appropriate and an appeal has been made by the attending chiropractor, enrollee, or designee.

EFFECTIVE DATE. This section is effective January 1, 2021, and applies to health plans offered, sold, issued, or renewed on or after that date.

Sec. 14. Minnesota Statutes 2018, section 62M.09, subdivision 5, is amended to read:

Subd. 5. **Written clinical criteria.** A utilization review organization's decisions must be supported by written clinical criteria and review procedures. Clinical criteria and review procedures must be established with appropriate involvement from actively practicing physicians. A utilization review organization must use written clinical criteria, as required, for determining the appropriateness of the ~~certification~~ authorization request. The utilization review organization must have a procedure for ensuring, at a minimum, the annual evaluation and updating of the written criteria based on sound clinical principles.

EFFECTIVE DATE. This section is effective January 1, 2021, and applies to health plans offered, sold, issued, or renewed on or after that date.

Sec. 15. Minnesota Statutes 2018, section 62M.11, is amended to read:

62M.11 COMPLAINTS TO COMMERCE OR HEALTH.

Notwithstanding the provisions of ~~sections 62M.01 to 62M.16~~ this chapter, an enrollee may file a complaint regarding ~~a~~ an adverse determination ~~not to certify~~ directly to the commissioner responsible for regulating the utilization review organization.

EFFECTIVE DATE. This section is effective January 1, 2021, and applies to health plans offered, sold, issued, or renewed on or after that date.

Sec. 16. Minnesota Statutes 2018, section 62M.12, is amended to read:

62M.12 PROHIBITION OF INAPPROPRIATE INCENTIVES.

No individual who is performing utilization review may receive any financial incentive based on the number of ~~denials of certifications~~ adverse determinations made by such individual, provided that utilization review organizations may establish medically appropriate performance standards. This prohibition does not apply to financial incentives established between health plan companies and providers.

EFFECTIVE DATE. This section is effective January 1, 2021, and applies to health plans offered, sold, issued, or renewed on or after that date.

Sec. 17. Minnesota Statutes 2018, section 62Q.71, is amended to read:

62Q.71 NOTICE TO ENROLLEES.

Each health plan company shall provide to enrollees a clear and concise description of its complaint resolution procedure, if applicable under section 62Q.68, subdivision 1, and

the procedure used for utilization review as defined under chapter 62M as part of the member handbook, subscriber contract, or certificate of coverage. If the health plan company does not issue a member handbook, the health plan company may provide the description in another written document. The description must specifically inform enrollees:

(1) how to submit a complaint to the health plan company;

(2) if the health plan includes utilization review requirements, how to notify the utilization review organization in a timely manner and how to obtain ~~certification~~ authorization for health care services;

(3) how to request an appeal either through the procedures described in section 62Q.70, if applicable, or through the procedures described in chapter 62M;

(4) of the right to file a complaint with either the commissioner of health or commerce at any time during the complaint and appeal process;

(5) of the toll-free telephone number of the appropriate commissioner; and

(6) of the right, for individual and group coverage, to obtain an external review under section 62Q.73 and a description of when and how that right may be exercised, including that under most circumstances an enrollee must exhaust the internal complaint or appeal process prior to external review. However, an enrollee may proceed to external review without exhausting the internal complaint or appeal process under the following circumstances:

(i) the health plan company waives the exhaustion requirement;

(ii) the health plan company is considered to have waived the exhaustion requirement by failing to substantially comply with any requirements including, but not limited to, time limits for internal complaints or appeals; or

(iii) the enrollee has applied for an expedited external review at the same time the enrollee ~~qualifies for and~~ has applied for ~~an expedited~~ internal review under chapter 62M.

EFFECTIVE DATE. This section is effective January 1, 2021, and applies to health plans offered, sold, issued, or renewed on or after that date.

Sec. 18. Minnesota Statutes 2018, section 62Q.73, subdivision 1, is amended to read:

Subdivision 1. **Definition.** For purposes of this section, "adverse determination" means:

(1) for individual health plans, a complaint decision relating to a health care service or claim that is partially or wholly adverse to the complainant;

(2) an individual health plan that is grandfathered plan coverage may instead apply the definition of adverse determination for group coverage in clause (3);

(3) for group health plans, a complaint decision relating to a health care service or claim that has been appealed in accordance with section 62Q.70 and the appeal decision is partially or wholly adverse to the complainant;

(4) any ~~initial~~ adverse determination ~~not to certify~~, as defined in section 62M.02, subdivision 1a, that has been appealed in accordance with section 62M.06 and the appeal did not reverse the ~~initial~~ adverse determination ~~not to certify~~;

(5) a decision relating to a health care service made by a health plan company licensed under chapter 60A that denies the service on the basis that the service was not medically necessary; or

(6) the enrollee has met the requirements of subdivision 6, paragraph (e).

An adverse determination does not include complaints relating to fraudulent marketing practices or agent misrepresentation.

EFFECTIVE DATE. This section is effective January 1, 2021, and applies to health plans offered, sold, issued, or renewed on or after that date.

Sec. 19. Minnesota Statutes 2018, section 256B.692, subdivision 2, is amended to read:

Subd. 2. **Duties of commissioner of health.** (a) Notwithstanding chapters 62D and 62N, a county that elects to purchase medical assistance in return for a fixed sum without regard to the frequency or extent of services furnished to any particular enrollee is not required to obtain a certificate of authority under chapter 62D or 62N. The county board of commissioners is the governing body of a county-based purchasing program. In a multicounty arrangement, the governing body is a joint powers board established under section 471.59.

(b) A county that elects to purchase medical assistance services under this section must satisfy the commissioner of health that the requirements for assurance of consumer protection, provider protection, and fiscal solvency of chapter 62D, applicable to health maintenance organizations will be met according to the following schedule:

(1) for a county-based purchasing plan approved on or before June 30, 2008, the plan must have in reserve:

(i) at least 50 percent of the minimum amount required under chapter 62D as of January 1, 2010;

(ii) at least 75 percent of the minimum amount required under chapter 62D as of January 1, 2011;

(iii) at least 87.5 percent of the minimum amount required under chapter 62D as of January 1, 2012; and

(iv) at least 100 percent of the minimum amount required under chapter 62D as of January 1, 2013; and

(2) for a county-based purchasing plan first approved after June 30, 2008, the plan must have in reserve:

(i) at least 50 percent of the minimum amount required under chapter 62D at the time the plan begins enrolling enrollees;

(ii) at least 75 percent of the minimum amount required under chapter 62D after the first full calendar year;

(iii) at least 87.5 percent of the minimum amount required under chapter 62D after the second full calendar year; and

(iv) at least 100 percent of the minimum amount required under chapter 62D after the third full calendar year.

(c) Until a plan is required to have reserves equaling at least 100 percent of the minimum amount required under chapter 62D, the plan may demonstrate its ability to cover any losses by satisfying the requirements of chapter 62N. A county-based purchasing plan must also assure the commissioner of health that the requirements of sections 62J.041; 62J.48; 62J.71 to 62J.73; ~~62M.01 to 62M.16;~~ all applicable provisions of chapter 62Q, including sections 62Q.075; 62Q.1055; 62Q.106; 62Q.12; 62Q.135; 62Q.14; 62Q.145; 62Q.19; 62Q.23, paragraph (c); 62Q.43; 62Q.47; 62Q.50; 62Q.52 to 62Q.56; 62Q.58; 62Q.68 to 62Q.72; and 72A.201 will be met.

(d) All enforcement and rulemaking powers available under chapters 62D, 62J, ~~62M,~~ 62N, and 62Q are hereby granted to the commissioner of health with respect to counties that purchase medical assistance services under this section.

(e) The commissioner, in consultation with county government, shall develop administrative and financial reporting requirements for county-based purchasing programs relating to sections 62D.041, 62D.042, 62D.045, 62D.08, 62N.28, 62N.29, and 62N.31, and other sections as necessary, that are specific to county administrative, accounting, and reporting systems and consistent with other statutory requirements of counties.

(f) The commissioner shall collect from a county-based purchasing plan under this section the following fees:

(1) fees attributable to the costs of audits and other examinations of plan financial operations. These fees are subject to the provisions of Minnesota Rules, part 4685.2800, subpart 1, item F; and

(2) an annual fee of $21,500, to be paid by June 15 of each calendar year.

All fees collected under this paragraph shall be deposited in the state government special revenue fund.

Sec. 20. **REVISOR INSTRUCTIONS.**

(a) In Minnesota Statutes, chapter 62M, the revisor of statutes shall replace references to "sections 62M.01 to 62M.16" with "this chapter." In Minnesota Statutes, section 256B.692, subdivision 2, the revisor of statutes shall replace a reference to "sections 62M.01 to 62M.16" with "chapter 62M." The revisor shall make any necessary technical and conforming changes to sentence structure to preserve the meaning of the text.

(b) The revisor of statutes shall replace the term "DETERMINATIONS NOT TO CERTIFY" with "ADVERSE DETERMINATIONS" in the section headnote for Minnesota Statutes, section 62M.06.

EFFECTIVE DATE. Paragraph (a) is effective August 1, 2020. Paragraph (b) is effective January 1, 2021.

62M.02 DEFINITIONS.

Subd. 19. **Reconsideration request.** "Reconsideration request" means an initial request by telephone for additional review of a utilization review organization's determination not to certify an admission, extension of stay, or other health care service.

4685.0100 DEFINITIONS.

Subp. 9b. **Medically necessary care.** "Medically necessary care" means health care services appropriate, in terms of type, frequency, level, setting, and duration, to the enrollee's diagnosis or condition, and diagnostic testing and preventive services. Medically necessary care must:

A. be consistent with generally accepted practice parameters as determined by health care providers in the same or similar general specialty as typically manages the condition, procedure, or treatment at issue; and

B. help restore or maintain the enrollee's health; or

C. prevent deterioration of the enrollee's condition; or

D. prevent the reasonably likely onset of a health problem or detect an incipient problem.