HOUSE BILL 305

J5, J4, J1 3lr1084
CF 3lr1125

By: **Delegates Kerr, Shetty, Charkoudian, Conaway, Crutchfield, Edelson, Embry, Guyton, Guzzone, Kaufman, Palakovich Carr, Reznik, Ruth, Simpson, Smith, Solomon, Terrasa, Vogel, and Wells**

Introduced and read first time: January 25, 2023
Assigned to: Health and Government Operations

A BILL ENTITLED

AN ACT concerning

Health Insurance – Utilization Review – Revisions

FOR the purpose of altering and establishing requirements and prohibitions related to health insurance utilization review, including provisions regarding benchmarks for standardizing and automating the preauthorization process, the online preauthorization system for payors, preauthorizations for prescription drugs, and private review agents; altering timelines related to internal grievance procedures and adverse decision procedures; increasing the penalties for violating certain provisions of law regarding private review agents; requiring, rather than authorizing, the Maryland Insurance Commissioner to establish certain reporting requirements and requiring the Commissioner to establish certain review requirements related to private review agents; and generally relating to health insurance and utilization review.

BY repealing and reenacting, with amendments,
Article – Health – General
Section 19–108.2
Annotated Code of Maryland
(2019 Replacement Volume and 2022 Supplement)

BY repealing and reenacting, without amendments,
Article – Insurance
Section 15–1A–14(a), 15–1001, and 15–10A–01(a)
Annotated Code of Maryland
(2017 Replacement Volume and 2022 Supplement)

BY repealing and reenacting, with amendments,
Article – Insurance

EXPLANATION: **CAPITALS INDICATE MATTER ADDED TO EXISTING LAW.**
[Brackets**]** indicate matter deleted from existing law.

Section 15–1A–14(b), 15–854, 15–10A–01(k), 15–10A–02, 15–10A–06(a)(1)(vi), 15–10B–02, 15–10B–05 through 15–10B–07, 15–10B–11(8), 15–10B–12, and 15–10B–16
Annotated Code of Maryland
(2017 Replacement Volume and 2022 Supplement)

SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND, That the Laws of Maryland read as follows:

Article – Health – General

19–108.2.

(a) (1) In this section the following words have the meanings indicated.

(2) "Health care service" has the meaning stated in § 15–10A–01 of the Insurance Article.

(3) "Payor" means:

(i) An insurer or nonprofit health service plan that provides hospital, medical, or surgical benefits to individuals or groups on an expense–incurred basis under health insurance policies or contracts that are issued or delivered in the State;

(ii) A health maintenance organization that provides hospital, medical, or surgical benefits to individuals or groups under contracts that are issued or delivered in the State; or

(iii) A pharmacy benefits manager that is registered with the Maryland Insurance Commissioner.

(4) "Provider" has the meaning stated in § 19–7A–01 of this title.

(5) "Step therapy or fail–first protocol" has the meaning stated in § 15–142 of the Insurance Article.

(b) In addition to the duties stated elsewhere in this subtitle, the Commission shall work with payors and providers to attain benchmarks for:

(1) Standardizing and automating the process required by payors for preauthorizing health care services; and

(2) Overriding a payor's step therapy or fail–first protocol.

(c) The benchmarks described in subsection (b) of this section shall include:

(1) **[**On or before October 1, 2012 ("Phase 1"), establishment**]** **ESTABLISHMENT** of online access for providers to each payor's:

(i) List of health care services that require preauthorization; and

(ii) Key criteria for making a determination on a preauthorization request**, INCLUDING CRITERIA INCLUDED IN A CERTIFICATE APPLICATION BY A PRIVATE REVIEW AGENT AS REQUIRED UNDER § 15–10B–05(A) OF THE INSURANCE ARTICLE**;

(2) **[**On or before March 1, 2013 ("Phase 2"), establishment**]** **ESTABLISHMENT** by each payor of an online process for:

(i) Accepting electronically a preauthorization request from a provider; and

(ii) Assigning to a preauthorization request a unique electronic identification number that a provider may use to track the request during the preauthorization process, whether or not the request is tracked electronically, through a call center, or by fax;

(3) **[**On or before July 1, 2013 ("Phase 3"), establishment**]** **ESTABLISHMENT** by each payor of an online preauthorization system to approve:

(i) In real time, electronic preauthorization requests for pharmaceutical services:

1. For which no additional information is needed by the payor to process the preauthorization request; and

2. That meet the payor's criteria for approval**, INCLUDING THE CRITERIA INCLUDED IN A CERTIFICATE APPLICATION BY A PRIVATE REVIEW AGENT AS REQUIRED UNDER § 15–10B–05 OF THE INSURANCE ARTICLE**;

(ii) Within 1 **[**business**]** **CALENDAR** day after receiving all pertinent information on requests not approved in real time, electronic preauthorization requests for pharmaceutical services that:

1. Are not urgent; and

2. Do not meet the standards for real–time approval under item (i) of this item; and

(iii) Within 2 **[**business**]** **CALENDAR** days after receiving all pertinent information, electronic preauthorization requests for health care services, except pharmaceutical services, that are not urgent;

(4) **[**On or before July 1, 2015, establishment**]** **ESTABLISHMENT**, by each payor that requires a step therapy or fail–first protocol, of a process for a provider to override the step therapy or fail–first protocol of the payor; and

(5) **[**On or before July 1, 2015, utilization**]** **UTILIZATION** by providers of:

(i) The online preauthorization system established by payors; or

(ii) If a national transaction standard has been established and adopted by the health care industry, as determined by the Commission, the provider's practice management, electronic health record, or e–prescribing system.

(d) The benchmarks described in subsections (b) and (c) of this section do not apply to preauthorizations of health care services requested by providers employed by a group model health maintenance organization as defined in § 19–713.6 of this title.

(e) The online preauthorization system described in subsection (c)(3) of this section shall:

(1) Provide real–time notice to providers about preauthorization requests approved in real time; **[**and**]**

(2) Provide notice to providers, within the time frames specified in subsection (c)(3)(ii) and (iii) of this section and in a manner that is able to be tracked by providers, about preauthorization requests not approved in real time**; AND**

(3) COMPLY WITH ANY ADDITIONAL UTILIZATION REVIEW CRITERIA REQUIRED UNDER TITLE 15, SUBTITLE 10 OF THE INSURANCE ARTICLE.

(f) (1) The Commission shall establish by regulation a process through which a payor or provider may be waived from attaining the benchmarks described in subsections (b) and (c) of this section for extenuating circumstances.

(2) For a provider, the extenuating circumstances may include:

(i) The lack of broadband Internet access;

(ii) Low patient volume; or

(iii) Not making medical referrals or prescribing pharmaceuticals.

(3) For a payor, the extenuating circumstances may include:

(i) Low premium volume; or

(ii) For a group model health maintenance organization, as defined in § 19–713.6 of this title, preauthorizations of health care services requested by providers not employed by the group model health maintenance organization.

(g) **[**(1) On or before October 1, 2012, the Commission shall reconvene the multistakeholder workgroup whose collaboration resulted in the 2011 report "Recommendations for Implementing Electronic Prior Authorizations".

(2) The workgroup shall:

(i) Review the progress to date in attaining the benchmarks described in subsections (b) and (c) of this section; and

(ii) Make recommendations to the Commission for adjustments to the benchmark dates.

(h)**]** If necessary to attain the benchmarks, the Commission may adopt regulations to:

(1) **[**Adjust the Phase 2 or Phase 3 benchmark dates;

(2)**]** Require payors and providers to comply with the benchmarks; and

[(3)**] (2)** Establish penalties for noncompliance.

Article – Insurance

15–1A–14.

(a) (1) In this section the following words have the meanings indicated.

(2) "Emergency medical condition" means a medical condition that manifests itself by acute symptoms of such severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson, who possesses an average knowledge of health and medicine, to result in a condition described in § 1867(e)(1) of the Social Security Act.

(3) "Emergency services" means, with respect to an emergency medical condition:

(i) a medical screening examination that is within the capability of the emergency department of a hospital or freestanding medical facility, including ancillary services routinely available to the emergency department to evaluate an emergency medical condition; or

(ii) any other examination or treatment within the capabilities of the staff and facilities available at the hospital or freestanding medical facility that is necessary to stabilize the patient.

(b) If a carrier provides or covers any benefits for emergency services in an emergency department of a hospital or freestanding medical facility, the carrier:

(1) may not require an insured individual to obtain prior authorization for the emergency services**, INCLUDING HEALTH CARE SERVICES PROVIDED POSTEVALUATION OR POSTSTABILIZATION THAT ARE NECESSARY TO DISCHARGE THE PATIENT**; and

(2) shall provide coverage for the emergency services regardless of whether the health care provider providing the emergency services has a contractual relationship with the carrier to furnish emergency services.

15–854.

(a) (1) This section applies to:

(i) insurers and nonprofit health service plans that provide coverage for prescription drugs through a pharmacy benefit under individual, group, or blanket health insurance policies or contracts that are issued or delivered in the State; and

(ii) health maintenance organizations that provide coverage for prescription drugs through a pharmacy benefit under individual or group contracts that are issued or delivered in the State.

(2) An insurer, a nonprofit health service plan, or a health maintenance organization that provides coverage for prescription drugs through a pharmacy benefits manager or that contracts with a private review agent under Subtitle 10B of this article is subject to the requirements of this section.

(3) This section does not apply to a managed care organization as defined in § 15–101 of the Health – General Article.

(b) **[**(1) (i) If an entity subject to this section requires a prior authorization for a prescription drug, the prior authorization request shall allow a health care provider to indicate whether a prescription drug is to be used to treat a chronic condition.

(ii) If a health care provider indicates that the prescription drug is to treat a chronic condition, an entity subject to this section may not request a reauthorization for a repeat prescription for the prescription drug for 1 year or for the standard course of treatment for the chronic condition being treated, whichever is less.

(2)**]** For a prior authorization **FOR A PRESCRIPTION DRUG** that is filed electronically, the entity shall maintain a database that will prepopulate prior

authorization requests with an insured's available insurance and demographic information.

(c) **[**If**]** **IN ADDITION TO THE REQUIREMENTS IN SUBTITLES 10A AND 10B OF THIS TITLE, IF** an entity subject to this section **[**denies**]** **ISSUES AN ADVERSE DECISION DENYING** coverage for a prescription drug, the entity shall provide a detailed written explanation for the denial of coverage, including whether the denial was based on a requirement for prior authorization.

(d) (1) On receipt of information documenting a prior authorization from the insured or from the insured's health care provider, an entity subject to this section shall honor a prior authorization granted to an insured from a previous entity for at least the **[**initial 30**]** **LESSER OF 90** days **[**of an insured's prescription drug benefit coverage under the health benefit plan of the new entity**]** **OR THE LENGTH OF THE COURSE OF TREATMENT**.

(2) During the time period described in paragraph (1) of this subsection, an entity may perform its own review to grant a prior authorization for the prescription drug.

(e) (1) An entity subject to this section shall honor a prior authorization issued by the entity for a prescription drug:

(i) if the insured changes health benefit plans that are both covered by the same entity and the prescription drug is a covered benefit under the current health benefit plan; or

(ii) except as provided in paragraph (2) of this subsection, when the dosage for the approved prescription drug changes and the change is consistent with federal Food and Drug Administration labeled dosages.

(2) An entity may not be required to honor a prior authorization for a change in dosage for an opioid under this subsection.

(F) AN ENTITY SUBJECT TO THIS SECTION MAY NOT REQUIRE A PRIOR AUTHORIZATION FOR:

(1) A CHANGE IN DOSAGE OF A PRESCRIPTION DRUG BY A PRESCRIBER IF THE ENTITY HAS ALREADY PREAUTHORIZED THE USE OF THE PRESCRIPTION DRUG FOR THE INSURED AND THE DOSAGE CHANGE IS CONSISTENT WITH FEDERAL FOOD AND DRUG ADMINISTRATION LABELED DOSAGES;

(2) A PRESCRIPTION DRUG THAT IS A GENERIC; OR

(3) A PRESCRIPTION DRUG IF:

(I) THE INSURED RECEIVED AN INITIAL PRIOR AUTHORIZATION FOR THE PRESCRIPTION DRUG; AND

(II) BASED ON THE PROFESSIONAL JUDGMENT OF THE PRESCRIBER, THE PRESCRIPTION DRUG IS EFFECTIVELY TREATING THE INSURED'S MEDICAL CONDITION.

(G) AN ENTITY SUBJECT TO THIS SECTION MAY NOT REQUIRE MORE THAN ONE PRIOR AUTHORIZATION FOR A PRESCRIPTION DRUG WITH DIFFERENT FORMULATIONS THAT IS PRESCRIBED THROUGH TWO OR MORE PRESCRIPTIONS AT THE SAME TIME AS PART OF AN INSURED'S TREATMENT PLAN.

[(f)**] (H)** If an entity under this section implements a new prior authorization requirement for a prescription drug, the entity shall provide notice of the new requirement at least 30 days before the implementation of a new prior authorization requirement:

(1) in writing to any insured who is prescribed the prescription drug; and

(2) either in writing or electronically to all contracted health care providers.

15–1001.

(a) This section applies to entities that propose to issue or deliver individual, group, or blanket health insurance policies or contracts in the State or to administer health benefit programs that provide for the coverage of health care services and the utilization review of those services, including:

(1) an authorized insurer that provides health insurance in the State;

(2) a nonprofit health service plan;

(3) a health maintenance organization;

(4) a dental plan organization; or

(5) except for a managed care organization as defined in Title 15, Subtitle 1 of the Health – General Article, any other person that provides health benefit plans subject to regulation by the State.

(b) (1) Subject to paragraph (2) of this subsection, each entity subject to this section shall:

(i) 1. have a certificate issued under Subtitle 10B of this title; or

2. contract with a private review agent that has a certificate issued under Subtitle 10B of this title; and

(ii) when conducting utilization review for mental health and substance use benefits, ensure that the criteria and standards used are in compliance with the federal Mental Health Parity and Addiction Equity Act.

(2) For hospital services, each entity subject to this section may contract with or delegate utilization review to a hospital utilization review program approved under § 19–319(d) of the Health – General Article.

(c) Notwithstanding any other provision of this article, if the medical necessity of providing a covered benefit is disputed, an entity subject to this section that does not meet the requirements of subsection (b) of this section shall pay any person entitled to reimbursement under the policy or contract in accordance with the determination of medical necessity by:

(1) the treating provider; or

(2) when hospital services are provided, the hospital utilization review program approved under § 19–319(d) of the Health – General Article.

(d) An entity subject to this section may not:

(1) act as a private review agent without holding a certificate issued under Subtitle 10B of this title; or

(2) use a private review agent that does not hold a certificate issued under Subtitle 10B of this title.

(e) An entity that violates any provision of this section is subject to the penalties provided under § 15–10B–12 of this title.

15–10A–01.

(a) In this subtitle the following words have the meanings indicated.

(k) "Health care service" means a health or medical care procedure or service rendered by a health care provider that:

(1) provides testing, diagnosis, or treatment of a human disease or dysfunction; **[**or**]**

(2) dispenses drugs, medical devices, medical appliances, or medical goods for the treatment of a human disease or dysfunction**; OR**

(3) PROVIDES ANY OTHER CARE, SERVICE, OR TREATMENT OF DISEASE OR INJURY, THE CORRECTION OF DEFECTS, OR THE MAINTENANCE OF PHYSICAL OR MENTAL WELL–BEING OF HUMAN BEINGS.

15–10A–02.

(a) Each carrier shall establish an internal grievance process for its members.

(b) (1) An internal grievance process shall meet the same requirements established under Subtitle 10B of this title.

(2) In addition to the requirements of Subtitle 10B of this title, an internal grievance process established by a carrier under this section shall:

(i) include an expedited procedure for use in an emergency case for purposes of rendering a grievance decision within 24 hours of the date a grievance is filed with the carrier;

(ii) provide that a carrier render a final decision in writing on a grievance within **[**30 working**] 10 CALENDAR** days after the date on which the grievance is filed unless:

1. the grievance involves an emergency case under item (i) of this paragraph;

2. the member, the member's representative, or a health care provider filing a grievance on behalf of a member agrees in writing to an extension for a period of no longer than 30 working days; or

3. the grievance involves a retrospective denial under item (iv) of this paragraph;

(iii) allow a grievance to be filed on behalf of a member by a health care provider or the member's representative;

(iv) provide that a carrier render a final decision in writing on a grievance within **[**45 working**] 30 CALENDAR** days after the date on which the grievance is filed when the grievance involves a retrospective denial; and

(v) for a retrospective denial, allow a member, the member's representative, or a health care provider on behalf of a member to file a grievance for at least 180 days after the member receives an adverse decision.

(3) For purposes of using the expedited procedure for an emergency case that a carrier is required to include under paragraph (2)(i) of this subsection, the Commissioner shall define by regulation the standards required for a grievance to be considered an emergency case.

(c) Except as provided in subsection (d) of this section, the carrier's internal grievance process shall be exhausted prior to filing a complaint with the Commissioner under this subtitle.

(d) (1) (i) A member, the member's representative, or a health care provider filing a complaint on behalf of a member may file a complaint with the Commissioner without first filing a grievance with a carrier and receiving a final decision on the grievance if:

1. the carrier waives the requirement that the carrier's internal grievance process be exhausted before filing a complaint with the Commissioner;

2. the carrier has failed to comply with any of the requirements of the internal grievance process as described in this section; or

3. the member, the member's representative, or the health care provider provides sufficient information and supporting documentation in the complaint that demonstrates a compelling reason to do so.

(ii) The Commissioner shall define by regulation the standards that the Commissioner shall use to decide what demonstrates a compelling reason under subparagraph (i) of this paragraph.

(2) Subject to subsections (b)(2)(ii) and (h) of this section, a member, a member's representative, or a health care provider may file a complaint with the Commissioner if the member, the member's representative, or the health care provider does not receive a grievance decision from the carrier on or before the **[**30th working**]** **10TH CALENDAR** day on which the grievance is filed.

(3) Whenever the Commissioner receives a complaint under paragraph (1) or (2) of this subsection, the Commissioner shall notify the carrier that is the subject of the complaint within 5 working days after the date the complaint is filed with the Commissioner.

(e) Each carrier shall:

(1) file for review with the Commissioner and submit to the Health Advocacy Unit a copy of its internal grievance process established under this subtitle; and

(2) file any revision to the internal grievance process with the Commissioner and the Health Advocacy Unit at least 30 days before its intended use.

(f) For nonemergency cases, when a carrier renders an adverse decision, the carrier shall:

(1) **AFTER COMPLYING WITH § 15–10B–07(A) OF THIS TITLE,** document the adverse decision in writing **[**after the carrier has provided**]** **AND PROVIDE** oral communication of the decision to the member, the member's representative, or the health care provider acting on behalf of the member; and

(2) send, within **[**5 working**]** **2 CALENDAR** days after the adverse decision has been made, a written notice to the member, the member's representative, and a health care provider acting on behalf of the member that:

(i) states in detail in clear, understandable language the specific factual bases for the carrier's decision;

(ii) references the specific criteria and standards, including interpretive guidelines, on which the decision was based, and may not solely use generalized terms such as "experimental procedure not covered", "cosmetic procedure not covered", "service included under another procedure", or "not medically necessary";

(iii) states the name, business address, and business telephone number of:

1. the medical director or associate medical director, as appropriate, who made the decision if the carrier is a health maintenance organization; or

2. the designated employee or representative of the carrier who has responsibility for the carrier's internal grievance process if the carrier is not a health maintenance organization;

(iv) gives written details of the carrier's internal grievance process and procedures under this subtitle; and

(v) includes the following information:

1. that the member, the member's representative, or a health care provider on behalf of the member has a right to file a complaint with the Commissioner within 4 months after receipt of a carrier's grievance decision;

2. that a complaint may be filed without first filing a grievance if the member, the member's representative, or a health care provider filing a grievance on behalf of the member can demonstrate a compelling reason to do so as determined by the Commissioner;

3. the Commissioner's address, telephone number, and facsimile number;

4. a statement that the Health Advocacy Unit is available to assist the member or the member's representative in both mediating and filing a grievance under the carrier's internal grievance process; and

5. the address, telephone number, facsimile number, and electronic mail address of the Health Advocacy Unit.

(g) If within **[**5 working**]** **3 CALENDAR** days after a member, the member's representative, or a health care provider, who has filed a grievance on behalf of a member, files a grievance with the carrier, and if the carrier does not have sufficient information to complete its internal grievance process, the carrier shall:

(1) notify the member, the member's representative, or the health care provider that it cannot proceed with reviewing the grievance unless additional information is provided **AND SPECIFY:**

1. THE ADDITIONAL INFORMATION THAT MUST BE PROVIDED TO COMPLETE THE INTERNAL GRIEVANCE PROCESS; AND

2. THE CRITERIA AND STANDARDS TO SUPPORT THE NEED FOR THE ADDITIONAL INFORMATION; and

(2) assist the member, the member's representative, or the health care provider in gathering the necessary information without further delay.

(h) A carrier may extend the **[**30–day**]** **10–DAY** or **[**45–day**]** **30–DAY** period required for making a final grievance decision under subsection (b)(2)(ii) of this section with the written consent of the member, the member's representative, or the health care provider who filed the grievance on behalf of the member.

(i) (1) For nonemergency cases, when a carrier renders a grievance decision, the carrier shall:

(i) document the grievance decision in writing after the carrier has provided oral communication of the decision to the member, the member's representative, or the health care provider acting on behalf of the member; and

(ii) send, within **[**5 working**]** **3 CALENDAR** days after the grievance decision has been made, a written notice to the member, the member's representative, and a health care provider acting on behalf of the member that:

1. states in detail in clear, understandable language the specific factual bases for the carrier's decision;

2. references the specific criteria and standards, including interpretive guidelines, on which the grievance decision was based;

3. states the name, business address, and business telephone number of:

A. the medical director or associate medical director, as appropriate, who made the grievance decision if the carrier is a health maintenance organization; or

B. the designated employee or representative of the carrier who has responsibility for the carrier's internal grievance process if the carrier is not a health maintenance organization; and

4. includes the following information:

A. that the member or the member's representative has a right to file a complaint with the Commissioner within 4 months after receipt of a carrier's grievance decision;

B. the Commissioner's address, telephone number, and facsimile number;

C. a statement that the Health Advocacy Unit is available to assist the member or the member's representative in filing a complaint with the Commissioner; and

D. the address, telephone number, facsimile number, and electronic mail address of the Health Advocacy Unit.

(2) A carrier may not use solely in a notice sent under paragraph (1) of this subsection generalized terms such as "experimental procedure not covered", "cosmetic procedure not covered", "service included under another procedure", or "not medically necessary" to satisfy the requirements of this subsection.

(j) (1) For an emergency case under subsection (b)(2)(i) of this section, **AFTER THE CARRIER HAS COMPLIED WITH § 15–10B–07(A) OF THIS TITLE AND** within 1 **CALENDAR** day after a decision has been orally communicated to the member, the member's representative, or the health care provider, the carrier shall send notice in writing of any adverse decision or grievance decision to:

(i) the member and the member's representative, if any; and

(ii) if the grievance was filed on behalf of the member under subsection (b)(2)(iii) of this section, the health care provider.

(2) A notice required to be sent under paragraph (1) of this subsection shall include the following:

(i) for an adverse decision, the information required under subsection (f) of this section; and

(ii) for a grievance decision, the information required under subsection (i) of this section.

(k) (1) Each carrier shall include the information required by subsection (f)(2)(iii), (iv), and (v) of this section in the policy, plan, certificate, enrollment materials, or other evidence of coverage that the carrier provides to a member at the time of the member's initial coverage or renewal of coverage.

(2) Each carrier shall include as part of the information required by paragraph (1) of this subsection a statement indicating that, when filing a complaint with the Commissioner, the member or the member's representative will be required to authorize the release of any medical records of the member that may be required to be reviewed for the purpose of reaching a decision on the complaint.

(l) (1) Nothing in this subtitle prohibits a carrier from delegating its internal grievance process to a private review agent that has a certificate issued under Subtitle 10B of this title and is acting on behalf of the carrier.

(2) If a carrier delegates its internal grievance process to a private review agent, the carrier shall be:

(i) bound by the grievance decision made by the private review agent acting on behalf of the carrier; and

(ii) responsible for a violation of any provision of this subtitle regardless of the delegation made by the carrier under paragraph (1) of this subsection.

15–10A–06.

(a) On a quarterly basis, each carrier shall submit to the Commissioner, on the form the Commissioner requires, a report that describes:

(1) the activities of the carrier under this subtitle, including:

(vi) **1.** the number of adverse decisions issued by the carrier under § 15–10A–02(f) of this subtitle **[**and**];**

2. the type of service **AND THE HEALTH CARE SPECIALTY** at issue in the adverse decisions**; AND**

3. THE UTILIZATION MANAGEMENT TECHNIQUE USED BY THE CARRIER IN ISSUING THE ADVERSE DECISIONS; and

15–10B–02.

The purpose of this subtitle is to:

(1) promote the delivery of quality health care in a cost effective manner **THAT ENSURES TIMELY ACCESS TO HEALTH CARE SERVICES**;

(2) foster greater coordination**, COMMUNICATION, AND TRANSPARENCY** between payors and providers conducting utilization review activities;

(3) protect patients, business, and providers by ensuring that private review agents are qualified to perform utilization review activities and to make informed decisions on the appropriateness of medical care; and

(4) ensure that private review agents maintain the confidentiality of medical records in accordance with applicable State and federal laws.

15–10B–05.

(a) In conjunction with the application, the private review agent shall submit information that the Commissioner requires including:

(1) a utilization review plan that includes:

(i) the specific criteria and standards to be used in conducting utilization review of proposed or delivered health care services **IN ACCORDANCE WITH ITEM (11) OF THIS SUBSECTION**;

(ii) those circumstances, if any, under which utilization review may be delegated to a hospital utilization review program; and

(iii) if applicable, any provisions by which patients, physicians, or hospitals may seek reconsideration;

(2) the type and qualifications of the personnel either employed or under contract to perform the utilization review;

(3) a copy of the private review agent's internal grievance process if a carrier delegates its internal grievance process to the private review agent in accordance with § 15–10A–02(l) of this title;

(4) the procedures and policies to ensure**:**

(I) that a representative of the private review agent is reasonably accessible to patients and health care providers 7 days a week, 24 hours a day in this State**; AND**

(II) COMPLIANCE WITH § 15–10B–07 OF THIS SUBTITLE;

(5) if applicable, the procedures and policies to ensure that a representative of the private review agent is accessible to health care providers to make all determinations on whether to authorize or certify an emergency inpatient admission, or an admission for residential crisis services as defined in § 15–840 of this title, for the treatment of a mental, emotional, or substance abuse disorder within 2 hours after receipt of the information necessary to make the determination;

(6) the policies and procedures to ensure that all applicable State and federal laws to protect the confidentiality of individual medical records are followed;

(7) a copy of the materials designed to inform applicable patients and providers of the requirements of the utilization review plan;

(8) a list of the third party payors for which the private review agent is performing utilization review in this State;

(9) the policies and procedures to ensure that the private review agent has a formal program for the orientation and training of the personnel either employed or under contract to perform the utilization review;

(10) a list of the persons **AND THEIR QUALIFICATIONS, INCLUDING ANY CERTIFICATIONS AND CLINICAL SPECIALTIES,** involved in establishing the specific criteria and standards to be used in conducting utilization review; and

(11) certification by the private review agent that the criteria and standards to be used in conducting utilization review **[**are**]**:

[(i) objective;

(ii) clinically valid;

(iii) compatible with established principles of health care; and

(iv) flexible enough to allow deviations from norms when justified on a case by case basis**]**

(I) ARE EVIDENCE–BASED, PEER–REVIEWED, AND DEVELOPED BY:

1. AN ORGANIZATION THAT WORKS DIRECTLY WITH HEALTH CARE PROVIDERS IN THE SAME SPECIALTY FOR THE DESIGNATED CRITERIA WHO ARE EMPLOYED OR ENGAGED WITHIN THE ORGANIZATION OR OUTSIDE THE ORGANIZATION TO DEVELOP THE CLINICAL CRITERIA, PROVIDED THAT THE ORGANIZATION DOES NOT RECEIVE DIRECT PAYMENTS BASED ON THE OUTCOME OR PRIOR AUTHORIZATION DECISIONS; OR

2. A PROFESSIONAL MEDICAL SPECIALTY SOCIETY; AND

(II) SHALL:

1. TAKE INTO ACCOUNT THE NEEDS OF ATYPICAL PATIENT POPULATIONS AND DIAGNOSES;

2. ENSURE QUALITY OF CARE AND ACCESS TO NEEDED HEALTH CARE SERVICES;

3. BE SUFFICIENTLY FLEXIBLE TO ALLOW DEVIATIONS FROM NORMS WHEN JUSTIFIED ON A CASE–BY–CASE BASIS; AND

4. BE EVALUATED AT LEAST ANNUALLY AND UPDATED AS NECESSARY.

(b) **(1) [**On the written request of any person or health care facility, the**] THE** private review agent shall **[**provide 1 copy of**] POST** the specific criteria and standards to be used in conducting utilization review of proposed or delivered services and any subsequent revisions, modifications, or additions to the specific criteria and standards to be used in conducting utilization review of proposed or delivered services **[**to the person or health care facility making the request**] IN ACCORDANCE WITH § 19–108.2(C)(1) OF THE HEALTH – GENERAL ARTICLE**.

(2) THE INFORMATION POSTED IN ACCORDANCE WITH PARAGRAPH (1) OF THIS SUBSECTION SHALL INCLUDE THE INFORMATION REQUIRED UNDER SUBSECTION (A)(10) OF THIS SECTION.

(c) **[**The private review agent may charge a reasonable fee for a copy of the specific criteria and standards or any subsequent revisions, modifications, or additions to the specific criteria to any person or health care facility requesting a copy under subsection (b) of this section.

(d)**]** A private review agent shall advise the Commissioner, in writing, of a change in:

(1) ownership, medical director, or chief executive officer within 30 days of the date of the change;

(2) the name, address, or telephone number of the private review agent within 30 days of the date of the change; or

(3) the private review agent's scope of responsibility under a contract.

15–10B–06.

(a) (1) **[**A**] EXCEPT AS PROVIDED IN § 19–108.2 OF THE HEALTH – GENERAL ARTICLE, A** private review agent shall:

(i) make all initial determinations on whether to authorize or certify a nonemergency course of treatment for a patient within 2 **[**working**] CALENDAR** days after receipt of the information necessary to make the determination;

(ii) make all determinations on whether to authorize or certify an extended stay in a health care facility or additional health care services within 1 **[**working**] CALENDAR** day after receipt of the information necessary to make the determination; and

(iii) promptly notify the health care provider of the determination.

(2) If within **[**3**] 2** calendar days after receipt of the initial request for health care services the private review agent does not have sufficient information to make a determination, the private review agent shall **[**inform**] SPECIFY TO** the health care provider **[**that**]:**

(I) THE additional information **THAT** must be provided **TO MAKE THE DETERMINATION; AND**

(II) THE CRITERIA AND STANDARDS TO SUPPORT THE NEED FOR THE ADDITIONAL INFORMATION.

(3) If a private review agent requires prior authorization for an emergency inpatient admission, or an admission for residential crisis services as defined in § 15–840 of this title, for the treatment of a mental, emotional, or substance abuse disorder, the private review agent shall:

(i) make all determinations on whether to authorize or certify an inpatient admission, or an admission for residential crisis services as defined in § 15–840 of this title, within 2 hours after receipt of the information necessary to make the determination; and

(ii) promptly notify the health care provider of the determination.

[(b) If an initial determination is made by a private review agent not to authorize or certify a health care service and the health care provider believes the determination warrants an immediate reconsideration, a private review agent may provide the health care provider the opportunity to speak with the physician that rendered the determination, by telephone on an expedited basis, within a period of time not to exceed 24 hours of the health care provider seeking the reconsideration.**]**

(B) BEFORE ISSUING AN ADVERSE DECISION, A PRIVATE REVIEW AGENT SHALL GIVE THE PATIENT'S TREATING PHYSICIAN, DENTIST, OR OTHER HEALTH CARE PRACTITIONER THE OPPORTUNITY TO SPEAK ABOUT THE MEDICAL NECESSITY OF THE TREATMENT REQUEST WITH THE PHYSICIAN, DENTIST, OR PANEL RESPONSIBLE FOR THE ADVERSE DECISION.

(c) For emergency inpatient admissions, a private review agent may not render an adverse decision solely because the hospital did not notify the private review agent of the emergency admission within 24 hours or other prescribed period of time after that admission if the patient's medical condition prevented the hospital from determining:

(1) the patient's insurance status; and

(2) if applicable, the private review agent's emergency admission notification requirements.

(d) (1) Subject to paragraph (2) of this subsection, a private review agent may not render an adverse decision as to an admission of a patient during the first 24 hours after admission when:

(i) the admission is based on a determination that the patient is in imminent danger to self or others;

(ii) the determination has been made by the patient's physician or psychologist in conjunction with a member of the medical staff of the facility who has privileges to make the admission; and

(iii) the hospital immediately notifies the private review agent of:

1. the admission of the patient; and

2. the reasons for the admission.

(2) A private review agent may not render an adverse decision as to an admission of a patient to a hospital for up to 72 hours, as determined to be medically necessary by the patient's treating physician, when:

(i) the admission is an involuntary admission under §§ 10–615 and 10–617(a) of the Health – General Article; and

(ii) the hospital immediately notifies the private review agent of:

1. the admission of the patient; and

2. the reasons for the admission.

(e) (1) A private review agent that requires a health care provider to submit a treatment plan in order for the private review agent to conduct utilization review of proposed or delivered services for the treatment of a mental illness, emotional disorder, or a substance abuse disorder:

(i) shall accept:

1. the uniform treatment plan form adopted by the Commissioner under § 15–10B–03(d) of this subtitle as a properly submitted treatment plan form; or

2. if a service was provided in another state, a treatment plan form mandated by the state in which the service was provided; and

(ii) may not impose any requirement to:

1. modify the uniform treatment plan form or its content; or

2. submit additional treatment plan forms.

(2) A uniform treatment plan form submitted under the provisions of this subsection:

(i) shall be properly completed by the health care provider; and

(ii) may be submitted by electronic transfer.

15–10B–07.

(a) (1) **(I)** Except as provided in **[**paragraphs (2) and (3)**]** **SUBPARAGRAPHS (II) AND (III)** of this **[**subsection**]** **PARAGRAPH**, all adverse decisions shall be made by a physician, or a panel of other appropriate health care service reviewers with at least one physician on the panel who is**:**

1. board certified or eligible in the same specialty as the treatment under review**; AND**

2. KNOWLEDGEABLE OF AND HAS EXPERIENCE IN THE DIAGNOSIS AND TREATMENT UNDER REVIEW.

[(2)**]** **(II)** When the health care service under review is a mental health or substance abuse service, the adverse decision shall be made by a physician, or a panel of other appropriate health care service reviewers with at least one physician, selected by the private review agent who **IS**:

[(i)**]** **1.** **[**is**]** board certified or eligible in the same specialty as the treatment under review; or

[(ii)**]** **2.** **[**is**]** actively practicing or has demonstrated expertise in the substance abuse or mental health service or treatment under review.

[(3)**]** **(III)** When the health care service under review is a dental service, the adverse decision shall be made by a licensed dentist, or a panel of other appropriate health care service reviewers with at least one licensed dentist on the panel.

(2) A PHYSICIAN OR DENTIST WHO MAKES AN ADVERSE DECISION OR PARTICIPATES ON THE PANEL THAT MAKES AN ADVERSE DECISION IN ACCORDANCE WITH PARAGRAPH (1) OF THIS SUBSECTION SHALL HOLD A CURRENT, VALID, AND UNRESTRICTED LICENSE TO PRACTICE MEDICINE OR DENTISTRY IN THE STATE.

(b) All adverse decisions shall be made by a physician or a panel of other appropriate health care service reviewers who are not compensated by the private review agent in a manner that violates § 19–705.1 of the Health – General Article or that deters the delivery of medically appropriate care.

(c) Except as provided in subsection (d) of this section, if a course of treatment has been preauthorized or approved for a patient, a private review agent may not retrospectively render an adverse decision regarding the preauthorized or approved services delivered to that patient.

(d) A private review agent may retrospectively render an adverse decision regarding preauthorized or approved services delivered to a patient if:

(1) the information submitted to the private review agent regarding the services to be delivered to the patient was fraudulent or intentionally misrepresentative;

(2) critical information requested by the private review agent regarding services to be delivered to the patient was omitted such that the private review agent's determination would have been different had the agent known the critical information; or

(3) the planned course of treatment for the patient that was approved by the private review agent was not substantially followed by the provider.

(e) If a course of treatment has been preauthorized or approved for a patient, a private review agent may not revise or modify the specific criteria or standards used for the utilization review to make an adverse decision regarding the services delivered to that patient.

15–10B–11.

A private review agent may not:

(8) use criteria and standards to conduct utilization review **[**unless the criteria and standards used by the private review agent are:

(i) objective;

(ii) clinically valid;

(iii) compatible with established principles of health care; or

(iv) flexible enough to allow deviations from norms when justified on a case–by–case basis**] THAT DO NOT CONFORM TO INFORMATION SUBMITTED WITH THE CERTIFICATE APPLICATION OF THE PRIVATE REVIEW AGENT AS REQUIRED UNDER § 15–10B–05 OF THIS SUBTITLE**; or

15–10B–12.

(a) (1) A person who violates any provision of § 15–10B–11 of this subtitle is guilty of a misdemeanor and on conviction is subject to a penalty not exceeding **[**$1,000**] $5,000**.

(2) Each day a violation is continued after the first conviction is a separate offense.

(b) In addition to the provisions of subsection (a) of this section, if any person violates any provision of § 15–10B–11 of this subtitle, the Commissioner may:

(1) deny, suspend, or revoke the certificate to do business as a private review agent;

(2) issue an order to cease and desist from acting as a private review agent without holding a certificate issued under this subtitle;

(3) require a private review agent to make restitution to a patient who has suffered actual economic damage because of the violation; and

(4) impose an administrative penalty of up to **[**$5,000**] $10,000** for each violation of any provision of this subtitle.

15–10B–16.

The Commissioner **[**may**] SHALL** establish reporting **AND REVIEW** requirements to:

(1) evaluate the effectiveness of private review agents; and

(2) determine if the utilization review programs are in compliance with the provisions of this section and applicable regulations.

SECTION 2. AND BE IT FURTHER ENACTED, That the Maryland Health Care Commission shall:

(1) in consultation with health care practitioners, payors of health care services, and the State–designated health information exchange, develop findings and recommendations for:

(i) revising the electronic process required under § 19–108.2 of the Health – General Article, as enacted by Section 1 of this Act, for health care services to achieve greater standardization and uniformity across payors to ease the burden of prior authorization and other utilization management techniques for patients, providers, and payors;

(ii) replacing the use of proprietary health plan web–based portals with the adoption of uniform implementation specifications and standardization of certification criteria for health care services, including the use of a single sign–on option for payor and third–party administrator websites; and

(iii) a pilot program through the State–designated health information exchange to implement items (i) and (ii) of this item;

(2) in consultation with the Maryland Department of Health, examine requiring managed care organizations that participate in the Maryland Medical Assistance Program to use the standardized electronic process recommended in item (1) of this section; and

(3) on or before December 1, 2023, submit a report to the General Assembly, in accordance with § 2–1257 of the State Government Article, of its findings and recommendations, including draft legislation necessary to implement the pilot program.

SECTION 3. AND BE IT FURTHER ENACTED, That:

(a) The Maryland Health Care Commission and the Maryland Insurance Administration, in consultation with health care practitioners and payors of health care services, jointly shall conduct a study on the development of standards for the implementation of payor programs to modify prior authorization requirements for prescription drugs, medical care, and other health care services based on health care practitioner–specific criteria.

(b) The study conducted under subsection (a) of this section shall include an examination of:

(1) adjustments to payor prior authorization requirements based on a health care practitioner's:

(i) prior approval rates;

(ii) ordering and prescribing patterns; and

(iii) participation in a payor's two–sided incentive arrangement or a capitation program; and

(2) any other information or metrics necessary to implement the payor programs.

(c) On or before December 1, 2023, the Maryland Health Care Commission and Maryland Insurance Administration jointly shall submit a report to the General Assembly, in accordance with § 2–1257 of the State Government Article, with the findings and recommendations from the study, including recommendations for legislative initiatives necessary for the establishment of payor programs modifying prior authorization requirements based on health care practitioner–specific criteria.

SECTION 4. AND BE IT FURTHER ENACTED, That, on or before October 1, 2023, the Maryland Insurance Administration, in consultation with the Health Education and Advocacy Unit in the Maryland Office of the Attorney General, shall work with medical associations or societies and consumer advocacy organizations to develop an education campaign to educate the public on their rights under Maryland's Health Care Appeals and Grievance Law.

SECTION 5. AND BE IT FURTHER ENACTED, That Section 1 of this Act shall take effect January 1, 2024.

SECTION 6. AND BE IT FURTHER ENACTED, That, except as provided in Section 5 of this Act, this Act shall take effect July 1, 2023.