SENATE BILL 540

J1, C3 (2lr1843)

ENROLLED BILL

— Finance/Health and Government Operations —

Introduced by ~~**Senator Astle**~~ **Senators Astle, Glassman, Kelley, Kittleman, Klausmeier, Mathias, Middleton, and Pugh**

Read and Examined by Proofreaders:

_____

Proofreader.

_____

Proofreader.

Sealed with the Great Seal and presented to the Governor, for his approval this

_____ day of _____ at _____ o'clock, _____M.

_____

President.

CHAPTER _____

AN ACT concerning

Maryland Health Care Commission – Preauthorization of ~~Medical Services and Pharmaceuticals – Standards~~ Health Care Services – Benchmarks

FOR the purpose of requiring the Maryland Health Care Commission to ~~adopt regulations to establish standards for the preauthorization of medical services and pharmaceuticals by certain payors, pharmacy benefits managers, and providers; requiring certain standards to include a certain exemption process; providing that certain standards may include certain penalties~~ work with payors and providers to attain benchmarks for standardizing and automating the process required by payors for preauthorizing health care services; requiring the benchmarks to include, on or before certain dates, establishment or utilization of certain features; providing that the benchmarks do not apply to certain preauthorizations; requiring the Commission to establish by regulation a process through which a payor or provider may be waived from attaining the

EXPLANATION: **CAPITALS INDICATE MATTER ADDED TO EXISTING LAW**.

[Brackets**]** indicate matter deleted from existing law.

Underlining indicates amendments to bill.

~~Strike out~~ indicates matter stricken from the bill by amendment or deleted from the law by amendment.

Italics indicate opposite chamber/conference committee amendments.

benchmarks for certain extenuating circumstances; requiring the Commission, on or before a certain date, to reconvene a certain workgroup for a certain purpose; requiring payors to report to the Commission on or before certain dates on their attainment and plans for attainment of certain benchmarks; requiring the Commission, on or before certain dates, to report to the Governor and ~~to certain committees of~~ the General Assembly on the progress in attaining the benchmarks and, taking into account the recommendations of the workgroup, any adjustment needed to certain benchmark dates; authorizing the Commission to adopt certain regulations; defining certain terms; and generally relating to the Maryland Health Care Commission and ~~certain preauthorization standards~~ benchmarks for preauthorization of health care services.

BY repealing and reenacting, without amendments,
Article – Health – General
Section 19–101
Annotated Code of Maryland
(2009 Replacement Volume and 2011 Supplement)

BY adding to
Article – Health – General
Section 19–108.2
Annotated Code of Maryland
(2009 Replacement Volume and 2011 Supplement)

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

Article – Health – General

19–101.

In this subtitle, "Commission" means the Maryland Health Care Commission.

19–108.2.

(A) (1) IN THIS SECTION THE FOLLOWING WORDS HAVE THE MEANINGS INDICATED.

~~**(2) "HEALTH CARE PRACTITIONER" HAS THE MEANING STATED IN § 19–111 OF THIS SUBTITLE.**~~

(2) "HEALTH CARE SERVICE" HAS THE MEANING STATED IN § 15–10A–01 OF THE INSURANCE ARTICLE.

(3) "PAYOR" ~~HAS THE MEANING STATED IN § 19–111 OF THIS SUBTITLE~~ 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) "PHARMACY BENEFITS MANAGER" HAS THE MEANING STATED IN § 15–1601 OF THE INSURANCE ARTICLE.**~~

~~**(5)**~~ **(4) "PROVIDER" HAS THE MEANING STATED IN § 19–7A–01 OF THIS TITLE.**

~~**(B) IN ADDITION TO THE DUTIES STATED ELSEWHERE IN THIS SUBTITLE, THE COMMISSION SHALL ADOPT REGULATIONS ESTABLISHING STANDARDS FOR PREAUTHORIZATION BY:**~~

~~**(1) PAYORS FOR MEDICAL SERVICES AND PHARMACEUTICALS TO BE PROVIDED AFTER DECEMBER 31, 2012;**~~

~~**(2) PHARMACY BENEFITS MANAGERS FOR MEDICAL SERVICES AND PHARMACEUTICALS TO BE PROVIDED AFTER DECEMBER 31, 2012; AND**~~

~~**(3) PROVIDERS FOR MEDICAL SERVICES AND PHARMACEUTICALS ORDERED AFTER DECEMBER 31, 2015.**~~

~~**(C) THE STANDARDS ADOPTED UNDER SUBSECTION (B) OF THIS SECTION:**~~

~~**(1) SHALL INCLUDE A PROCESS FOR A PAYOR, PHARMACY BENEFITS MANAGER, OR PROVIDER UNDER SUBSECTION (B) OF THIS SECTION TO OBTAIN AN EXEMPTION FROM COMPLIANCE WITH THE STANDARDS FOR EXTENUATING CIRCUMSTANCES, INCLUDING:**~~

~~**(I) THE LACK OF BROADBAND INTERNET ACCESS;**~~

~~(II) A PRACTICE WITH A LOW PATIENT VOLUME AS DEFINED BY THE COMMISSION; OR~~

~~(III) A SPECIALTY PROVIDER THAT DOES NOT MAKE MEDICAL REFERRALS OR PRESCRIBE PHARMACEUTICALS; AND~~

~~(2) MAY INCLUDE PENALTIES FOR NONCOMPLIANCE.~~

(B) IN ADDITION TO THE DUTIES STATED ELSEWHERE IN THIS SUBTITLE, THE COMMISSION SHALL WORK WITH PAYORS AND PROVIDERS TO ATTAIN BENCHMARKS FOR STANDARDIZING AND AUTOMATING THE PROCESS REQUIRED BY PAYORS FOR PREAUTHORIZING HEALTH CARE SERVICES.

(C) THE BENCHMARKS DESCRIBED IN SUBSECTION (B) OF THIS SECTION SHALL INCLUDE:

(1) ON OR BEFORE OCTOBER 1, 2012 ("PHASE 1"), 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;

(2) ON OR BEFORE MARCH 1, 2013 ("PHASE 2"), 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 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;

(II) WITHIN 1 BUSINESS 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 DAYS AFTER RECEIVING ALL PERTINENT INFORMATION, ELECTRONIC PREAUTHORIZATION REQUESTS FOR HEALTH CARE SERVICES, EXCEPT PHARMACEUTICAL SERVICES, THAT ARE NOT URGENT; AND

(4) ON OR BEFORE JULY 1, 2015, 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.

(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) (1) PAYORS SHALL REPORT TO THE COMMISSION:

(I) ON OR BEFORE MARCH 1, 2013, ON:

1. THE STATUS OF THEIR ATTAINMENT OF THE PHASE 1 AND PHASE 2 BENCHMARKS; AND

2. AN OUTLINE OF THEIR PLANS FOR ATTAINING THE PHASE 3 BENCHMARKS; AND

(II) ON OR BEFORE DECEMBER 1, 2013, ON THEIR ATTAINMENT OF THE PHASE 3 BENCHMARKS.

(2) THE COMMISSION SHALL SPECIFY THE CRITERIA PAYORS MUST USE IN REPORTING ON THEIR ATTAINMENT AND PLANS.

(I) (1) ON OR BEFORE MARCH 31, 2013, THE COMMISSION SHALL REPORT TO THE GOVERNOR AND, IN ACCORDANCE WITH § 2–1246 OF THE STATE GOVERNMENT ARTICLE, THE ~~SENATE FINANCE COMMITTEE AND THE HOUSE HEALTH AND GOVERNMENT OPERATIONS COMMITTEE~~ *GENERAL ASSEMBLY*, ON:

(I) THE PROGRESS IN ATTAINING THE BENCHMARKS FOR STANDARDIZING AND AUTOMATING THE PROCESS REQUIRED BY PAYORS FOR PREAUTHORIZING HEALTH CARE SERVICES; AND

(II) TAKING INTO ACCOUNT THE RECOMMENDATIONS OF THE MULTISTAKEHOLDER WORKGROUP UNDER SUBSECTION (G) OF THIS SECTION, ANY ADJUSTMENT NEEDED TO THE PHASE 2 OR PHASE 3 BENCHMARK DATES.

(2) ON OR BEFORE DECEMBER 31, 2013, AND ON OR BEFORE DECEMBER 31 IN EACH SUCCEEDING YEAR THROUGH 2016, THE COMMISSION SHALL REPORT TO THE GOVERNOR AND, IN ACCORDANCE WITH § 2–1246 OF THE STATE GOVERNMENT ARTICLE, THE ~~SENATE FINANCE COMMITTEE AND THE HOUSE HEALTH AND GOVERNMENT OPERATIONS COMMITTEE~~ *GENERAL ASSEMBLY* ON THE ATTAINMENT OF THE BENCHMARKS FOR STANDARDIZING AND AUTOMATING THE PROCESS REQUIRED BY PAYORS FOR PREAUTHORIZING HEALTH CARE SERVICES.

(J) 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) ESTABLISH PENALTIES FOR NONCOMPLIANCE.

SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall take effect ~~October~~ June 1, 2012.

Approved:

_____

Governor.

_____

President of the Senate.

_____

Speaker of the House of Delegates.