SB0540/137778/1

BY: Finance Committee

AMENDMENTS TO SENATE BILL 540
(First Reading File Bill)

AMENDMENT NO. 1

On page 1, in the sponsor line, strike "Senator Astle" and substitute "Senators Astle, Glassman, Kelley, Kittleman, Klausmeier, Mathias, Middleton, and Pugh"; in lines 2 and 3, strike "Medical Services and Pharmaceuticals – Standards" and substitute "Health Care Services - Benchmarks"; strike beginning with "adopt" in line 4 down through "penalties" in line 8 and substitute "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 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 in lines 9 and 10, strike "certain preauthorization standards" and substitute "benchmarks for preauthorization of health care services".

AMENDMENT NO. 2

On page 2, strike in their entirety lines 4 and 5, inclusive, and substitute:

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

(Over)

in lines 6 and 7, strike "**HAS THE MEANING STATED IN § 19-111 OF THIS SUBTITLE**" and substitute "**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";

strike in their entirety lines 8 and 9, inclusive; and in line 10, strike "**(5)**" and substitute "**(4)**".

AMENDMENT NO. 3

On pages 2 and 3, strike in their entirety the lines beginning with line 12 on page 2 through line 3 on page 3, inclusive, and substitute:

"**(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 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 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.".

AMENDMENT NO. 4

On page 3, in line 5, strike "October" and substitute "June".