Department of Legislative Services

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FISCAL AND POLICY NOTE
Revised

Senate Bill 540 (Senator Astle, *et al.*)
Finance Health and Government Operations

Maryland Health Care Commission - Preauthorization of Health Care Services - Benchmarks

This bill requires the Maryland Health Care Commission (MHCC) to work with specified health care payors and providers to attain benchmarks for standardizing and automating the process required by payors for preauthorizing health care services. The bill establishes dates by which benchmarks must be met, requires MHCC to establish by regulation a process for waiving a payor or provider from the benchmarks for extenuating circumstances, requires MHCC to reconvene a specified workgroup, establishes multiple reporting requirements, and authorizes MHCC to adopt other specified regulations.

The bill takes effect June 1, 2012.

Fiscal Summary

State Effect: Potential fiscal and operational impact on the State Employee and Retiree Health and Welfare Benefits Program to the extent that carriers' costs to implement the bill are passed on to consumers. MHCC can adopt regulations using existing budgeted resources. Revenues are not affected.

Local Effect: Potential fiscal and operational impact on local health insurance expenditures.

Small Business Effect: Potential meaningful.

Analysis

Bill Summary:

Benchmarks for Prior Authorization of Health Care Services: Benchmarks must include:

- by October 1, 2012 (Phase 1), establishment of online access for providers to each payor's list of health care services that require preauthorization and key criteria for making a determination on a preauthorization request;

- by March 1, 2013 (Phase 2), establishment by each payor of an online process for accepting electronically a preauthorization request from a provider and assigning to a preauthorization request a unique electronic identification number that a provider may use to track the request;

- by July 1, 2013 (Phase 3), establishment by each payor of an online preauthorization system to approve specified requests within specified timeframes; and

- by July 1, 2015, utilization by providers of either the online preauthorization system or, if a national transaction standard has been established and adopted by the health care industry, as determined by MHCC, the provider's practice management, electronic health record, or e-prescribing system.

The benchmarks do not apply to preauthorizations of health care services requested by providers employed by a group model health maintenance organization.

The online preauthorization system under Phase 3 must provide real-time notice to providers about preauthorization requests approved and must provide notice to providers, within the timeframes specified under the bill and in a manner that is able to be tracked by providers, about preauthorization requests not approved in real time.

Workgroup: By October 1, 2012, MHCC must reconvene a specified workgroup to review the progress to date in attaining the benchmarks and make recommendations to MHCC for adjustments to the benchmark dates.

Reporting Requirements: Payors must report to MHCC by (1) March 1, 2013, on the status of their attainment of Phase 1 and Phase 2 benchmarks and an outline of their plans for attaining Phase 3 benchmarks; and (2) December 1, 2013, on their attainment of Phase 3 benchmarks. MHCC must specify the criteria payors must use in reporting on their attainment and plans.

By March 31, 2013, MHCC must report on the progress in attaining the benchmarks and any adjustment needed to the Phase 2 or Phase 3 benchmark dates based on the recommendations of the workgroup. By December 31, 2013, and annually through 2016, MHCC must report on the attainment of the benchmarks.

Regulatory Authority: If necessary to attain the benchmarks, MHCC may adopt regulations to adjust the Phase 2 or Phase 3 benchmark dates, require payors and providers to comply with the benchmarks, and establish penalties for noncompliance.

Current Law: A private review agent who performs utilization review on behalf of a payor must (1) make all initial determinations on whether to authorize or certify a nonemergency course of treatment for a patient within two working days after receiving the information necessary to make the determination; (2) make all determinations on whether to authorize or certify an extended stay in a health care facility or additional health care services within one working day after receiving the necessary information; and (3) make all determinations on whether to authorize or certify an emergency inpatient admission or an admission for residential crisis services for treatment of a mental, emotional, or substance abuse disorder within two hours after receipt of the necessary information. The private review agent must promptly notify the health care provider of the determination. If a private review agent makes an initial determination not to authorize a health care service, the law provides a process for a health care provider to seek reconsideration.

If a course of treatment has been preauthorized or approved for a patient, a carrier or a private review agent may not retrospectively render an adverse decision regarding the services delivered to the patient, unless (1) the information submitted to the private review agent was fraudulent or intentionally misrepresentative; (2) critical information requested by the private review agent was omitted; or (3) the planned course of treatment that was approved for the patient was not substantially followed.

The Maryland Insurance Commissioner must do a market conduct examination of a private review agent at least once every five years. For a PBM registered as a private review agent, the market conduct examination must be carried out at least once every three years.

Background: The federal Health Insurance Portability and Accountability Act (HIPAA) required the U.S. Department of Health and Human Services (HHS) to establish national standards for electronic health care transactions, including preauthorization. The federal Patient Protection and Affordable Care Act (ACA) requires HHS to develop a complete set of requirements, processes, and operating rules necessary to electronically submit and receive each HIPAA standard transaction. Under ACA, health plans must adopt and implement operating rules for referral certification and authorization transactions by

July 1, 2014, to take effect by January 1, 2016. ACA also requires health plans to certify that their data and information systems comply with the most current published standards, including the operating rules for certain transactions.

During the 2011 interim, the Joint Committee on Health Care Delivery and Financing discussed the issue of prior authorization for health care services at two of its meetings.

At the committee's request, MHCC convened a workgroup to develop recommendations on best practices and standards for electronic prior-authorizations of prescription medications and health care services. MHCC issued a report in December 2011, *Recommendations for Implementing Electronic Prior Authorizations*, which reflected the workgroup's findings. The report noted that, while the ideal solution would be national standards for sending prior-authorization requests electronically from the provider's practice management or electronic health record system directly to the payor or third-party administrator (TPA), such standards do not yet exist (though they have been in development for some time). MHCC reported that, in general, the consensus of the workgroup was to focus on short-term solutions that incrementally reduce the burden on providers, payors, and TPAs, and require minimal rework once national standards are adopted. Stakeholders were generally supportive of the recommendations and most preferred voluntary adoption as opposed to legislation.

The workgroup recommended:

- requiring payors and TPAs to accept a single sign-on authority, designated by MHCC, for providers to access their prior-authorization websites or portals;

- following a phased approach from July 1, 2012, to July 1, 2013, for payors and TPAs to implement electronic prior-authorization requests;

- requiring payors and TPAs to report to MHCC on their implementation of electronic prior-authorization; and

- requiring providers to utilize an electronic prior-authorization process by January 1, 2015.

The bill implements three of the four recommendations of the workgroup, by establishing a phased approach for implementation of electronic prior-authorization requests, requiring reporting, and requiring providers to use an online prior-authorization process by July 1, 2015.

Additional Information

Prior Introductions: None.

Cross File: HB 470 (Delegate Tarrant, *et al.*) - Health and Government Operations.

Information Source(s): *Recommendations for Implementing Electronic Prior Authorizations: A Report Prepared for the Maryland General Assembly Joint Committee on Health Care Delivery and Financing*, Maryland Health Care Commission, December 2011; American Medical Association; Department of Budget and Management; Department of Health and Mental Hygiene; Maryland Insurance Administration; Department of Legislative Services

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