



Proposed Amendments COMAR 10.25.17

MARCH 19, 2026

Presentation Overview



- ▶ Federal and state level prior authorization reforms
- ▶ Maryland law
- ▶ Impact on care delivery
- ▶ Regulations
- ▶ Next steps

Setting the Stage – Prior Authorization Reform



Prior authorization reform is advancing through a combination of federal and state level policies that aim to improve access to care, promote transparency, and reduce administrative burden.

Key changes include process-oriented rules (e.g., shortening decision timeframes) and technical requirements to digitize prior authorizations within electronic health record (EHR) systems (e.g., real-time benefit checks).

Federal Rules



Advancing Interoperability and Improving Prior Authorization

- ▶ In January 2024, CMS finalized a rule that includes requirements for federally regulated payors to speed up and standardize the prior authorization process within EHR systems
 - Applies to medical items and services (not prescription drugs)
- ▶ Payor compliance timelines:
 - January 1, 2026 - non-technical provisions, including delivering prior authorization decisions within specified timeframes, reporting certain metrics, and providing reasons for a prior authorization denial
 - January 1, 2027 - technical provisions, including implementation of standards-based application programming interfaces (APIs) consisting of rules that enable software applications to communicate and exchange data securely
- ▶ Implementation of APIs requires technological and operational changes for payors and providers

See Appendix for more information on federal policy and initiatives

State Laws



- ▶ A growing number of states are adopting a wide array of approaches to support prior authorization reform
- ▶ Some legislative priorities center on:
 - Aligning use of APIs with federal standards and timelines (CA, CO, MN, OK, TN, WA)
 - Prohibiting the sole use of AI to deny, delay, or modify a health care service (AZ, CA, IL, MD, NE, TX)
 - Exploring programs that exempt certain providers from prior authorization requirements based on prior approval rates (“gold-carding”) (AR, CO, GA, IL, IN, LA, MI, NM, WV, TX, WY)
 - Promoting use of real-time benefit check tools at the point of prescribing (CO, CA, OH, MD, ME, TN, TX, VA)

Information was compiled from a scan of state laws conducted in 2025

Maryland Law



- ▶ Legislation enacted in 2012 required payors to implement electronic prior authorization processes in a phased approach*
 - The MHCC adopted COMAR 10.25.17 to support implementation of the law; all payors have complied
- ▶ A 2024 law** aims to advance electronic prior authorization
 - By July 1, 2026, payors must establish and maintain an online process that meets specified parameters
 - The MHCC is required to establish by regulation a waiver process for health care providers unable to access the online process

**See Appendix for information on four preauthorization benchmarks*

*** Chapter 848 (Senate Bill 791) and Chapter 847 (House Bill 932), Health Insurance - Utilization Review – Revisions (2024) – Other provisions pertain to health insurance utilization review, internal grievance and adverse decision procedures, payor reporting on adverse decisions, and the provision of patient benefit information*

Impact on Care Delivery

State-Mandated Online Process



- ▶ Supports fully electronic, standardized, real-time exchange of data within e-prescribing workflows
- ▶ Allows providers to obtain patient-specific information about prescription benefits, out-of-pocket costs, and prior authorization requirements before prescriptions are sent to a pharmacy
- ▶ Providers can submit and receive decisions faster, reducing administrative delays
- ▶ Patients benefit from faster access to needed treatments and real-time visibility into their out-of-pocket costs and lower-cost medication alternatives



Regulations

Informal Comments



- ▶ Draft amendments to COMAR 10.25.17 were released for informal public comment in October 2025
- ▶ Received 11 comment letters representing 25 organizations*
 - 8 comment letters representing 22 organizations generally support the amendments
- ▶ Note: The scope of the amendments was narrowed in the proposed regulations to technology implementation (Maryland Code, Health-General § 19-108.5)

**See Appendix for all organizations that submitted a comment letter*

Informal Comments

Narrowed Scope of Amendments



Category (Comment Letters)	Expressed Concern	Expressed Support	General Comment	Staff Action
Scope/purpose (3)	3	0	3	Clarified scope of the online process
Definitions (1)	0	0	1	Considered – no change required
Online process (2)	0	1	2	Considered – no change required
MHCC fining authority (2)	0	0	2	Considered – no change required

Snapshot – Proposed Amendments



- ▶ Add health care provider to the Chapter's scope – regulation .01
- ▶ Add new definitions for carrier, health care provider, and online process – regulation .02
- ▶ Require payors to implement and support technology for an online process consistent with legislation enacted in 2024 – regulation .03
- ▶ Add a new regulation for a waiver process for health care providers – regulation .06
- ▶ Clarify fining authority – regulation .07

Technology Requirements



- ▶ The proposed amendments require payors to implement an online process that meets specified parameters by July 1, 2026, consistent with Maryland law (2024)
 - Links to all e-prescribing and EHR systems using data exchange standards*
 - Accepts electronic prior authorization requests from a health care provider
 - Approves prior authorization requests when no additional information or clinical review is required, and that meet the payor's criteria for approval
 - Links directly to real-time patient out-of-pocket costs (i.e., copayment, deductible, and coinsurance) and more affordable medication alternatives at the point of prescribing

** Includes the NCPDP SCRIPT Standard and the NCPDP Real Time Benefit Standard*



Commission Action

Staff requests the Commission adopt COMAR 10.25.17 as proposed regulations

If approved, the proposed regulations are anticipated to be published in the May 1, 2026 edition of the Maryland Register for a 30-day public comment period through June 1, 2026





Appendix

Other Federal Rules

Improving Transparency in Prior Authorization and Access to Care



- ▶ In April 2023, CMS finalized a rule that requires Medicare Advantage plans to implement improvements to the prior authorization process starting in 2024 (CMS-4201-F)
 - Internal coverage criteria must be publicly available and based on current evidence in widely used treatment guidelines or clinical literature
 - Prior authorization requests must be reviewed by clinicians with relevant expertise and be valid for an entire course of approved treatment and during transitions to a new plan for at least 90 days

- ▶ In April 2025, CMS finalized a rule that further strengthens protections for consumers enrolled in or seeking coverage from Medicare Advantage plans in 2026 (CMS-4208-F)
 - Restricts plans from reopening and modifying previously approved prior authorizations for inpatient hospital decisions
 - Ensures the appeals process applies to any denial whether the decision is made before, during, or after care is received



A Call to Action

- ▶ In response to growing concerns that prior authorization delays patient access to care, AHIP* in collaboration with the federal government, implemented an initiative that aims to improve access to care and reduce administrative burdens for patients and providers
- ▶ More than 50 payors have voluntarily pledged a commitment to:
 - Standardize electronic prior authorization
 - Reduce the scope of claims subject to prior authorization
 - Ensure continuity of care when patients change plans
 - Enhance communication and transparency on determinations
 - Expand real-time responses
 - Ensure medical review of non-approved requests

**AHIP (America's Health Insurance Plans) is a national trade association representing numerous payers; <https://www.ahip.org/news/press-releases/health-plans-take-action-to-simplify-prior-authorization>*

Benchmarks, 2012



1. Provide online access to a listing of all medical services and pharmaceuticals that require preauthorization and the key criteria for making a preauthorization determination
2. Establish an online system to receive preauthorization requests electronically and assign a unique identification number to each request for tracking purposes
3. Ensure all electronic preauthorization requests for medical services and pharmaceuticals are approved within established timeframes
4. Provide online access to a listing of all medical services and pharmaceuticals that require preauthorization and the key criteria for making a preauthorization determination

Comment Letters – Organizations



1. American Clinical Laboratory Association
2. CareFirst
3. Inseparable
4. Kaiser Permanente
5. League of Life and Health Insurers of Maryland
6. Legal Action Center, AHEC West, Community Behavioral Health Association of Maryland, Disability Rights Maryland, The Greater Washington Society for Clinical Social Work, Institutes for Behavior Resources, The Kennedy Forum, Maryland Addiction Directors Council, Maryland Association for the Treatment of Opioid Dependence, Maryland Psychiatric Society, Inc., Maryland Psychological Association, Mental Health Association of Maryland, NAMI Maryland, NCADD Maryland, On Our Own of Maryland, Voices of Hope
7. NAMI Maryland
8. Maryland Hospital Association
9. MedChi, The State Medical Society and the Maryland Academy of Family Physicians
10. The Kennedy Forum
11. Total Health Care