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§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 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;

(4) On or before July 1, 2015, 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 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) 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 General Assembly on the attainment of the benchmarks for standardizing and automating the process required by payors for preauthorizing health care services.

(i) 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.

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