MARYLAND
HEALTH CARE
COMMISSION

State Regulated Payor & Pharmacy Benefit Manager

PREAUTHORIZATION BENCHMARK ATTAINMENT

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the Governor of Maryland and
the General Assembly

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Executive Summary

Use of electronic preauthorization produces administrative efficiencies in the preauthorization process, by eliminating paper-based processes and enabling the electronic submission of preauthorization requests via online portals or through electronic health networks[1] using national transaction standards (standards). Online portals are stand-alone web-based systems used to submit preauthorization requests electronically. Standards enable submission of preauthorization requests using patient data from an electronic health record (EHR) or standalone electronic prescribing (e-prescribing) system. Since use of standards is still undergoing evaluation by the health care industry, online portals are currently the most commonly available method to submit an electronic preauthorization request.

Maryland was one of the first states to require State-regulated payors (payors) and pharmacy benefit managers (PBMs) to implement electronic preauthorization processes. Health-General Article § 19-108.2 (2012)[2, 3] established three benchmarks that required payors and PBMs,[4] in a phased approach, to: (1) provide online access to a listing of all medical services and pharmaceuticals requiring preauthorization and the key criteria for making a preauthorization determination by October 1, 2012; (2) establish an online system to receive preauthorization requests electronically and assign a unique identification number to each request for tracking purposes by March 1, 2013; and (3) process all electronic preauthorization requests for pharmaceuticals in real-time or within one business day of receiving all pertinent information, and for non-urgent medical services, within two business days of receiving all pertinent information. In May 2014, the law was amended, adding a fourth benchmark that required payors and PBMs to establish a process to override a step therapy or fail-first protocol for preauthorization requests for pharmaceutical services by July 1, 2015.[5, 6]

Health care professionals' use of payors' and PBMs' online portals to submit electronic preauthorization requests for medical services has increased in Maryland since the program was launched in 2012; however, growth in electronic preauthorization for pharmaceuticals over the same period has been disappointing.[7] Electronic preauthorization for medical services increased from 22 percent in 2012 to 36 percent in June 2014; electronic preauthorization for

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[1] Electronic Health Networks (EHNs) are entities involved in the exchange of electronic health care transactions between EHNs, payors, providers, vendors, or other entities.
[2] See Appendix A.
[3] Code of Maryland Regulations (COMAR) 10.25.17. See Appendix B.
[4] Payors are insurers, nonprofit health services plans, or any other entity that provides health benefit plans subject to regulation by the State. Self-insured health care plans and government plans are exempt from State insurance regulation under the Employee Retirement Security Act of 1974 (ERISA). PBMs are identified based on their filing with the Maryland Insurance Administration.
[5] Step therapy or fail-first protocol is defined as a protocol established by an insurer, a nonprofit health service plan, or a health maintenance organization that requires a certain prescription drug or sequence of prescription drugs to be used by an insured individual or an enrollee before another specific prescription drug ordered by a prescriber is covered.
[6] See Appendix C for the status of payors' and PBMs' attainment of the preauthorization benchmarks.
[7] For purposes of this report, the term *health care professional* includes health care practitioners who are licensed to provide health care services in the State, as well as administrative staff that may also be involved in the process of submitting and monitoring the status of preauthorization requests.

pharmaceuticals has consistently remained below one percent since 2012. Vendors offering preauthorization services suggest that low usage of the online portals may be attributed to the online portals not being part of existing clinical workflow processes. The implementation of a standard by the National Council for Prescription Drug Programs (NCPDP ePA standard) will enable submission of electronic preauthorization requests through EHRs and standalone e-prescribing systems. Maryland law permits utilization of a standard once established and adopted by the health care industry, as determined by MHCC.[8]

Maryland law requires providers to utilize the electronic preauthorization systems or standards by July 1, 2015. The law also requires the establishment of a provider waiver process for reasons such as low patient volume or lack of broadband Internet access. Stakeholders have deployed a variety of marketing strategies in an effort to promote awareness about the availability of their online portals. In general, their marketing strategies have included training sessions, followed by communications on payors' and PBMs' websites, newsletters, and faxes.[9] Because the effectiveness of these marketing strategies has not yet been fully determined, MHCC cannot assess usability or make recommendations for improving the online portals at this time. Preliminary feedback obtained from interviews of users indicates that they find the online portals convenient to use and appreciate the elimination of filling out paper forms and waiting on hold for a decision to be made.

Background

Preauthorization

Preauthorization is required by State-regulated payors (payors) and pharmacy benefit managers (PBMs) before certain health care services can be rendered.[10] Preauthorization aims to ensure patients are receiving the most cost-effective and appropriate treatment; for example, preauthorization for certain pharmaceutical services may be required due to the availability of low-cost generic alternatives, age restrictions, or prescriptions for higher than normal dosages. Traditionally, the preauthorization process has varied across payors and PBMs, relying heavily on paper forms, faxes, and phone calls. Additionally, providers have generally reported that the preauthorization process is burdensome and that necessary follow-up activities are time consuming.[11]

Improving the preauthorization process requires collaboration among all stakeholders – payors, vendors, health care professionals,[12] and policymakers. Over the last several years, the health care industry has been working to create administrative efficiencies in the preauthorization process by eliminating paper-based processes and enabling health care professionals to submit and track

[8] For more historical information on the development of standards, please refer to the Background section of this report.
[9] See Appendix H for information on payor and PBM marketing strategies.
[10] COMAR 10.25.17.02B(5). See Appendix B. Preauthorization determines insurance coverage and eligibility for certain pharmaceuticals and medical services and sometimes involves a decision of medical necessity.
[11] MedChi, The Maryland State Medical Society, *Prior Authorization: Impact on Patient Care in Maryland*, a survey of the members, July 2011. Available at: www.medchi.org/sites/default/files/MedChi%20Prior%20Authorization%20Survey%202011.pdf.
[12] See n.7, *supra.*

preauthorization requests electronically. There are typically two ways for health care professionals to submit electronic preauthorization requests:

1) Online portals, where health care professionals use the Internet to access a webpage, log in, type and/or search for patient information, and then submit the preauthorization request electronically; or

2) Electronic transaction standards[13] (standards) that allow health care professionals to submit a preauthorization request directly from an electronic health record (EHR) or standalone electronic prescribing (e-prescribing) system.[14]

Online portals are currently the most commonly available method to submit a preauthorization request electronically, as use of standards is still being evaluated by the industry. Since online portals operate as standalone systems, the health care industry has been developing methods to increase the availability and use of standards, which allow health care professionals using EHRs or standalone e-prescribing systems to incorporate the preauthorization process into clinical workflows. These standards enable health care professionals to electronically transmit a preauthorization request from their EHR or standalone e-prescribing system directly to the payor or PBM.

The first electronic transaction standard developed for preauthorization was the American National Standards Institute Accredited Standards Committee 278 standard (278 standard). The Health Insurance Portability and Accountability Act of 1996 (HIPAA) Administrative Simplification Rules currently require the use of the 278 standard by January 1, 2016 for medical service and pharmaceutical preauthorization requests. In 2006, use of the 278 standard for pharmaceutical preauthorization was tested in four pilots. The pilots determined that the 278 standard was burdensome, inefficient, and transmitted duplicative information, because the 278 standard was designed for medical service preauthorization requests, not pharmaceutical preauthorization requests.[15]

In 2008, the Centers for Medicare and Medicare Services Office of eHealth Standards and Services convened a panel that recommended a new standard be developed for pharmaceutical preauthorization. From 2009 through July 2013, the National Council for Prescription Drug Programs (NCPDP) worked with the industry to develop a preauthorization standard for pharmaceuticals only (NCPDP ePA standard). In May 2014, a letter was submitted to the Department of Health and Human Services requesting that the HIPAA Administrative Simplification Rules be modified to permit use of the NCPDP ePA standard for pharmaceutical preauthorizations

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[13] Certain transactions involving the electronic transfer of information between two parties for specific purposes must use adopted standards, specifically ASC X12N (for medical and pharmaceutical services) or NCPDP (for certain pharmaceuticals services only). For more information, visit: www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/TransactionCodeSetsStands/index.html?redirect=/TransactionCodeSetsStands/.

[14] In 2012, approximately 87 percent of electronic prescribers used the system associated with their EHR systems rather than standalone e-prescribing software applications. NCPDP, *Challenges and Opportunities for Stakeholders Regarding ePrescribing Technologies and Formulary Compliance*, August 2013. Available at: www.ncpdp.org/NCPDP/media/pdf/wp/ePrescribingTechnologiesandFormularyCompliance.pdf.

[15] Point-of-Care Partners, *Electronic Prior Authorization: Navigating the Regulatory Minefield*, November 2013. Available at: pocp.com/blog/electronic-prior-authorization-navigating-the-regulatory-minefield/.

and is awaiting a response.[16] Additional research is needed to identify the best method for submitting electronic preauthorization requests.

Maryland's Progress

In 2012, Maryland became one of the first states to require payors and PBMs to implement electronic preauthorization processes in a phased benchmark approach. The requirements were based on recommendations from MHCC's 2011 stakeholder workgroup.[17] The recommendations, if implemented, were intended to reduce the administrative burden on health care professionals, payors, and PBMs, resulting from traditional paper-based preauthorization processes. In general, the workgroup proposed that MHCC work with payors and PBMs to implement three benchmarks:

1) Provide by October 1, 2012 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 by March 1, 2013 an online system to receive preauthorization requests electronically and assign a unique identification number to each request for tracking purposes; and

3) Ensure by July 1, 2013 that all electronic preauthorization requests for pharmaceuticals are approved in real-time or within one business day of receiving all pertinent information, and for non-urgent medical services, within two business days of receiving all pertinent information.[18, 19]

Amendments to the law enacted in 2014, require payors and PBMs to implement a fourth benchmark by July 1, 2015 that gives health care professionals the ability to override a step therapy or fail-first protocol when submitting an electronic preauthorization request.[20, 21] In addition, the law requires that by July 1, 2015 , a provider must utilize the electronic preauthorization systems established by payors and PBMs, or, if the Commission determines that a standard has been established and adopted by the health care industry, the provider's practice management, EHR, or e-prescribing system.[22]

Payors and PBMs operating in the State have done a laudable job in implementing the preauthorization benchmarks. All payors and PBMs are currently in compliance with the law.[23]

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[16] In May 2014, the National Committee on Vital and Health Statistics (NCVHS) sent a letter to the Secretary of the Department of Health and Human Services (HHS) requesting HHS to name the NCPDP standard as the adopted standard for pharmaceutical preauthorizations. *Letter from NCVHS to HHS*. May 15, 2014, available at: www.ncvhs.hhs.gov/140515lt2.pdf.

[17] MHCC, *Recommendations for Implementing Electronic Prior Authorizations*, December 2011. Available at: mhcc.maryland.gov/mhcc/pages/hit/hit/documents/HIT_Recommend_Implement_Electronic_Prior_Auth_Rpt_20111201.pdf.

[18] Md. Code Ann., Health-Gen. § 19-108.2 (2012). See Appendix A.

[19] COMAR 10.25.17. See Appendix B.

[20] See n. 4, *supra*, for a definition of step therapy or fail-first protocol.

[21] *Health Insurance – Step Therapy or Fail-First Protocol*, Senate Bill 622 (Chapter 316) (2014 Regular Session)

[22] Md. Code Ann., Health-Gen. §19-108.2 (2012). See Appendix A.

[23] Some payors and PBMs have requested and have been granted waivers from meeting certain benchmarks under certain extenuating circumstances outlined in the law.

The law requires MHCC to report to the Governor and General Assembly annually from 2012 through 2016 on payors' and PBMs' progress in implementing the law. Previous reports focused on payor and PBM implementation of electronic preauthorization technology; this report aims to assess opportunities to expand the usage of electronic preauthorization systems among health care professionals.

The MHCC collected payor and PBM data on usage of their electronic preauthorization systems via online questionnaires, which were customized based on payors' and PBMs' status in implementing the preauthorization benchmarks in the prior year assessment. Payors and PBMs also reported the volume of preauthorization requests (electronic and non-electronic) received, usability features of their online preauthorization systems, and current or planned marketing efforts to health care professionals in Maryland to promote the adoption and use of their online portals.[24, 25]

Limitations

This report includes self-reported information as of August 2014 that was obtained via online questionnaires and phone interviews with payors, PBMs, health care professionals, and select companies offering electronic preauthorization services nationally. Information collected from payors and PBMs was not audited by MHCC. This report does not include an in-depth workflow assessment on the impact of online portals.

Electronic Preauthorization National Market Assessment

Industry Update/Challenges

The health care industry continues to work toward the adoption of electronic preauthorization processes. Nationally, eight preauthorization vendors work with payors and PBMs to provide access to an online portal.[26] An environmental scan of the largest national payors and PBMs found that approximately 31 payors and PBMs have either worked with one of these preauthorization vendors or developed their own online portals to accept preauthorization requests electronically. The MHCC identified the following challenges with electronic preauthorization processes.[27]

E-Prescribing Process and Vendor Variations

Electronic prescriptions can be generated and transmitted to pharmacies using EHRs or standalone e-prescribing systems. This method may use patient data from an EHR or standalone e-prescribing system and/or present a set of questions regarding the patient that a health care professional can answer within their EHR or standalone e-prescribing system. E-prescribing enables providers to:

1) Check eligibility and coverage information to ensure the selected medication is covered by the patient's drug benefit plan;

[24] See Appendix E for a copy of the reporting tool distributed to payors and PBMs.
[25] Payors and PBMs that have received waivers for reasons such as low premium/patient volume in Maryland were not asked to respond to the 2014 assessment. See Appendix F for information on the payor and PBM waiver process, including those payors and PBMs that have received waivers.
[26] See Appendix G for information on select national vendors offering electronic preauthorization services.
[27] These challenges were identified during MHCC staff interviews with vendors that are implementing the electronic preauthorization standards.

2) View a patient's medication history by electronically requesting historical information from payors, PBMs, and pharmacies; and

3) Transmit the electronic prescription to the patient's pharmacy.

Several challenges exist with the e-prescribing and preauthorization process. As of 2013, there were over 500 EHR and standalone e-prescribing vendors, and each vendor displays the same payor or PBM drug formulary a different way. The absence of standards for presenting drug formulary content in an EHR or standalone e-prescribing system poses challenges to prescribers in identifying whether a medication is a covered benefit and if so, whether preauthorization is required.[28] In addition, there is no consistency in how vendors use terminology (e.g., prior authorization, preauthorization, step therapy, or fail-first) or list pharmaceuticals (e.g., by brand name, cost, or generic).

Real-Time Benefit Check Inaccuracies

When a medication is selected by a health care professional using an EHR or standalone e-prescribing system, a drug formulary inquiry is sent to the payor or PBM to determine coverage and preauthorization requirements. Drug formulary inquiry functionality has been available since about 2009 and relies on payors and PBMs sharing current drug formulary information with preauthorization vendors such as Surescripts or CoverMyMeds. While Medicare plans are required to share current drug formulary information with preauthorization vendors, payors and PBMs are not required to provide the same information for non-Medicare patients.

As a result of not having up-to-date information on drug formularies, real-time benefit check inaccuracies result in the NCPDP ePA standard[29] not always functioning successfully within an EHR or standalone e-prescribing system. In fact, one national preauthorization vendor estimated that the benefit check is only 40 percent accurate.[30] Thus, one of the main challenges with both the drug formulary inquiry and the real-time benefit check is that it has not historically proven to be accurate.

Competing Priorities

Preauthorization vendors are working with EHR and e-prescribing vendors to implement the standards for preauthorization. However, due to competing priorities, implementation of the standards has been a slow process. In general, EHR and e-prescribing vendors have been focused on ICD-10[31] implementation and Meaningful Use certification,[32] which do not currently require

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[28] NCPDP, *Challenges and Opportunities for Stakeholders Regarding ePrescribing Technologies and Formulary Compliance*, August 2013. Available at: www.ncpdp.org/NCPDP/media/pdf/wp/ePrescribingTechnologiesandFormularyCompliance.pdf.

[29] The MHCC notes that the NCPDP ePA standard is in the initial stages of implementation by the health care industry.

[30] The 40 percent estimate is based on feedback from providers to a national company that facilitates the real-time benefit check.

[31] The International Statistical Classification of Diseases and Related Health Problems (ICD) is the standard diagnostic tool for epidemiology, health management and clinical purposes. An ICD-10 code set was established to replace the ICD-9 code set; the health care industry must comply with ICD-10 by October 1, 2015. For more information visit: www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-

electronic preauthorization. Preauthorization vendors indicated that 2015 may be the earliest that EHR and e-prescribing vendors will be able to implement the standards into their products and interface with electronic preauthorization vendors to transmit prescriptions. NCPDP anticipates that it could take health care organizations up to 24 months to implement the ePA standard.[33]

Implementation of standards in EHR and standalone e-prescribing systems could have an impact on the use of payor and PBM online portals, as providers will have the ability to submit preauthorization requests from their EHRs or standalone e-prescribing systems. More time is needed to determine whether EHR or standalone e-prescribing systems will adopt the standards and if there will be a cost to providers to upgrade their EHRs and/or standalone e-prescribing systems to utilize the standards.

Workflow Compatibility

Preauthorization vendors noted that electronic preauthorization needs to be easily incorporated into clinical workflows to be successful, and that this can be technically challenging to accomplish. It requires EHR and e-prescribing vendors' engagement to ensure that any new elements added to the workflow are compatible and do not create a burden on health care professionals. Preauthorization vendors providing online portals indicated that utilization might not be as high as expected due to the online portals not being part of existing workflow processes.

Key Findings on State Legislation

Twenty states, including Maryland, have passed legislation on electronic preauthorization, and seven states have pending legislation.[34] A review of all states' legislation (passed and pending) revealed the following:

- The majority of states with electronic preauthorization legislation have focused on legislation concerning pharmaceutical preauthorizations, with only eight states addressing medical service preauthorizations;
- Many states require that a uniform preauthorization form be used by health care professionals to collect standard information, regardless of the medical service or

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practice/coding-billing-insurance/hipaahealth-insurance-portability-accountability-act/transaction-code-set-standards/icd10-code-set.page.

[32] The federal EHR Incentive Programs offer financial incentives to eligible providers, hospitals, and critical access hopsitals as they adopt and implement certified EHR technology. Certified EHR technology, which meets federal criteria and standards, first became available in 2011 as required by meaningful use. There are three stages of meaningful use that include a series of measures that must be met in order to qualify for an incentive payment. For more information, visit: www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Getting_Started.html.

[33] Managed Healthcare Executive, *Real time prior auth standards approved*, July 2013. Available at: managedhealthcareexecutive.modernmedicine.com/managed-healthcare-executive/news/real-time-prior-auth-standards-approved?contextCategoryId=39.

[34] While the state of New York has already passed legislation on preauthorization, new legislation regarding the assignment of a unique identification number is currently pending. For purposes of this assessment, New York is included in the count of 20 states that have passed some form of preauthorization legislation.

pharmaceutical being requested.[35] In 2011, Maryland decided against the adoption of a uniform preauthorization form.[36]

- Many states have set timeframes in which a preauthorization request must be approved or denied, with the shortest timeframe being one business day for an expedited request, and the average timeframe being two business days. Maryland is the only state to require real-time approvals, specifically for electronic pharmaceutical preauthorization requests.
- Maryland and Louisiana are the only two states that have enacted legislation pertaining to a step-therapy override;[37] both were passed in 2014.
- Maryland is the only state that mandates use of electronic preauthorization processes in July 2015.[38]

Attainment of Preauthorization Benchmarks

The following payors and PBMs have implemented the first three benchmarks as required by law: Aetna, Inc.; CareFirst BlueCross BlueShield; Cigna Health and Life Insurance Company/Connecticut General Life Insurance Company; Coventry Health Care of Delaware, Inc.; UnitedHealthcare;[39] CVS Caremark; Envision Pharmaceutical Services, Inc.; and Express Scripts, Inc.[40, 41] Four payors and PBMs indicated they have implemented the fourth benchmark that was added following 2014 amendments to the law, which require payors and PBMs to establish a process by July 1, 2015 allowing providers to override a step therapy or fail-first protocol.[42, 43] In 2015, MHCC will audit payors' and PBMs' override processes to ensure compliance with the law.

[35] Uniform preauthorization forms may be utilized for paper or electronic preauthorization requests.
[36] The 2011 Preauthorization Workgroup concluded that using a standardized form might increase the odds that a request for follow-up information will be needed, which can make the process more burdensome for all stakeholders, including providers. For a further discussion on uniform preauthorization forms for Maryland, see MHCC's report, *Recommendations for Implementing Electronic Prior Authorizations*. Available at: mhcc.maryland.gov/mhcc/pages/hit/hit/documents/HIT_Recommend_Implement_Electronic_Prior_Auth_Rpt_20111201.pdf.
[37] Effective January 2014, Louisiana requires a step-therapy override for Medicaid preauthorizations under three circumstances: (1) physician demonstrates the preferred therapy has been ineffective; (2) physician demonstrates that the preferred therapy would be ineffective based on the patient's other medical conditions; or (3) physician demonstrates the preferred therapy would cause an adverse reaction.
[38] See Appendix I for information on electronic preauthorization legislation among states.
[39] For this report, UnitedHealthcare companies include: UnitedHealthcare Optum Rx, Behavioral Health, and Choice/Choice Plus.
[40] See Appendix C for information on the status of payors and PBMs attainment of the preauthorization benchmarks.
[41] See Appendix D for information on payors and PBMs implementation of preauthorization phase 1 and 2 benchmarks.
[42] Md. Code Ann., Health-General Article §19-108.2 (2012). Refer to Appendix A.
[43] Only payors and PBMs offering coverage for pharmaceutical services that require step therapy or a fail-first protocol are required to comply with the fourth benchmark.

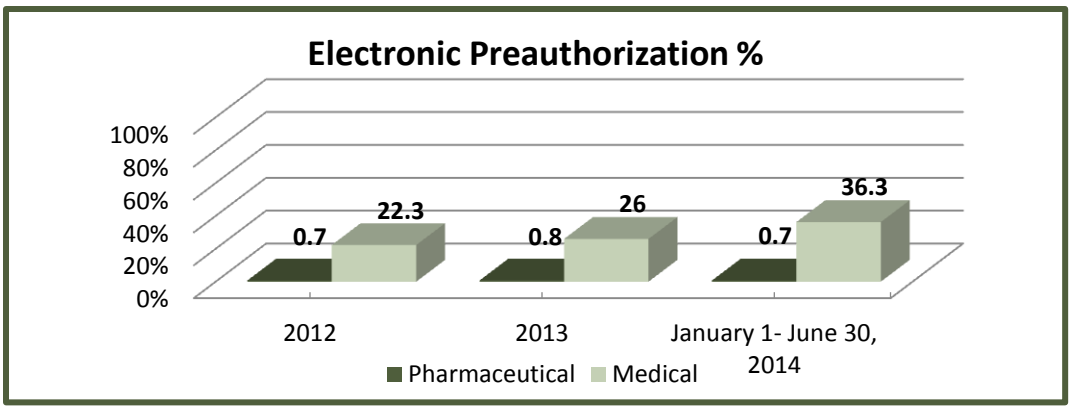
Step Therapy/Fail-First Protocol		
Payor/PBM	***Step therapy or fail-first protocol required?***	***Status of implementing step therapy or fail-first protocol override***
Aetna, Inc.	Yes	Assessing
CareFirst BlueCross BlueShield	Yes	Assessing
Catamaran	Yes	Plan to seek waiver
Cigna Health and Life Insurance Company/Connecticut General Life Insurance Company Pharmaceutical Services	Yes	Implemented
Coventry Health Care of Delaware, Inc.	Yes	Implemented
CVS Caremark	Yes	Implemented
Envision Pharmaceutical Services, Inc.	Yes	Implemented
Express Scripts, Inc.	Yes	Assessing
UnitedHealthcare OptumRx	Yes	Assessing

Electronic Preauthorization Volume

In response to MHCC's request, payors and PBMs reported the following information: total estimated number of medical and pharmaceutical claims; total estimated number of medical and pharmaceutical preauthorization requests (submitted via electronic and paper-based processes) and the estimated percentage of preauthorization requests submitted electronically. This information was used to assess utilization of payors and PBMs online portals to submit preauthorization requests electronically. Since 2012, electronic medical service preauthorization requests have increased, whereas electronic pharmaceutical preauthorization requests have remained below one percent. One PBM indicated that this may be due to limited integration of preauthorization processes into the e-prescribing workflow.

EHR and e-prescribing vendors need to incorporate a process into the e-prescribing workflow to verify if preauthorization is required for pharmaceuticals. The ability for health care professionals to prospectively identify at the point of care whether a prescription requires preauthorization can improve workflow efficiencies and benefit providers, payors, PBMs, pharmacies, and patients. The development of national standards, specifically the NCPDP ePA standard, offers a solution to enable real-time communications between EHR and standalone e-prescribing systems and payors and PBMs.[44] The following graph illustrates the percent of preauthorizations submitted electronically for medical services and pharmaceuticals from January 2012 through June 2014.[45, 46]

[44] Healthcare Information and Management Systems Society (HIMSS), Electronic Prior Authorization: The e-prescribing capabilities doctors have been waiting for has arrived, June 2014. Available at: www.himsswire.com/article/completepa/electronic_prior_authorization_e-prescribing_capabilities_doctors_have_been_waiti.
[45] Detailed data used to calculate electronic preauthorization percentages is available upon request.



Preauthorization by Provider Specialty

Payors and PBMs were asked to identify provider specialties that submitted the highest volume of preauthorization requests in 2013; a wide range of responses were received. The three provider specialties most frequently reported by payors and PBMs as having a high volume of preauthorizations include: (1) internal medicine; (2) family medicine; and (3) psychiatry. Other specialties frequently reported as submitting a high volume of preauthorization requests include obstetrics/gynecology, dermatology, and physical therapy.

Online Portal Usability Assessment

Payor and PBM Feedback

Payors and PBMs identified the most common types of troubleshooting inquiries received. Troubleshooting inquiries were limited, which may be due to the online portals being intuitive to use or because of the low volume of health care professionals currently using the online portals. To determine if barriers exist regarding access to the online portals, MHCC staff asked payors and PBMs to provide information on who is allowed to access their online portals to submit preauthorization requests. All payors and PBMs indicated that physicians and their support staff can access the online portals.

Payor and PBM Online Portal Usability Evaluation

Payor/PBM	***Most common types of troubleshooting inquiries***	***Out-of-network providers can obtain access to the portal***
Aetna, Inc.	N/A	Yes
CareFirst BlueCross BlueShield	General clinical questions and Internet Explorer compatibility view issues	Yes
Cigna Health and Life Insurance Company/Connecticut General Life Insurance Company Medical Services	Member eligibility and updating provider data online	Yes

[46] See Appendix J for information on the total number of preauthorizations and percentage submitted electronically in calendar year 2013 and from January 1, 2014 through June 30, 2014.

Payor and PBM Online Portal Usability Evaluation		
Payor/PBM	***Most common types of troubleshooting inquiries***	***Out-of-network providers can obtain access to the portal***
Cigna Health and Life Insurance Company/Connecticut General Life Insurance Company Pharmaceutical Services	None Reported	Yes
Coventry Health Care of Delaware, Inc.	None Reported	Yes
UnitedHealthcare Behavioral Health	Member not found and whether preauthorization is required	No
UnitedHealthcare Choice and Choice Plus	Difficulty finding a physician/facility; why system indicates that preauthorization is not required; system did not provide a reference number	Yes
CVS Caremark	None Reported	Yes
Envision Pharmaceutical Services, Inc.	None Reported	Yes
United Healthcare OptumRx	None Reported	Yes

Health Care Professional Feedback

To assess payor and PBM electronic preauthorization marketing strategies, MHCC interviewed approximately 18 health care professionals who use the online portals.[47] The health care professionals interviewed were asked two questions: 1) how they were informed about the availability of payors or PBMs online portals; and 2) what prompted them to use the online portal instead of submitting preauthorizations via fax or phone. In general, health care professionals provided the following observations:

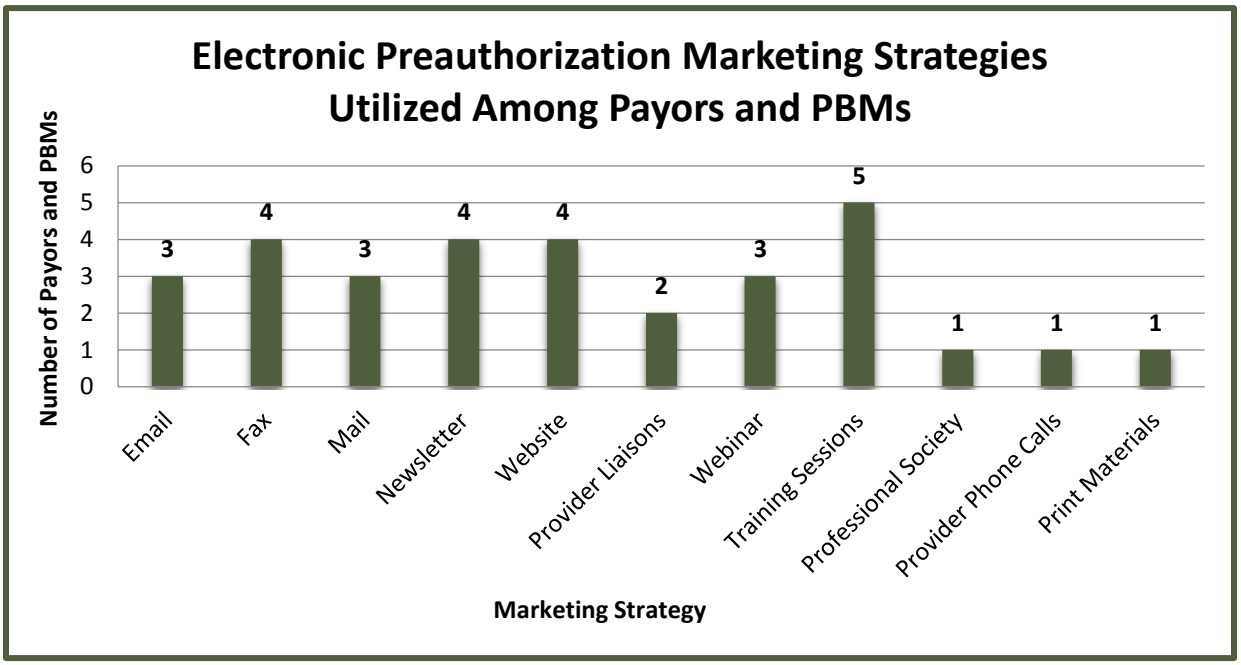
- The majority of interviewees indicated they heard about payors' and PBMs' online portals through a colleague or that the online portals were already being used by the practice.
- Two interviewees indicated they heard about the online portals via on-hold messages when calling a payor or PBM.
- The most common benefit of using the online portals was the ability for a determination to be rendered in real-time.

Payor and PBM Marketing Efforts

Payors and PBMs reported their marketing strategies to promote the availability of their online portals. Nearly all payors and PBMs have deployed one or more marketing strategy. The most

[47] Payors and PBMs provided a list of at least five references that have utilized their online preauthorization systems. The MHCC contacted the references and when available, spoke with a practice manager or other staff member who had experience using the online portals.

commonly utilized marketing approaches were training sessions, followed by faxes, newsletters, and websites.[48]



Increasing Provider Awareness

The MHCC convened a workgroup of payors, PBMs, and MedChi, The Maryland State Medical Society, on August 15, 2014, to discuss plans and initiatives for increasing awareness about the online portals. The workgroup concluded that adoption of a consistent message by payors and PBMs informing health care professionals about the pending July 1, 2015 requirement to use the online portals would be valuable. Payors and PBMs that participated in the workgroup agreed to assess the feasibility of incorporating the consistent message into on-hold messages and on confirmations of receipt, approval, and denial for preauthorization requests submitted by fax and mail. Draft language was considered by the workgroup.[49] As of October 2014, payors and PBMs are reviewing the feasibility of incorporating the message, specifically in communications to Maryland health care professionals. UnitedHealthcare stated that it will incorporate the message on outgoing faxes for preauthorization. CareFirst is undecided as it is trying to identify a way to notify only the targeted health care professional population in Maryland; CareFirst did indicate plans to incorporate a similar notice if the consistent message cannot be adopted. Cigna indicated that it will not adopt the message as it is unable to identify a way to reach the targeted health care professional population in Maryland. All other payors and PBMs were unresponsive to repeated inquiries about their plans to adopt the consistent message.

[48] See Appendix H for information on payor and PBM marketing strategies.
[49] See Appendix K for the draft language as proposed by the workgroup.

Next Steps

Stakeholders will need to continue increasing awareness about the requirement for providers to utilize the online portals or a standard once adopted by the health care industry by July 1, 2015. Payors and PBMs have done a laudable job implementing the first three preauthorization benchmarks; implementing a consistent message will require collaboration amongst all stakeholders going forward. Over the next year, MHCC will assess payors' and PBMs' implementation of the fourth benchmark. In the 2015 *Preauthorization Benchmark Attainment* report, MHCC will further explore policy considerations to advance the adoption of electronic preauthorization.

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UnitedHealthcare Behavioral Health
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UnitedHealthcare OptumRx
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Appendix A: Md. Code Ann., Health-Gen § 19-108.2

Md. Health-General Code Ann. § 19-108.2[50]

Health – General

Title 19. Health Care Facilities

Subtitle 1. Health Care Planning And Systems Regulation

Part I. Maryland Health Care Commission

Begin quoted text

§ 19-108.2. Benchmarks for preauthorization of health care services.

(a) Definitions. --

(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 general. -- 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) Elements. -- The benchmarks described in subsection (b) of this section shall include:

[50] Annotated Code of Maryland. Copyright 2012 by Matthew Bender and Company, Inc., a member of the LexisNexis Group. All rights reserved.

(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, 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) Applicability. -- 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) Online preauthorization system to provide notice. -- 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) Waivers. --

(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) Multistakeholder workgroup. --

(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) Reports to Commission by payors; criteria. --

(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) Commission reports. --

(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 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 General Assembly on the attainment of the benchmarks for standardizing and automating the process required by payors for preauthorizing health care services.

(j) Regulations. -- 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.

HISTORY: 2012, chs. 534, 535.

End quoted text

Appendix B: COMAR 10.25.17

Subtitle 25 MARYLAND HEALTH CARE COMMISSION

10.25.17 Benchmarks for Preauthorization of Health Care Services

Authority: Health-General Article, §§19-101 and 19-108.2, Annotated Code of Maryland

.01 Scope.

A. This chapter applies to a payor that:

(1) Requires preauthorization for health care services; and

(2) Is required to report to the Maryland Health Care Commission (Commission) on or before certain dates on its attainment and plans for attainment of certain preauthorization benchmarks.

B. This chapter does not apply to a pharmacy benefits manager that only provides services for workers' compensation claims pursuant to Labor and Employment Article, §9-101, et seq., Annotated Code of Maryland, or for personal injury protection claims pursuant to Insurance Article, §19-101, et seq., Annotated Code of Maryland.

.02 Definitions.

A. In this chapter, the following terms have the meanings indicated.

B. Terms Defined.

(1) "Commission" means the Maryland Health Care Commission.

(2) "Executive Director" means the Executive Director of the Commission or the Executive Director's designee.

(3) "Health Care Service" has the meaning stated in Insurance Article, §15-10A-01, Annotated Code of Maryland.

(4) "Payor" means one of the following State-regulated entities that require preauthorization for a health care service:

(a) 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;

(b) 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

(c) A pharmacy benefits manager that is registered with the Maryland Insurance Commissioner, except for a pharmacy benefits manager that only provides services for workers' compensation claims pursuant to Labor and Employment Article, §9-101, et seq., Annotated Code of Maryland, or for personal injury protection claims pursuant to Insurance Article, §19-101, et seq., Annotated Code of Maryland.

(5) "Preauthorization" means the process of obtaining approval from a payor by meeting certain criteria before a certain health care service can be rendered by the health care provider.

.03 Benchmarks.

A. On or before October 1, 2012, each payor shall establish online access for a provider to the following:

(1) A list of each health care service that requires preauthorization by the payor; and

(2) Key criteria used by the payor for making a determination on a preauthorization request.

B. On or before March 1, 2013, or another date established by the Commission, in consultation with its multistakeholder workgroup and published in the Maryland Register, each payor shall establish an online process for:

(1) Accepting electronically a preauthorization request from a provider; and

(2) 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.

C. On or before July 1, 2013, or another date established by the Commission, in consultation with its multistakeholder workgroup and published in the Maryland Register, each payor shall establish an online preauthorization system that meets the requirements of Insurance Article, §19-108.2(e), Annotated Code of Maryland, to approve:

(1) In real time, electronic preauthorization requests for pharmaceutical services:

(a) For which no additional information is needed by the payor to process the preauthorization request; and

(b) That meet the payor's criteria for approval;

(2) Within 1 business day after receiving all pertinent information on requests not approved in real time, electronic preauthorization requests for pharmaceutical services that:

(a) Are not urgent; and

(b) Do not meet the standards for real-time approval under item (1) of this item; and

(3) Within 2 business days after receiving all pertinent information, electronic preauthorization requests for health care services, except pharmaceutical services, that are not urgent.

D. A payor that becomes authorized to provide benefits or services within the State of Maryland after October 1, 2012, shall meet each benchmark in Regulation .03B of this chapter within 3 months of the payor's offering of services or benefits within the State.

.04 Reporting.

A. On or before March 1, 2013, a payor shall report to the Commission in a form and manner specified by the Commission on:

(1) The status of the payor's attainment of the benchmarks in Regulation .03A and B of this chapter; and

(2) An outline of the payor's plans for attaining the benchmark in Regulation .03C of this chapter.

B. On or before December 1, 2013, a payor shall report to the Commission in a form and manner specified by the Commission on the payor's attainment of the benchmarks in Regulation .03C.

.05 Waiver from Benchmark Requirement.

A. A payor may request that the Commission issue or renew a waiver from the requirement to meet a benchmark in Regulation .03B of this chapter by the demonstration of extenuating circumstances, including:

(1) For an insurer or nonprofit health service plan, a premium volume that is less than $1,000,000 annually in the State;

(2) For a group model health maintenance organization, as defined in Health-General Article, §19-713.6, Annotated Code of Maryland, preauthorizations of health care services requested by providers not employed by the group model health maintenance organization; or

(3) Other circumstances determined by the Executive Director to be extenuating.

B. Submission of Request for Waiver or Renewal of Waiver.

(1) A request for a waiver or renewal of waiver shall be in writing and shall include:

(a) A description of each preauthorization benchmark for which a waiver is requested; and

(b) A detailed explanation of the extenuating circumstances necessitating the waiver.

(2) A request for a waiver shall be filed with the Commission in accordance with the following:

(a) For the benchmark in Regulation .03A of this chapter, no later than 30 days after the effective date of this chapter;

(b) For benchmarks in Regulation .03B and C of this chapter, no later than 60 days prior to the compliance date; or

(c) For renewal of a waiver, no later than 45 days prior to its expiration.

(3) For a payor that becomes authorized to provide benefits or services within the State of Maryland after October 1, 2012, within 30 days after the date the payor is authorized to provide benefits or services within the State.

C. Issuance of Waivers.

(1) The Executive Director may issue a waiver from a preauthorization benchmark to a payor that demonstrates extenuating circumstances within this chapter.

(2) The Executive Director will review and provide a decision on all waiver requests within a reasonable timeframe.

(3) A waiver or renewal of a waiver shall be valid for 1 year, unless withdrawn by the Executive Director, after notice to the payor.

D. Review of Denial of Waiver.

(1) A payor that has been denied a waiver may seek Commission review of a denial by filing a written request for review with the Commission within 20 days of receipt of the Executive Director's denial of waiver.

(2) The full Commission may hear the request for review directly or, at the discretion of the Chair of the Commission, appoint a Commissioner to review the request, who will make a recommendation to the full Commission.

(3) The payor may address the Commission before the Commission determines whether or not to issue a waiver after a request for review of denial of waiver by the Executive Director.

E. A waiver or renewal of waiver from the requirements of this chapter may not be sold, assigned, leased, or transferred.

.06 Fines.

A payor that does not meet the reporting requirements of this chapter may be assessed a fine in accordance with COMAR 10.25.12.01, et seq.

CRAIG P. TANIO, M.D.
Chair
Maryland Health Care Commission

Appendix C: Payor and PBM Attainment of the Electronic Preauthorization Benchmarks

Payor and PBM Attainment of the Electronic Preauthorization Benchmarks							
Payor	**Benchmark 1 - Oct 2012**	**Benchmark 2 - March 2013**		**Benchmark 3 - July 2013**			**Benchmark 4 - January 2015**
	Online Access to a Listing of all Pharmaceutical and Medical Services Requiring Preauthorization and Key Criteria for Making a Preauthorization Determination on	***Accept Preauthorization Requests Electronically***	***Assign a Unique ID Number to Electronic Preauthorization Requests***	***Approve in Real-time Complete Preauthorization Requests for Pharmaceuticals***	***Approve Within One Business Day of Receiving all Pertinent Information Preauthorization Requests for Pharmaceuticals Not Approved in Real-time***	***Approve Within Two Business Days of Receiving all Pertinent Information Preauthorization Requests for non-urgent Medical Services***	***Allow for Override of Step Therapy or Fail-First Protocol for Pharmaceutical Preauthorization Requests***
Aetna, Inc. Medical Services	✓	✓	✓	✓	✓	✓	*
CareFirst BlueCross BlueShield	✓	✓	✓	✓	✓	✓	*
Cigna Health and Life Insurance Company/ Connecticut General Life Insurance Company	✓	✓	✓	✓	✓	✓	✓
Coventry Health Care of Delaware, Inc.	✓	✓	✓	✓	✓	✓	✓
UnitedHealthcare Behavioral Health	✓	✓	✓	*Pharmaceutical service requests are not applicable to this payor*		✓	*Step therapy requirements are not applicable to this payor*
UnitedHealthcare Choice/Choice Plus	✓	✓	✓			✓	
UnitedHealthcare MIPA/OCI	✓	✓	✓			✓	
PBM							
Catamaran	✓	▲	▲	▲	▲	*Medical service requests are not applicable to PBMs*	●
CVS Caremark	✓	✓	✓¥	✓	✓		✓
Envision Pharmaceutical Services, Inc.	✓	✓	✓	✓	✓		✓
Express Scripts, Inc.	✓	✓	✓	✓	✓		*
UnitedHealthcare OptumRx	✓	✓	✓	✓	✓		*

Notes:

✓= Completed

▲ = Payor/PBM has obtained a waiver for this benchmark

● = Payor/PBM plans to seek waiver for this benchmark

¥ = CVS does not provide a unique ID number, but allows providers to track requests via provider name, patient name, and patient date of birth.

* = Payor/PBM is assessing the benchmark

Appendix D: Implementation of Preauthorization Phase 1 and 2 Benchmarks

The MHCC staff reviewed payor and PBM websites to ensure they complied with the Phase 1 requirement of including on their sites a list of medical and pharmaceutical services that require preauthorization and the key criteria for making determinations. In addition, MHCC staff reviewed the accessibility of payors' and PBMs' online portals. The list below provides website addresses to payors' and PBMs' Phase 1 information and their electronic preauthorization systems.

Payors

1. Aetna, Inc.
    a. List of Services
        i. Medical: www.aetna.com/healthcare-professionals/policies-guidelines/medical_precertification_list.html
        ii. Pharmaceutical: www.aetna.com/pharmacy-insurance/healthcare-professional/aetna-pharmacy-management-index.html
    b. Electronic Preauthorization System
        i. Medical: navinet.navimedix.com/sign-in?ReturnUrl=/Main.aspx
2. CareFirst BlueCross BlueShield
    a. List of Services
        i. Medical: provider.carefirst.com/wps/portal/Provider/ProviderLanding?WCM_GLOBAL_CONTEXT=/wcmwps/wcm/connect/Content-Provider/CareFirst/ProviderPortal/Generic/Tab/mprInNetwork&WT.z_from=providerQuicklinks
        ii. Pharmaceutical: provider.carefirst.com/wcmwps/wcm/connect/fc491d804cd6c2999217d7d0dbe97053/PRV4249.pdf?MOD=AJPERES&CACHEID=fc491d804cd6c2999217d7d0dbe97053
    b. Electronic Preauthorization System
        i. Medical and Pharmaceutical: provider.carefirst.com/wps/portal/Provider/ProviderHome
3. Cigna Health and Life Insurance Company/Connecticut General Life Insurance Company
    a. List of Services
        i. Medical and Pharmaceutical: www.cigna.com/healthcareprofessionals/resources-for-health-care-professionals/clinical-payment-and-reimbursement-policies/coverage-policies-overview.html
    b. Electronic Preauthorization System
        i. Medical and Pharmaceutical: cignaforhcp.cigna.com/web/public/guest/!ut/p/b1/04_Sj9CPykssy0xPLMnMz0vMAfGjzOKDnMyMDA0sHL0dA92MDDwtjTx8zbw9DQ08zYEKIoEKDHAARwNC-sP1o8BK8Jjg55Gfm6pfkBthoOuoqAgA9of03Q!!/dl4/d5/L2dBISEvZ0FBIS9nQSEh/
4. Coventry Health Care of Delaware, Inc.

a. List of Services
    i. Medical: chcdelaware.coventryhealthcare.com/services-and-support/providers/pre-authorizations/index.htm
    ii. Pharmaceutical: chcdelaware.coventryhealthcare.com/health-care-solutions/prescription-coverage/prescription-documents/index.htm
b. Electronic Preauthorization System
    i. Medical and Pharmaceutical: www.directprovider.com/providerPortalWeb/appmanager/coventry/extUsers

5. UnitedHealthcare
    a. List of Services
        i. Medical and Pharmaceutical: www.unitedhealthcareonline.com/b2c/CmaAction.do?channelId=ca174ccb4726b010VgnVCM100000c520720a__
    b. Electronic Preauthorization System
        i. Medical: www.unitedhealthcareonline.com/b2c/CmaAction.do?channelId=64e9c7958f5fa010VgnVCM100000c520720a___

PBMs

1. CVS Caremark
    a. List of Services: www.caremark.com/wps/portal/FOR_HEALTH_PROS_TAB
    b. Electronic Preauthorization System: eprescribe.allscripts.com/Login.aspx?ReturnUrl=/
2. Envision Pharmaceutical Services
    a. List of Services: www.envisionrx.com/healthdrug/mdpa.aspx
    b. Electronic Preauthorization System: envision.promptpa.com/
3. Express Scripts, Inc.
    a. List of Services: www.express-scripts.com/services/physicians/pa/
    b. Electronic Preauthorization System: www.express-path.com/
4. Pharmaceutical Technologies, Inc.
    a. Electronic Preauthorization System: secure.pti-nps.com/coveragedetermination/
5. PBM Plus
    a. List of Services: www.pbmplus.com/MemberPortal/PADrugList.pdf

Appendix E: Reporting Tool Completed by Payors and PBMs

2014 Electronic Preauthorization Reporting Tool

Introduction

Maryland law, Md. Code Ann., Health-General Article §§19-101 and 19-108.2 (law), required certain State-regulated payors (payors) and pharmacy benefit managers (PBMs) to implement an online process for accepting electronically preauthorization requests from providers. Payor and PBM responses to this reporting tool will be used to report to the Governor and General Assembly. Please complete the reporting tool by **July 31, 2014.**

Reporting Questions

Contact information:
Name:
Title:
Organization:
E-mail:
Phone Number:

Section 1 – Preauthorization Phase Attainment

Payors and PBMs are required to answer the following questions.

The following reporting requirements identify progress in attaining the Phase 2 and 3 preauthorization benchmarks. (The Phase 2 and 3 questions are for the payors and PBMs that had waivers for extension of time until 2014)

1. Does your organization have an online process for accepting electronic preauthorization requests from providers? (select one)

   ☐ Yes
   ☐ No

2. Does your organization assign a unique electronic identification number to a preauthorization request that a provider may use to track the request during the preauthorization process, regardless of whether the request is tracked electronically, through a call center, or by fax? (select one)

   ☐ Yes
   ☐ No

3. Has your organization established an online preauthorization process capable of returning an approval for pharmaceutical preauthorization requests, for which no additional information is needed to process the preauthorization request and meets the criteria for approval in real-time? (select one)

   ☐ Yes
   ☐ No
   ☐ Not Applicable

4. Has your organization established an online preauthorization process capable of returning an approval for pharmaceutical preauthorization requests within one business day after receiving all pertinent information on requests not approved in real-time, and that are not urgent? (select one)

   ☐ Yes
   ☐ No
   ☐ Not Applicable

5. Has your organization established an online preauthorization process capable of returning an approval for medical service preauthorization requests within two business days of receiving all pertinent information? (select one)

   ☐ Yes
   ☐ No
   ☐ Not Applicable

The following questions aim to identify progress in attaining the new preauthorization benchmark identified in Senate Bill 622 (from the 2014 Legislative Session and signed into law on May 5, 2014), that requires on or before July 1, 2015 establishment by each payor and PBM that requires a step therapy or fail-first protocol, a process for a provider to override a step therapy or fail-first protocol. Step therapy/fail-first protocol is defined as a protocol that requires a prescription drug or sequence of prescription drugs to be used by an insured or an enrollee before a prescription drug ordered by a prescriber for the insured or the enrollee is covered.

6. As of July 1, 2014, does your organization require step therapy or fail-first protocol?

   ☐ Yes *(Proceed to question 7)*
   ☐ No *(Skip to Section 2)*

7. As of July 1, 2014, does your online preauthorization process allow providers to override a step therapy or fail-first protocol?

   ☐ Yes
   ☐ No *(answer the following question)*

   Identify the status of your organization as of July 1, 2014, in meeting this requirement:

   ☐ Assessing a step therapy/fail-first protocol override strategy for the online preauthorization system: expected completion date (Month/Year)?

   ☐ Implementing a step therapy/fail-first protocol override strategy for the online preauthorization system: expected completion date (Month/Year)?

   ☐ Seeking waiver: If your organization will be seeking a waiver for this requirement, please indicate the basis for the request:

   ☐ Other (please specify):

Section 2

The MHCC plans to include the following information in the report to the Governor and General Assembly to identify the impact and policy implications of electronic preauthorizations. In addition, MHCC will use the information to gauge the usability of payors and PBMs online preauthorization systems. Please provide your best estimate to the following.

Part I: Volume of Pharmaceutical Service Claims and Preauthorization Requests

8. Identify the lines of business you are including in the following responses (e.g. fully-insured, self-insured, Medicare etc.)?

9. Provide the estimated number of pharmaceutical claims and preauthorization requests (i.e. electronic & non-electronic submissions), including the estimated percentage of electronic preauthorization requests submitted by Maryland providers for each time period below. Indicate "N/A" if not applicable. If data is unavailable, please provide an explanation as to why the estimated figure is unavailable.

Total Number of Pharmaceutical Claims		**Total Number of Pharmaceutical Preauthorization Requests**		**Estimated Percentage of Pharmaceutical Preauthorization Requests Submitted Electronically via the Online Preauthorization System**	
Calendar Year 2013	January 1, 2014 to June 30, 2014	Calendar Year 2013	January 1, 2014 to June 30, 2014	Calendar Year 2013	January 1, 2014 to June 30, 2014

10. Identify the top five provider specialties that submit the highest volume of all pharmaceutical preauthorization requests by Maryland providers in calendar year 2013, by specialty.

    ☐ Unavailable: Please provide an explanation as to why provider specialties that submit the highest number of pharmaceutical preauthorization requests is unavailable:

Part II: Volume of Medical Service Claims and Preauthorization Requests

11. Identify the lines of business you are including in the following responses (e.g. fully-insured, self-insured, Medicare etc.)?

12. Provide the estimated number of medical service claims and preauthorization requests (i.e. electronic & non-electronic submissions), including the estimated percentage of electronic preauthorization requests submitted by Maryland providers for each time period below. Indicate "N/A" if not applicable. If data is unavailable, please provide an explanation as to why the estimated figure is unavailable.

Total Number of Medical Service Claims		**Total Number of Medical Service Preauthorization Requests**		**Estimated Percentage of Medical Service Preauthorization Requests Submitted Electronically via the Online Preauthorization System**	
Calendar Year 2013	January 1, 2014 to June 30, 2014	Calendar Year 2013	January 1, 2014 to June 30, 2014	Calendar Year 2013	January 1, 2014 to June 30, 2014

13. Identify the top five provider specialties that submit the highest volume of all medical service preauthorization requests by Maryland providers in calendar year 2013, by specialty.

    ☐ Unavailable: Please provide an explanation as to why provider specialties that submit the highest number of pharmaceutical preauthorization requests is unavailable:

Part III: Usability

14. Rate your perception of your company's online preauthorization system on a scale of 1 to 5 for provider usability (including effectiveness, efficiency, and satisfaction):

    ☐ 1 – Very complicated or confusing

    ☐ 2 - Somewhat complicated or confusing

    ☐ 3 – Neutral

    ☐ 4 – Somewhat clear, intuitive and easy to use

    ☐ 5 – Very clear, intuitive, and easy to use

15. Have you received any troubleshooting inquiries from Maryland users of the online preauthorization system?

    ☐ Yes (*Skip to question 16*)

    ☐ No (*Skip to question 17*)

16. What are the most common inquiries from Maryland users of the online preauthorization system?

17. Who can obtain access to the online preauthorization system to create and submit preauthorization requests electronically? (Check all that apply)

    ☐ Physicians

    ☐ Nurse Practitioners

    ☐ Practice Managers

    ☐ Registered Nurses

    ☐ Front desk staff

    ☐ Registrar

    ☐ Other (please specify):

18. Can out-of-network or non-participating providers access the online preauthorization system to create and submit electronic preauthorizations?

    ☐ Yes

    ☐ No *(Skip to question 20)*

    ☐ Not applicable (credentials are not required to submit a preauthorization) (*Skip to question 20*)

19. Briefly describe the process for out-of-network or non-participating providers to obtain a username and password to utilize the online preauthorization system.
20. How many unique practices used the online preauthorization system to submit requests electronically in calendar year 2013?
21. Since July 2013, have you made changes to the manner in which a provider can access the online preauthorization system?

    ☐ Yes

    ☐ No *(Skip to Part IV)*
22. How many clicks are required to arrive at the provider portal from the homepage?
23. How many clicks are required to arrive at the landing page of the preauthorization request website from the provider portal homepage?
24. On average, how many minutes does it take to complete a preauthorization request (pharmaceutical and medical), starting from the landing page of the preauthorization request website to the assignment of a unique electronic identification number?

    ☐ Pharmaceutical

    ☐ Medical
25. Does your company provide training on how to use the online preauthorization system?

    ☐ Yes – Please specify the types of training available (i.e. online tutorials/guides, webinars, on-site training, etc.)
    ☐ No

Part VI: Supporting Documentation

26. Has your company made any changes to how it accepts supporting documentation in the online preauthorization system since July 2013?

    ☐ Yes

    ☐ No *(skip to question 28)*
27. If supporting documentation must be submitted for an electronic preauthorization, in what ways were documents submitted by Maryland providers? (Indicate the percentage of documents received, by method.)

    ☐ Electronic preauthorization system

    ☐ Email

    ☐ Fax

    ☐ Mail

    ☐ Other (specify)

    ☐ Not applicable

Marketing

28. Has your company deployed any marketing strategies to inform and educate providers and their staff about the online preauthorization system?

    ☐ Yes

    ☐ No *(Skip to question 31)*

29. Use the following table to indicate if your company has used any of the following marketing materials, including the volume and frequency for each (i.e. particular specialties, high preauthorization requestors, quarterly emails, monthly webinars, number of training sessions, etc.). Indicate your perception of the effectiveness of each marketing strategy and a brief explanation regarding your rating.

Marketing Material	Used? (Check if Yes)	Estimated Volume	Estimated Frequency	Perception of Effectiveness (1-5 with 1 being not effective and 5 being very effective)	Provide a brief explanation of your rating
Email	☐				
Fax	☐				
Mail	☐				
Newsletter	☐				
Website	☐				
Provider Liaisons	☐				
Webinar	☐				
Training Sessions	☐				
Other	☐				
None of the Above	☐				

30. Does your company have plans to increase the volume or frequency of your marketing communications with providers and/or deploy any additional marketing tools?
    ☐ Yes, please describe your plans in the table below
    ☐ No

Marketing Material	Plans to increase volume/ frequency? (Check if Yes)	Estimated Volume	Estimated Frequency	If there is a specific reason your company is increasing the volume/frequency of a material, please provide the reason
Email	☐			
Fax	☐			
Mail	☐			
Newsletter	☐			
Website	☐			
Provider Liaisons	☐			

Webinar	☐			
Training Sessions	☐			
Other	☐			
None of the Above	☐			

31. Does your company have any plans to deploy a marketing strategy?

    ☐ Yes, please describe the marketing strategy plan in the table below

    ☐ No, please indicate why your company does not have plans

Marketing Material	Plans to Use Marketing Material? (Check if Yes)	Anticipated Volume	Anticipated Frequency	Provide a brief explanation as to why there are plans to use this marketing material
Email	☐			
Fax	☐			
Mail	☐			
Newsletter	☐			
Website	☐			
Provider Liaisons	☐			
Webinar	☐			
Training Sessions	☐			
Other	☐			
None of the Above	☐			

Section 3 –Waivers *(Included in the survey for those payors/PBMs with a waiver for an extension of time for a particular benchmark)*

32. What is your company's current stage of development for implementing an online process for accepting electronic preauthorization requests from providers?

    ☐ Assessing

    ☐ Implementing

    ☐ Other (please specify)

33. What is the expected completion date (Month/Year)?

34. What is your company's current stage of development for implementing a system to assign preauthorization requests submitted online with a unique identification number?

    ☐ Assessing

    ☐ Implementing

- ☐ Other (please specify)

35. What is the expected completion date (Month/Year)?
36. What is your current stage of development for implementing an online process to approve pharmaceutical preauthorization requests, for which no additional information is needed and meets the criteria for approval, in real-time?
    - ☐ Assessing
    - ☐ Implementing
    - ☐ Other (please specify)
37. What is the expected completion date (Month/Year)?
38. What is your current stage of development for implementing an online process to approve pharmaceutical preauthorization requests within one business day after receiving all pertinent information on requests not approved in real time, and that are not urgent?
    - ☐ Assessing
    - ☐ Implementing
    - ☐ Other (please specify)
39. What is the expected completion date (Month/Year)?

Section 5 – Attestation

I affirm under perjury and penalty that the information given in this survey is true and correct to the best of my knowledge and belief.

Name:
Typing a name in the signature box above is the equivalent of a physical signature.

Date:

Appendix F: Status of Payor and PBM Waivers

As required by law[51] and previously discussed, MHCC developed a waiver process for compliance with the electronic preauthorization requirements for payors and PBMs. The benchmarks include:

1) Provide by October 1, 2012 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 by March 1, 2013 an online system to receive preauthorization requests electronically and assign a unique identification number to each request for tracking purposes; and
3) Ensure by July 1, 2013 that all electronic preauthorization requests for pharmaceuticals are approved in real-time or within one business day of receiving all pertinent information, and for non-urgent medical services, within two business days of receiving all pertinent information.

Amendments to the law enacted in 2014, require payors and PBMs to implement a fourth benchmark by July 1, 2015 that gives health care professionals the ability to override a step therapy or fail-first protocol when submitting an electronic preauthorization request.[52, 53]

COMAR 10.25.17, *Benchmarks for Preauthorization of Health Care Services*,[54] established the circumstances under which a payor or PBM can apply for a waiver, as well as the waiver application and approval process. Payors and PBMs that are group model health maintenance organizations, have low premium volume, and those with other extenuating circumstances may be waived from meeting one or more benchmarks. Some payors and PBMs were granted waivers, receiving extensions of time to comply with certain benchmarks.

Payor and PBM Waivers			
Payors	***Benchmark 1***	***Benchmark 2***	***Benchmark 3***
Kaiser Permanente	Group model health maintenance organization		
PBMs			
Benecard Services, Inc.	Low market share		
Catamaran, Inc.	N/A	Combining three companies and platforms onto one technology platform	
Direct Pharmacy Services, Inc.	Low market share		
Fairview Pharmacy Services, LLC	Low market share		
MaxorPlus	Low market share		

[51] Md. Code Ann., Health-Gen. §19-108.2 (2012).
[52] Step therapy or fail-first protocol is defined as a protocol established by an insurer, a nonprofit health service plan, or a health maintenance organization that requires a certain prescription drug or sequence of prescription drugs to be used by an insured individual or an enrollee before another specific prescription drug ordered by a prescriber is covered.
[53] *Health Insurance – Step Therapy or Fail-First Protocol*, Senate Bill 622 (Chapter 316) (2014 Regular Session)
[54] See Appendix B.

Payor and PBM Waivers			
Payors	***Benchmark 1***	***Benchmark 2***	***Benchmark 3***
PBM Plus	N/A	Low market share	
Pharmaceutical Technologies, Inc.	N/A	N/A	Low market share
Prescription Corporation of America	Low market share		
Prime Therapeutics, LLC	Low market share		
Serve You Rx	Low market share		
WellDyne Rx, Inc.	Low market share/union sponsored health plan		

Note: "N/A" represents benchmarks that have been implemented. Thus, there is no reason for a waiver.

Appendix G: National Vendors offering Electronic Preauthorization Services

Five of the eight national vendors that were identified as offering preauthorization services agreed to be interviewed. Included below is information on the five preauthorization vendors that provide online portals and are working towards implementing the electronic preauthorization standards.

Agadia Systems

Agadia Systems provides preauthorization software (pharmaceutical and medical services) to payors and PBMs, offering both an online portal, called PaHub, and the ePA transaction standards. Agadia is working with EHR and e-prescribing vendors to integrate the ePA standards into providers' workflows. Medical service preauthorizations must still be submitted through the online portal; Agadia does not believe that this will change in the near future, since the industry is working to implement the ePA standard for pharmaceutical preauthorizations. Nationally, Agadia processes 3.5 to 4 million pharmaceutical and medical service preauthorizations per year. Agadia provides one of the few online portals that does not require providers or their staff to login to the portal to submit preauthorization requests. It also allows patients to submit an initial preauthorization request that a provider can finalize. Agadia found that these features have increased use of their online portal, and still allow the secure submission and approval of preauthorizations.

CoverMyMeds

CoverMyMeds (CMM) provides an online portal for providers and pharmacists that is used exclusively for pharmaceutical preauthorization requests. CMM has worked to collect every paper preauthorization form (roughly 12,000-13,000 forms) used in the nation to make them available electronically. The forms are completed in the portal and sent to payors and PBMs via whatever method they accept, including electronic and fax methods. More than 100,000 practices and 45,000 pharmacies currently use the CMM portal. CMM has the ePA standard live for several plans and will soon be live with seven of the top 10 payors/PBMs that use the standard transaction. Additionally, CMM has integrated with two EHR/e-prescribing systems, and will continue to integrate with additional systems through 2015. Through its online portal and EHR/e-prescribing integrations, CMM has initiated more than 10 million pharmaceutical preauthorization requests, and averages approximately 30,000 pharmaceutical preauthorization requests per day.

Health Information Designs, Inc.

Health Information Designs, Inc. (HID) reports that it provides pharmacy preauthorization solutions for payors and PBMs. HID manages a preauthorization call center that manually adjudicates more than 300,000 preauthorization requests annually. HID also provides automated adjudication of preauthorization requests through its RxPert system. RxPert is a rules-based criteria engine that can be interfaced into a payor's or PBM's system. When the need for preauthorization is required by a claims system, the request is automatically sent to RxPert where it is evaluated against the patient's data (including medical and pharmacy historical claims). Requests are adjudicated in less than 500 milliseconds on average, and real-time approval or denial messaging is returned to the payor/PBM, which is then sent to the pharmacy. Additionally,

providers can access RxPert through an online portal and request a preauthorization at the point of care. RxPert adjudicates more than 6 million pharmaceutical preauthorization requests annually. HID is working to incorporate the ePA standard transaction into its infrastructure and anticipates rolling out the functionality by the end of 2014.

NaviNet

NaviNet provides a multi-payor web portal for providers and their staff that supports administrative and clinical transactions, including preauthorizations. NaviNet has 420,000 users that can access more than 40 national plans. NaviNet supports both medical service and pharmaceutical preauthorization requests. NaviNet utilizes the 278 transaction standard for medical service preauthorization requests, but has not yet implemented the ePA standard for pharmaceutical service requests. NaviNet is currently evaluating the standard for future implementation.

Surescripts

Surescripts provides e-Prescribing infrastructure to EHRs and e-prescribing systems. Surescripts recently launched its CompletEPA™ solution which allows providers to submit preauthorizations in real-time during the e-prescribing process. Surescripts CompletEPA™ uses the NCPDP standards to reference formulary and benefit information, request preauthorization questions from payors or PBMs, send provider responses back to the payor or PBM, and provide real-time approval to the provider. Surescripts is working with payors, PBMs, and EHR/e-prescribing vendors to implement the CompletEPA solution and believes it will have a significant portion of the market completed by fourth quarter 2014.

Appendix H: Payor and PBM Marketing Strategies

Payors and PBMs reported the following marketing strategies used to promote the availability of their online portals as well as any planned marketing strategies.

Payor and PBM Marketing Strategies		
Payor/PBM	***Marketing Strategies Utilized***	***Planned Marketing Strategies***
Aetna, Inc.	Monthly Training Sessions	No
CareFirst BlueCross BlueShield	Email, Fax, Mail, Newsletter, Website, Provider Liaisons, Webinar, Training Sessions, Professional Society Meetings	No
Cigna Health and Life Insurance Company/Connecticut General Life Insurance Company Medical Services	Email, Mail, Newsletter, Website, Provider Liaisons, Webinar, Training Sessions	No
Cigna Health and Life Insurance Company/Connecticut General Life Insurance Company Pharmaceutical Services	No	No
Coventry Health Care of Delaware, Inc.	Fax, Website, Webinar	No
UnitedHealthcare Behavioral Health	Training page with video tutorial	No
UnitedHealthcare Choice and Choice Plus	Newsletters, Training Sessions	Provider Liaison; developing communication strategy for including supporting documentation
CVS Caremark	Email, Fax, Mail, Newsletter, Website, Training Sessions	Yes, plan to use email, fax, mail, newsletter, and website for initial marketing to drive use of ePA to support pre-NCPDP pilot use to prove success of transaction; new marketing to support overall industry launch of ePA within EHRs
Envision Pharmaceutical Services, Inc.	Daily fax	Discussing the use of mail and website
United Healthcare OptumRx	Other: print materials, provider phone calls	Considering additional communications, although plans have not yet been finalized

Appendix I: Electronic Preauthorization Legislation Among States

The following table provides an overview of legislation pertaining to electronic preauthorization. States with pending legislation from the most current sessions are noted with an asterisk (*). Fields that are blank indicate states that do not require or have not addressed a particular item in its legislation. States that are not included in the chart have not passed legislation pertaining to non-electronic preauthorization processes.

Electronic Preauthorization Legislative Progress Among States								
State♦	**Scope**	**Uniform PA Request Form**	**PA Unique ID Number**	**PA Criteria Listed on Payors/PBMs Website**	**Payors/PBM s PA Response Timing**	**Payors/PBMs Accept ePA**	**State Work Group**	**Other**
***Arizona**	Pharmaceutical	✓		✓	Two business days; one business day if expedited	✓		
California	Pharmaceutical	✓			Two business Days	✓		
Colorado	Pharmaceutical	✓	✓	✓	Two business days; one day if expedited	✓	Tasked with making recommendations on the development of a standard prior authorization process, while taking into consideration national ePA standards, CMS and specialty society guidelines, and clinical criteria; recommended the use of a rules engine when developing ePA systems.[55]	
Florida	Pharmaceutical (Medicaid Managed Care Plans Only)					✓		Medicaid managed care plans must post their drug formularies online.
Georgia	Pharmaceutical					Within two years after adoption of standards by the NCPDP		

[55] A rules engine can be used to expedite an urgent preauthorization request. The rules engine is programmed according to a health plan's criteria and can use a patient's historical claims data and current diagnoses to streamline the process for submitting a preauthorization request.

Electronic Preauthorization Legislative Progress Among States								
State♦	**Scope**	**Uniform PA Request Form**	**PA Unique ID Number**	**PA Criteria Listed on Payors/PBMs Website**	**Payors/PBM s PA Response Timing**	**Payors/PBMs Accept ePA**	**State Work Group**	**Other**
***Illinois**	Pharmaceutical				72 hours; 24 hours if expedited			
***Indiana**	Pharmaceutical				Two business days	✓		
***Iowa**	Pharmaceutical	✓[56]			72 hours	✓		
Kansas	Pharmaceutical						Tasked with studying ePA and step therapy protocols. A January 2013 report recommended that stakeholders work with NCPDP to develop ePA standards.	
Kentucky	Pharmaceutical						To be convened within 24 months after national ePA standards developed by the NCPDP become available. The workgroup should develop electronic prescribing and ePA regulations in consideration of those standards.	
Maryland	Pharmaceutical and Medical		✓	✓	Pharmaceutical: real-time (under certain circumstances) or within one business day Medical: two business days.	✓		Health care professionals required to use online portals or national standards (if approved) by July 2015; Step Therapy/Fail-First Protocol Override required by July 2015.
Massachusetts	Pharmaceutical and Medical	✓[57]			Two business days	✓		
Michigan	Pharmaceutical				15 days; 72 hours if expedited		Tasked with the development of a standard preauthorization methodology by January 1, 2015.	

[56] Providers must use the form on or before July 2015.
[57] Various forms will be developed for different health care services and benefits (e.g. prescription, imaging, laboratory, etc.). Providers must use the forms within six months after the forms' development.

Electronic Preauthorization Legislative Progress Among States								
State♦	**Scope**	**Uniform PA Request Form**	**PA Unique ID Number**	**PA Criteria Listed on Payors/PBMs Website**	**Payors/PBM s PA Response Timing**	**Payors/PBMs Accept ePA**	**State Work Group**	**Other**
Minnesota	Pharmaceutical	✓[58]					Responsible for developing the uniform preauthorization form, in addition to developing an ePA guide for providers and payors.	
***Missouri**	Pharmaceutical and Medical				72 hours		Responsible for participating in the NCPDP ePA workgroup; must report and monitor the progress of an ePA pilot program before February 1, 2019.	
Mississippi	Pharmaceutical	✓			Two business days	✓		
Nevada	Pharmaceutical	✓						Piloting use of Direct Secure Messaging to electronically send preauthorization requests.
***New Jersey**	Pharmaceutical	✓				✓		
New Mexico	Pharmaceutical	✓			Three business days	Medicaid Only		Within 24 months after the adoption of national standards, payors/PBMs must exchange PA requests with providers that have e-prescribing capabilities.
***New York**	Pharmaceutical and Medical	✓			Three business days			
North Dakota	Pharmaceutical					✓		
***Ohio**	Medical (Medicaid Only)	✓			48 hours	✓		

[58] Providers must submit the form electronically by January 1, 2015; facsimile is not considered an electronic transmission.

Electronic Preauthorization Legislative Progress Among States								
State♦	**Scope**	**Uniform PA Request Form**	**PA Unique ID Number**	**PA Criteria Listed on Payors/PBMs Website**	**Payors/PBM s PA Response Timing**	**Payors/PBMs Accept ePA**	**State Work Group**	**Other**
Oregon	Pharmaceutical	✓			Two business days	✓		
Rhode Island	Pharmaceutical and Medical		✓	✓		✓	Workgroup tasked with developing guidelines for consistent preauthorization processes and timeframes, which includes establishing guidelines for payors/PBMs to develop a method for submitting preauthorization requests online.	
Tennessee	Pharmaceutical and Medical			✓				Payors/PBMs must provide on their website statistics regarding preauthorization approvals/denials.
Utah	Pharmaceutical						Workgroup tasked with studying preauthorizations for prescription drugs, including standards when using an electronically transmissible uniform PA request form.	
Vermont	Pharmaceutical						Workgroup recommendations published in a report include developing a multi-payor web portal and aligning the state's strategy for electronic preauthorization with national standards.	
Washington	Pharmaceutical and Medical						Workgroup responsible for developing recommendations on best practices for submitting preauthorization requests and must consider requiring payors/ PBMs to: list preauthorization criteria on their website; issue an acknowledgment of receipt or reference number for a preauthorization request within a certain time frame.	

♦Arizona
Health insurance; prescriptions; prior authorization. Arizona S.B. 1361, 2014 Regular Session. Available at: legiscan.com/AZ/text/SB1361/id/945620.
California
CA Health & Safety Code § 1367.241 (through 2012 Leg Sess) Available at:
law.justia.com/codes/california/2011/hsc/division-2/1367-1374.195/1367.241.
C.R.S. 10-16-124.5 Available at:
www.lexisnexis.com/hottopics/colorado/?app=00075&view=full&interface=1&docinfo=off&searchtype=ge.
Colorado
C.R.S. 10-16-124.5 Available at:
www.lexisnexis.com/hottopics/colorado/?app=00075&view=full&interface=1&docinfo=off&searchtype=ge.
Senate Bill 13-277 Work Group to Assist the Commissioner In Developing the Prior Authorization Process for Prescription Drugs Final Recommendations. January 3, 2014. Available at:
cdn.colorado.gov/cs/Satellite?blobcol=urldata&blobheadername1=Content-Disposition&blobheadername2=Content-Type&blobheadervalue1=inline%3B+filename%3D%22Final+Recommendations+of+SB13-277+Work+Group+1-3-14.pdf%22&blobheadervalue2=application%2Fpdf&blobkey=id&blobtable=MungoBlobs&blobwhere=1251926340477&ssbinary=true.
Florida
FL S.B 2144, 2011 Regular Session. Available at: flsenate.gov/Session/Bill/2011/2144/BillText/er/HTML.
Georgia
GA S.B. 415, 2011-2012 Regular Session. Available at: www.legis.ga.gov/Legislation/20112012/127560.pdf.
Illinois
Health Insurance Consumer Protection Act of 2014, Illinois H.B.3638, 2014 Regular Session. Available at:
www.ilga.gov/legislation/fulltext.asp?DocName=&SessionId=85&GA=98&DocTypeId=HB&DocNum=3638&GAID=12&LegID=76572&SpecSess=&Session=.
Indiana
Uniform prior authorization form. Indiana H.B. 1357, 2014 Regular Session. Available at: iga.in.gov/static-documents/c/c/b/e/ccbe5e8a/HB1357.01.INTR.pdf.
Iowa
A bill for an act requiring the development and use of a standard process and form for prior authorization of prescription drug benefits, Iowa H.F 2376, 85th General Assembly. Available at: legiscan.com/IA/text/HF2376/id/968249.
Kansas
K.S.A. 65-1637b (c)(4) Available at:
www.kslegislature.org/li/b2013_14/statute/065_000_0000_chapter/065_016_0000_article/065_016_0037b_section/065_016_0037b_k/.
Study on Electronic Transmission of Prior Authorization and Step Therapy. Available at:
www.rxobserver.com/wp-content/uploads/2013/01/2013-epa-Study-Report1.pdf.
Kentucky
KRS 218A.171 Available at: www.lrc.ky.gov/statutes/statute.aspx?id=40699.
Maryland
Maryland law, Md. Code Ann., Health-General Article § 19-108.2 Available at: www.dsd.state.md.us/comar/SubtitleSearch.aspx?search=10.25.
Massachusetts
MA Gen L ch 176O § 25 Available at: law.justia.com/codes/massachusetts/2014/part-i/title-xxii/chapter-176o/section-25/.
Michigan

MI Comp L § 500.2212c (2014) Available at: law.justia.com/codes/michigan/2014/chapter-500/statute-act-218-of-1956/division-218-1956-22/section-500.2212c/.

Minnesota

Minnesota Session Law, Chapter 336-S.F., No. 2974, Section 4-5. Available at: www.health.state.mn.us/divs/hpsc/ohit/certificate/ms2010336.pdf.

Missouri

Establishes the Missouri Electronic Prior Authorization Committee regarding national standards for the process of obtaining prior approval from an insurer for certain services or medications, Missouri H.B. 1827, 2012 Regular Session 2012. Available at: legiscan.com/gaits/text/646701.

Mississippi

Prescription drug benefits; require use of a uniform prior authorization form by health insurers providing. Mississippi H.B.301, 2013 Regular Session. Available at: billstatus.ls.state.ms.us/documents/2013/html/HB/0300-0399/HB0301SG.htm.

New Jersey

Requires Commissioner of Banking and Insurance to develop standard prior authorization form for prescription drug benefits for use by network providers. New Jersey A1713, 2014 Regular Session. Available at: legiscan.com/NJ/text/A1713/2014.

New Mexico

NM Stat § 59A-22-52 (2013) Available at:
law.justia.com/codes/new-mexico/2013/chapter-59a/article-22/section-59a-22-52.

NM Stat § 59A-2-9.8 (2013) Available at:
law.justia.com/codes/new-mexico/2013/chapter-59a/article-2/section-59a-2-9.8.

NM Stat § 59A-46-52 (2013) Available at:
law.justia.com/codes/new-mexico/2013/chapter-59a/article-46/section-59a-46-52/.

New York

NY Pub Health L § 4903 (2012) Available at: law.justia.com/codes/new-york/2013/pbh/article-49/title-1/4903/.

Directs the commissioner of health and superintendent of financial services to establish a standard prior authorization request for a utilization review of prescription drug coverage. New York S7369-2013, 2013-2014 General Assembly. Available at: legiscan.com/NY/text/S07369/2013.

North Dakota

North Dakota Century Code, § 23-01-38 (2013) Available at:
law.justia.com/codes/north-dakota/2013/title-23/chapter-23-01/.

Ohio

To amend the law related to the prior authorization requirements of insurers and of the medical assistance programs administered by the Department of Medicaid, Ohio S.B. 330, 2013-2014 Regular Session. Available at: legiscan.com/OH/text/SB330/id/1010898.

Oregon

OR Rev Stat § 743.065 (2013) Available at: www.oregonlegislature.gov/bills_laws/lawsstatutes/2013ors743.html.

Rhode Island

RI Gen L § 42-14.5-3 (2013) Available at:
law.justia.com/codes/rhode-island/2013/title-42/chapter-42-14.5/section-42-14.5-3/.

Tennessee

Tennessee Code Annotated, § 56-6-703 Available at: www.capitol.tn.gov/Bills/108/Bill/HB0926.pdf.

Utah

Utah Code Annotated 1953, §31A-22-614.7 Available at: le.utah.gov/~2013/bills/hbillenr/hb0323.pdf.

Vermont

Vermont Act 48, 2011 Regular Session. Available at: www.leg.state.vt.us/docs/2012/Acts/ACT048.pdf.
Vermont Act 51, 2011 Regular Session. Available at: www.leg.state.vt.us/docs/2012/Acts/ACT051.pdf.
Report to the Vermont Legislature: Single Formulary and Electronic Prior Authorization Recommendations, February 2012. Department of Vermont Health Access. Available at: www.leg.state.vt.us/reports/2012ExternalReports/276572.pdf.

Washington

Addressing the prior authorization of health care services, Washington S.B. 6511, 2014 Regular Session. Available at: apps.leg.wa.gov/documents/billdocs/2013-14/Pdf/Bills/Session%20Laws/Senate/6511-S.SL.pdf.

Appendix J: Electronic Preauthorization Volume

Payors and PBMs reported information on claims and preauthorization volume for calendar year 2013 and for the period January 1, 2014 through June 30, 2014. Note: Fluctuations in the total number of preauthorizations reported by payors and PBMs may be attributed but not limited to changes in membership volume, health benefit plan requirements, and the available of new specialty drugs.

Estimated Volume of Medical Service Preauthorization Requests

Payor	*Medical Service Claims*		*Medical Service Preauthorization Requests*		*Medical Service Preauthorization Requests Submitted Electronically*	
	2013	*January 1-June 30, 2014*	*2013*	*January 1-June 30, 2014*	*2013*	*January 1-June 30, 2014*
	(#)		*(# / % of claims)*		*(%)*	
Aetna, Inc. Medical Services[1]	6,008,275	2,788,319	43,821/ 0.7%	21,589/ 0.7%	38.9%	35.7%
CareFirst BlueCross BlueShield[2]	34,922,860	15,570,373	104,706/ 0.3%	91,464/ 0.6%	36.2%	52.1%
Cigna Health and Life Insurance Company/ Connecticut General Life Insurance Company Medical Services[3]	1,435,549	862,515	1,743/ 0.1%	1,377/ 0.2%	15.9%	10%
Coventry Health Care of Delaware, Inc.[4]	14,155	6,668	1,000/ 7%	559/ 8.4%	7.1%	8.5%
United Healthcare Behavioral Health[5]	454,456	225,146	19,781/ 4.4%	10,518/ 4.7%	14.9%	15%
United Healthcare Choice/Choice Plus†[6]	5,129,956	2,329,099	167,267/ 3.4%	103,929/ 4.5%	17.8%	24.6%

Notes

1 = Fully-insured, commercial

2 = Includes Maryland, Virginia, and Washington D.C. fully-insured, self-insured, and Medicare Part D

3 = Fully-insured, self-insured

4 = Commercial, Medicare

5 = Fully-insured, self-insured, Medicare, Medicaid, point of service

6 = Fully-insured, self-insured, Medicare, Medicaid

†=In previous years, UnitedHealthcare separately reported information for their Choice/Choice Plus and MIPA/OCI plans. In 2014, the numbers were reported together. The MHCC combined UnitedHealthcare's information for 2012 and 2013 in the table.

Estimated Volume of Pharmaceutical Service Preauthorization Requests						
Payor	***Total Number of Pharmaceutical Claims***		***Total Number of Pharmaceutical Preauthorization Requests***		***Percent of Pharmaceutical Preauthorization Requests Submitted Electronically***	
	2013	***January 1-June 30, 2014***	***2013***	***January 1-June 30, 2014***	***2013***	***January 1-June 30, 2014***
	(#)		***(# / % of claims)***		***(%)***	
Aetna, Inc. Pharmaceutical Services[1]	2,910,790	1,708,922	98,081/ 3.4%	59,034/ 3.5%	0%	0%
CareFirst BlueCross BlueShield[2]	11,759,549	6,184,926	28,499/ 0.2%	19,844/ 0.3%	0.7%	1.9%
Cigna Health and Life Insurance Company/ Connecticut General Life Insurance Company Pharmaceutical Services[3]	614,276	652,439	5,489/ 0.9%	4,489/ 0.7%	0.3%	5.7%
Coventry Health Care of Delaware, Inc.[4]	338,799	140,292	2,416/ 0.7%	429/ 0.3%	8.1%	34.5%
PBM						
Catamaran[5]	2,470,877	1,270,238	1,130/ 0.1%	1,485/ 0.1%	*	*
CVS Caremark[6]	18,600,000	12,400,000	106,000/ 0.6%	111,000/ 0.9%	<1%	<1%
Envision Pharmaceutical Services, Inc. [7]	636,493	343,281	1,237/ 0.2%	1,072/ 0.3%	0.08%	0.5%
Express Scripts, Inc.[8]	185,900	74,551	55,621/ 29.9%	51,591/ 74.6%	*	*
United Healthcare OptumRx[9]	104,339	32,734	6,763/ 6.5%	8,799/ 26.9%	0.9%	0.7%

Notes

1 = Fully-insured, commercial

2 = Includes Maryland, Virginia, and Washington D.C.; fully-insured, self-insured, Medicare Part D

3 = Fully-insured, self-insured

4 = Commercial, Medicare

5 = Fully-insured, self-insured, Medicare, Medicaid

6 = Fully-insured, self-insured, commercial, Medicare, Medicaid

7 = Self-insured, Medicare

8 = Fully-insured, self-insured, Medicare

9 = Fully-insured

** = Online portal to accept preauthorizations was not available during the identified time period*

Appendix K: Electronic Preauthorization Notification

During a workgroup meeting on August 15, 2014, payors, PBMs, and MedChi, The Maryland State Medical Society, discussed the value of adopting a consistent message to remind health care professionals about the July 1, 2015 electronic preauthorization requirement. The message could be incorporated in telephone on hold messages and fax receipt acknowledgements for approvals/denials of preauthorization requests. This suggestion, if implemented by payors and PBMs, is expected to help increase the volume of electronic preauthorization requests.

Electronic Preauthorization Notification

IMPORTANT NOTICE RE. SUBMITTING PREAUTHORIZATION REQUESTS

Effective July 1, 2015, Maryland law will require providers to submit preauthorization requests for pharmaceutical and medical services through an electronic process. Providers should contact XXXXX for instructions on how to access each carrier's or PBM's online system.

MARYLAND
HEALTH CARE
COMMISSION

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