

State Regulated Payor & Pharmacy Benefit Manager

**PREAUTHORIZATION
BENCHMARK ATTAINMENT**

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Prepared for
The Governor of Maryland and
The General Assembly

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Table of Contents

Overview	1
Limitations	2
Maryland's Progress.....	2
Usability Challenges	6
Remarks.....	8
Acknowledgements	9
Appendix A: State Legislation.....	10
Appendix B: Md. Code Ann., Health-Gen § 19-108.2	11
Appendix C: COMAR 10.25.17	16
Appendix D: Survey Completed by Payors and PBMs	22
Appendix E: Payor and PBM Waiver Status.....	31
Appendix F: Payor and PBM Benchmark Attainment	32
Appendix G: Payor and PBM Claims/Preauthorization Volume	33
Appendix H: Payor and PBM Top Five Provider Specialties Submitting Highest Volume of Preauthorization Requests	35
Appendix I: Payor and PBM Education & Awareness Strategies	36
Appendix J: Electronic Preauthorization Notification.....	38

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Overview

Maryland was one of the first states to enact legislation for the implementation of electronic preauthorization.¹ The law, Md. Code Ann., Health-General Article § 19-108.2, required the Maryland Health Care Commission (MHCC) to work with State-regulated payors (payors) and pharmacy benefits managers (PBMs) to implement, in a phased approach, electronic preauthorization processes in a series of three benchmarks.^{2,3} In the 2014 session of the General Assembly, the law was amended adding a fourth benchmark. 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 electronic preauthorization requests and assign a unique identification number to each request for tracking purposes;
- 3) Process by July 1, 2013 electronic preauthorization requests for pharmaceuticals in real-time or within one business day of receiving all pertinent information, and process non-urgent medical services within two business days of receiving all pertinent information; and
- 4) Establish by July 1, 2015 an electronic override process for a step therapy or fail-first protocol for the submission of electronic preauthorization requests for pharmaceuticals.^{4,5}

The law requires MHCC to report annually to the Governor and General Assembly on payors' and PBMs' attainment of the benchmarks through December 2016. Since 2012, MHCC has surveyed payors and PBMs inquiring about their attainment of the benchmarks as well as utilization of their online preauthorization systems. The 2014 survey assessed the status of payors' and PBMs' implementation of the fourth benchmark and their outreach strategies to inform and educate Maryland health care professionals⁶ about their online preauthorization systems. The MHCC also contacted a small number of health care professionals to help assess usability of the online preauthorization systems.

Maryland law aims to automate the preauthorization process by eliminating paper-based processes and enabling health care professionals to submit and track preauthorization requests electronically. Historically, preauthorization processes have relied heavily on paper forms and more cumbersome means of communication, such as faxes, phone calls, and mail that places an administrative burden

¹ See Appendix A for information on electronic preauthorization legislation by state.

² See Appendix B – Md. Code Ann., Health-Gen. § 19-108.2.

³ See Appendix C – COMAR 10.25.17.

⁴ Step therapy or fail-first protocol is a protocol established by an insurer, a nonprofit health service plan, a health maintenance organization, or a pharmacy benefits manager 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.

⁵ Only payors and PBMs that offer a step therapy or a fail-first protocol for pharmaceuticals are required to comply with benchmark four.

⁶ 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.

on health care professionals, payors, and PBMs. Electronic preauthorization improves medical and pharmacy efficiencies by enabling more timely responses from payors and PBMs, minimizing resources utilized with the manual preauthorization process, and helping to enhance patient care and safety.⁷ Electronic preauthorization requests can be submitted using one of two methods: (1) online portals;⁸ or (2) existing health information technology (health IT) systems, such as electronic health records (EHRs) and electronic prescribing (e-prescribing) systems.

Limitations

This report relies on information that payors and PBMs provided regarding implementing the preauthorization benchmarks as of June 2015. Information was collected through an online questionnaire that was developed based on responses by payors and PBMs in the prior reporting period.⁹ Responses to the online questionnaire were not verified for accuracy. Information on health care professional usability does not reflect the views of all health care professionals.

Maryland's Progress

All payors and PBMs have met the first three benchmark requirements of the law.¹⁰ These payors and PBMs include: Aetna Inc./Coventry Health Care Inc. (Aetna/Coventry);¹¹ CareFirst BlueCross BlueShield (CareFirst); Catamaran Corporation (Catamaran);¹² Cigna Health and Life Insurance Company (CHLIC)/Connecticut General Life Insurance Company (CGLIC) (collectively Cigna); Cigna Pharmacy Management, Inc.; CVS Caremark; Express Scripts, Inc.; UnitedHealthcare Behavioral Health; UnitedHealthcare Insurance Company (UHC)/MD-Individual Practice Association, Inc. (MDIPA)/MAMSI Life and Health Insurance Company (MAMSI)/Optimum Choice, Inc. (OCI) (collectively UnitedHealthcare); and UnitedHealthcare OptumRx.¹³ Almost all payors and PBMs implemented the fourth benchmark by July 1, 2015 as required by the law. Express Scripts, Inc. was granted additional time to address technical challenges (Table 1).¹⁴

⁷ Center for Health Transformation, *Electronic Prior Authorization and Its Potential Impact on Healthcare*, March 2012. Available at: wayne-oliver.com/wp-content/uploads/2012/05/Electronic-Prior-Authorization-White-Paper-Final-Mar-161.pdf.

⁸ Also referred to as an "online preauthorization system" herein, which are stand-alone web-based systems.

⁹ See Appendix D for copy of the survey completed by payors and PBMs.

¹⁰ Select payors and PBMs requested and have been granted a waiver from meeting certain benchmarks for extenuating circumstances outlined in law. See Appendix E for information on payor and PBM waiver status and the reasoning for the waiver.

¹¹ Aetna acquired Coventry Health Care on May 7, 2013.

¹² UnitedHealthcare OptumRx acquired Catamaran on July 23, 2015.

¹³ See Appendix F for information on payor and PBM attainment of all four benchmarks.

¹⁴ Express Scripts was granted a waiver until November 30, 2015 as a portion of their client base has various preauthorization rules that require a separate effort to assist plans in customizing their benefits to allow for online adjudication and an override command when necessary.

Table 1: Implementation of Benchmark 4
Electronic Override for Step Therapy and Fail-First Protocols

Payor/PBM	Implemented Benchmark	Date Completed/ Expected Date of Completion
Aetna/Coventry	Yes	June 1, 2015
CareFirst	Yes	July 1, 2015
Catamaran	Yes	July 1, 2014
Cigna Pharmacy Management	Yes	July 1, 2013
CVS Caremark	Yes	June 1, 2012
Express Scripts	No	November 1, 2015
UnitedHealthcare OptumRX	Yes	July 1, 2015

Electronic preauthorization for medical services increased by nearly 52 percent between 2012 and 2014 (Figure 1).^{15, 16} In comparison, pharmaceutical electronic preauthorization requests experienced much smaller growth during this same time period. The use of online portals for pharmaceutical services is not expected to increase significantly in the future due to the move towards standards that allow submission via existing health IT systems. In 2012, the National Council for Prescription Drug Programs (NCPDP) published the Electronic Prior Authorization Transaction Standard (ePA standard).^{17, 18, 19} The ePA standard enables health care professionals to complete the preauthorization process using their existing EHR or e-prescribing system rather than an online portal and is becoming increasingly available.²⁰ Approximately 22 percent of EHR and e-prescribing vendors have implemented the ePA standard. In addition, about 54 percent are planning to implement the ePA standard in the near future.²¹

¹⁵ See Appendix G for payor and PBM claims and preauthorization volume by year.

¹⁶ See Appendix H for the top five provider specialties submitting the highest volume of preauthorization requests by payor and PBM.

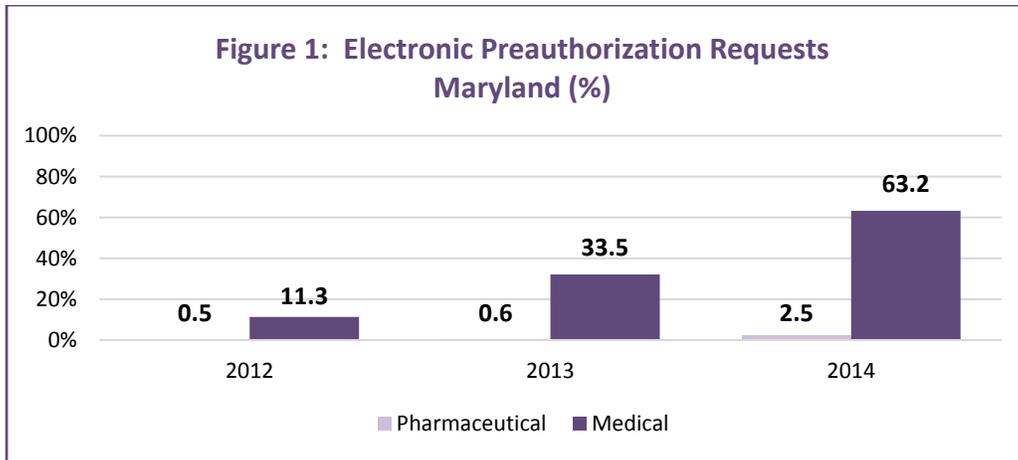
¹⁷ NCPDP, *SCRIPT Electronic Prior Authorization Transactions Overview, August 2013*. Available at: www.ncpdp.org/NCPDP/media/pdf/NCPDP_SCRIPT_ePA_Standard.pdf.

¹⁸ The ePA standard is part of the approved, published NCPDP SCRIPT Standard for e-prescribing, which was named in the Medicare Modernization Act and a requirement of Meaningful Use.

¹⁹ NCPDP had worked many years to develop ePA standards and formed the first NCPDP ePA Task Group in 2004 to promote standardized electronic preauthorization.

²⁰ Typically, the manual preauthorization process results in preauthorization requests for pharmaceuticals to be initiated retrospectively after a claim is rejected at the pharmacy.

²¹ CoverMyMeds, *National Adoption Scorecard Electronic Prior Authorization*, March 2015. Available at: epascorecard.covermymeds.com.



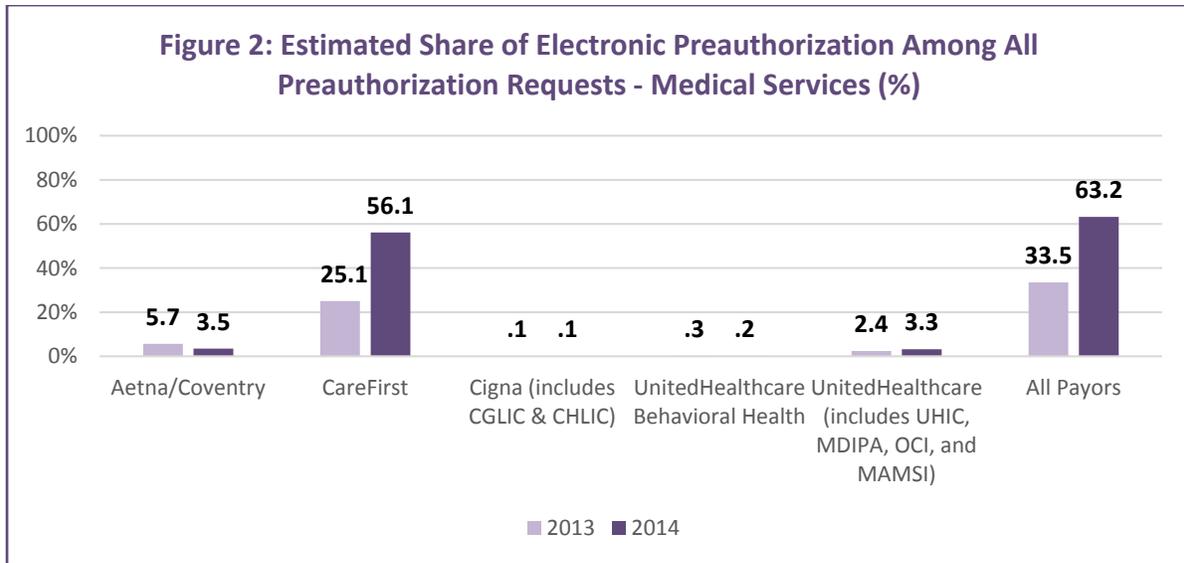
The increase in the number of electronic preauthorization requests for medical services is largely attributed to CareFirst, which nearly doubled the volume it reported from the prior year (Table 2). In comparison, most other payors reported about a 10 percent increase in electronic preauthorization requests. CareFirst also experienced a notable increase in its share of electronic medical services preauthorization over the last year; the share reported by nearly all other payors remained about the same (Figure 2).

Payor	2013		2014		Percent Change
	# ^a	%	#	%	
Aetna/Coventry	17,117	23.0	15,550	37.3	14.3
CareFirst	75,808 ^b	36.2	250,962	70.9	34.7
Cigna (includes CGLIC & CHLIC)	170	9.8	486	12.8	3.0
UnitedHealthcare Behavioral Health	846	14.9	953	28.3	13.4
UnitedHealthcare (includes UHIC, MDIPA, OCI, and MAMSI)	7,116	17.8	14,540	33.0	15.2
Total	101,057	33.5	282,491	63.2	29.7

Notes:

^a The number of electronic preauthorization requests was extrapolated based on the percent of electronic preauthorization requests and number of all preauthorization requests reported by the payor(s).

^b CareFirst transitioned to new preauthorization system in 2013; percent reported represents roughly a half year of data; information in the table was annualized for comparison purposes.



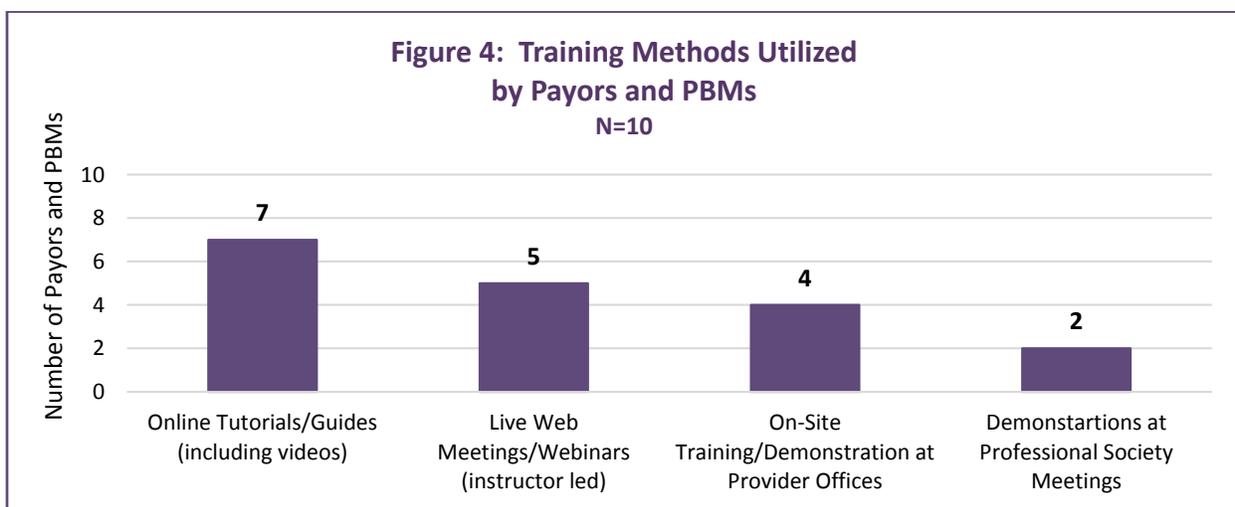
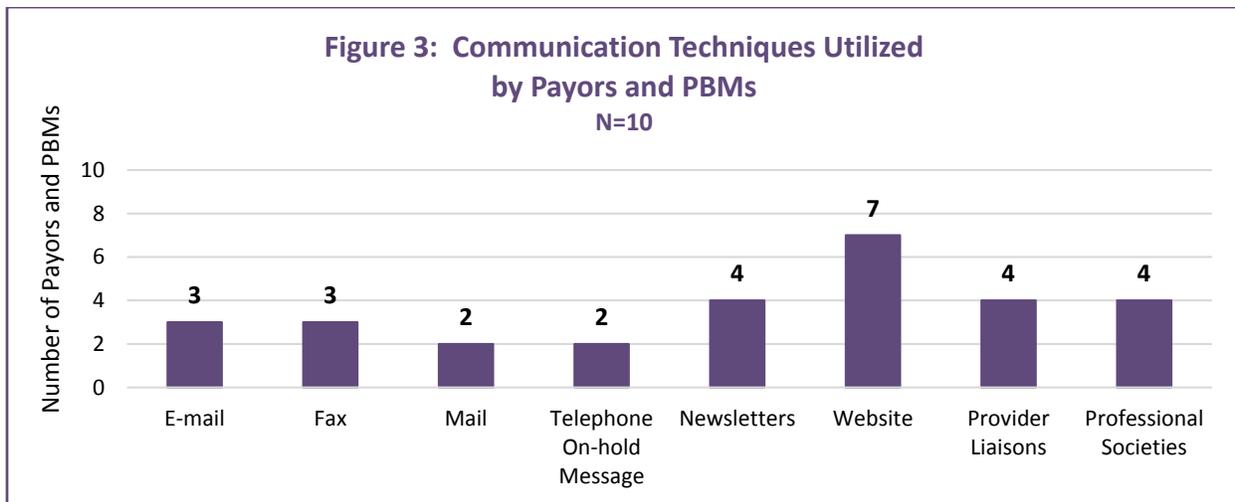
Payors and PBMs rely on various communication techniques to promote the use of online preauthorization systems (Figure 3).^{22, 23, 24} Web-based communication is used more than other forms of awareness building by almost two to one. Most payors and PBMs indicated that implementing telephone on-hold messages created operational challenges for them in customizing a Maryland specific message.²⁵ The majority of payors and PBMs, nearly 70 percent, offer online training programs (Figure 4). On-site training ranked third on the list of training methods used; however, several payers identified on-site training as the most effective way to build awareness.

²² Catamaran does not send out communications about its online preauthorization system as the service must be purchased by their clients; as such, broad communications to health care professionals would not be appropriate if the service is not available to health care professionals in instances where a member's plan has not subscribed to the service. Catamaran does provide training on how to use its online preauthorization system.

²³ Cigna Pharmacy Management and UnitedHealthcare OptumRX did not deploy an awareness and education strategy in 2014. Cigna Pharmacy Management stated that its online preauthorization system is designed to be self-explanatory and has instructions on the landing page. UnitedHealthcare OptumRx stated its online preauthorization system is usable and straight forward.

²⁴ See Appendix I for details regarding payor and PBMs education and awareness strategies.

²⁵ See Appendix J for information on a payor and PBM electronic preauthorization notification strategy.



Usability Challenges

Nearly 25 percent of health care professionals who participated in an MHCC-lead environmental scan did not identify any concerns in using online portals.²⁶ About one in four experienced some difficulty incorporating the online preauthorization process into their workflow. For the most part, completing an online preauthorization request was preferred over submitting a preauthorization request via telephone. Roughly 13 percent indicated that telephoning in a preauthorization request caused workflow disruptions.²⁷

Most payors and PBMs report their online portals are easy-to-use and an efficient way for health care professionals to obtain preauthorization for medical services and pharmaceuticals. A few indicated that some health care professionals had difficulty in locating member information through the online portals (Table 3). Nearly all payors and PBMs enable out-of-network providers

²⁶ Open ended survey questions asked providers to identify challenges a practice encounters when using online portals for medical services and pharmaceuticals.

²⁷ One practice consisting of five physicians stated its staff spends 10 hours a week submitting preauthorization requests for Medicaid patients.

to access their online portals by completing a registration process. The amount of time it takes to register varies by payor and PBM. About one-third indicated the registration process can be completed in minutes, while the majority require up to two weeks to complete the process. Only UnitedHealthcare Behavioral Health does not provide access for out-of-network providers to its online portal.²⁸

Payor/PBM	Most Common Troubleshooting Inquires	Out-of-Network Provider Access	Estimated Time Frame to Obtain Access
Aetna/Coventry	General information; provider set-up	Yes	Up to 10 days
CareFirst	Member eligibility	Yes	~5 minutes
Catamaran	None reported	Yes*	~1 day
Cigna (includes CGLIC & CHLIC)	None reported	Yes	Up to 10 days
Cigna Pharmacy Management	None reported	Yes	Instantaneous
CVS Caremark	None reported	Yes	~5 minutes
Express Scripts	None reported	Yes	Up to 4 hours**
UnitedHealthcare (includes UHIC, MDIPA, OCI, MAMSI)	Member not found; member does/does not require a preauthorization; reset password; general navigation	Yes	~5-7 days***
UnitedHealthcare Behavioral Health	Member not found; benefits clarification	No	N/A
UnitedHealthcare OptumRx	None reported	Yes	~1-2 days

Notes:

* Access only available if Catamaran’s clients subscribe to the online portal

** Time frame is dependent upon finding the National Provider Identifier in the Centers for Medicare & Medicaid Services database

*** For security reasons, the user identification is sent by mail and the password is sent separately by e-mail

Almost 11 percent of health care professionals report that uploading supporting documentation to a payor or PBM online portal can deter its use. While more than half of payors and PBMs support appending documentation to pharmaceutical preauthorization requests, only CareFirst supports uploading documentation for medical services (Table 4).

²⁸ UnitedHealthcare Behavioral Health allows any behavioral health care provider to request a preauthorization 24/7 via phone.

**Table 4: Payor/PBM Online Portal
Uploading Supporting Documentation**

Payor/PBM	Medical Services	Pharmaceuticals
Aetna/Coventry	No	Yes
CareFirst	Yes	Yes
Catamaran	<i>Not applicable to this PBM</i>	Yes
Cigna (includes CGLIC & CHLIC)	No*	<i>See Cigna Pharmacy Management</i>
Cigna Pharmacy Management	<i>Not applicable to this PBM</i>	Yes
CVS Caremark	<i>Not applicable to this PBM</i>	Yes
Express Scripts	<i>Not applicable to this PBM</i>	Yes
UnitedHealthcare (includes UHIC, MDIPA, OCI, MAMSI)	Yes – Outpatient Services No – Inpatient Services**	<i>See UnitedHealthcare OptumRX</i>
UnitedHealthcare Behavioral Health	No***	<i>See UnitedHealthcare OptumRX</i>
UnitedHealthcare OptumRx	<i>Not applicable to this PBM</i>	No

Notes:

- * Cigna instructs users of its online portal to fax or mail in supporting documentation. Cigna has been working to enhance this functionality to allow users to affix supporting documentation; the new capability is scheduled to go live in 2016.
- ** UnitedHealthcare expects to complete a system enhancement to enable supporting documentation to be uploaded for inpatient services by Q4 2015; in the interim, all supporting documentation for inpatient services must be faxed.
- *** UnitedHealthcare Behavioral Health does not require supporting documentation for outpatient services. Supporting documentation for inpatient services must be faxed or e-mailed.

Remarks

The use of online portals provides an efficient means to submit, process, and track preauthorization requests. Payors and PBMs have done a laudable job in implementing the technology to support Maryland law. However, the online portals for pharmaceutical services may not be necessary in the future once the ePA standard becomes widely adopted by health IT systems. For most payors, more work is needed to resolve challenges that lead health care professionals to submit preauthorization requests for medical services by telephone or fax. Over the next year, MHCC plans to work with payors and PBMs to address health care professional challenges when using online portals.

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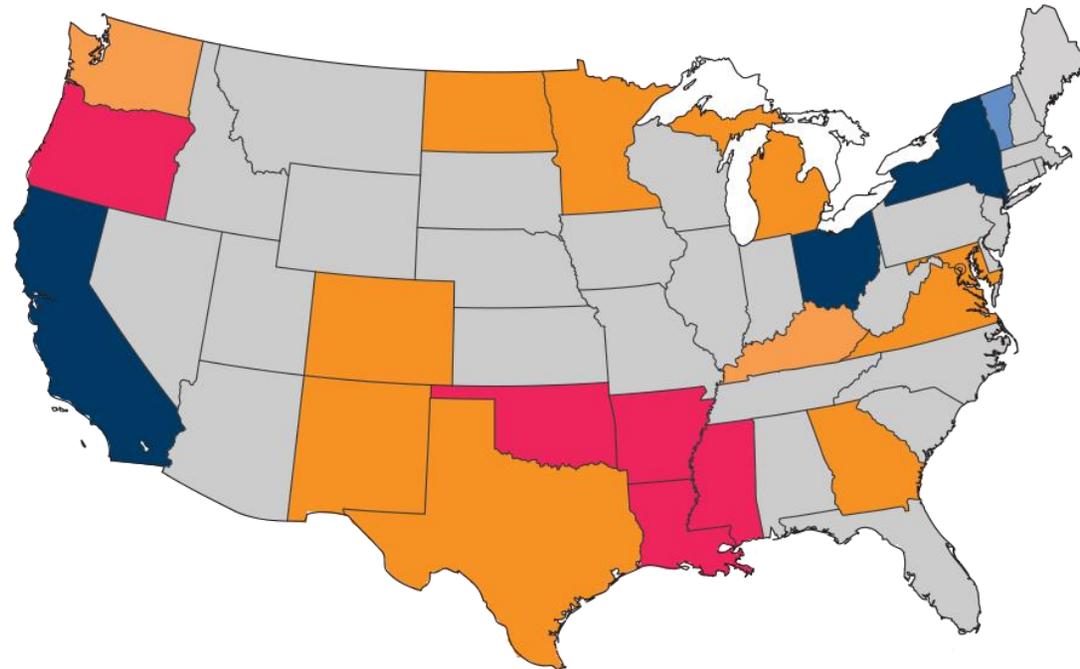
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Optimum Choice, Inc.
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Appendix A: State Legislation

The following map details electronic preauthorization legislation status among states:



- = Mandate electronic submission, some pending deadlines
- = Require electronically available ePA forms
- = Law mandates electronic transaction, not being enforced
- = Legislation proposed

Source: CoverMyMeds, *National Adoption Scorecard Electronic Prior Authorization*, March 2015. Available at: epascorecard.covermymeds.com.

Appendix B: Md. Code Ann., Health-Gen § 19-108.2

Md. Health-General Code Ann. § 19-108.2²⁹

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.

²⁹ Annotated Code of Maryland. Copyright 2012 by Matthew Bender and Company, Inc., a member of the LexisNexis Group. All rights reserved.

(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:

- (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 C: 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.

(6) “Prescriber” means a health care practitioner who has the required license and, if necessary, scope of practice or delegation agreement that permits the health care practitioner to prescribe drugs to treat medical conditions or diseases.

(7) “Step therapy or fail-first protocol” is a protocol established by an insurer, a nonprofit health service plan, a health maintenance organization, or a pharmacy benefits manager 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.

(8) “Supporting Medical Information” means:

(a) A paid claim from a payor that requires a step therapy or fail-first protocol for an insured or an enrollee;

(b) A pharmacy record that documents that a prescription has been filled and delivered to an insured or enrollee, or to a representative of an insured or enrollee; or

(c) Other information mutually agreed to that constitutes sufficient supporting medical information by an insured’s or enrollee’s prescriber and a payor that requires a step therapy or fail-first protocol.

.03 Benchmarks.

A. Each payor shall establish and maintain 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. Each payor shall establish and maintain 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. Each payor shall establish and maintain an online preauthorization system that meets the requirements of, Health General §19-108.2(e), Annotated Code of Maryland, to:

- (1) Approve 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) Render a determination 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 subsection (1) of this item; and

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

D. On or before July 1, 2015, a payor that requires a step therapy or fail-first protocol shall:

(1) Establish and shall thereafter maintain an online process to allow a prescriber to override the step therapy or fail-first protocol if:

(a) The step therapy drug has not been approved by the U.S. Food and Drug Administration for the medical condition being treated;
or

(b) A prescriber provides supporting medical information to the payor that a prescription drug covered by the payor:

(i) Was ordered by the prescriber for the insured or enrollee within the past 180 days; and

(ii) Based on the professional judgment of the prescriber, was effective in treating the insured's or enrollee's disease or medical condition;

(2) Provide notice to prescribers regarding the availability of its online process; and

(3) Provide information to insureds or enrollees on the availability of the step therapy or fail-first protocol within its network.

E. A payor that becomes authorized to provide benefits or services within the State of Maryland after October 1, 2012, shall meet each benchmark within this chapter within three months of the payor's offering of services or benefits within the State and shall thereafter maintain the processes or actions required by each benchmark.

.04 Reporting.

A. On or before August 1, 2015, a payor that requires a step therapy or fail-first protocol shall report to the Commission in a form and manner specified by the Commission on its attainment of the benchmark in Section .03D.

B. A payor that becomes authorized to provide benefits or services within the State of Maryland after October 1, 2012, shall report to the Commission in a form and manner specified by the Commission on its attainments of each benchmark in Regulation .03 of this chapter within 3 months of the payor's offering of services or benefits within the State.

C. If requested by the Commission, a payor shall demonstrate continued compliance with the benchmarks in Regulation .03.

.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 .03 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) An identification 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 benchmarks in this chapter, no later than 60 days prior to the compliance date; or

(b) For renewal of a waiver, no later than 30 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 Waiver.

(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 two years, 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 a determination is made by the Commission as to 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.

Appendix D: Survey Completed by Payors and PBMs

Md. Code Ann., Health-General Article §19-108.2 (2012) established three benchmarks requiring State-regulated payors (payors) and pharmacy benefits managers (PBMs) to implement, in a phased approach, electronic preauthorization processes. In 2014, the law was amended adding a fourth benchmark, which requires certain payors and PBMs to establish a process by July 1, 2015 that allows providers to override a step therapy or fail-first protocol for electronic pharmaceutical preauthorization requests. The law requires payors and PBMs to report to the Maryland Health Care Commission (MHCC) on their attainment of the benchmarks. Payor and PBM responses to this survey will be used to report to the Governor and General Assembly.

Please answer the survey for calendar year 2014.

Contact information

Respondent Name:

Title:

Organization:

E-mail:

Phone Number:

Section 1 – Preauthorization Benchmark Attainment

The following questions inquire about payor and PBM progress in attaining the fourth benchmark that requires the establishment of an online process by July 1, 2015 that allows providers to override a step therapy or fail-first protocol for electronic pharmaceutical preauthorization requests. *Note: A 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.*

1. Does your online preauthorization system allow providers to override a step therapy or fail first protocol?
 - Yes – If yes, when was the electronic step therapy/fail first protocol override process completed (MM/DD/YYYY)?
 - No – Answer question below:
 - Identify the status of your organization in meeting this requirement:

- Assessing a step therapy/fail first protocol override process for the online preauthorization system
Expected completion date (MM/DD/YYYY)?
- Implementing a step therapy/fail first protocol override strategy for the online preauthorization system
Expected completion date (MM/DD/YYYY)?
- Seeking waiver

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

Section 2 – Claims/Preauthorization Volume

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 preauthorization.

Part I: Pharmaceutical Claims and Preauthorization Requests

2. Identify the lines of business you are including in the responses below (e.g., fully-insured, self-insured, Medicare etc.)?
3. Provide the estimated number of pharmaceutical claims and preauthorization requests submitted by Maryland providers in calendar year 2014.

Pharmaceuticals		
Total Number of Claims	Total Number of Preauthorization Requests	Total Number of Preauthorization Requests Submitted Electronically via the Online Preauthorization System

4. In ranking order, identify the top five provider specialties in Maryland that submitted the highest volume of pharmaceutical preauthorization requests in calendar year 2014 (e.g., chiropractic, physical therapy, gynecology, etc.). Put “N/A” if your company is unable to obtain this information.
 1. _____
 2. _____
 3. _____

4. _____
5. _____

Part II: Medical Service Claims and Preauthorization Requests

5. Identify the lines of business you are including in the responses below (e.g., fully-insured, self-insured, Medicare etc.)?
6. Provide the estimated number of medical service claims and preauthorization requests submitted by Maryland providers in calendar year 2014.

Medical Services		
Total Number of Claims	Total Number of Preauthorization Requests	Total Number of Preauthorization Requests Submitted Electronically via the Online Preauthorization System

7. In ranking order, identify the top five provider specialties in Maryland that submitted the highest volume of medical service preauthorization requests in calendar year 2014 (e.g., chiropractic, physical therapy, gynecology, etc.). Put "N/A" if your company is unable to obtain this information.
 1. _____
 2. _____
 3. _____
 4. _____
 5. _____

Section 3 - Usability

8. Have you received any troubleshooting inquiries from Maryland users of the online preauthorization system?
 - Yes (Proceed to question 9)
 - No (Skip to question 10)

9. What are the top three most common troubleshooting inquiries received from Maryland users of the online preauthorization system?
1. _____
 2. _____
 3. _____

Section 4 – Awareness & Education

10. Did your company deploy an awareness and education strategy in calendar year 2014 to inform and educate Maryland providers and their staff about the online preauthorization system (e.g., use of e-mail, fax, newsletters, website, etc. to communicate information about the online preauthorization system)?
- Yes (Proceed to question 11)
 - No (Skip to question 17)
11. Indicate how often (i.e., daily, weekly, bi-weekly, monthly, quarterly, yearly, upon request, and never used) your company used the following mediums in 2014 to communicate information about the availability of your online preauthorization to Maryland providers.
- Email
 - Fax
 - Mail
 - Telephone on-hold message
 - Newsletters
 - Website
 - Provider liaisons
 - Professional societies
 - Social media
 - Other – Specify:
12. If information about the online preauthorization system is provided on your company's website, specify where this information is located. Put "N/A" if your company does not include information about the online preauthorization system on your company's website.

13. If your company communicates information about the online preauthorization system via professional societies, specify which types of professional societies. Put "N/A" if your company does not communicate information about the online preauthorization system via professional societies.
14. If your company communicates information about the online preauthorization system using social media, specify which types of social media. Put "N/A" if your company does not communicate information about the online preauthorization system using social media.
15. In ranking order, identify the top three mediums your company finds to be the most effective for informing Maryland providers about the online preauthorization system with 1 being the most effective?
- Email
 - Fax
 - Mail
 - Telephone on-hold message
 - Newsletters
 - Website
 - Provider liaisons
 - Professional societies
 - Social media
 - Other
 - None of the above
 - None of the above
 - None of the above

Please provide an explanation as to why your company considers the mediums selected above to be the most effective. If your company finds none of the above mediums to be effective, please explain why?

16. Do communications about the availability of your company's online preauthorization system target any specific provider specialties (e.g., chiropractic, physical therapy, gynecology, etc.) that submit a high number of preauthorization requests?
- Yes – Please specify the targeted provider specialty or specialties:

- No – Please explain why your company’s communications about the availability of the online preauthorization system does not target specific provider specialties.

17. Does your company have plans to communicate information about the availability of your online preauthorization to Maryland providers?

- Yes – What types of mediums does your company plan to use to communicate information about the availability of your online preauthorization to Maryland providers?
 - Email
 - Fax
 - Mail
 - Telephone on-hold message
 - Newsletters
 - Website
 - Provider liaisons
 - Professional societies
 - Social media
 - Other – Specify:
- No - Please explain why your company does not have plans to communicate information about the availability of your online preauthorization to Maryland providers.

18. What types of training for the online preauthorization system does your company currently make available to Maryland providers?

- Online tutorials/guides (including videos)
 - If your company provides training to Maryland providers via online tutorials/guides (including videos), please provide link(s), if possible. Put "N/A" if your company does not offer online tutorials/guides to Maryland providers.
- Live web meetings/webinars (instructor led)
 - If your company provides training to Maryland providers via live web meetings/webinars (instructor led), please specify how often these occur (e.g., weekly, monthly, quarterly, etc.)? Put "N/A" if your company does not offer live meetings/webinars to Maryland providers.
- On-site training/demonstration at provider offices

– If your company provides on-site training/demonstrations at Maryland provider offices, please specify how often these occur (e.g., weekly, monthly, quarterly, etc.)? Put "N/A" if your company does not offer on-site training/demonstrations at Maryland provider offices.

- Demonstrations at professional society meetings
 - If your company provides training to Maryland providers via demonstrations at professional society meetings, please specify how often these occur (e.g., weekly, monthly, quarterly, etc.)? Put "N/A" if your company does not offer demonstrations at professional society meetings.
- Other – specify:
- None of the above (Skip to Question 20)

19. In ranking order, identify the top three types of training your company finds to be the most effective for training Maryland providers on how to use the online preauthorization system? (select up to three) (Skip to Question 21)

- Online tutorials/guides (including videos)
- Live web meetings/webinars (instructor led)
- On-site training/demonstration at a provider's office
- Demonstrations at professional society meetings
- Other
- None of the above
- None of the above
- None of the above

Please provide an explanation as to why your company considers the training types selected above to be the most effective. If your company finds none of the above training types to be effective, please explain why?

20. Does your company have plans to offer training to Maryland providers on how to use the online preauthorization system?

- Yes – What types of training for the online preauthorization system does your company plan to (in the future) make available to Maryland providers:
 - Online tutorials/guides (including videos)
 - Live web meetings/webinars (instructor led)
 - On-site training/demonstration at a provider's office
 - Demonstrations at professional society meetings

- Other – specify:
- No – Please explain why your company does not have plans to offer training to Maryland providers on how to use the online preauthorization system.

21. Has your company implemented the draft language below or a similar notice on any communications to Maryland providers?

Note: The draft language below was discussed during a preauthorization workgroup meeting convened by MHCC in August 2014. The draft language or similar notice was intended to increase utilization of the online preauthorization systems and remind health care practitioners about the July 1, 2015 requirement to submit all preauthorization requests electronically. The draft language could be incorporated in telephone on-hold messages or fax receipt acknowledgements for approvals/denials of 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.

- Implemented draft language
 - If your company implemented the draft language, please specify the communication type(s) (e.g., e-mail, fax, mail, telephone on-hold message, etc.) that include the draft language and the implementation date(s) (Month/Year):
- Implemented similar notice
 - If your company implemented a similar notice, please provide the language used, the communication type(s) (e.g., e-mail, fax, mail, telephone on-hold message, etc.) that include the language and the implementation date(s) (Month/Year):
- Did not implement draft language or similar notice
 - Please explain why your company has not implemented the draft language or a similar notice?

Section 5 – Provider Challenges

22. In ranking order, identify the top three challenges that your company believes impacts Maryland providers’ adoption and use of the online preauthorization system

1. _____
2. _____

3. _____

Specify any other challenges: _____

Section 6 – 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 is the equivalent of a physical signature.

Date:

The MHCC thanks you for completing this survey

Appendix E: Payor and PBM Waiver Status

COMAR 10.25.17, *Benchmarks for Preauthorization of Health Care Services*, 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. The following payors and PBMs were granted waivers for an extension of time to comply with certain benchmarks.

Benchmark Waiver Status/Reasoning				
Payor/PBM	Benchmark 1	Benchmark 2	Benchmark 3	Benchmark 4
Kaiser Permanente	Group model health maintenance organization			
Benecard Services, Inc.	Low market share			
Catamaran	In the process of migrating a portion of their client base to one technology platform – scheduled to be completed by December 2015			
Direct Pharmacy Services, Inc.	Low market share			
Express Scripts	N/A			Estimated completion November 2015
Fairview Pharmacy Services, LLC	Low market share			
MaxorPlus	Low market share			
PBM Plus	Low market share			
Pharmaceutical Technologies, Inc.	Low market share			
Prime Therapeutics, LLC	Low market share			
WellDyne Rx, Inc.	Low market share/union sponsored health plan			

Appendix F: Payor and PBM Benchmark Attainment

Payor and PBM Attainment of the 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	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/ Coventry	✓	✓	✓	✓	✓	✓	✓
CareFirst	✓	✓	✓	✓	✓	✓	✓
Cigna (includes CHLIC and CGLIC)	✓	✓	✓	✓	✓	✓	✓
UnitedHealthcare Behavioral Health	✓	✓	✓	Not applicable to this payor – refer to UnitedHealthcare OptumRx		✓	Not applicable to this payor – refer to UnitedHealthcare OptumRx
UnitedHealthcare (includes UHIC, MDIPA, OCI, and MAMSI)	✓	✓	✓			✓	
PBM							
Catamaran*	✓	▲	▲	▲	▲	Not applicable to PBMs	▲
CVS Caremark	✓	✓	✓ [¥]	✓	✓		✓
Express Scripts	✓	✓	✓	✓	✓		▲
UnitedHealthcare OptumRx	✓	✓	✓	✓	✓		*

Key:

✓ = Benchmark implemented

* = PBM has implemented and is in compliance with all four benchmarks; the temporary benchmark waiver is for a portion of their client base that is in the process of migrating to one technology platform, which is scheduled to be completed by December 2015.

▲ = Temporary benchmark waiver obtained.

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

Appendix G: Payor and PBM Claims/Preauthorization Volume

Payors and PBMs reported information on claims and preauthorization volume for calendar year 2014. Note: Fluctuations in the total number of preauthorization requests 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.

Medical Services									
Payor	Total Number Claims		Total Number of Preauthorization Requests				Percent of Electronic Preauthorization Requests		
	2013	2014	2013		2014		2013	2014	
	#	#	#	% of claims	#	% of claims	%	#	%
Aetna*	6,008,275	3,048,233	43,821	0.73	41,644	1.37	38.90	15,551	37.34
Coventry	14,155		1,000	7.06			7.10		
CareFirst BlueCross BlueShield	34,922,860	24,488,211	209,412 ^b	0.60 ^b	354,109	1.45	36.20	250,962	70.87
Cigna (includes CGLIC & CHLIC)	1,435,549	1,799,952	1,743	0.12	3,803	0.21	9.75	486	12.78
UnitedHealthcare Behavioral Health	129,519	111,327	5,677	4.38	3,374	3.03	14.90	953	28.25
UnitedHealthcare (includes UHIC, MDIPA, OCI, and MAMSI)	2,490,505	2,318,929	39,976	1.61	44,074	1.90	17.80	14,540	32.99

* Aetna acquired Coventry in May 2013.

^b CareFirst transitioned to new preauthorization system in 2013; percent reported represents roughly a half-year of data; information in the table was annualized for comparison purposes.

Pharmaceuticals									
PBM	Total Number of Claims		Total Number of Preauthorization Requests				Percent of Electronic Preauthorization Requests		
	2013	2014	2013		2014		2013	2014	
	#	#	#	% of claims	#	% of claims	%	#	%
Aetna	2,910,790	2,179,328	98,081	3.37%	17,171	0.79%	0%	110	0.64%
Coventry	338,799		2,416	0.71%			8.11%		
CareFirst BlueCross BlueShield	11,759,549	8,702,811	28,499	0.24%	29,461	0.34%	0.70%	513	1.74%
Cigna Pharmacy Management	614,276	563,922	5,489	0.89%	9,822	1.74%	0.32%	784	7.98%
Catamaran	2,470,877	2,540,000	1,130	0.05%	1,650	0.06%	*	0	0.00%
CVS Caremark	18,600,000	19,000,000	146,142	0.79%	182,589	0.96%	<1%	6,929	3.79%
Express Scripts	185,900	13,760,772	55,621	29.92%	75,933	0.55%	*	1	0.00%
UnitedHealthcare OptumRx	538,293	669,941	14,765	2.74%	30,593	4.57%	0.57%	166	0.54%

* Data unavailable or online portal was not yet available to accept preauthorization requests during the identified time period.

Appendix H: Payor and PBM Top Five Provider Specialties Submitting Highest Volume of Preauthorization Requests

Top Five Specialties (in rank order) Submitting the Highest Volume of Preauthorization Requests										
Payor/PBM	Medical Specialties					Pharmaceutical Specialties				
	1	2	3	4	5	1	2	3	4	5
Aetna/Coventry	Surgery	Endocrinology, Reproductive	Rheumatology	Oncology	Internal Medicine	Internal Medicine	Family Practice	Pediatrics	Psychiatry	OB/GYN
CareFirst	Internal Medicine	OB-GYN	Licensed Chiropractor	Physical Therapist	General Surgery	Unavailable				
Catamaran	<i>Not applicable to this PBM</i>					Unavailable				
Cigna (includes CGLIC & CHLIC)	Internal Medicine	Anesthesiology	Emergency Medicine	Cardiology	Hematology	<i>Not applicable to this payor – refer to Cigna Pharmacy Management</i>				
Cigna Pharmacy Managment	<i>Not applicable to this PBM</i>					Unavailable				
CVS Caremark	<i>Not applicable to this PBM</i>					Internal Medicine	Family Practice	Pediatrics	Psychiatry	OB/GYN
Express Scripts	<i>Not applicable to this PBM</i>					Unavailable				
UnitedHealthcare (includes UHIC, MDIPA, OCI, MAMSI)	Imaging	Medical (PCP, General Internists, Surgeons, etc.)	Diagnostic Testing	Maternity	Surgical	<i>Not applicable to this payor – refer to UnitedHealthcare OptumRX</i>				
UnitedHealthcare Behavioral Health	Unavailable					<i>Not applicable to this payor – refer to UnitedHealthcare OptumRX</i>				
UnitedHealthcare OptumRx	<i>Not applicable to this PBM</i>					Internal Medicine	Family Practice	Psychiatry	Gastroenterology	Cardia Electrophysiology

Appendix I: Payor and PBM Education & Awareness Strategies

Online Preauthorization System Awareness and Education 2014 Mediums Utilized by Payor/PBM Including Frequency									
Payor/PBM	E-mail	Fax	Mail	Telephone On-hold Message	Newsletters	Website	Provider Liaisons	Professional Societies	Total Mediums Utilized
Aenta/Coventry	Quarterly	Upon Request	Annually	Daily	Annually	Daily	Upon Request	Upon Request	8
CareFirst	Quarterly				Quarterly	Daily	Upon Request	Upon Request	5
Catamaran									0
Cigna (includes CGLIC and CHLIC)					Quarterly	Daily	Upon Request		3
CVS Caremark		Daily	Monthly	Daily		Daily			4
Express Scripts		Annually				Daily		Upon Request	3
UnitedHealthcare OptumRX									0
UnitedHealthcare Behavioral Health						Daily			1
UnitedHealthcare (includes UHIC, MDIPA, OCI, and MAMSI)	Bi-Annually				Monthly	Daily	Upon Request	Upon Request	5
Total	3	3	2	2	4	7	4	4	

**Online Preauthorization System Training
2014 Methods Utilized by Payor/PBM**

Payor/PBM	Online Tutorials/ Guides (including videos)	Live Web Meetings/ Webinars (instructor led)	On-Site Training/ Demonstration at Provider Offices	Demonstrations at Professional Society Meetings	Total Training Methods Utilized
Aenta/Coventry	Ongoing	Monthly	Upon Request	Upon Request	4
CareFirst		Monthly	Upon Request		2
Catamaran	Ongoing				1
Cigna (includes CHLIC and CGLIC)	Ongoing	Quarterly	Upon Request		3
CVS Caremark	Ongoing	Monthly			2
Express Scripts	Ongoing				1
UnitedHealthcare OptumRX					0
UnitedHealthcare Behavioral Health	Ongoing				1
UnitedHealthcare (includes UHIC, MDIPA, OCI, and MAMSI)	Ongoing	Monthly	Upon Request	Upon Request	4
Total	7	5	4	2	

Appendix J: 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, or similar 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.



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