MARYLAND HEALTH CARE COMMISSION

State Regulated Payor & Pharmacy Benefits Manager

PREAUTHORIZATION BENCHMARK ATTAINMENT

October 2016

Prepared for
The Governor of Maryland and
The General Assembly

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Overview

In 2012, Maryland became one of the first states to enact legislation (the law)[1] that required State-regulated payors (payors) and pharmacy benefits managers (PBMs) to implement an electronic preauthorization process by establishing online portals.[2] Since then, a number of states have passed similar legislation in an effort to simplify the process.[3] Historically, preauthorization has relied heavily on telephone, fax, and paper-based communications. These methods are often viewed by health care professionals[4] as administratively burdensome and costly to support.[5, 6] The American Medical Association (AMA) reports that physicians spend an average of 20 hours per week on preauthorization activities accounting for more than 868 million hours annually.[7]

Electronic preauthorization emerged as a way to streamline communications between health care professionals, payors, and PBMs regarding patient coverage, eligibility, and/or the medical necessity of a medical service or pharmaceutical. Widespread diffusion of electronic preauthorization has the potential to create efficiencies and enhance care delivery.[8, 9] The law required the Maryland Health Care Commission (MHCC) to work with payors and PBMs to implement electronic preauthorization processes in a series of four benchmarks.[10] The benchmarks include:

1) Provide by October 1, 2012 online access to a listing of all medical 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;

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[1] See Appendix A – Md. Code Ann., Health-Gen. § 19-108.2.
[2] An online portal is a standalone web-based system, also referred to as an "online preauthorization system."
[3] See Appendix B for information on electronic preauthorization legislation by state.
[4] 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.
[5] Zubiller, M. McKesson Health Solutions, *Mastering Change: Succeeding in Healthcare's New World Order, Rethinking Utilization Management to Bring Value to the Point of Care*, January 2015. Available at: mhsdialogue.com/wp-content/uploads/2015/01/McK_Mastering_Change_WP_010515.pdf.
[6] See Appendix C for information on time and cost savings associated with electronic preauthorization.
[7] Medical Economics, *The Prior Authorization Predicament*, July 2014. Available at: medicaleconomics.modernmedicine.com/medical-economics/content/tags/insurance-companies/prior-authorization-predicament?page=full.
[8] Medical Practice Insider, *Reduce costs and simplify administrative processes with electronic prior authorization*, October 2013. Available at: www.medicalpracticeinsider.com/best-practices/reduce-costs-and-simplify-administrative-processes-electronic-prior-authorization.
[9] Council for Affordable Quality Healthcare. *2013 U.S. Healthcare Efficiency Index: Electronic Administrative Transaction Adoption and Savings*, May 2014. Available at: www.caqh.org/sites/default/files/explorations/index/report/2013Index.pdf.
[10] See Appendix D – COMAR 10.25.17.

3) Process by July 1, 2013 electronic preauthorizations for pharmaceuticals in real-time or within one business day of receiving all pertinent information, and process non-urgent medical requests 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 electronic preauthorizations for pharmaceuticals. [11, 12]

The law requires MHCC to report annually to the Governor and General Assembly on payors' and PBMs' attainment of the benchmarks through December 2016. The MHCC surveyed payors and PBMs about utilization of their online portals in developing this annual report.

Limitations

The information included in this report is based on self-reported data from payors and PBMs as of August 2016. Accuracy of the information was not validated through audits. The information collected through online questionnaires[13] and telephone interviews may have been influenced by varying interpretations of the questions among respondents.

Maryland's Progress

The largest payors and PBMs operating in Maryland are compliant with the benchmark requirements established in law (Table 1).[14] The law is aimed at reducing the amount of time required for a health care professional to submit a preauthorization request, as well as establishing consistency in the submission process through online portals. Reengineering the manual process was intended to reduce administrative burdens on health care professionals while improving patients' experience and creating efficiencies in the preauthorization process. The goal of establishing a real-time preauthorization process under certain conditions at the point of care was achieved among payors and PBMs statewide. The regulations, COMAR 10.25.17, *Benchmarks for Preauthorization of Health Care Services,* applies to payors and PBMs with a premium volume of $1M or more annually.

[11] Step therapy or a fail-first protocol requires a certain prescription drug or sequence of prescription drugs to be used by an insured or enrollee before another prescription drug is covered.
[12] Only payors and PBMs that offer a step therapy or fail-first protocol for pharmaceuticals are required to comply with benchmark four.
[13] See Appendix E for a copy of the survey questions.
[14] Select payors and PBMs have received a waiver from meeting certain benchmarks for extenuating circumstances outlined in the law. See Appendix F for more information on payor and PBM waiver status.

Table 1: Payors and PBMs
Aetna Inc./Coventry Health Care Inc. (Aetna/Coventry)[15]
CareFirst BlueCross BlueShield (CareFirst)
Catamaran Corporation (Catamaran)[16]
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 (UHIC), MD-Individual Practice Association, Inc. (MDIPA), MAMSI Life and Health Insurance Company (MAMSI), and Optimum Choice, Inc. (OCI) (collectively UnitedHealthcare)
OptumRx

Electronic preauthorization for medical has increased by over 60 percent over the last four years (Figure 1). Expanded use of electronic preauthorization by health care professionals simplifies the administrative process and reduces the turnaround time for receiving an approval on the request. Over the last year, use of online portals has increased by nearly 12 percent. This increase is largely attributed to CareFirst (Table 2), whose education and outreach initiatives include on-demand training, instructor led webinars, fax back flyers, and newsletter articles, among other things.[17] While other payors established education and outreach initiatives[18], their efforts appear to have been less successful in increasing utilization of their online portals.

[15] Aetna acquired Coventry Health Care on May 7, 2013.
[16] OptumRx acquired Catamaran on July 23, 2015.
[17] CareFirst education and outreach efforts also include seminars, one-on-one training, letters to providers, post cards, eBlasts, and meetings with key providers and executive management at hospitals.
[18] Payor and PBM education and outreach methods include emails, fax, mail, telephone on-hold messages, newsletters, website, provider liaisons, professional societies, online tutorials, live webinars, onsite trainings, and society meetings.

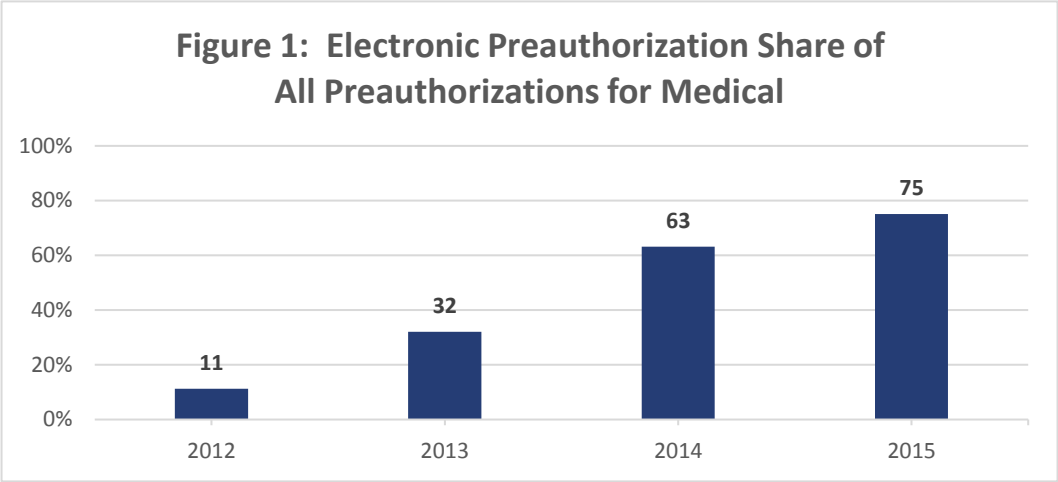
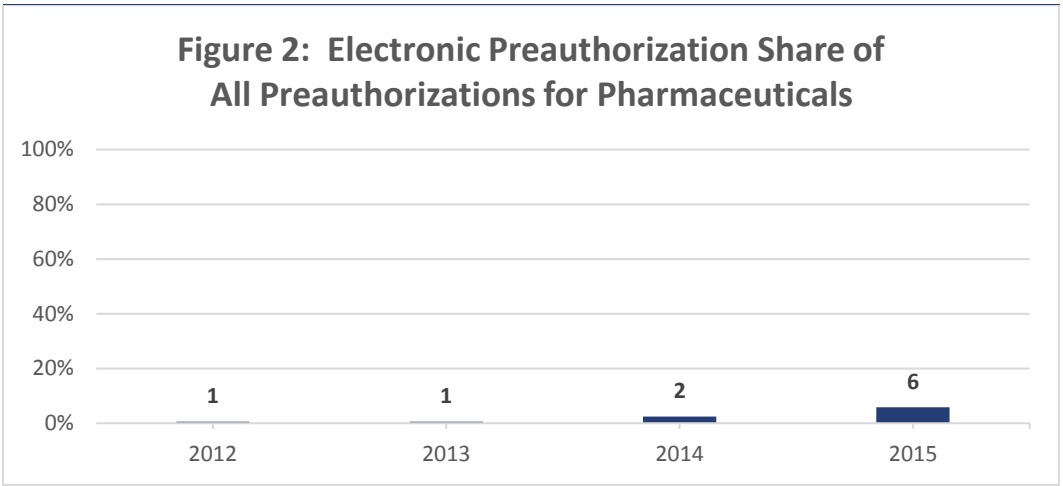


Table 2: Electronic Preauthorization Share of All Preauthorizations for Medical By Payer				
Payor	**2013**	**2014**	**2015**	**Change in percent** *(3 Years)*
	%			
Aetna/Coventry	23	37	34	11
CareFirst	36	71	87	51
Cigna	10	13	8	-2*
UnitedHealthcare Behavioral Health	15	28	28	13
UnitedHealthcare	18	33	33	15
* *System challenge in identifying electronic preauthorizations from fax, phone calls, and paper forms methods are attributed to the decrease from prior year.*				

Use of online portals for pharmaceuticals remains nominal (Figure 2). This can be attributed to the fact that online portals require health care professionals to deviate from existing workflows to check for and initiate a preauthorization.[19] Various forms of eprescribing technology have been available to providers, payors, and PBMs for nearly 15 years. Originally developed as a standalone technology, it has become increasingly integrated with electronic health record technology. The Centers for Medicare & Medicaid Services (CMS) published the first set of standards for eprescribing in November 2005.[20] In 2009, CMS established a five-year incentive program to spur eprescribing for Medicare patients.[21] Most eprescribing technology enables completing the preauthorization process

[19] See Appendix G for more information on the electronic preauthorization process for pharmaceuticals.
[20] CMS, *E-Prescribing*, Accessed August 2016. Available at: www.cms.gov/Medicare/E-Health/Eprescribing/index.html.
[21] American Medical Association, *Understanding the basics of Medicare's Electronic Prescribing Program*, February 2012. Available at: www.sccma-mcms.org/portals/19/assets/docs/faq-cms-incentive-program.pdf.

within the providers' workflow. The volume of pharmaceutical claims that require preauthorization remains notably low at less than one percent.[22]



Impact of Health Care Reform on Preauthorization

Health care reform requires providers, payors, and PBMs to work collaboratively in achieving improved outcomes. In January 2015, CMS announced plans to make alternative payment models account for 30 percent of Medicare reimbursement by 2016 and 50 percent by 2018.[23, 24] In general, preauthorization is disliked by providers who view the requirements as time consuming and distracting from patient care.[25] Preauthorization requirements are expected to increase as value-based care delivery models become widely implemented.[26, 27] Value-based care restructures the way patient care is viewed and delivered by shifting the focus to improving quality of care.[28]

Health care reform initiatives place an increased emphasis on use of technology to coordinate care where payors and PBMs apply more automation to the preauthorization process based on data, and providers adjust approaches to care delivery using data analytics.[29] Value-based care requires a shift

[22] See Appendix H for more information on the percent of claims requiring preauthorization for Maryland payors and PBMs.
[23] Harvard Business Review, *The Strategy That Will Fix Health Care*, October 2013. Available at: hbr.org/2013/10/the-strategy-that-will-fix-health-care.
[24] Healthcare Financial Management Association, *Mitigating Financial Risk in Value-Based Care Models*, August 2016. Available at: www.hfma.org/Content.aspx?id=49674.
[25] Medical Economics, *Curing the prior authorization headache,* October 2013. Available at: medicaleconomics.modernmedicine.com/medical-economics/content/tags/americas-health-insurance-plans/curing-prior-authorization-headache.
[26] Managed Healthcare Executive, *Prior auths are here to stay, Value-based shift will have no impact*, May 2015. Available at: managedhealthcareexecutive.modernmedicine.com/managed-healthcare-executive/news/prior-auths-are-here-stay.
[27] Payors expressed the shift towards value-based care has contributed to an increase in the percent of medical claims requiring preauthorization over the past three years and expects the increase to continue.
[28] Managed Care, *Fixing Utilization Management to Fit With a Value-Based World*, March 2016. Available at: www.managedcaremag.com/archives/2016/3/fixing-utilization-management-fit-value-based-world.
[29] Ibid.

in traditional forms of collaboration among payors, PBMs, and providers.[30] This new direction will likely be one where preauthorization becomes more of a notification to payors and PBMs as opposed to a request for approval to be reimbursed for services rendered.

Remarks

This report marks the final report as required by law.[31] Over the past four years, payors and PBMs have successfully introduced technology to support electronic preauthorization. Meeting the benchmarks required a considerable commitment on the part of payors and PBMs. The benchmarks were phased in over a span of about two years, and payors and PBMs collaborated with providers in design testing of the benchmarks. More work is needed by payors and PBMs, however, to maximize the benefits of the technology for themselves and providers. The MHCC intends to continue collaborating with payors and PBMs to enhance the value of their preauthorization portals and with MedChi, The State Medical Society, on their outreach and education initiatives.

[30] Managed Healthcare Executive, *Prior auths are here to stay: Value-based shift will have no impact*, May 2015. Available at: managedhealthcareexecutive.modernmedicine.com/managed-healthcare-executive/news/prior-auths-are-here-stay.

[31] See Appendix A – Md. Code Ann., Health-Gen. § 19-108.2.

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MD-Individual Practice Association, Inc.
MAMSI Life and Health Insurance Company
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Appendix A: Md. Code Ann., Health-Gen § 19-108.2

Md. Health-General Code Ann. § 19-108.2[32]

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.

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

(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

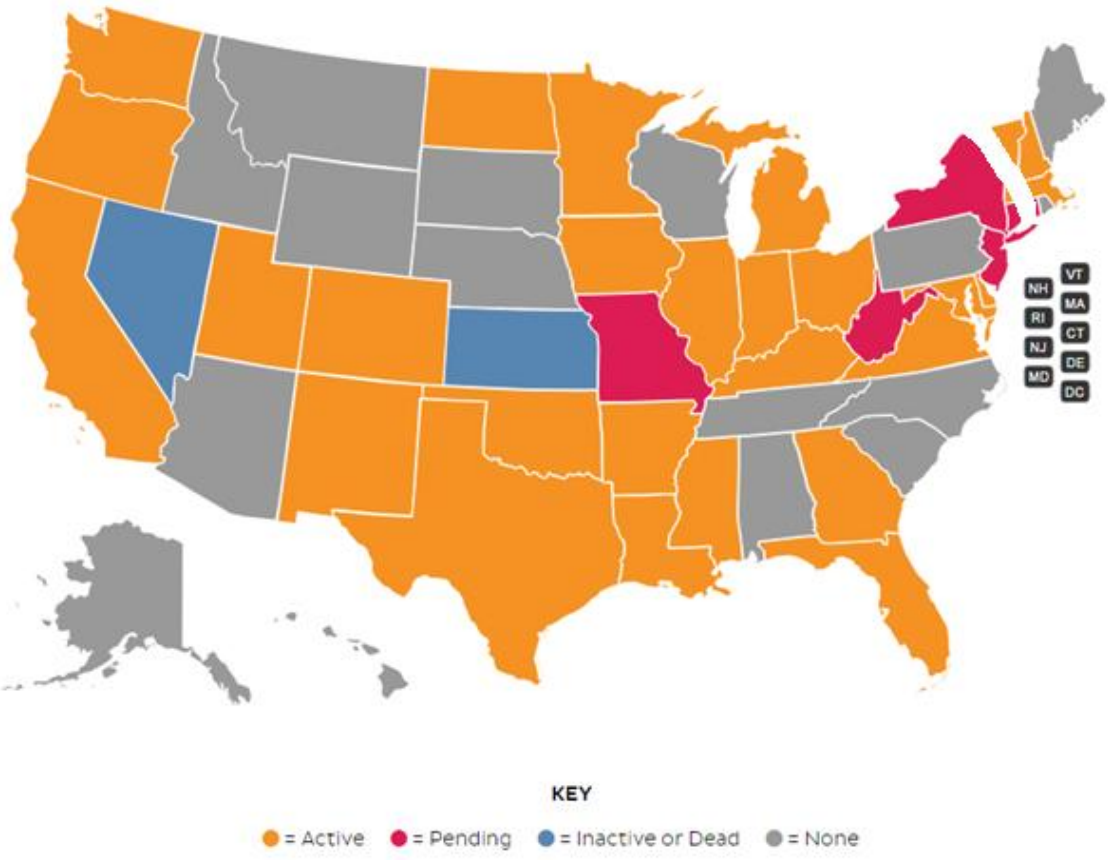
(3) Establish penalties for noncompliance.

HISTORY: 2012, chs. 534, 535.

End quoted text

Appendix B: State Legislation

The following map details electronic preauthorization legislation status among the states:



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

Appendix C: Estimated Costs of Preauthorization

The following table details the estimated cost difference between manual and electronic preauthorization:

Preauthorization *Estimated Per-Transaction Cost in Dollars*						
Transaction	**Health Plan**		**Provider-Facility**		**Total Industry**	
	Manual	Electronic	Manual	Electronic	Manual	Electronic
Preauthorization	3.95	0.18	18.53	5.2	22.48	5.38
Source: Council for Affordable Quality Healthcare. *2013 U.S. Healthcare Efficiency Index: Electronic Administrative Transaction Adoption and Savings*, May 2014. Available at: www.caqh.org/sites/default/files/explorations/index/report/2013Index.pdf.						

Appendix D: 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 E: Survey Completed by Payors and PBMs

Md. Code Ann., Health-General Article §19-108.2 established four benchmarks requiring State-regulated payors (payors) and pharmacy benefits managers (PBMs) to implement, in a phased approach, electronic preauthorization processes. Since 2012, the Maryland Health Care Commission (MHCC) has requested information from payors and PBMs to help assess the impact and policy implications of electronic preauthorization. Payor and PBM responses to this survey will be used to report to the Governor and General Assembly.

Section 1 – Claims/Preauthorization Volume

Part I: Pharmaceutical Claims and Preauthorization Requests

1. Please identify the lines of business you are including in the responses below (e.g., fully-insured, self-insured, Medicare etc.)?

2. Provide the estimated number of pharmaceutical claims and preauthorization requests received in 2015 for Maryland business. Put "N/A" if your company does not accept electronic preauthorization requests via an online portal or the specified transaction type.

   Note: For purposes of this survey, online portals are web-based systems that allow health care professionals to submit a track preauthorization requests for patients. Certain transaction standards can be used for the electronic transfer of information between parties (e.g. prescribers, pharmacies, payors, PBMs, etc.). For purposes of this survey, preauthorization transaction standards include the:

   - ***278 Transaction Standard****: A method used by health care professionals to submit and receive information related to pharmacy or medical preauthorization requests for a patient.*
   - ***The National Council for Prescription Drug Programs (NCPDP) ePA Transaction Standard****: A method used by health care professionals to submit and receive information related to a pharmacy preauthorization request for a patient.*

Calendar Year 2015 Pharmaceutical				
Total Claims	Total Preauthorization Requests Received (Paper and Electronic)	Total Preauthorization Requests Received via the **Online Portal**	Total Preauthorization Requests Received via the **278 Transaction Standard**	Total Preauthorization Requests Received via the **NCPDP ePA Transaction Standard**

3. In ranking order, identify the top five provider specialties (e.g., psychiatry, internal medicine, gynecology, etc.) that submitted the highest volume of pharmaceutical preauthorization requests in 2015 for Maryland business. 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

4. Please identify the lines of business you are including in the responses below (e.g., fully-insured, self-insured, Medicare etc.)?

5. Provide the estimated number of medical service claims and preauthorization requests submitted in 2015 for Maryland business. Put "N/A" if your company does not accept electronic preauthorization requests via an online portal or the specified transaction type.

   Note: For purposes of this survey, online portals are web-based systems that allow health care professionals to submit a track preauthorization requests for patients. Certain transaction standards can be used for the electronic transfer of information between parties (e.g. prescribers, pharmacies, payors, PBMs, etc.). For purposes of this survey, preauthorization transaction standards include the:

   - ***278 Transaction Standard****: A method used by health care professionals to submit and receive information related to pharmacy or medical preauthorization requests for a patient.*
   - ***The National Council for Prescription Drug Programs (NCPDP) ePA Transaction Standard****: A method used by health care professionals to submit and receive information related to a pharmacy preauthorization request for a patient.*

Calendar Year 2015 Medical			
Total Claims	Total Preauthorization Requests Received (Paper and Electronic)	Total Preauthorization Requests Received via the **Online Portal**	Total Preauthorization Requests Received via the **278 Transaction Standard**

6. In ranking order, identify the top five provider specialties (e.g., chiropractic, physical therapy, gynecology, etc.) that submitted the highest volume of medical service preauthorization requests in 2015 for Maryland business. Put "N/A" if your company is unable to obtain this information.

   1. _____
   2. _____

3. _____
4. _____
5. _____

Section 2 – Online Portal Usability

7. What are the most common troubleshooting inquiries received from Maryland users of the online portal? (select all that apply)
    - Member Eligibility
    - Seeking additional information
    - Member not found
    - Benefits clarification
    - Set up and navigation
    - Other (specify)

Section 3 – Awareness & Education

8. Please select from the list below the methods your company used in 2015 to communicate information about the availability and benefits of electronic preauthorization?
    - Email
    - Fax
    - Mail
    - Telephone on-hold message
    - Newsletters
    - Website
    - Provider liaisons
    - Professional societies
    - Social media
    - Other – Specify:
    - None – Please explain why your company does not communicate information about the availability and benefits of electronic preauthorization.
9. Please select the types of training your company offered in 2015 to educate health care professionals about electronic preauthorization?
    - Online tutorials/guides (including videos)
    - Live web meetings/webinars (instructor led)
    - On-site training/demonstration at provider offices

- Demonstrations at professional society meetings
- Other – specify:
- None – Please explain why your company does not offer training for electronic preauthorization.

Section 4 –Challenges

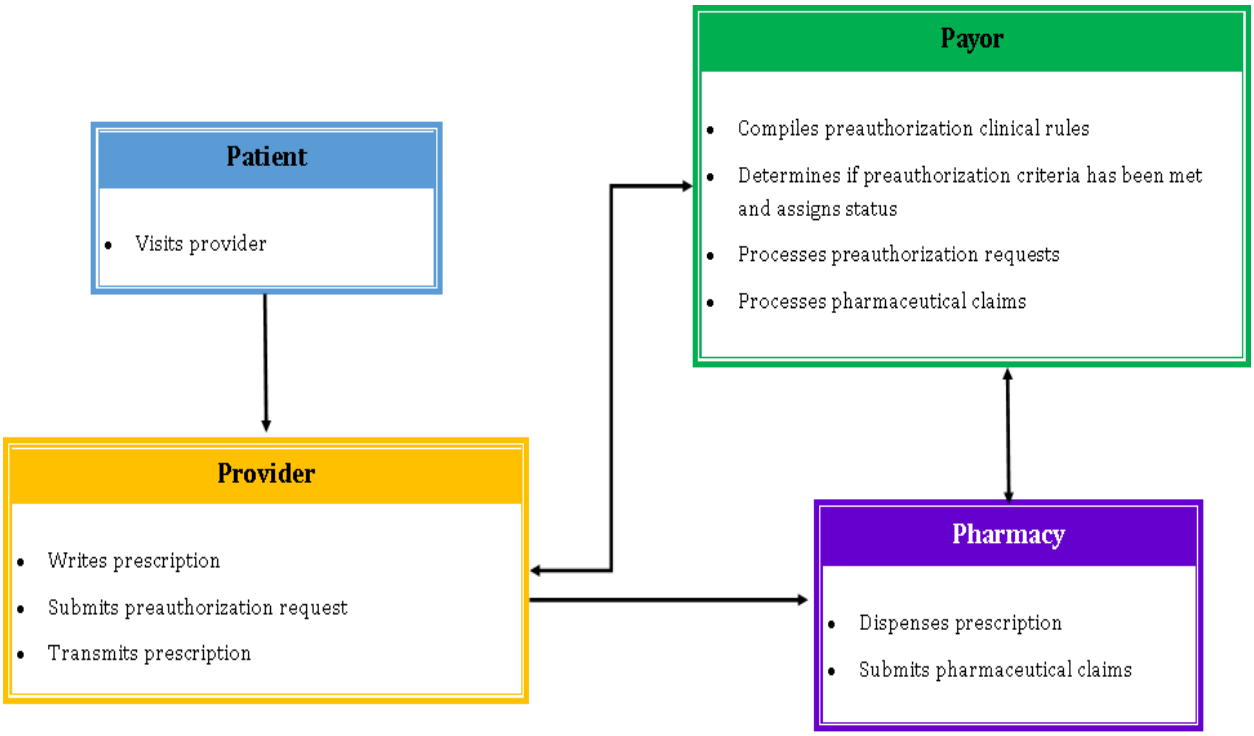
10. Please rank the top three (3) challenges your company believes impacts the adoption and use of electronic preauthorization where 1=most challenging.
    - Health care professionals behavior change
    - Changes in clinical workflows
    - Accustomed to routine, paper-based processes
    - Multiple online portals for different payors and PBMs
    - EHR adoption/availability of preauthorization interface
    - Other, please specify:_____

Appendix F: 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				
Payor/PBM	**Benchmark 1**	**Benchmark 2**	**Benchmark 3**	**Benchmark 4**
Kaiser Permanente	Group model health maintenance organization			
Benecard Services, Inc.	Low market share			
Direct Pharmacy Services, Inc.	Low market share			
Fairview Pharmacy Services, LLC	Low market share			
MaxorPlus	Low market share			
Pharmaceutical Technologies, Inc.	Low market share			
Prime Therapeutics, LLC	Low market share			
Trustmark Insurance Company	Low market share			
WellDyne Rx, Inc.	Low market share/union sponsored health plan			

Appendix G: Electronic Preauthorization Process for Pharmaceuticals



Adapted from NCPDP SCRIPT Electronic Prior Authorization Transactions Overview, August 2013.

Appendix H: Payor and PBM Claims/Preauthorization Volume

Payors and PBMs reported information on claims and preauthorization volume for calendar year 2015. 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																
Payor	Total Claims			Total Preauthorizations						Total Electronic Preauthorizations						
	2013	2014	2015	2013		2014		2015		2013		2014		2015		
	#	#	#	#	% of claims	#	% of claims	#	% of claims	#	% of PAs	#	% of PAs	#	% of PAs	
Aetna[a]	6,008,275	3,048,233	5,114,000	43,821	0.73	41,644	1.37	34,761	0.68	17046	38.90	15,551	37.34	11,708	33.68	
Coventry	14,155			1,000	7.06					71	7.1					
CareFirst	34,922,860	24,488,211	19,300,000	209,412[b]	0.60	354,109	1.45	379,000	1.96	75808	36.20	250,962	70.87	330,000	87.07	
Cigna	1,435,549	1,799,952	1,948,031	1,743	0.12	3,803	0.21	8,158	0.42	170	9.75	486	12.78	618	7.58	
UnitedHealthcare Behavioral Health	68,921	65,049	53,721	5,677	8.24	3,374	5.19	2,460	4.58	846	14.90	953	28.25	684	27.80	
UnitedHealthcare	2,490,505	2,318,929	2,217,846	39,976	1.61	44,074	1.90	57,626	2.60	7116	17.80	14,540	32.99	18,976	32.93	
Totals:	**44,940,265**	**31,720,374**	**28,633,598**	**301,629**	**0.67**	**447,004**	**1.41**	**482,005**	**1.68**	**101,057**	**23.51**	**282,492**	**63.20**	**361,986**	**75.10**	

[a]Aetna acquired Coventry in May 2013.

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

Pharmaceuticals															
Payor/PBM	Total Claims			Total Preauthorizations						Total Electronic Preauthorizations					
	2013	2014	2015	2013		2014		2015		2013		2014		2015	
	#	#	#	#	% of claims	#	% of claims	#	% of claims	#	% of PAs	#	% of PAs	#	% of PAs
Aetna[a]	2,910,790	2,179,328	2,199,973	98,081	3.37	17,171	0.79	19,790	0.90	0	0	110	0.64	129	0.65
Coventry	338,799			2,416	0.71					196	8.11				
CareFirst	11,759,549	8,702,811	7,100,000	28,499	0.24	29,461	0.34	27,066	0.38	200	0.70	513	1.74	1260	4.66
Cigna Pharmacy Management, Inc.	614,276	563,922	1,141,026	5,489	0.89	9,822	1.74	8,120	0.71	18	0.32	784	7.98	854	10.52
Catamaran	2,470,877	2,540,000	3,699,229	1,130	0.05	1,650	0.06	2,816	0.08	*	*	0	0	0	0
CVS Caremark	18,600,000	19,000,000	17,893,154	146,142	0.79	182,589	0.96	152,996	0.86	*	<1	6,929	3.79	10,293	6.73
Express Scripts, Inc.	9,700,000	8,300,000	8,500,000	55,621	0.57	75,933	0.91	67,000	0.79	*	*	1	0.00	4,800	7.16
OptumRx	538,293	669,941	682,858	14,765	2.74	30,593	4.57	26,186	3.83	84	0.57	166	0.54	547	2.09
Totals	**46,932,584**	**41,956,002**	**41,216,240**	**352,143**	**0.75**	**347,219**	**0.83**	**303,974**	**0.74**			**8,503**	**2.45**	**17,883**	**5.88**

[a]Aetna acquired Coventry in May 2013.

* Data unavailable or implementation of online portal was not yet complete to accept preauthorizations during the specified time period.

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