MARYLAND HEALTH CARE COMMISSION

STATE-REGULATED PAYER AND PHARMACY BENEFIT MANAGER PREAUTHORIZATION BENCHMARK ATTAINMENT

March 2013

Prepared for
the Governor of Maryland and
the General Assembly

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MARYLAND HEALTH CARE COMMISSION

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Summary

Maryland law outlines a phased implementation approach for State-regulated payers (payers) and pharmacy benefit managers (PBMs)[1] for standardizing and automating the process for preauthorization of medical and pharmaceutical service requests.[2] The law requires the Maryland Health Care Commission (MHCC) to report to the Governor and General Assembly on or before March 31, 2013 on progress made by payers and PBMs in attaining the benchmarks and to identify any changes needed to the timeframes for the Phase 2 or Phase 3 benchmark dates. Preauthorization is required by many payers and PBMs before certain medical services may be undertaken or certain prescriptions may be filled. The current preauthorization process is typically manual, requiring providers to print and fax preauthorization forms. The preauthorization process is manual largely due to the lack of a national standard for sending preauthorizations electronically from a provider's practice management, electronic health record, or e-prescribing system.[3]

The law created a three phased electronic preauthorization implementation approach with benchmarks and timelines for payers and PBMs:

Phase 1 – By October 1, 2012, provide online the list of services requiring preauthorization and the key criteria for making a determination for a preauthorization request.

Phase 2 – By March 1, 2013, establish an online process for accepting a preauthorization request electronically and assigning a unique electronic identification number to each preauthorization request.

Phase 3 – By July 1, 2013, establish an online system to approve in real-time electronic pharmaceutical service preauthorization requests for which no additional information is required; approve electronic pharmaceutical service preauthorization requests within one business day upon receiving all necessary information; and approve electronic medical service preauthorization requests within two business days upon receiving all necessary information.

Summary of Payer and PBM Attainment of the Electronic Preauthorization Phases

Payer and PBM Attainment of Phase 1 and Phase 2

Payers and PBMs reported to MHCC in September 2012 on their progress in meeting the Phase 1 and Phase 2 benchmarks, and outlined their plans for attaining the Phase 3 benchmarks.[4] All payers and PBMs that were required to meet the Phase 1 benchmarks reported they have met the Phase 1 benchmarks.[5] Approximately 60 percent of payers and about 33 percent of PBMs reported they meet the Phase 2 benchmarks. Nearly all remaining payers and PBMs reported that they plan to

[1] State-regulated payers are insurers, nonprofit health services plans, or any other person that provides health benefit plans subject to regulation by the State. Self-insured health care plans and government plans are exempt from State insurance regulation under the Employee Retirement Security Act of 1974 (ERISA). State mandated health insurance benefits affect around 25 percent of insured Maryland residents. Additional information is available from the U.S. Department of Labor at: http://www.dol.gov/dol/topic/health-plans/erisa.htm. Pharmacy benefit managers are identified based on their filing with the Maryland Insurance Administration.
[2] Md. Code Ann., Health-Gen. § 19-101 & 19-108.2 (2012). See Appendix A.
[3] A number of organizations are working on piloting and finalizing national standards that are expected to be in place in 2015 or later. Appendix B provides an overview of the development of national standards.
[4] See Appendix C for a table of payer and PBM progress in attaining each of the benchmarks.
[5] See Appendix C for a table of payer and PBM progress in attaining each of the benchmarks.

complete implementation of the Phase 2 benchmarks by the required date, March 1, 2013. MHCC recommends no changes to the Phase 2 implementation date.

Payer and PBM Attainment and Plans to Attain Phase 3

Phase 3 contains three benchmarks: the capability for real-time approval of electronic preauthorization pharmaceutical requests for which no additional information is required; the capability to approve electronic preauthorization pharmaceutical service requests within one business day of receiving additional information; and the capability to approve electronic preauthorization medical service requests within two business days upon receiving all information. Nearly all payers and PBMs reported that they plan to complete implementation of the Phase 3 benchmarks on or before the compliance date of July 1, 2013. MHCC does not recommend changes to the Phase 3 implementation date.

Approximately 20 percent of payers and roughly 67 percent of PBMs reported the capability to approve pharmaceutical preauthorizations in real-time when no additional information is required.[6] Cigna Health and Life Insurance Company/Connecticut General Life Insurance Company indicated they are implementing this benchmark, and Envision Pharmaceutical Services, Inc. indicated they are developing this requirement. Roughly 40 percent of payers and about 33 percent of PBMs reported the capability to approve electronic preauthorization pharmaceutical service requests within one business day of receiving additional information.[7] CVS Caremark indicated they are assessing this benchmark and Envision Pharmaceutical Services, Inc. reported they are developing this requirement. About 40 percent of payers reported the capability to approve electronic preauthorization medical service requests within two business days upon receiving all information.[8]

Several payers and PBMS reported that they had not begun implementing the Phase 3 benchmarks and that they plan to complete the implementation of the Phase 3 benchmarks by the July 1, 2013 timeframe. CareFirst BlueCross BlueShield reported they are implementing the Phase 3 benchmarks with an expected completion date of February 2013. Coventry Health Care of Delaware, Inc. indicated they are implementing the Phase 3 benchmarks and plan to complete the implementation by July 1, 2013. Envision Pharmaceutical Services, Inc. reported they are assessing the Phase 3 benchmarks and plan to complete the implementation by March 1, 2013. UnitedHealthcare reported they plan to submit a waiver request for an extension of time to complete the Phase 3 benchmarks.

Next Steps

MHCC will continue to work with payers and PBMs in implementing the electronic process for preauthorization of medical and pharmaceutical services. Payers and PBMs that seek an extension of time to implement the benchmarks through the waiver process are required to include a plan detailing their efforts to meet the requirements in a reasonable timeframe. Several payers and PBMs have indicated that additional time may be needed to comply with the Phase 3 benchmark requirements. MHCC plans to work with these payers and PBMs to ensure compliance with the

[6] See Appendix C for a table of payer and PBM progress in attaining each of the benchmarks.
[7] See Appendix C for a table of payer and PBM progress in attaining each of the benchmarks.
[8] See Appendix C for a table of payer and PBM progress in attaining each of the benchmarks.

benchmark requirements. MHCC plans to work with physicians, payers and PBMs in assessing the impact of implementing the benchmarks over the next year. Using this information, recommendations will be developed to enhance the electronic preauthorization process.

Limitations

Information in this report identifies the progress that payers and PBMs have made as of October 1, 2012 in attaining the benchmarks for electronic preauthorizations required by law. The information used in developing this report was self-reported by the payers and PBMs using a standardized questionnaire; auditing of the responses was limited to the Phase 1 benchmarks.

Background

Maryland law enacted in 2012 outlines a phased implementation approach for payers and PBMs to, among other things, create an online process for electronic preauthorization requests for medical and pharmaceutical service requests.[9] MHCC is required by law to work with payers, PBMs and providers in implementing the requirements of the law and to report to the Governor and General Assembly by March 31, 2013 on payer and PBM attainment of Phase 1 and Phase 2 benchmarks and their plan for implementing the Phase 3 benchmarks. Maryland law requires payers and PBMs to report to MHCC on their progress in standardizing and automating the preauthorization of medical and pharmaceutical services. In addition, the law requires by July 1, 2015, providers to utilize an online preauthorization system or submit requests electronically if national standards have been established for their electronic health record (EHR), practice management, or e-prescribing system.

The law was enacted as a result of a MHCC report based on recommendations from a multi-stakeholder workgroup in 2011.[10] At the request of the Joint Committee on Health Care Delivery and Financing, a workgroup, which included payers, PBMs, MedChi, The State Medical Society, and providers, was convened to develop recommendations to improve the preauthorization process for providers. Preauthorizations, also called prior authorizations, precertifications, prospective reviews, or prior notifications, are processes used by payers and PBMs to approve certain pharmaceutical and medical services prior to that service being delivered. In general, preauthorizations are intended to ensure that providers prescribe pharmaceutical and deliver medical services that are medically necessary, diagnosis based, cost effective, and safe for patients. The preauthorization process is currently manual largely because of the absence of national standards for sending preauthorizations electronically from a provider's practice management, EHR system, or e-prescribing system.[11]

To assess the number of preauthorization requests in Maryland, MHCC requested payers and PBMs to provide the number of preauthorization requests they received in calendar year 2011 for pharmaceutical and medical services. MHCC also requested payers and PBMs to identify their number of covered lives to better understand the proportion of preauthorization requests. The table below presents the preauthorization volume provided by each payer and PBM. This table

[9] Md. Code Ann., Health-Gen. § 19-101 & 19-108.2 (2012). See Appendix A.
[10] *Recommendations for Implementing Electronic Prior Authorizations*. December 2011. Maryland Health Care Commission. Available at: http://mhcc.maryland.gov/mhcc/pages/hit/hit_preauthorization/documents/EPA_Recommend_Implement_EPA_rpt_20111201.pdf.
[11] Appendix B provides an overview of the development of national standards for electronic preauthorization.

presents a snapshot of the number of preauthorization requests in calendar year 2011; however, it does not include the total number of pharmaceutical and medical services.

Estimated Number of Preauthorization Requests in Maryland
2011

Payer	*Medical Service* #	*Pharmaceutical Service* #	*Covered Lives* #
Aetna, Inc.	19,778[1]	24,000[4]	*
CareFirst BlueCross BlueShield *Includes Maryland, Virginia, and Washington D.C.*	138,070[2]	29,536[5]	*
Cigna Health and Life Insurance Company/Connecticut General Life Insurance Company	4,868	7,282	*
Coventry Health Care of Delaware, Inc.	8,900[3]	3,800[6]	•
UnitedHealthcare	*	*	*
PBM			
CVS Caremark	**	20,000[7]	*
Envision Pharmaceutical Services, Inc.	**	*	*
Express Scripts, Inc.	**	•	*

Note

** = Not provided*

*** = Not Applicable*

• = Reported as confidential

1. *An annualized approximation based on year-to-date preauthorization requests in Maryland*
2. *Includes fully insured, self-insured and Medicare plans*
3. *Includes fully insured and self-insured plans*
4. *Maryland comprises approximately 2 percent of the national preauthorization requests of roughly 100,000 monthly*
5. *Includes fully insured, self-insured and Medicare plans*
6. *Includes fully insured and self-insured plans*
7. *Includes Medicaid, self-insured, and fully insured plans*

Payer and PBM Progress in Implementing Electronic Preauthorizations

Consistent with the law, MHCC developed reporting criteria for payers and PBMs that were made available on September 1, 2012.[12] Payers and PBMs reported their attainment of the Phase 1 and Phase 2 benchmarks and their plan for implementing the Phase 3 benchmarks. The law requires payers and PBMs to report to MHCC again by December 1, 2013 on their progress in implementing

[12] See Appendix D for the payer and PBM reporting tool.

Phase 3. Additionally, the law requires the MHCC to report annually through December 31, 2016 to the Governor and the General Assembly on the attainment of the benchmarks.[13]

Phase 1

The intent of Phase 1 is to make certain preauthorization request information available online. Phase 1 requires payers and PBMs by October 1, 2012, to post on their website: a list of the pharmaceutical and medical services requiring a preauthorization; and the key criteria for making a determination on a preauthorization request. All payers and PBMs that were required to comply with the law have met the Phase 1 benchmarks.[14, 15] Phase 1 enables physicians to have access, through the Internet, to the pharmaceutical and medical services requiring a preauthorization and the key criteria for making a determination on a preauthorization request. The following table provides an overview of payer and PBM's self-reported progress towards the Phase 1 benchmarks.

Attainment of Phase 1

Payer	*List of the Pharmaceutical and Medical Services Requiring a Preauthorization Available Online by October 1, 2012*	*Key Criteria for Making a Determination on a Preauthorization Request Available Online by October 1, 2012*
Aetna, Inc.	✓	✓
CareFirst BlueCross BlueShield	✓	✓
Cigna Health and Life Insurance Company/Connecticut General Life Insurance Company	✓	✓
Coventry Health Care of Delaware, Inc.	✓	✓
UnitedHealthcare	✓	✓
PBM		
CVS Caremark	✓	✓
Envision Pharmaceutical Services, Inc.	✓	✓
Express Scripts, Inc.	✓	✓

Note

✓ = Meets benchmark

MHCC Phase 1 Payer and PBM Website Audit

MHCC audited payer and PBM websites to ensure compliance with the Phase 1 benchmarks.[16] In general, MHCC determined that all payers met the Phase 1 requirements and made available on their websites the list of medical and pharmaceutical services that require preauthorization and the key criteria for making a determination of a preauthorization request. The preauthorization

[13] Payers and PBMs that have not attained the benchmarks, such as those that have received a waiver for extension of time and those that are new to the Maryland market, will report to MHCC annually through 2016.
[14] See Appendix H for details of payer and PBM Phase 1 waiver requests.
[15] See Appendix E for a list of payers and PBMs and the links to the website addresses for compliance with the Phase 1 benchmarks.
[16] See Appendix E for a list of payer and PBM websites that list the pharmaceutical and medical services that require preauthorization and the key criteria for making a preauthorization determination.

process is complex and the implementation of the electronic preauthorization Phases is intended to create administrative efficiencies. To meet the intent of the Phase 1 requirements, MHCC encouraged payers and PBMs to develop preauthorization websites that include simple, intuitive, logical navigation. The information should be reachable with minimal clicks from the home page; sitemaps, website-wide search capabilities, and sidebar navigation are examples of how payers and PBMs can increase the usability of websites.

CareFirst BlueCross BlueShield, Coventry Health Care of Delaware, Inc., CVS Caremark, Envision Pharmaceutical Services, Inc. and Express Scripts, Inc. included links to the Phase 1 requirements on their provider homepages, while other payers and PBM websites require greater navigation to locate the list of medical and pharmaceutical services that require preauthorization and the key criteria for making a determination of a preauthorization request. MHCC distributed guidance for payers and PBMs to encourage them to provide consistent navigation across their websites.[17] MHCC plans to work with payers and PBMs during the Phase 2 and Phase 3 implementation to minimize complexities in locating information.

Phase 2

Phase 2 benchmarks require payers and PBMs by March 1, 2013, to establish an online process for: accepting electronically a preauthorization request from providers; and assigning preauthorization requests a unique electronic identification (ID) number that may be used for tracking the request, whether or not the request is tracked electronically, through a call center, or by fax. Approximately 60 percent of payers and roughly 33 percent of PBMs reported they meet the Phase 2 benchmarks. Nearly all remaining payers and PBMs reported that they plan to complete implementation of the Phase 2 benchmarks by the required date of March 1, 2013. MHCC does not recommend changes to the Phase 2 benchmark timeline at this time. The implementation of this phase will enable providers to have an electronic method for submitting preauthorization requests. The ID number verifies for the provider that the request has been received, but it does not guarantee approval of the request. The following table provides an overview of each payer and PBM's self-reported progress towards the Phase 2 benchmarks.

[17] See Appendix F for the guidance document distributed to payers and PBMs regarding website navigation.

Attainment of Phase 2		
Payer	***Accept Electronically Preauthorization Requests by March 1, 2013***	***Assign A Unique ID to Electronic Preauthorization Requests by March 1, 2013***
Aetna, Inc.	✓	✓
CareFirst BlueCross BlueShield	*	*
Cigna Health and Life Insurance Company/Connecticut General Life Insurance Company	✓	✓
Coventry Health Care of Delaware, Inc.	✓	✓
UnitedHealthcare	○	✓
PBM		
CVS Caremark	✓	○
Envision Pharmaceutical Services, Inc.	●	✓
Express Scripts, Inc.	✓	✓

Note

✓ = Meets benchmark

* = Implementing

● = Assessing

○ = Indicated they intend to request a waiver; UnitedHealthcare indicated they intend to request a waiver for an extension of time in meeting the benchmark

Phase 3

The Phase 3 benchmarks require that by July 1, 2013, payers and PBMs must establish an online preauthorization system to: approve in real-time[18] electronic preauthorization pharmaceutical requests that do not require additional information by the payer or PBM to process the request and meet the payer or PBM criteria for approval; approve within one business day of receiving all pertinent information (for non-urgent requests only) for electronic preauthorization pharmaceutical requests that were not approved in real-time; and approve within two business days after receiving all pertinent information for medical service preauthorization requests that are not urgent.

Several payers and PBMs reported that they met the Phase 3 benchmarks. Approximately 20 percent of payers and roughly 67 percent of PBMs reported the capability to approve electronic preauthorization requests in real-time. In addition, roughly 40 percent of payers and 33 percent of PBMs reported meeting the capability to approve electronic preauthorization requests within one business day of receiving pertinent information for pharmaceutical requests that were not approved in real-time. About 40 percent of payers reported the capability to approve

[18] A definition of *real-time* was generally agreed upon by the payers and PBMs in the development of: *Recommendations for Implementing Electronic Prior Authorizations*. MHCC. December 2011. Available at: http://mhcc.maryland.gov/mhcc/pages/hit/hit_preauthorization/documents/EPA_Recommend_Implement_EPA_rpt_20111201.pdf.

preauthorization requests within two business days of receiving complete medical service requests. Most of the remaining payers and PBMs have indicated that they plan to comply with the law on or before July 1, 2013. MHCC does not recommend changes to the benchmark timeline at this time. The table below provides an overview of payer and PBM progress towards complying with the Phase 3 benchmarks.

Attainment of Phase 3			
Payer	***Online Preauthorization System to Approve in Real-time Complete Pharmaceutical Requests***	***Online Preauthorization System to Approve Preauthorization Requests Within One Business Day of Receiving Pertinent Information For Pharmaceutical Requests Not Approved in Real-time***	***Online Preauthorization System to Approve Preauthorization Requests Within Two Business Days of Receiving Complete Medical Service Request***
Aetna, Inc.	✓	✓	✓
CareFirst BlueCross BlueShield	*	*	*
Cigna Health and Life Insurance Company/Connecticut General Life Insurance Company	*	✓	✓
Coventry Health Care of Delaware, Inc.	*	*	*
UnitedHealthcare	○	○	○
PBM			
CVS Caremark	✓	●	*Medical service requests are not applicable to PBMs*
Envision Pharmaceutical Services, Inc.	■	■	
Express Scripts, Inc.	✓	✓	

Note

✓ = Meets benchmark

* = Implementing

● = Assessing

■ = Developing

○ = Indicated they intend to request a waiver for an extension of time

Electronic Preauthorization Waiver Process

The law requires MHCC to create a process for payers, PBMs, and providers to be waived from complying with the electronic preauthorization requirements. In January 2013, MHCC adopted COMAR 10.25.17, *Benchmarks for Preauthorization of Health Care Services,* [19] which establishes the process for requesting a waiver and identifies the extenuating circumstances for a waiver request, including: low premium volumes; preauthorizations requested by providers not employed by the

[19] See Appendix G for COMAR 10.25.17, *Benchmarks for Preauthorization of Health Care Services.*

group model health maintenance organization; or other extenuating circumstances. To date, approximately one payer and roughly six PBMs requested a waiver from compliance with the Phase 1 benchmarks.[20] Payers and PBMs that intend to submit a waiver request for Phase 2 and Phase 3 will submit waiver requests in accordance with the regulation.

Remarks

Automating the electronic preauthorization process is expected to advance the use of technology and create administrative efficiencies. The work of the payers and PBMs in meeting the Phase 1 benchmark is laudable. Effective implementation of technology requires considerable attention to planning, design, and deployment. Most payers and PBMs dedicated significant resources to implementing the Phase 1 benchmark to ensure compliance with the October 1, 2012 timeframe. Most payers and PBMs have already made notable progress in meeting the Phase 2 and Phase 3 benchmark requirements. While the law does not require standards around the online presentation of the information, payers and PBMs are encouraged to develop web pages that allow physicians to obtain preauthorization information with minimal effort. Physicians that view web pages as difficult to navigate will likely continue to rely on existing manual processes for obtaining preauthorization.

The law requires the MHCC to report annually through December 31, 2016 to the Governor and the General Assembly on the attainment of the benchmarks for standardizing and automating the preauthorization process of pharmaceutical and medical services. Over the next year, the MHCC plans to work with physicians, payers and PBMs in assessing the impact of implementing the benchmarks. The MHCC will use this information to make recommendations in an upcoming report for enhancing the electronic preauthorization process.

[20] See Appendix H for information regarding the payers and PBMs that received waivers for the Phase 1 benchmarks.

Appendix A: Md. Code Ann., Health-Gen §19-101 and 19-108.2

Md. HEALTH-GENERAL Code Ann. § 19-101[21]

In this subtitle, "Commission" means the Maryland Health Care Commission.

Md. HEALTH-GENERAL Code Ann. § 19-108.2[22]

*** Current through all Chapters Effective October 1, 2012, of the 2012 General Assembly Regular Session, First Special Session, and Second Special Session. ***

HEALTH - GENERAL

TITLE 19. HEALTH CARE FACILITIES

SUBTITLE 1. HEALTH CARE PLANNING AND SYSTEMS REGULATION

PART I. MARYLAND HEALTH CARE COMMISSION

§ 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.

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

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

(4) "Provider" has the meaning stated in § 19-7A-01 of this title.

(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 standardizing and automating the process required by payors for preauthorizing health care services.

(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, 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.

Appendix B: Literature Review

Over the last few years, the industry has seen an increasing focus on preauthorization requirements and the processes for requesting a preauthorization. The literature review provides an overview on the current landscape of preauthorizations, the development of standards to support an electronic preauthorization request from an electronic health record system, the pilot projects that are testing the technical standards, and other states' progress with electronic preauthorizations.

Current Landscape

Industry wide, State-regulated payers (payers) and pharmacy benefit managers (PBMs) have been expanding preauthorization requirements. From 2006 to 2011, the number of written prescriptions that require a preauthorization nearly doubled, with Medicare instituting the largest increase.[23] The 2012 American Medical Association (AMA) National Health Insurer Report Card reviewed eight major national payers' claims (including Medicare) from February 1, 2012 to March 31, 2012. The AMA found that the percentage of claims requiring a preauthorization ranged from less than one percent to nearly 14 percent across the eight payers, and that 4.7 percent of all claims examined required a preauthorization.[24, 25] The percentage of claims requiring a preauthorization increased from 2011 to 2012 for all but two payers.

The AMA has estimated in a published report that, in 2012, this expansion of preauthorizations will add $728 million in administrative costs to the nation's health system.[26] It is unlikely that preauthorization requirements will decrease over the next few years, due to two main reasons. First, between now and 2016, the pharmaceutical industry is facing the loss of patents for a number of major brand name medications, a looming shift which is often called the "patent cliff." In order to push members to generics, rather than continuing prescriptions for costly brand-name medications, payers customarily implement preauthorization or step therapy[27] requirements for these medications, a practice that will expand as more patents expire.[28] A second reason for the expected continuing increase in preauthorizations is the move by pharmaceutical companies to develop new classes of specialty medications.[29] Specialty medications are very costly and have many off label

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[23] *Electronic Prior Authorizations for Medications: The Time is Right for Plans, PBMs, Payers*. February 2012. Point of Care Partners. Available at: http://www.pocp.com/images/upload_images/file/ePA%20for%20Medications%20-%20final%2012-15-11.pdf.

[24] *2012 National Health Insurer Report Card.* June 2012. AMA. Available at: http://www.ama-assn.org/ama/pub/physician-resources/practice-management-center/health-insurer-payer-relations/national-health-insurer-report-card/admin-requirements.page?.

[25] *AMA Efforts with Health Insurers Cut Medical Claims Errors by Half*. June 18, 2012. AMA Press Release. Available at: http://www.ama-assn.org/ama/pub/news/news/2012-06-18-national-health-insurer-report-card.page.

[26] Ibid.

[27] Step therapy is the process of beginning with the most cost-effective medication and progressing to higher cost medications, only when the initial medications fail to treat the patient.

[28] Report to the 2012 Louisiana Legislature: In Response to HR 108 & SR 81 of 2011 Louisiana Legislature. February 2012. Legislative Workgroup on Electronic Prescribing. Available at: http://www.pharmacy.la.gov/assets/LegWkgrpE-Rx/FinalReport.pdf.

[29] Specialty medications are high-cost medications, including infused or injectable medications that usually require special storage and close monitoring. Specialty medications are generally prescribed to people with an ongoing or complex medical condition.

uses.[30] Consequently, payers and TPAs will implement preauthorizations to ensure that these medications are used only in limited ways.[31]

Given the expected increase in preauthorizations, there has been a renewed focus on electronic preauthorization nationally by medical societies, standards developing organizations, and state legislatures. While an industry-standard electronic preauthorization process has not yet been finalized, a number of organizations, including the National Council for Prescription Drug Programs (NCPDP), CVS Caremark, Surescripts, and the American Medical Association (AMA), have been working towards a solution. These organizations are creating a standard to enable electronic preauthorization transactions from initial request to final determination.[32]

Without a standard, payers and technology vendors are faced with developing proprietary methods,[33] which is complex, costly, and inefficient. When proprietary methods are used, vendors must build a different transmission format for each payer and PBM to use. This increases costs for the vendors, payers, and PBMs. In addition, due to the lack of a final standard, the Center for Medicare and Medicaid Services (CMS) decided against including electronic preauthorizations in its final Medicare Regulatory Reform rule released in May 2012, despite requests from the industry to include a standard in the rule.[34] CMS has decided to let the industry determine the standard(s) that will be used for preauthorization.

Standards Development

The NCPDP is an accredited technical standards development organization mostly for pharmacy standards. The e-prescribing standards developed by NCPDP are collectively known as SCRIPT. The SCRIPT standard supports the electronic transmission of prescription requests, refill requests, medication history, fill notifications, and other e-prescribing processes. SCRIPT is used by providers, pharmacies, payers, PBMs, and many other groups. NCPDP utilizes a workgroup process to create the standards and a balloting process to approve them. In 2006, as a result of the Medicare Drug Improvement and Modernization Act, five pilots for e-prescribing were initiated, four of which included electronic preauthorization.[35]

The pilots revealed that there were challenges during testing of NCPDP's electronic preauthorization standard and the Accredited Standards Committee (ASC) X12 275/278 standard,[36] and that further improvements were needed. Specifically, the formulary and benefits standard

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[30] Off label uses are the use of a medications for an unapproved indication or in an unapproved age group, unapproved dose, or unapproved form of administration. Off label prescribing is a legal practice.
[31] Ibid.
[32] More information on the work being done by NCPDP, CVS, Surescripts, and the AMA is available at: http://www.ncpdp.org/indstry_outreach.aspx.
[33] Proprietary methods are those built and owned by individual companies. They are not an open standard that can be used by multiple organizations.
[34] Medicare and Medicaid Program; *Regulatory Provisions to Promote Program Efficiency, Transparency, and Burden Reduction, Final Rule.* Federal Register 77:95 (May 6, 2012) p. 29019. Available at: http://www.gpo.gov/fdsys/pkg/FR-2012-05-16/pdf/2012-11543.pdf.
[35] Pub. L. No. 108-173, 117 Stat. 2066 (2003) (codified at 26 USCA §§ 139A, 223, 4980G; 42 USCA §§ 299b-7, 1395b-8, 1395b-9, 1395w-3a, 1395w-3b, 1395w-27a, 1395w-29, 1395w-101 to 1395w-104, 1395w-111 to 1395w-116, 1395w-131 to 1395w-134, 1395w-141, 1395w- 151, 1395w-152, 1395cc-3, 1395kk-1, 1395zz, 1395hhh, 1396u-5)
[36] ASC X12 was chartered by the American National Standards Institute over 30 years ago. The organization develops and maintains electronic data interchange (EDI) standards and extensible markup language (XML) schemas. X12 transactions are used for electronic communication between payers, third party administrators, and providers.

lacked consistency in the data it provided and the ASC X12 275/278 standard did not have all of the technical capabilities necessary for requesting a preauthorization.[37] In 2008, based in part upon this finding, NCPDP created a new preauthorization standard. However, no organizations volunteered to conduct testing of the standard, so work on the electronic preauthorization standard ceased until 2011.[38]

In November 2011, the NCPDP reconvened its Prescription Drug Prior Authorization Workflow to Transactions Task Group (task group), due to renewed industry focus on electronic preauthorizations.[39] In addition to reviewing the standards for electronically transmitting preauthorizations, the task group has also identified issues with the formulary and benefits standard that delivers information about the patient's insurance coverage for a particular medication. The formulary and benefits check is the first step in the e-prescribing process. Prior to prescribing a medication, a provider will use the formulary and benefits check to determine whether the medication is covered by the patient's insurance plan. The current standard is a static file that does not always provide patient-specific information and is often unavailable.[40] The task group has been reviewing use of the Surescripts Real-Time Benefit Check, which is currently considered a proprietary transaction since it has not been balloted and approved by NCPDP. The Real-Time Benefit Check provides, in near real-time, patient specific information for various medications, including co-pay cost, preauthorization requirement (or a note that preauthorization has already been received), and the most cost effective pharmacy for the patient. As none of this information is available in the current formulary and benefit standard, NCPDP is working with Surescripts on the Real-Time Benefit Check.[41]

CVS Caremark, in parallel to its participation on the NCPDP task group, has worked on modifying the NCPDP electronic preauthorization draft standard. In June 2012, the NCPDP task group voted to use the NCPDP electronic preauthorization standard that CVS Caremark has been working on. Based on the current projections, CVS Caremark will have a draft standard finalized by the end of the first quarter of 2013, and will pilot that draft standard. Based on the pilot, the standard may be modified and would then proceed through the balloting process. NCPDP will also be required to request a waiver from CMS for the industry to utilize the NCPDP standard, rather than the current HIPAA standard for preauthorizations. HIPAA requires specific standards to be used for electronic data interchange (EDI); HIPAA and the Affordable Care Act have set specific deadlines by which payers must use the standards for individual EDI transaction types. January 1, 2016 is the deadline for use of the current HIPAA standard for referrals and certifications, the ASC X12 275/278

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[37] *Findings from the Evaluation of E-Prescribing Pilot Sites.* Agency for Health Research and Quality (AHRQ) Publication No. 07-0047-EF. 2007. National Opinion Research Center. Please note that the pilot sites utilized RxHub, which is now Surescripts.

[38] For more information on the history of electronic preauthorization standards development, see *Recommendations for Implementing Electronic Prior Authorizations*. December 2011. Maryland Health Care Commission. Available at: http://mhcc.maryland.gov/mhcc/pages/hit/hit_preauthorization/documents/EPA_Recommend_Implement_EPA_rpt_20111201.pdf.

[39] Electronic Prior Authorization Update: Presentation to the NCPDP Electronic Preauthorization Task Group. December 15, 2011. Available at: http://www.ncpdp.org/pdf/NCPDPePATaskGroup_WhereHaveWeBeen_%20Final121511.pdf.

[40] C. Jason Wang et al. Journal of the American Medical Informatics Association. *Perceptions of Standards-based Electronic Prescribing Systems as Implemented in Outpatient Primary Care: A Physician Survey.* 16.4: 493-502. 2009. Please note that the physicians surveyed utilized RxHub, which is now Surescripts.

[41] Tony Schueth. *ePrescribing's Formulary and Benefits: At a Crossroad.* HIT Perspectives. June 2012. Point of Care Partners. Available at: http://www.pocp.com/images/documents/June_2012_whole_3_articles.pdf.

transaction. In order to use the NCPDP standard for preauthorizations, NCPDP will need to seek a waiver from CMS. The organization has successfully done this in the past with other standards, and consequently, a number of the NCPDP standards are the HIPAA compliant EDI standards.

Similarly, the AMA has been working with the task group and refining a process for using the ASC X12 275/278 standard for preauthorizations. The HIPAA v4010 278 transaction can be used for preauthorization requests, but was determined in the 2006 CMS pilot to be inadequate for both prescription and medical service requests.[42] Consequently, ASC X12 added a number of workarounds to the HIPAA v5010 275/278 transaction standard that allow it to be used for preauthorizations, but require payers to customize their implementation of the standard. The workarounds introduced in v5010 will be fixed and finalized in v6020, which does not currently have an implementation date. Based on the June 2012 vote by the NCPDP task group, the industry standard moving forward is not likely to be the X12 275/278 standard for prescription medications; however, the use of the NCPDP electronic preauthorization standard rather than the X12 standard is contingent on CMS issuing a waiver, as noted above.

Pilot Projects

A number of pilot projects are in place to test various electronic transmissions for preauthorizations. The pilots are typically focused on prescription medications and the results are being shared with the NCPDP workgroup to determine the best standard for the industry. For the last 12 to 24 months, Surescripts has been piloting the Real-Time Benefit Check to provide patient specific information on coverage. The company's plan moving forward is to finalize the standard and to begin development of the final Real-Time Benefit Check for launch in 2013.[43] The standard will be shared with NCPDP when it is finalized for inclusion in the electronic preauthorization standard.

In 2011, CVS Caremark developed its own standard for electronic preauthorization transactions for prescription medications. The transaction can be used from a provider's e-prescribing system or electronic health record system, as well as through the CVS Caremark portal. CVS Caremark evaluated the NCPDP standard and determined that only portions of the 2008 test standard could be used, and the organization subsequently developed its own transaction utilizing portions of the NCPDP draft standard.

In May 2012, CVS Caremark launched its pilot with the Allscripts' ePrescribe product and currently has electronic preauthorization transactions travelling across the network. CVS Caremark has reached agreement with two additional vendors to participate in the pilot: Navinet / CoverMyMeds (August launch date) and InstandDX (launch date to be determined). These vendors will implement the draft standard for electronic preauthorization requests that are made through their systems. CVS Caremark has been working closely with the NCPDP electronic preauthorization task group to drive a "best of breed" electronic preauthorization standard.[44]

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[42] *Standardization of Prior Authorization Process for Medical Services.* 2011. AMA White Paper. Available at: http://www.ama-assn.org/resources/doc/psa/standardization-prior-auth-whitepaper.pdf.

[43] E-Prescribing Process Review: Presentation to the NCPDP Electronic Preauthorization Workgroup. March 15, 2012. Available at: http://www.ncpdp.org/pdf/E-Prescribing_Process_Review_&_RTBC_20120315.pdf.

[44] Information on the CVS Caremark Pilot was received via email from Michael Ayotte, Director of Government Affairs, CVS Caremark, on June 6, 2012.

Humana and Agadia (a preauthorization technology vendor) have also been piloting an electronic preauthorization process. Rather than creating a new transaction standard from scratch, the pilot is utilizing the portions of the NCPDP transaction test standard from 2008 with modifications as necessary. The process is integrated into providers' e-prescribing or EHR systems. The pilot is live, and Humana and Agadia are sharing their results with the NCPDP.[45]

RelayHealth is in production with its RelayRx™ PriorAuthPlus product. When a prescription is sent to a pharmacy and determined to need a preauthorization, the pharmacist can utilize patient information from the pharmacy's system to generate a partially completed form. The PriorAuthPlus product then uses NCPDP standards to electronically transmit the form to the prescribing provider, who can complete, sign, and submit it to the health plan via another RelayHealth product, CoverMyMeds. RelayHealth is participating in the NCPDP task group and is sharing the results of its use of NCPDP standards with the group.[46]

State Progress

A number of states have recently passed legislation to support electronic preauthorizations:

- Georgia passed Senate Bill 416 defining electronic preauthorizations as not including fax and requiring that within two years of final standards from the NCPDP, pharmacy benefit managers must be able to accept and process standards-based electronic preauthorizations.
- Florida law now requires Medicaid managed care plans to post their drug formularies online; all changes must be published within 24 hours. The drug formulary is the list of generic and brand name medications a payer prefers. Medications not on the preferred list typically require a preauthorization before prescribing. In addition, the managed care plans are required to accept preauthorizations electronically.
- At the end of 2011, the Louisiana legislature passed a resolution creating the Legislative Workgroup on Electronic Prescribing. The work of the group included creating a standardized preauthorization form and creating best practices for an electronic preauthorization process that would allow providers to submit and receive approval electronically.[47] In February 2012, the group published its report to the legislature and concluded that the best path forward for electronic preauthorizations was to allow standards to develop nationally.
- In Missouri, House Bill 1827 created the Missouri Electronic Prior Authorization Committee, which is responsible for participating in the NCPDP electronic preauthorization workgroup and reporting to the legislature and governor on the progress of the group. Furthermore, the bill authorizes the committee to choose a national pharmacy benefits manager to

[45] Electronic Prior Authorization Update. Presentation to NCPDP Task Group. December 8, 2011. Available at: http://www.ncpdp.org/pdf/NCPDPePATaskGroupLevelSetv1.0.pdf.

[46] More information available at: http://www.relayhealth.com/solutions/PriorAuthPlus-for-Retail-Pharmacy.html.

[47] Report to the 2012 Louisiana Legislature: In Response to HR 108 & SR 81 of 2011 Louisiana Legislature. February 2012. Legislative Workgroup on Electronic Prescribing. Available at: http://www.pharmacy.la.gov/assets/LegWkgrpE-Rx/FinalReport.pdf.

participate in an electronic preauthorization pilot in Missouri that must be operational by January 1, 2014.[48]

- In 2011, the Nevada legislature passed legislation regarding standards for electronic preauthorization.[49, 50] Since then, the Nevada Department of Health and Human Services has worked with stakeholders to develop a uniform preauthorization form for prescription medications that will be a fillable PDF. In conjunction with the new form, the Department began implementing a pilot that will use Direct secure messaging to electronically send a preauthorization request from a provider to a payer.[51] Nevada is participating in the NCPDP task group and monitoring the development of national standards.
- The North Dakota legislature passed House Bill 1422 in 2011. The bill requires that electronic preauthorization be available to providers by August 1, 2013. In the Health Information Technology Director's recent testimony to the legislature about progress in meeting the bill requirements, he reported that the Health Information Technology Advisory Committee is participating in the NCPDP task group. He also indicated that the committee has determined not to move forward with its own transaction standards, but rather wait for NCPDP to finalize a national standard.
- The Department of Vermont Health Access (DVHA), acting on legislation passed in 2011, published a report to the legislature making a number of short-term and long-term recommendations for electronic preauthorizations. The DVHA short-term recommendations follow closely with the MHCC recommendations made in December 2011. The DVHA recommended that the state develop a plan for a multi-payer single web portal and ensure that the strategy for electronic preauthorizations aligns with the state's health information exchange development. The DVHA is evaluating capabilities that include a single web portal for performing identity management, authentication, and digital verification; pre-populating information to payer websites as much as possible, and ensuring that the portal supports electronic preauthorization submissions. The DVHA is also participating in the NCPDP task group.[52]

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

[49] Nevada Revised Statutes Chapter 313, Section 5.1. Available at: http://search.leg.state.nv.us/isysquery/5a35be7f-9d76-443f-9b13-3bfc2968fd03/2/doc/Stats201114.html.

[50] Nevada Revised Statutes Chapter 313, Section 26.5. Available at: http://search.leg.state.nv.us/isysquery/5a35be7f-9d76-443f-9b13-3bfc2968fd03/2/doc/Stats201114.html.

[51] Direct messaging is a standard developed by the Office of the National Coordinator for Health IT that uses existing Internet protocols to send a HIPAA compliant message between two known entities. More information about Direct messaging is available at: http://wiki.directproject.org/home.

[52] Report to the Vermont Legislature: Single Formulary and Electronic Prior Authorization Recommendations. February 2012. Department of Vermont Health Access. Available at: http://www.leg.state.vt.us/reports/2012ExternalReports/276572.pdf.

Appendix C: Payer and PBM Progress in Implementing Electronic Preauthorization

Payer and PBM Progress in Attaining the Electronic Preauthorization Benchmarks							
Payer	***Phase 1- Oct 2012***		***Phase 2 – March 2013***		***Phase 3 – July 2013***		
	Pharmaceutical and Medical Services Requiring a Pre-authorization Available Online	*Key Criteria for Making a Determination on a Pre-authorization Request Available Online*	*Accept Electronically Pre-authorization Requests*	*Assign A Unique ID to Electronic Pre-authorization Requests*	*Approve in Real-time Complete Pharmaceutical Requests*	*Approve Electronic Pre-authorization Requests Within One Business Day of Receiving Information for Pharmaceutical Requests Not Approved in Real-time*	*Approve Medical Service Requests Within Two Business Days of Receiving Complete Information*
Aetna, Inc.	✓	✓	✓	✓	✓	✓	✓
CareFirst BlueCross BlueShield	✓	✓	*	*	*	*	*
Cigna Health and Life Insurance Company/Connecticut General Life Insurance Company	✓	✓	✓	✓	*	✓	✓
Coventry Health Care of Delaware, Inc.	✓	✓	✓	✓	*	*	*
UnitedHealthcare	✓	✓	○	✓	○	○	○
PBM							
CVS Caremark	✓	✓	✓	○	✓	●	*Medical service requests are not applicable to PBMs*
Envision Pharmaceutical Services, Inc.	✓	✓	●	✓	■	■	
Express Scripts, Inc.	✓	✓	✓	✓	✓	✓	

Note

✓ = Meets benchmark

* = Implementing

● = Assessing

■ = Developing

○ = Indicated they intend to request a waiver

Appendix D: Payer and PBM Reporting Tool

2012 Electronic Preauthorization Reporting Form

Senate Bill 540 (SB 540), *Maryland Health Care Commission - Preauthorization of Health Care Services - Benchmarks*, signed into law on May 22, 2012, requires the Maryland Health Care Commission (MHCC) to work with payers and pharmacy benefit managers (PBMs) to attain benchmarks to facilitate electronic preauthorization requests for pharmaceutical and medical services. The law established three implementation phases, or benchmarks, and requires that payers and PBMs report to the MHCC on their progress in attaining the benchmarks. The MHCC has developed this standardized reporting tool for compliance with this legislation. Please complete the form no later than September 21, 2012.

Please contact Sarah Orth if you have questions or need guidance in completing the form, by e-mail at sorth@mhcc.state.md.us or by phone at 410-764-3449.

1. Please provide your contact information.
   - Name: _____
   - Title: _____
   - Organization: _____
   - E-mail: _____
   - Phone Number: _____

Phase 1: The following reporting requirement is part of Phase 1 preauthorization benchmarks. Payers are required to comply on or before October 1, 2012.

Payers and PBMs are required to answer the following questions.

2. As of September 1, 2012 is the list of all health care services that require preauthorization listed on your organization's website?
   - Yes
     - When was this completed? _____
     - Please provide the URL(s) for the list of healthcare services requiring preauthorization: _____
   - No
     - What is the expected completion date (Month/Year)? _____
     - If the expected completion date is after October 1, 2012, please provide an explanation: _____
   - Seeking Waiver
     - If your organization will be seeking a waiver for this requirement, please indicate the basis for the request: _____

3. As of September 1, 2012, are key criteria for making a determination on a preauthorization request available on your organization's website?
    - Yes
        - When was this completed? _____
        - Please provide the URL(s) for the key criteria: _____
    - No
        - What is the expected completion date (Month/Year)? _____
        - If the expected completion date is after October 1, 2012, please provide an explanation: _____
    - Seeking Waiver
        - If your organization will be seeking a waiver for this requirement, please indicate the basis for the request: _____

Phase 2: The following reporting requirements are part of the Phase 2 preauthorization benchmarks. Payers are required to comply on or before March 1, 2013.

Payers and PBMs are required to answer the following questions.

4. As of September 1, 2012, does your organization currently assign a unique electronic identification number to a preauthorization request that a provider may use to track the request during the preauthorization process, regardless of whether the request is tracked electronically, through a call center, or by fax?
    - Yes
        - When was this completed? _____
    - No
        - Is your organization currently assessing or implementing this requirement?
            - Assessing
            - Implementing
            - Other (please specify) _____
        - What is the expected completion date (Month/Year)? _____
    - Seeking Waiver
        - If your organization will be seeking a waiver for this requirement, please indicate the basis for the request: _____
5. As of September 1, 2012, does your organization currently accept electronic preauthorization requests from providers?
    - Yes

- When was this completed? _____

- No
  - Is your organization currently assessing this requirement or implementing this requirement?
    - Assessing
    - Implementing
    - Other (please specify) _____
  - What is the expected completion date (Month/Year)? _____

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

Phase 3: The following reporting requirements are part of the Phase 3 preauthorization benchmarks. Payers are required to comply on or before July 1, 2013.

Payers and PBMs are required to answer the following questions.

6. Does the electronic preauthorization system return an approval for pharmaceutical service preauthorization requests for which no additional information is needed by the payer/PBM to process the preauthorization request and meets the payer's/PBM's criteria for approval, in real-time?

- Yes
  - When was this completed? _____

- No
  - Is your organization currently assessing this requirement or implementing this requirement?
    - Assessing
    - Implementing
    - Other (please specify) _____
  - What is the expected completion date (Month/Year)? _____

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

- Not Applicable

7. Does the electronic preauthorization system return an approval for pharmaceutical service preauthorization requests within one business day after receiving all pertinent information on requests not approved in real time, and that are not urgent?

- Yes
    - When was this completed? _____
- No
    - Is your organization currently assessing this requirement or implementing this requirement?
        - Assessing
        - Implementing
        - Other (please specify) _____
    - What is the expected completion date (Month/Year)? _____
- Seeking Waiver
    - If your organization will be seeking a waiver for this requirement, please indicate the basis for the request: _____
- Not Applicable

8. Has your organization established an online process to accept and approve medical service preauthorization requests within two business days of receiving all pertinent information?
    - Yes
        - When was this completed? _____
    - No
        - Is your organization currently assessing this requirement or implementing this requirement?
            - Assessing
            - Implementing
            - Other (please specify) _____
        - What is the expected completion date (Month/Year)? _____
    - Seeking Waiver
        - If your organization will be seeking a waiver for this requirement, please indicate the basis for the request: _____
    - Not Applicable

The MHCC is requesting respondents to voluntarily provide answers to the following questions. The MHCC plans to include this information in the report to the Governor and General Assembly to identify the impact and policy implications of electronic preauthorizations.

9. If available, provide the estimated number of pharmaceutical service preauthorization requests submitted in calendar year 2011 by Maryland providers.

- Not Applicable
- Unavailable
    - Please provide an explanation for the estimated number of pharmaceutical service preauthorization requests being unavailable: _____
- Estimated Number: _____

10. If available, provide the estimated number of medical service preauthorization requests submitted in calendar year 2011 by Maryland providers.
    - Not Applicable
    - Unavailable
        - Please provide an explanation for the estimated number of medical service preauthorization requests being unavailable: _____
    - Estimated Number: _____
11. If available, provide the estimated number of pharmaceutical services that required a preauthorization in Maryland in calendar year 2011.
    - Not Applicable
    - Unavailable
        - Please provide an explanation for the estimated number of pharmaceutical services requiring a preauthorization request being unavailable: _____
    - Estimated Number: _____
12. If available, provide the estimated number of medical services that required a preauthorization in Maryland in calendar year 2011.
    - Not Applicable
    - Unavailable
        - Please provide an explanation for the estimated number of medical services requiring a preauthorization request being unavailable: _____
    - Estimated Number: _____
13. If available, provide the estimated number of preauthorization requests that were approved in Maryland on first submission in calendar year 2011 for prescription medications.
    - Not Applicable
    - Unavailable
        - Please provide an explanation for the estimated number of pharmaceutical service preauthorization requests approved on first submission being unavailable: _____
    - Estimated Number: _____

14. If available, provide the estimated number of medical service preauthorization requests that were approved in Maryland on first submission in calendar year 2011.
    - Not Applicable
    - Unavailable
        - Please provide an explanation for the estimated number of medical service preauthorization requests approved on first submission being unavailable: _____
    - Estimated Number: _____
15. If available, provide the estimated number of pharmaceutical service preauthorization requests that were incomplete in Maryland on first submission and additional information was requested in calendar year 2011.
    - Not Applicable
    - Unavailable
        - Please provide an explanation for the estimated number of pharmaceutical service preauthorization requests not approved on first submission due to incomplete information, being unavailable: _____
    - Estimated Number: _____
16. If available, provide the estimated number of medical service preauthorization requests that were incomplete in Maryland on first submission and additional information was requested in calendar year 2011.
    - Not Applicable
    - Unavailable
        - Please provide an explanation for the estimated number of medical service preauthorization requests not approved on first submission due to incomplete information, being unavailable: _____
    - Estimated Number: _____
17. If available, provide the estimated number of pharmaceutical services in Maryland that required step therapy in calendar year 2011.

Step therapy requires that you have tried an alternative therapy first or that your doctor has clinically documented why you cannot take the alternate therapy. Step therapy may include select covered over-the-counter products.

- Not Applicable
- Unavailable
    - Please provide an explanation for the estimated number of pharmaceutical services requiring step therapy being unavailable _____

- Estimated Number: _____

18. If available, provide the estimated number of preauthorization requests for pharmaceutical services in Maryland that were due to step therapy requirements in calendar year 2011.

Step therapy requires that you have tried an alternative therapy first or that your doctor has clinically documented why you cannot take the alternate therapy. Step therapy may include select covered over-the-counter products.

- Not Applicable
- Unavailable
    - Please provide an explanation for the estimated number of pharmaceutical service preauthorization requests related to step therapy being unavailable: _____
- Estimated Number: _____

19. List in rank order the five most common reasons for a preauthorization requirement, such as off-label use of a prescription medication, with one being the most common and five being the least common.
20. Attestation: I certify that the information in this report is accurate to the best of my knowledge, information, and belief.
    - Name: _____
    - Date: _____

Appendix E: Implementation of Preauthorization Phase 1 Benchmarks

Maryland law[53] requires the Maryland Health Care Commission (MHCC) to work with State-regulated payers (payers), pharmacy benefit managers (PBMs), and providers to attain benchmarks for standardizing and automating the preauthorization of medical and pharmaceutical services through a phased approach. Phase 1 requires payers and PBMs to include on their website lists of medical and pharmaceutical services requiring preauthorization and key criteria for making a determination on a preauthorization request on or before October 1, 2012. Payers and PBMs were required to report to the MHCC on their attainment of the Phase 1 benchmark and include web addresses to their online listings. Below is a list of payers and PBMs including web addresses to their webpage(s) that contain the Phase 1 benchmark information.

Payers

1. Aetna, Inc.
    - Medical Services: http://www.aetna.com/healthcare-professionals/policies-guidelines/medical_precertification_list.html
    - Pharmaceutical Services: http://www.aetna.com/pharmacy-insurance/healthcare-professional/aetna-pharmacy-management-index.html
2. CareFirst BlueCross BlueShield
    - Medical Services: https://provider.carefirst.com/wps/portal/Provider/ProviderLanding?WCM_GLOBAL_CONTEXT=/wcmwps/wcm/connect/Content-Provider/CareFirst/ProviderPortal/Generic/Tab/mprInNetwork&WT.z_from=providerQuicklinks
    - Pharmaceutical Services: https://provider.carefirst.com/wcmwps/wcm/connect/fc491d804cd6c2999217d7d0dbe97053/PRV4249.pdf?MOD=AJPERES&CACHEID=fc491d804cd6c2999217d7d0dbe97053
3. Cigna Health and Life Insurance Company/Connecticut General Life Insurance Company
    - Medical and pharmaceutical services: http://www.cigna.com/healthcareprofessionals/resources-for-health-care-professionals/clinical-payment-and-reimbursement-policies/coverage-policies-overview.html
4. Coventry Health Care of Delaware, Inc.
    - Medical services: http://chcdelaware.coventryhealthcare.com/services-and-support/providers/pre-authorizations/index.htm
    - Pharmaceutical services: http://chcdelaware.coventryhealthcare.com/health-care-solutions/prescription-coverage/prescription-documents/index.htm
5. UnitedHealthcare
    - Medical and pharmaceutical services: https://www.unitedhealthcareonline.com/b2c/CmaAction.do?channelId=ca174ccb4726b010VgnVCM100000c520720a___

[53] Health-General Article §§19-101 and 19-108.2

- Pharmacy services: https://www.unitedhealthcareonline.com/b2c/CmaAction.do?channelId=4d39cf5f18b99110VgnVCM1000007740dc0a___

PBMs

1. CVS Caremark: https://www.caremark.com/wps/portal/FOR_HEALTH_PROS_TAB
2. Envision Pharmaceutical Services, Inc: http://www.envisionrx.com/healthdrug/mdpa.aspx
3. Express Scripts, Inc.: http://www.express-scripts.com/services/physicians/pa/

Appendix F: Guidance for Preauthorization Phase 1 Implementation

The following document was distributed to State-regulated payers and pharmacy benefit managers on August 28, 2012 to provide items for consideration while implementing the electronic preauthorization Phase 1 benchmarks.

Begin quoted text

Items for Consideration in Implementing Electronic Preauthorization Phase 1

Introduction

In 2011, the Maryland Health Care Commission (MHCC) released the report *Recommendations for Implementing Prior Authorizations*.[54] The report was developed through a collaborative process with Maryland stakeholders, including: state regulated payers (payers), pharmacy benefit managers (PBMs), and MedChi, the state medical society. The recommendations contained a phased approach to implement electronic preauthorization requests, thus minimizing paper and faxed based preauthorization requests.

During the 2012 legislative session, the recommendations were proposed as Senate Bill 540, *Maryland Health Care Commission - Preauthorization of Health Care Services - Benchmarks* (SB 540).[55] The bill was passed and subsequently signed by Governor Martin O'Malley. Among other things, SB 540 requires the MHCC to work with payers and providers to attain benchmarks for standardizing and automating the process for preauthorization of health care services. Below is the text of SB 540 related to Phase 1:

> *On or before October 1, 2012 ("Phase 1"), establishment of online access for providers to each payor's: list of health care services that require preauthorization; and key criteria for making a determination on a preauthorization request.*

Items for Consideration

The intent of Phase 1 is to provide physicians and their office staff with easy access to information on the health care services that require a prior authorization as well as the criteria that are used to make a determination on a preauthorization request. To assist payers and PBMs with implementing Phase 1, the MHCC offers the following points for consideration:

- The list of health care services should be available to providers outside of a payer or PBM's secure portal, as well as within the secure portal.
- If the payer or PBM's website contains a designated section targeted to physicians, links to the prior authorization information should be contained on that landing page.

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[54] Maryland Health Care Commission, *Recommendations for Implementing Electronic Prior Authorizations*, December 2011. Available at: http://mhcc.maryland.gov/mhcc/pages/hit/hit_preauthorization/documents/EPA_Recommend_Implement_EPA_rpt_20111201.pdf.

[55] Senate Bill 540, Maryland Health Care Commission - *Preauthorization of Health Care Services – Benchmarks*. Available at: http://mlis.state.md.us/2012rs/billfile/sb0540.htm.

- Payers and PBMs should minimize the number of clicks to navigate to the list of health care services.
- Payers and PBMs should make the list of prescription medications and medical services easy to search.
- Payers and PBMs should limit the amount of information provided for each health care service to: the information that identifies the coverage limits; any step therapy requirements; and the required medical information that must be submitted in order for a preauthorization request to be considered complete.
- The information listed for health care services should be displayed in a manner that is relatively easy to navigate.

Appendix G: COMAR 10.25.17

Subtitle 25 MARYLAND HEALTH CARE COMMISSION

10.25.17 Benchmarks for Preauthorization of Health Care Services

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

.01 Scope.

A. This chapter applies to a payor that:

(1) Requires preauthorization for health care services; and

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

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

.02 Definitions.

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

B. Terms Defined.

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

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

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

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

(a) An insurer or nonprofit health service plan that provides hospital, medical, or surgical benefits to individuals or groups on an expense-incurred basis under health insurance policies or contracts that are issued or delivered in the State;

(b) A health maintenance organization that provides hospital, medical, or surgical benefits to individuals or groups under contracts that are issued or delivered in the State; or

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

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

.03 Benchmarks.

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

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

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

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

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

(2) Assigning to a preauthorization request a unique electronic identification number that a provider may use to track the request during the preauthorization process, whether or not the request is tracked electronically, through a call center, or by fax.

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

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

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

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

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

(a) Are not urgent; and

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

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

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

.04 Reporting.

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

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

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

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

.05 Waiver from Benchmark Requirement.

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

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

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

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

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

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

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

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

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

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

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

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

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

C. Issuance of Waivers.

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

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

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

D. Review of Denial of Waiver.

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

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

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

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

.06 Fines.

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

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

Appendix H: Phase 1 Waiver Details

One State-regulated payer (payer) and roughly six pharmacy benefit managers (PBMs) have requested a waiver for compliance with the preauthorization Phase 1 benchmarks. The table below details the payers and PBMs that have requested waivers from Phase 1 and the waiver reason. Maryland law (Md. Code Ann., Health-Gen. § 19-101 & 19-108.2 [2012]) identifies two extenuating circumstances for payers and PBMs to be waived from attaining the preauthorization benchmarks, including low premium volume or a group model health maintenance organization for preauthorizations of health care services requested by providers not employed by the group model health maintenance organization.

Payer/PBM	*Phase 1 Waiver Reason*
Benecard Services, Inc.	Low market share
Catamaran, Inc.	Combining three companies and platforms onto one technology platform
Direct Pharmacy Service, Inc.	Low market share
Kaiser Permanente	Non-employed group model health maintenance organization
MedImpact Healthcare Systems, Inc.	Low market share
Prime Therapeutics, LLC	Low market share
Serve You Rx	Low market share

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