MHCC | MARYLAND HEALTH CARE COMMISSION

STATE-REGULATED PAYOR & PHARMACY BENEFIT MANAGER

PREAUTHORIZATION BENCHMARK ATTAINMENT

October 2013

Prepared for
the Governor of Maryland
and the General Assembly

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Overview

Maryland law,[1] enacted in 2012, outlines a phased implementation approach for State-regulated payors (payors) and pharmacy benefit managers (PBMs) to standardize and automate the process for preauthorizing medical and pharmaceutical services.[2] Preauthorization is the process of obtaining approval from a payor or PBM before a medical or pharmaceutical service can be delivered. Submitting preauthorization requests has historically been a manual process requiring providers to submit forms via fax, phone, or mail.[3] The law was enacted as a result of recommendations developed by a multi-stakeholder workgroup in 2011[4] and aims to minimize administrative burdens on providers submitting preauthorization requests. The Maryland Health Care Commission (MHCC or Commission) is required to report to the Governor and General Assembly on or before December 31, 2013 regarding the progress in implementing the law.[5]

The law established a three-phase implementation approach with various benchmarks and time frames for completion. Phase 1 required payors and PBMs to provide online the list of medical and pharmaceutical services that need a preauthorization and the key criteria for making a determination by October 1, 2012. Phase 2 required payors and PBMs to accept medical and pharmaceutical service preauthorization requests electronically and assign a unique identification number to each request for tracking purposes by March 1, 2013. Phase 3 established time frames for approval and notification of preauthorization requests that were required to be in place by July 1, 2013.[6] Payors and PBMs reported to MHCC on their attainment of the three Phases, as well as information on usage, accessibility, and usability of their online preauthorization systems.[7] All payors and PBMs are in compliance with law.[8, 9]

Online preauthorization systems are fairly similar across payors and PBMs, providing about the same functionality. Payor and PBM outreach initiatives have resulted in a modest volume of electronic preauthorization requests. Payors report around 18 percent of medical service preauthorization requests are submitted electronically. Pharmacy preauthorization requests submitted electronically are more disappointing; less than two percent are submitted via online

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

[2] Payors 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). PBMs are identified based on their filing with the Maryland Insurance Administration.

[3] National standards for electronically submitting preauthorization requests directly from a provider's electronic health record or e-prescribing system have been under development for a few years and are not yet finalized. National standards for electronic preauthorization requests are expected to simplify the submission process.

[4] MHCC, *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_20 111201.pdf.

[5] The first report to the Governor and General Assembly was submitted in March 2013.

[6] Md. Code Ann., Health-Gen. §19-101 & 19-108.2 (2012). See Appendix A.

[7] The MHCC developed a reporting tool for payors and PBMs to report on their progress in implementing the Phases, which was distributed electronically in July 2013. See Appendix B for the reporting tool.

[8] See Appendix C for an implementation overview of each Phase by each payor and PBM.

[9] Payors and PBMs may be waived from meeting the requirements of the law. See Appendix D for information regarding payors and PBMs that received waivers.

processes. The MHCC is required to provide annual reports to the Governor and General Assembly on payor and PBM progress in meeting the law through December 31, 2016.

Limitations

This report identifies progress that payors and PBMs have made in implementing the preauthorization benchmarks as of July 19, 2013. All information was self-reported by payors and PBMs via an online questionnaire. In total, roughly 5 payors and 8 PBMs responded to the questionnaire. Questions were based upon information reported by payors and PBMs during the 2012 reporting cycle. Responses to the reporting tool have not been audited.

Background

In 2011, MHCC convened a Preauthorization Workgroup (workgroup) that included payors, PBMs, and providers to develop recommendations of best practices around electronic preauthorization requests for medical and pharmaceutical services. Requirements imposed by payors and PBMs for preauthorization can be an administrative burden to providers.[10, 11, 12] Much of the administrative burden can be attributed to the variation among payors and PBMs in the procedures for submitting and processing preauthorization requests and the criteria for granting preauthorizations. Historically, the preauthorization process was not technology-enabled and required faxes and phone calls. National standards have not been adopted for sending preauthorization requests from providers to payors and PBMs electronically. The workgroup identified a phased implementation approach for electronic preauthorization that aimed to require minimal rework should national electronic preauthorization standards be adopted.

The 2011 recommendations of the workgroup culminated in the new Maryland law enacted in 2012. Md. Code Ann., Health-General Article §§ 19-108.2[13] (law) requires MHCC to work with payors and PBMs to implement electronic preauthorization processes aimed at reducing the administrative burden on their own organizations and providers. Based on the recommendations of the workgroup, the law established three phases, with benchmarks, of implementation for payors and PBMs: (1) by October 1, 2012, provide online the list of medical and pharmaceutical services that require preauthorization and the key criteria used to make a determination; (2) by March 1, 2013 establish an online system to accept preauthorization requests and assign a unique tracking number; and (3) by July 1, 2013 establish an online system to approve pharmaceutical service preauthorization requests in real-time when all information is complete or within one business day of receiving all information and to approve non-urgent medical service preauthorization requests

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[10] Managed Healthcare Executive, *Manage Medical Advances with Automated Prior Authorization,* August, 2009. Available at:
http://managedhealthcareexecutive.modernmedicine.com/mhe/article/articleDetail.jsp?id=615491.
[11] Journal of the American Board of Family Medicine, *The Impact of Prior Authorization Requirements on Primary Care Physicians' Offices: Report of Two Parallel Network Studies,* Volume 26, No. 1 93-95, January-February 2013. Available at: http://www.jabfm.org/content/26/1/93.
[12] Health Affairs, *U.S. Physician Practices Versus Canadians: Spending Nearly Four Times as Much Money Interacting With Payors*, August 2011. Available at:
http://content.healthaffairs.org/content/early/2011/08/03/hlthaff.2010.0893.full.
[13] Md. Code Ann., Health-Gen. §19-108.2 (2012). See Appendix A.

within two business days. The law requires providers to utilize an electronic method to submit preauthorization requests beginning July 1, 2015.[14]

This report comprises MHCC's second report to the Governor and General Assembly regarding preauthorization benchmark attainment. The MHCC is required by law to report annually through 2016. The 2012[15] and 2013 reports focus primarily on payor and PBM implementation of electronic preauthorization technology. Beginning in July 2015, payors and PBMs may choose to implement a requirement consistent with the law, allowing them to require electronic submission of preauthorization requests. Meeting this requirement will necessitate a concerted effort to build provider awareness of the technology. Since the law was enacted, payors and PBMs have done a laudable job in implementing the electronic preauthorization requirements. Future reports to the Governor and General Assembly will evaluate payor and PBM progress around expanding the usage of electronic preauthorization processes.

Waivers

As required by law, MHCC developed a waiver process for compliance with the electronic preauthorization requirements for payors and PBMs. These regulations, COMAR 10.25.17, *Benchmarks for Preauthorization of Health Care Services*,[16] 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 a group model health maintenance organization, have low premium volume, and those with other extenuating circumstances may be waived from one or more Phases. Some payors and PBMs were granted a waiver for an extension of time to comply with certain Phases.[17] All combined, roughly 14 payors and PBMs were granted waivers for compliance with the benchmarks. Approximately 83 percent of all payors and nearly 44 percent of all PBMs in Maryland have met Phase 1 requirements; around 67 percent of payors and about 38 percent of PBMs have met Phase 2 requirements; and roughly 84 percent payors and nearly 31 percent of PBMs have met Phase 3 requirements.

2013 Reporting Tool

To assess payor and PBM progress in attaining the three Phases, MHCC developed an online reporting tool that was distributed to payors and PBMs required to comply with the law. Payors and PBMs that were granted a waiver other than for an extension of time were exempt from reporting to MHCC. The reporting tool was customized for each organization, and was based upon the progress reported in October 2012.

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[14] Providers may request that MHCC issue a waiver from utilizing online preauthorization systems in the case of extenuating circumstances, including but not limited to: lack of broadband internet access; low patient volume; or no referrals made for medical services or prescribing pharmaceuticals.

[15] MHCC, *State-Regulated Payor and Pharmacy Benefit Manager Preauthorization Benchmark Attainment*, March 2013. Available at:
http://mhcc.maryland.gov/mhcc/pages/hit/hit_preauthorization/documents/EPA_1_State_Regulated_Payer_Pharmacy_Benefit_%20Mgr_Preauth_Benchmark_Rpt_20130301.pdf.

[16] The regulations are provided in Appendix E.

[17] See Appendix D for information regarding payors and PBMs that received waivers.

Preauthorization Volume

The MHCC collected the following information from payors and PBMs: the number of medical and pharmaceutical service preauthorization requests; total claims; and the estimated percentage of preauthorization requests submitted electronically in 2012 and 2013.[18] In 2012, payors and PBMs reported that approximately one percent of medical service claims had an associated preauthorization request and roughly one percent of pharmaceutical claims had an associated pharmaceutical preauthorization request.[19] By comparison, the American Medical Association found that in 2012, roughly 5.1 percent of professional claims submitted nationally to payors and PBMs required a preauthorization.[20, 21]

Payors and PBMs that had electronic preauthorization systems available in 2012 reported that on average roughly 17.9 percent of medical service preauthorization requests and nearly 1.3 percent of pharmaceutical service preauthorization requests were submitted electronically. Use of electronic preauthorization systems remained consistently low from calendar year 2012 through the 2013 reporting period. This is somewhat attributed to payors and PBMs focus on implementing the electronic preauthorization systems as opposed to building industry awareness of its availability.

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[18] Data collection period is January 1, 2013 through June 30, 2013.

[19] Data does not indicate the number of approved and denied claims or approved, denied, unnecessary, and duplicative preauthorization requests. Note, preauthorization requests may not always result in a claim.

[20] American Medical Association, National Health Insurer Report Card 2013, *Administrative Requirements – Prior Authorization*. 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.

[21] Antidotal data suggest that variation between Maryland and national payor and PBM medical policies pertaining to preauthorization account for the differences in the volume of preauthorization requests in Maryland and the nation.

Estimated Volume of Medical Service Preauthorization Requests in Maryland					
Payor	Preauthorization Requests 2011	Preauthorization Requests 2012	Claims 2012	Percent of Preauthorization Requests Submitted Electronically 2012 (%)	Percent of Preauthorization Requests Submitted Electronically January-June 2013 (%)
Aetna, Inc. Medical Services[1]	19,778	58,142	6,139,217	42.6	39.7
CareFirst BlueCross BlueShield[2]	138,070	200,000	31,749,849	*	☐
Cigna Health and Life Insurance Company/ Connecticut General Life Insurance Company Medical Services[3]	4,868	70,747	1,459,236	17	22.1
Coventry Health Care of Delaware, Inc.[4]	14,700	65,598	345,949	1.9	4.7
UnitedHealthcare Behavioral Health[5]	♦	6,725	402,100	2	2
UnitedHealthcare Choice/Choice Plus[6]	♦	142,000	2,884,000	25.8	25.7
UnitedHealthcare MIPA/OCI[3]	♦	50,350	704,300	*	■

Notes

1= Includes fully-insured, self-insured, commercial, Medicare (excludes student health and Medicaid); allows providers to submit preauthorization requests through electronic health networks
2 = Includes Maryland, Virginia, and Washington D.C.; fully-insured, self-insured, Federal Employee Program
3 = Fully-insured
4 = Fully-insured, self-insured
5 = Fully-insured, self-insured, Medicare, Medicaid, point of service
6 = Fully-insured, self-insured, Medicare, Medicaid
* = Online system to accept preauthorizations was not available in 2012
♦ = Data not provided
☐ = Payor received a waiver through July 1, 2013 and implemented electronic preauthorization on June 22, 2013; data were unavailable.
■ = Payor/PBM has a waiver for an extension of time for this requirement

Estimated Volume of Pharmaceutical Service Preauthorization Requests in Maryland					
	Preauthorization Requests 2011	**Preauthorization Requests 2012**	**Claims 2012**	**Percent of Preauthorization Requests Submitted Electronically 2012 (%)**	**Percent of Preauthorization Requests Submitted Electronically January-June 2013 (%)**
Payor					
Aetna, Inc. Pharmaceutical Services[1]	24,000	114,141	1,440,800	< 1	< 1
Aetna, Inc. Specialty Pharmaceutical Services[1]	♦		86,000	< 2	< 5
CareFirst BlueCross BlueShield[2]	29,536	23,500	11,235,795	*	< 1
Cigna Health and Life Insurance Company/ Connecticut General Life Insurance Company Pharmaceutical Services[3]	7,282	♦	1,036,719	♦	
Coventry Health Care of Delaware, Inc.[4]	3,800	2,400	380,000	*	< 1
PBM					
Catamaran[5]	**	128,481	3,038,088	*	■
CVS Caremark[6]	20,000	180,000	25,000,000	< 1	< 1
Envision Pharmaceutical Services, Inc.[7]	♦	2,450	213,390	*	0
Express Scripts, Inc.[8]	●	112,241	17,500,715	< 1	< 1
Pharmaceutical Technologies, Inc.[9]	**			*	0
UnitedHealthcare OptumRx[3]	**				< 1

Notes

1 = Fully-insured, self-insured, commercial, Medicare (excludes Medicaid)
2 = Includes Maryland, Virginia, and Washington D.C.; fully-insured, self-insured, Medicare Part D
3 = Fully-insured
4 = Fully-insured, self-insured
5 = Fully-insured, self-insured, Medicare
6 = Fully-insured, self-insured, commercial, Medicare, Medicaid
7 = Self-insured and Medicare Part D
8 = Fully-insured, employer, Medicaid, Medicare

9 = Fully-insured, self-insured, commercial, Medicare, and workmen's compensation
* = Online system to accept preauthorization requests was not available in 2012
** = Payor/PBM did not operate in Maryland in 2011 and/or 2012
♦ = Data not provided
● = Reported as confidential
■ = Payor/PBM has a waiver for an extension of time for this requirement

Achieving the Benchmarks

Phase 1

Phase 1 required payors and PBMs by October 1, 2012 to make the following available online by October 1, 2012: the list of pharmaceutical and medical services that require preauthorizations; and the key criteria for making a determination on a preauthorization request. All payors and PBMs that were in the market were compliant with the Phase 1 benchmarks by the established due date.[22, 23] In 2013, four additional PBMs entered the Maryland market. Per COMAR 10.25.17, each PBM had three months from the start of their service offerings to comply with the Phase 1 requirements. The following three PBMs met the Phase 1 benchmarks: Humana; Pharmaceutical Technologies, Inc.; and PBM Plus. One PBM, Fairview Pharmacy Services, received a waiver for compliance with Phases 1, 2, and 3 due to low volume.[24] MHCC audited the websites of these new PBMs and determined that they met the Phase 1 requirements.

Phase 2

Phase 2 requires digitization of the process for submitting preauthorization requests and eliminates the need for providers to fax or call a payor or PBM to request a preauthorization. By March 1, 2013, payors and PBMs were required to establish an online process for the following: accepting preauthorization requests electronically; assigning preauthorization requests a unique tracking identification (ID) number; and enabling providers to track the status of a request electronically or by telephone.[25] Approximately 60 percent of payors and about 33 percent of PBMs implemented the Phase 2 benchmarks by October 2012 and all payors and PBMs had implemented the Phase 2 requirements by July 1, 2013.[26, 27]

Phase 3

Phase 3 establishes time frames for approval of preauthorization requests for medical and pharmaceutical services. By July 1, 2013, payors and PBMs were required to establish a system capable of the following: approval of electronic pharmaceutical service preauthorization requests for which no additional information is needed, and real-time notification of approval; for requests not approved in real-time, approval within one business day of after receipt of all pertinent information; and approval of non-urgent electronic medical service preauthorization requests within two business days after receipt of all required information.[28] In October 2012, roughly 20 percent of payors and about 67 percent of PBMs had implemented the capability to approve

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[22] See Appendix F for a list of payor and PBM websites with electronic preauthorization information.
[23] MHCC previously audited payor and PBM websites and determined that they were in compliance.
[24] Fairview Pharmacy Services received a waiver for compliance with Phases 1, 2, and 3. See Appendix D for information regarding payors and PBMs that received waivers.
[25] The unique ID number does not guarantee approval of the request.
[26] Humana and PBM Plus received waivers for compliance with Phase 2. See Appendix D for information regarding payors and PBMs that received waivers.
[27] See Appendix F for a list of payor and PBM websites with electronic preauthorization information.
[28] Md. Code Ann., Insurance.§15–10B–07. The process for making an adverse determination on a preauthorization request is governed by Maryland law and requires that a licensed physician review the preauthorization request prior to issuing a denial.

pharmaceutical preauthorization requests in real-time. As of July 1, 2013, all payors and PBMs implemented the Phase 3 requirements[29]

Payor and PBM Technology Evaluation

The MHCC audited payor and PBM implementations of Phase 2 to ensure compliance with the law.[30] Payors and PBMs provided either a virtual demonstration of their electronic preauthorization systems or screen shots that demonstrated the process from initiation of a preauthorization request to assignment of a unique ID number. In general, MHCC determined that all payors and PBMs implemented electronic preauthorization systems consistent with the law.

Accessibility

The MHCC encouraged payors and PBMs to implement electronic preauthorization processes in a manner that is easily accessible for providers.[31] Payors and PBMs have developed similar processes for their own ease in accessing their electronic preauthorization systems. Nearly all payors and PBMs allow providers to access their provider portal by a single click from their home page. Once providers access the online system, about 31 percent enable providers to access the preauthorization landing page in a single click. The average time for a provider to complete a preauthorization request ranges from as little as two minutes to less than 10 minutes.

Accessibility of Payor and PBM Electronic Preauthorization Systems			
	Number of clicks to access the provider portal from the payor or PBM provider home page	*Number of clicks to access the preauthorization page from the payor or PBM home page*	*Average number of minutes to complete a preauthorization request*
Payor			
Aetna, Inc. Medical Services	1	2	2-3
Aetna, Inc. Pharmaceutical Services	1	3	2
Aetna, Inc. Specialty Pharmaceutical Services	1	1	Less than 10
CareFirst BlueCross BlueShield	1	2	2-3

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[29] Humana; Pharmaceutical Technologies, Inc.; and PBM Plus received waivers for compliance with Phase 3. See Appendix D for information regarding payors and PBMs that received waivers.

[30] The MHCC did not audit Phase 3 because when utilizing test data for demonstration purposes, the systems cannot demonstrate real-time or one-business day approval for pharmaceutical preauthorization requests or two business days for medical service preauthorization requests.

[31] The MHCC provided items for consideration in implementing Phase 1 (see Appendix G) and Phases 2 and 3 (see Appendix H). Available at:
http://mhcc.maryland.gov/mhcc/pages/hit/hit_preauthorization/documents/EPA_Items_Consider_Implement_EPA_Phase1_20111201.pdf, and
http://mhcc.maryland.gov/mhcc/pages/hit/hit_preauthorization/documents/EPA_Items_Consider_Implement_EPA_Phase2_3_20130602.pdf.

Accessibility of Payor and PBM Electronic Preauthorization Systems			
	Number of clicks to access the provider portal from the payor or PBM provider home page	Number of clicks to access the preauthorization page from the payor or PBM home page	Average number of minutes to complete a preauthorization request
Cigna Health and Life Insurance Company/Connecticut General Life Insurance Company Medical Services	N/A*	4	3
Cigna Health and Life Insurance Company/Connecticut General Life Insurance Company Pharmaceutical Services	3	4	3
Coventry Health Care of Delaware, Inc.	1	3	2-4
UnitedHealthcare Behavioral Health	2	1	Less than 5
UnitedHealthcare Choice and Choice Plus	1	2	5-7
PBM			
CVS Caremark	1	3	2
Envision Pharmaceutical Services, Inc.	N/A*	1	2
Pharmaceutical Technologies, Inc.	1	1	3
United Healthcare OptumRx	3 from OptumRx, 1 from UnitedHealthCare homepage	3 from OptumRx, 1 from UnitedHealthCare homepage	4

Notes

* = The online preauthorization request submission process is not available in a provider portal.

Usability

The MHCC assessed usability of payor and PBM electronic preauthorization systems. Payor and PBM systems generally have many of the same functionalities. Nearly 78 percent of payors and PBMs allow providers to search for members when creating a preauthorization request. A small number of payors and PBMs allow providers to determine if a preauthorization is required before submitting a request. In addition, a few payors and PBMs include functionality for providers to submit supporting documentation electronically, which creates administrative efficiencies by eliminating the need to fax or mail documentation.[32]

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[32] Note: Some payors and PBMs do not require supporting documentation for preauthorization requests.

Features of Payor and PBM Electronic Preauthorization Systems			
	Search for members to create a preauthorization request	*Alerts user upon receiving member information if preauthorization is required*	*Submit supporting documentation electronically*
Payor			
Aetna, Inc.	✓		
CareFirst BlueCross BlueShield	✓		✓
Cigna Health and Life Insurance Company/Connecticut General Life Insurance Company Medical Services	✓		
Coventry Health Care of Delaware, Inc.	✓	✓	✓
UnitedHealthcare	✓	✓	
PBM			
CVS Caremark		✓1	✓
Envision Pharmaceutical Services, Inc.			
Pharmaceutical Technologies, Inc.	✓		
United Healthcare OptumRx	✓		

Notes
1 = CVS Caremark notes in a section of the form that a preauthorization is necessary before the provider completes and submits the form.

Next Steps

Payors and PBMs have dedicated significant resources to meeting the preauthorization requirements in law;[33] their accomplishments are laudable. The law requires that, by July 1, 2015, providers must utilize payor and PBM online preauthorization systems or their practice management, electronic health record, or e-prescribing system to submit preauthorization requests, if this method is available.[34, 35] Over the next year, MHCC plans to reconvene the workgroup to develop the supporting regulations for these requirements.

Payors and PBMs need to implement robust provider education and awareness initiatives to minimize the impact of the 2015 requirement on providers. The MHCC will report on the success of payors and PBMs in increasing provider usage of the preauthorization portal beginning with the 2014 report to the Governor and General Assembly.

[33] This excludes payors and PBMs that received a waiver. See Appendix D for information regarding payors and PBMs that received waivers.
[34] The MHCC will establish requirements in regulation specifying a process by which a provider may be waived from compliance with the law due to certain extenuating circumstances. COMAR 10.25.17, *Benchmarks for Preauthorization of Health Care Services*, will be modified to include the provider waiver process. See Appendix E for COMAR 10.25.16.
[35] The ideal solution to standardize the preauthorization request process would be establishing national standards for sending preauthorization requests electronically from the provider's practice management or electronic health record system directly to payor or PBM systems. Such standards do not yet exist, although they have been in development for some time.

Acknowledgements

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

Md. HEALTH-GENERAL Code Ann. § 19-108.2[36]

*** 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

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.

(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:

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

(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.

End quoted text

Appendix B: Payor and PBM Reporting Tool

2013 Electronic Preauthorization Reporting Tool

Begin quoted text

Introduction

Maryland law, Md. Code Ann., Health-General Article §§19-101 and 19-108.2 (law), outlined a three-phased implementation process for standardizing and automating the process for preauthorization of medical and pharmaceutical service requests. Preauthorization, as defined in COMAR 10.25.17.02(B)(5), is a 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. The law requires State-regulated payors (payors) and pharmacy benefit managers (PBMs) to report to the Maryland Health Care Commission (MHCC) on their attainment of the benchmarks. Payor and PBM responses to this reporting tool will be used to report to the Governor and General Assembly on payor and PBM progress in attaining the benchmarks, to assess compliance with the law, and to identify the level of use of the online preauthorization process. Please complete the reporting tool by **July 19, 2013.**

Contact Information
Please provide your contact information.
> Name:
> Title:
> Organization:
> Email:
> Phone Number:

Section 1 – Preauthorization Phase Attainment
Payors and PBMs are required to answer the following questions.

Payors and PBMs entering the Maryland market after October 1, 2012 are required to comply with Phase 1 preauthorization benchmark requirements within three months of entering the market, as stated in COMAR 10.25.17.03(D). The following reporting requirements identify progress in attaining the Phase 1 preauthorization benchmarks.

1. Is the list of all health care services that require preauthorization included on your organization's website? (select one)

    *Yes[37]
    **No[38]

---

[37] Users that answer *Yes* will be prompted: when was this completed (Month/Year)?
[38] Users that answer *No* will be prompted: what is the expected completion date (Month/Year)? Please provide an explanation for the timing of the expected completion date.

2. Please provide the URL(s) for the list of health care services requiring preauthorization.

3. Are key criteria used by the payor or PBM for making a determination on a preauthorization request available on your organization's website? (select one)

   *Yes
   **No

4. Please provide the URL(s) for the key criteria.

The following reporting requirements identify progress in attaining the Phase 2 preauthorization benchmarks. Payors and PBMs were required to comply on or before March 1, 2013.

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

   *Yes
   **No

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

   *Yes
   **No

The following reporting requirements identify progress in attaining the Phase 3 preauthorization benchmarks. Payors and PBMs were required to comply on or before July 1, 2013.

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

   *Yes
   **No

8. Has your organization established an online preauthorization process capable of returning 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? (select one)

*Yes
**No

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

*Yes
**No

Section 2

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

Part I: Volume of Pharmaceutical Service Preauthorizations

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

11. Provide the estimated number of pharmaceutical service claims submitted by Maryland providers in calendar year 2012.

    Estimated Number_____
    Unavailable - Please provide an explanation as to why the estimated number is unavailable:

12. Provide the estimated number of pharmaceutical preauthorization requests received from Maryland providers in calendar year 2012, regardless of whether the requests were submitted electronically.

    Estimated Number _____
    Unavailable - Please provide an explanation as to why the estimated number is unavailable:

13. Provide the estimated percentage of pharmaceutical service preauthorization requests submitted via the online preauthorization system by Maryland providers in calendar year 2012. (Note: If your online system was not available in 2012, please indicate that in the Unavailable text box.)

    Estimated Percentage _____

Unavailable - Please provide an explanation as to why the estimated percentage is unavailable:

14. Provide the estimated percentage of pharmaceutical service preauthorization requests submitted via the online preauthorization system by Maryland providers, January 1, 2013 through June 30, 2013.

Estimated Percentage _____
Unavailable - Please provide an explanation as to why the estimated percentage is unavailable:

Part II: Volume of Medical Service Preauthorizations

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

16. Provide the estimated number of medical service claims submitted by Maryland providers in calendar year 2012.

Estimated Number _____
Unavailable - Please provide an explanation as to why the estimated number is unavailable:

17. Provide the estimated number of medical service preauthorization requests received from Maryland providers in calendar year 2012, regardless of whether the requests were submitted electronically.

Estimated Number _____
Unavailable - Please provide an explanation as to why the estimated number is unavailable:

18. Provide the estimated percentage of medical service preauthorization requests submitted via the online preauthorization system by Maryland providers in calendar year 2012. (Note: If your online system was not available in 2012, please indicate that in the Unavailable text box.)

Estimated Percentage _____
Unavailable - Please provide an explanation as to why the estimated percentage is unavailable:

19. Provide the estimated percentage of medical service preauthorization requests submitted via the online preauthorization system by Maryland providers, January 1, 2013 through June 30, 2013.

Estimated Percentage _____
Unavailable - Please provide an explanation as to why the estimated percentage is unavailable:

20. Provide the estimated number of electronic pharmaceutical service preauthorization requests received from Maryland providers, for calendar year 2012, for which no additional information was needed by the payor/PBM to process the preauthorization request and met the payor's/PBM's criteria for approval, that were approved in real-time? (Note: If your online system was not available in 2012, please indicate that in the Unavailable text box.)

    Estimated Number _____
    Unavailable - Please provide an explanation as to why the estimated number is unavailable:

21. Provide the estimated number of electronic pharmaceutical service preauthorization requests received from Maryland providers, for January 1, 2013 through June 30, 2013, for which no additional information was needed by the payor/PBM to process the preauthorization request and met the payor's/PBM's criteria for approval, that were approved in real-time?

    Estimated Number _____
    Unavailable - Please provide an explanation as to why the estimated number is unavailable:

22. Provide the estimated number of electronic pharmaceutical service preauthorization requests received from Maryland providers, for calendar year 2012, that were approved within one business day after receiving all pertinent information on requests not approved in real-time, and that were not urgent? (Note: If your online system was not available in 2012, please indicate that in the Unavailable text box.)

    Estimated Number _____
    Unavailable - Please provide an explanation as to why the estimated number is unavailable:

23. Provide the estimated number of electronic pharmaceutical service preauthorization requests received from Maryland providers, January 1, 2013 through June 30, 2013, that were approved within one business day after receiving all pertinent information on requests not approved in real-time, and that were not urgent?

    Estimated Number _____
    Unavailable - Please provide an explanation as to why the estimated number is unavailable:

24. Provide the estimated number of electronic medical service preauthorization requests received from Maryland providers that were approved within two business days of receiving all pertinent information in calendar year 2012? (Note: If your online system was not available in 2012, please indicate that in the Unavailable text box.)

Estimated Number _____

Unavailable - Please provide an explanation as to why the estimated number is unavailable:

25. Provide the estimated number of electronic medical service preauthorization requests received from Maryland providers that were approved within two business days of receiving all pertinent information January 1, 2013 through June 30, 2013?

    Estimated Number _____

    Unavailable - Please provide an explanation as to why the estimated number is unavailable:

Part IV: Website Hits

26. Provide the estimated number of total logins by Maryland providers or their staff to your preauthorization portal in calendar year 2012. (Note: If your online system was not available in 2012, please indicate that in the Unavailable text box.)

    Estimated Number _____

    Unavailable - Please provide an explanation as to why the estimated number is unavailable:

27. Provide the estimated number of total logins by Maryland providers or their staff to your preauthorization portal, January 1 through June 30, 2013.

    Estimated Number _____

    Unavailable - Please provide an explanation as to why the estimated number is unavailable:

28. Provide the estimated number of unique logins by Maryland providers or their staff to your preauthorization portal in calendar year 2012. (Note: If your online system was not available in 2012, please indicate that in the Unavailable text box.)

    Estimated Number _____

    Unavailable - Please provide an explanation as to why the estimated number is unavailable:

29. Provide the estimated number of unique logins by Maryland providers or their staff to your preauthorization portal, January 1, 2013 through June 30, 2013.

    Estimated Number _____

    Unavailable - Please provide an explanation as to why the estimated number is unavailable:

Part V: Usability

30. Rate your perception of your company's electronic preauthorization system on the scale below for provider usability (including effectiveness, efficiency, and satisfaction):

a. General online process:
    1 – Very complicated or confusing
    2 – Somewhat complicated or confusing
    3 – Neutral
    4 – Somewhat clear and easy to use
    5 – Very clear, easy to use

b. Instructions for online process:
    1 – Very complicated or confusing
    2 – Somewhat complicated or confusing
    3 – Neutral
    4 – Somewhat clear and easy to use
    5 – Very clear, easy to use

31. Has your organization evaluated the provider usability (including effectiveness, efficiency, navigation and satisfaction) of your electronic preauthorization system? (select one)

    Yes (Proceed to question 32)
    No (Skip to question 33)

32. Briefly describe your evaluation approach and provide the results of your evaluation.

33. Have you received any troubleshooting inquiries from Maryland users of the electronic preauthorization system? (select one)

    Yes (Proceed to question 34)
    No (Skip to question 35)

34. What are the most common inquiries?

35. How many mouse clicks are required to arrive at the payor/PBM physician portal from the payor/PBM homepage?

36. How many mouse clicks are required to arrive at the landing page of the preauthorization request website from the physician portal homepage?

37. On average, how many minutes does it take to complete a preauthorization request, starting from the landing page of the preauthorization request website to the assignment of a unique electronic identification number?

38. Do you provide a training guide on how to use your online preauthorization system? (select one)

Yes
No

Part VI: Supporting Documentation

39. Of all electronic preauthorization requests received from Maryland providers January 1 through June 30, 2013, what percentage of requests required the provider to supply supporting documentation?

    Estimated Percentage _____
    Unavailable - Please provide an explanation as to why the estimated percentage is unavailable.

40. If supporting documentation must be submitted for an online preauthorization, in what ways were documents submitted by Maryland providers? (Indicate the percentage of documents received, by method.)
    i. Electronic preauthorization system
    ii. Email
    iii. Fax
    iv. Mail
    v. Not applicable
    vi. Other (please specify) _____

Section 3 –Waivers *(asked only of payors/PBMs with a waiver for an extension of time for a particular Phase/benchmark)*

Payors and PBMs are required to answer the following questions.

The following reporting requirements identify progress in attaining the preauthorization benchmarks for which your organization has a waiver for an extension of time.

1. What is your current stage of development for providing on your organization's website a list of all health care services that require a preauthorization? (Select one)

    Assessing
    Implementing
    Other (please specify) _____

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

3. What is your current stage of development for making available the key criteria used for making a determination on a preauthorization request on your organization's website?

Assessing
Implementing
Other (please specify) _____

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

5. What is your current stage of development for implementing an online process for accepting electronic preauthorization requests from providers? (Select one)

Assessing
Implementing
Other (please specify) _____

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

7. What is your current stage of development for implementing a system to assign preauthorization requests submitted online with a unique ID number?

Assessing
Implementing
Other (please specify) _____

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

9. What is your current stage of development for implementing an online process to approve pharmaceutical service preauthorization requests, for which no additional information is needed by the payor/PBM to process the preauthorization request, and meets the payor's/PBM's criteria for approval, in real-time? (Select one)

Assessing
Implementing
Other (please specify) _____

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

11. What is your current stage of development for implementing an online process to approve 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? (Select one)

Assessing
Implementing
Other (please specify) _____

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

13. What is your current stage of development for establishing an online process to approve medical service preauthorization requests within two business days of receiving all pertinent information?

Assessing
Implementing
Other (please specify) _____

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

Section 4 – Attestation *(All respondents)*

I certify that the information in this report is accurate to the best of my knowledge, information, and belief. Typing a name and date in the signature boxes below is the equivalent of a physical signature.

Name:

Date:

End quoted text

Appendix C: Payor and PBM Progress in Implementing Electronic Preauthorization

Payor	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 Pertinent Information for Pharmaceutical Requests Not Approved in Real-time*	*Approve Medical Service Pre-authorization Requests within Two Business Days of Receiving Complete Information*
Aetna, Inc. Medical Services	✓	✓	✓	✓	✓	✓	✓
CareFirst BlueCross BlueShield	✓	✓	✓	✓	✓	✓	✓
Cigna Health and Life Insurance Company / Connecticut General Life Insurance Company	✓	✓	✓	✓	✓	✓	✓
Coventry Health Care of Delaware, Inc.	✓	✓	✓	✓	✓	✓	✓
United Healthcare Behavioral and Choice/Choice Plus	✓	✓	✓	✓	*Pharmaceutical service requests are not applicable to this Payor*		✓
United Healthcare MIPA/OCI	✓	✓	▲	▲			▲
PBM							
CVS Caremark	✓	✓	✓	❖	✓	✓	*Medical service requests are not applicable to PBMs*
Envision Pharmaceutical Services, Inc.	✓	✓	✓	✓	✓	✓	
Express Scripts, Inc.	✓	✓	▲	▲	▲	▲	
Humana	✓	✓	▲	▲	▲	▲	
Pharmaceutical Technologies, Inc.	✓	✓	✓	✓	▲	▲	
PBM Plus	✓	✓	▲	▲	▲	▲	
United Healthcare OptumRx	✓	✓	✓	✓	✓	✓	

Notes

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

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

✓ = Completed

Appendix D: Payor and PBM Waivers

Payor and PBM Waiver Reason			
	Phase 1	*Phase 2*	*Phase 3*
Payor			
Kaiser Permanente	Group model health maintenance organization		
PBMs			
Benecard Services, Inc.	Low market share		
Catamaran, Inc.	Combining three companies and platforms onto one technology platform		
Direct Pharmacy Services, Inc.	Low market share		
Express Scripts, Inc.	✓	Combining two companies and platforms onto one technology platform	
Fairview Pharmacy Services, LLC	Low market share		
Humana	✓	Low market share	
MaxorPlus	Low market share		
PBM Plus	✓	Low market share	
Pharmaceutical Technologies, Inc.	✓	Low market share	
Prescription Corporation of America	Low market share		
Prime Therapeutics, LLC	Low market share		
Serve You Rx	Low market share		
WellDyne Rx, Inc.	Low market share/union sponsored health plan		

Notes

✓ = Completed

Appendix E: COMAR 10.25.17

Begin quoted text

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

End quoted text

Appendix F: Payor and PBM Implementation of Preauthorization Phase 1 and 2

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

Payors

1. Aetna, Inc.
   a. List of Services
      i. Medical: http://www.aetna.com/healthcare-professionals/policies-guidelines/medical_precertification_list.html
      ii. Pharmaceutical: http://www.aetna.com/pharmacy-insurance/healthcare-professional/aetna-pharmacy-management-index.html
   b. Electronic Preauthorization System
      i. Medical: https://navinet.navimedix.com/sign-in?ReturnUrl=/Main.aspx
2. CareFirst BlueCross BlueShield
   a. List of Services
      i. Medical: 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
      ii. Pharmaceutical: https://provider.carefirst.com/wcmwps/wcm/connect/fc491d804cd6c2999217d7d0dbe97053/PRV4249.pdf?MOD=AJPERES&CACHEID=fc491d804cd6c2999217d7d0dbe97053
   b. Electronic Preauthorization System
      i. Medical and Pharmaceutical: https://provider.carefirst.com/wps/portal/Provider/ProviderHome
3. Cigna Health and Life Insurance Company/Connecticut General Life Insurance Company
   a. List of Services
      i. Medical: https://secure.cigna.com/health/provider/medical/pre_certification.html
      ii. Pharmaceutical: http://www.cigna.com/sites/cignamedicare/pages/formulary/pdp-formulary.html
   b. Electronic Preauthorization System
      i. Medical and Pharmaceutical: https://cignaforhcp.cigna.com/web/public/guest/!ut/p/b1/04_Sj9CPykssy0xPLMnMz0vMAfGjzOKDnMyMDA0sHL0dA92MDDwtjTx8zbw9DQ08zYEKIoEKDHAARwNC-sP1o8BK8Jjg55Gfm6pfkBthoOuoqAgA9of03Q!!/dl4/d5/L2dBISEvZ0FBIS9nQSEh/

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4. Coventry Health Care of Delaware, Inc.
   a. List of Services
      i. Medical: http://chcdelaware.coventryhealthcare.com/services-and-support/providers/pre-authorizations/index.htm
      ii. Pharmaceutical: http://chcdelaware.coventryhealthcare.com/health-care-solutions/prescription-coverage/prescription-documents/index.htm
   b. Electronic Preauthorization System
      i. Medical and Pharmaceutical:
      https://www.directprovider.com/providerPortalWeb/appmanager/coventry/extUsers
5. United Healthcare
   a. List of Services
      i. Medical:
      https://www.unitedhealthcareonline.com/b2c/CmaAction.do?channelId=12f8c7958f5fa010VgnVCM100000c520720a____
      ii. Pharmaceutical:
      https://www.unitedhealthcareonline.com/b2c/CmaAction.do?channelId=4d39cf5f18b99110VgnVCM1000007740dc0a____
   b. Electronic Preauthorization System
      i. Medical:
      https://www.unitedhealthcareonline.com/b2c/CmaAction.do?channelId=64e9c7958f5fa010VgnVCM100000c520720a____

PBMs

1. CVS Caremark
   a. List of Services: https://www.caremark.com/wps/portal/FOR_HEALTH_PROS_TAB

   b. Electronic Preauthorization System:
   https://eprescribe.allscripts.com/Login.aspx?ReturnUrl=/

2. Envision Pharmaceutical Services

   a. List of Services: http://www.envisionrx.com/healthdrug/mdpa.aspx

   b. Electronic Preauthorization System: https://envision.promptpa.com/

3. Express Scripts, Inc.

   a. List of Services: http://www.express-scripts.com/services/physicians/pa/

4. Humana

   a. List of Services: https://www.humana.com/provider/medical-providers/pharmacy/rx-tools/prior-authorization

5. Pharmaceutical Technologies, Inc.

   a. Electronic Preauthorization System: https://secure.pti-nps.com/coveragedetermination/

6. PBM Plus

   a. List of Services: https://www.pbmplus.com/MemberPortal/PADrugList.pdf

Appendix G: Items for Consideration for Phase 1 Implementation

The following document was distributed to State-regulated payors 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*.[39] The report was developed through a collaborative process with Maryland stakeholders, including: state regulated payors (payors), 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).[40] The bill was passed and subsequently signed by Governor Martin O'Malley. Among other things, SB 540 requires MHCC to work with payors and providers to attain benchmarks for standardizing and automating the process for preauthorization of health care services. The text of SB 540 related to Phase 1 follows:

> *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 payors and PBMs with implementing Phase 1, MHCC offers the following points for consideration:

- The list of health care services should be available to providers outside of a payor or PBM's secure portal, as well as within the secure portal.
- If the payor 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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[39] 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_2011120 1.pdf.
[40] Senate Bill 540, Maryland Health Care Commission - *Preauthorization of Health Care Services – Benchmarks*. Available at: http://mlis.state.md.us/2012rs/billfile/sb0540.htm.

- Payors and PBMs should minimize the number of clicks to navigate to the list of health care services.
- Payors and PBMs should make the list of prescription medications and medical services easy to search.
- Payors 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.

End quoted text

Appendix H: Items for Consideration for Phase 2 and 3 Implementation

The following document was distributed to payors and PBMs in April 2013 to provide guidance for implementing Phases 2 and 3. The guidance is intended to assist payors and PBMs with implementing systems that are accessible and usable.

Begin quoted text

<div align="center">

Electronic Preauthorization

Phase 2 & Phase 3

April 2013

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Background

The Maryland Health Care Commission (MHCC) continues to provide guidance to State-regulated payors (payors) and pharmacy benefit managers (PBMs) that are required to implement COMAR 10.25.17, *Benchmarks for Preauthorization of Health Care Services*.[41] Over the last couple of months, some payors and PBMs have asked MHCC to publish key consideration items regarding implementing the Phase 2 and Phase 3 benchmarks.[42] Maryland law,[43] enacted in 2012, and the subsequent regulation outlines a phased implementation approach for payors and PBMs[44] to standardize and automate the process for preauthorizing medical and pharmaceutical service requests.

Each phase of the regulation requires payors and PBMs to implement technology and a process to facilitate electronic preauthorization. Phase 2 establishes an online process for accepting a preauthorization request electronically and assigns a unique electronic identification number to each preauthorization request. Phase 3 establishes an online system to approve in real-time[45] electronic pharmaceutical service preauthorization requests where no additional information is required, approve electronic pharmaceutical service preauthorization requests within one business day upon receipt of all necessary information, and approve electronic medical service preauthorization requests within two business days upon receipt of all necessary information.

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[41] COMAR 10.25.17 went into effect on February 18, 2013.

[42] The MHCC released items for consideration in implementing the Phase 1 benchmarks which are available online here:
http://mhcc.maryland.gov/mhcc/pages/hit/hit_preauthorization/documents/EPA_Items_Consider_Implement_EPA_Phase1_20111201.pdf.

[43] Md. Code Ann., Health-Gen. § 19-101 & 19-108.2 (2012).

[44] State-regulated payors 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). PBMs are identified based on their registration with the Maryland Insurance Administration.

[45] *Real-time* is considered as being completed in a single communication session, as defined by the Workgroup for Electronic Data Interchange (WEDI), and as generally agreed upon by payors and PBMs in the development of the MHCC report, *Recommendations for Implementing Electronic Prior Authorizations,* available at:
http://mhcc.maryland.gov/mhcc/pages/hit/hit_preauthorization/documents/EPA_Recommend_Implement_EPA_rpt_20111201.pdf.

Consideration Items

The MHCC identified the below items for payors and PBMs to consider as they implement the electronic preauthorization for Phases 2 and 3 benchmarks:

- Preauthorization is generally regarded as the process of approving a service prior to rendering the service. Technology supporting the regulation should be viewed as a proactive solution to the authorization process.[46]

- Electronic preauthorization refers to an online, web-based process and the technology solutions should not include telephone or fax.

- Providers frequently express frustration to MHCC over the challenges in locating information on payor and PBM websites. The MHCC encourages payors and PBMs to implement technology that minimizes the time required for providers to locate and complete the electronic preauthorization process.

Additional Information

Information regarding electronic preauthorization is available on MHCC's website at: http://mhcc.maryland.gov/mhcc/pages/hit/hit_preauthorization/hit_preauthorization.aspx.

End quoted text

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[46] Preauthorization, as defined in 10.25.17.02(B)(5), states that preauthorization is a 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.