Report to
The Vermont Legislature

Single Formulary and Electronic Prior Authorization Recommendations

In Accordance with
ACT 48, Section 18
An act relating to a universal and unified health system, and
ACT 51, Section 4
An act relating to modifications to the ban on gifts by manufacturers of prescribed products

Submitted to: House Committee on Health Care
Senate Committee on Health and Welfare

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VERMONT

AGENCY OF HUMAN SERVICES
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Executive Summary

This report addresses two reporting requirements enacted during the 2011 legislative session. The first, in Act 48, requires the Department of Vermont Health Access (DVHA) to develop recommendations regarding a single statewide formulary ("Single Formulary Report") and the other, in Act 51, requires DVHA to develop recommendations regarding the use of electronic means to request and grant prior authorizations for prescription drugs ("Electronic Prior Authorization Report").

In developing its recommendations, the Department of Vermont Health Access (DVHA) met with both internal and external stakeholders, assessed the status of national initiatives related to these topics, polled other states' activities, and conducted literature searches.

Based upon this research and analysis, the DVHA is proposing a three-stage implementation plan to develop a statewide single formulary that will be supported by electronic prior authorization capabilities. This begins in 2012 with a number of initiatives aimed at minimizing the burden experienced by prescribers, pharmacists, and patients created by the use of multiple formularies and those processes that support utilization management, such as prior authorization.

These initiatives will provide support and lay the foundation for migration to a single statewide formulary as Vermont transitions to a single-payer healthcare system. The first phase begins with the "early adopters" of the single payer system, such as the dually eligible Medicare/Medicaid populations, and will continue through 2017 as the single-payer system is fully embraced.

Introduction/Background

During the 2011 legislative session, the Vermont legislature enacted Acts 48 and 51, with each containing a reporting requirement. 2011 Act 48, An act relating to a universal and unified health system, Sec. 18: Single formulary recommendations, requires that:

> "*the department of Vermont health access provide recommendations to the house committee on health care and the senate committee on health and welfare regarding recommendations regarding the use of a single formulary.*"

2011 Act 51, An act relating to modifications to the ban on gifts by manufacturers of prescribed products, Sec. 4: Electronic prior authorization, requires that:

> "*the commissioner of Vermont health access and the Vermont information technology leaders (VITL) evaluate the use of electronic means for requesting and granting prior authorization for prescription drugs, and report their findings to the senate committee on health and welfare and the house committee on health care and make recommendations for processes to develop standards for electronic prior authorizations.*"

As the Department of Vermont Health Access (DVHA) began analyzing data, meeting with stakeholders, and drafting preliminary recommendations, it became apparent these two reports were interrelated because electronic prior authorizations (Act 51), as well as other technologies, are "phase one" solutions for simplifying the provider interface in DVHA's *Single Formulary Report.* Therefore, these two reports are hereby submitted to the Senate Committee on Health and Welfare and the House Committee on Health Care as a single report incorporating both sets of recommendations.

Pharmacy Benefit Management

This section describes some common cost control techniques, including drug formularies with preferred drug lists, utilization management including prior approval, and pharmacy benefit management (PBM) negotiated rebates.

Formularies: A formulary is a list of drugs available under a pharmacy benefit program (PBP). Whether to include a drug on the formulary is first based on its clinical safety and efficacy, as determined by a Pharmacy and Therapeutics (P&T) Committee following evidence-based literature and research. P&T Committees are comprised of physicians, pharmacists, and other clinicians.

Cost Considerations: After clinical evaluation, the status of a drug as preferred or non-preferred is determined based primarily on its cost relative to other drugs in the same class or drugs with a similar indication or use. Preferred drugs have a lower net cost to the pharmacy benefit plan, and are usually of lower cost to the patient, as well.

- Non-Medicaid formularies typically are structured with "tiered co-pays," in which the lowest cost-share is applied to generic drugs, a higher cost-share is applied to preferred brand drugs, and an even higher cost-share is applied to non-preferred brand drugs. In addition to the frequently used traditional three-tier drug formulary design, many plans have added fourth tiers called "specialty tiers," in which the co-pay is based on a percent of total drug cost rather than a fixed co-pay amount. [See example in Figure 1 below.] Specialty tiers can result in a patient cost-share of hundreds or even thousands of dollars per year (New England Coalition for Affordable Prescription Drugs). Last year, Vermont passed a moratorium on the use of these specialty tiers which expires in June 2012. (Vermont, 2011).

- Vermont Medicaid co-pays are determined based on the cost of the drug, not on a generic/brand model.

- Nationally, nearly 100% of Medicare Part D enrollees are in plans with a specialty tier. The median coinsurance for specialty drugs costing at least $600 per month has increased from 25% in 2006 to 30%; about half of PDPs charge a 33% coinsurance, and more than three-fourths of Medicare Advantage Prescription Drug Plans (MA-PDP) do. In contrast, only 14% of members are enrolled in commercial plans with four or more tiers (The Kaiser Family Foundation and Health Research and Educational Trust, 2011).

Figure 1 EXAMPLE OF TYPICAL FORMULARY TIERS

	TIER 1	TIER 2	TIER 3	TIER 4
Type of Drug	Generic	Preferred Brand	Non-Preferred Brand	**Specialty or Injectable**
Example of Each Drug Type	Simvastatin	Crestor	Lescol	**Interferon Injections**
Co-Payment/ Co-Insurance Amount	$12	$25	$55	**25%**

Formulary Utilization Management (UM): In addition to the drug list itself, formularies include utilization management rules that guide drug coverage, including prior authorization, quantity limits and step therapy.

- *Prior authorization (PA)*. PA is an administrative tool that requires prescribers to obtain prior approval to prescribe a drug in order for it to qualify for coverage under the PBP. PA requirements generally target new, expensive, and potentially unnecessary or dangerous medications, and encourage the use of less expensive and/or safer alternatives. The PA process allows coverage of specific medications when defined clinical criteria are met, and prevents the inappropriate prescribing of expensive, non-preferred drugs. This utilization management technique can be an effective tool in managing the increasing costs of pharmacy benefits.

- *Quantity Limits.* Plans may limit the amount of certain drugs they will cover per prescription or for a defined period of time.

- *Step Therapy.* Plans may require that certain lower cost drugs are tried first to treat a person's medical condition before a costlier drug will be covered.

Pharmacy Benefit Managers (PBMs): Each health plan in Vermont has a unique formulary because each plan independently contracts with a different Pharmacy Benefit Manager (PBM). A PBM is a company that administers a drug benefit program on behalf of an employer or health plan. A PBM typically manages an array of services, including drug claims processing and clinical services such as formulary management.

- Because PBMs manage very large populations, they are able to negotiate significant prescription drug rebates from drug manufacturers; these savings are passed along in varying financial arrangements to the employer or health plan. For example, the top three PBM's in the nation, Medco Health Solutions, Inc, Express-Scripts, and CVS-Caremark command over 45% of the PBM market in the U.S. based on data from the third quarter of 2010 (Atlantic Information Services, 2011). In exchange for rebates, manufacturers usually require a preferred status for their drug on the formulary, or that it have fewer or no restrictions on its use. This results in a larger market share for the drug, which in turn is advantageous to the manufacturer.

- Although Medicaid programs also contract with PBMs, they receive the majority of their rebates directly from manufacturers (per Federal Omnibus Budget Reconciliation Act '90 legislation). States also can negotiate directly with manufacturers for supplemental rebates on brand drugs.

Administrative Challenges

Currently, over 20 different formularies exist in Vermont, including insured and self-insured commercial plans, Medicare Part D plans, and other state and government plans. Multiple formularies place a burden on prescribers and pharmacists who must prescribe and dispense within the structure of each plan's unique formulary (e.g., different preferred drugs, quantity limits, PA requirements, rules and procedures, etc.).

While prior authorization offers an effective clinical and cost-containment tool for payers, some of the costs are shifted to prescribers and dispensers through increased administrative burden and higher operational costs. It is often the pharmacist who must coordinate with the prescriber's office to obtain prior authorization because physicians do not have a central repository for access to all formularies and patients often do not know whether a drug is non-preferred, requires prior authorization or has other limitations on its use. Not only does this place additional burden and costs on prescribers and pharmacies, but patients can also experience inconvenience at the pharmacy, higher out-of-pocket expenses, or even disruption in drug therapy.

Single Formulary Considerations

A single formulary with only one drug list, one set of utilization management rules and procedures, and one point of contact would eliminate a large percentage of the administrative burden currently experienced by providers and patients. However, requiring all insurers to use a single formulary regardless of their advantageous manufacturer discounts and rebates would result in each plan sacrificing significant cost savings from these negotiated contracts. This likely would result in plans paying higher PBM contract costs, higher drug costs, and could result in plans passing along these costs in the form of higher patient cost-share or premiums.

Administration of a single formulary in a multi-payer environment would be difficult and require a great deal of coordination among multiple participants. As a recent example, in October 2011, Ohio began to align the Medicaid Preferred Drug List (PDL) with seven other managed care plans. Participants meet quarterly to discuss drug alignment and prior approval requirements. Currently, there is 63% alignment of drugs on their respective lists, and coordinating activities and decisions has reportedly been challenging (Ohio Medicaid Program, 2012). In Vermont's current environment, managing a similar process would add administrative burden and expenses to plans and divert valuable human resources.

It is important to note that a single formulary is a natural by-product of the single-payer goals in Vermont, bringing many advantages while eliminating most, if not all, the disadvantages. These factors greatly influenced the following recommendations.

Recommendations

The DVHA's recommendations are divided into short, intermediate, and long-term goals. The overriding short-term goal is to creatively reduce the administrative burden providers experience in a multi-payer and multi-formulary environment by capitalizing on technology either already developed or under development, such as electronic health records, electronic prescribing (e-prescribing), and electronic prior authorization processes. In the absence of existing technology, some interim measures are suggested to bridge the gap.

Overall, the DVHA's approach is to align a single formulary with Vermont's single-payer efforts. DVHA believes that implementing a single formulary prior to a single-payer system would create additional administrative and operational burdens for the state and other insurers. At the same time, many problems associated with multiple formularies can be addressed through other initiatives as Vermont transitions to a single-payer, single-formulary environment. These initiatives completely align with national trends and developments, as well as with Vermont's vision for the future.

1. ***Short-Term Goal (2012-2013):*** A major focus of our short-term goals is to facilitate administrative simplification in a multi-payer environment. DVHA will establish focused workgroups beginning in first quarter 2012, to move forward on the following recommendations:
    - Promote physician access to e-prescribing.
        - Utilize provider incentives for adoption of electronic health records (EHR) and e-prescribing capabilities.
        - Develop and refine a formulary interface through electronic health records, working toward a consistent and accurate display of formulary information among all insurers.
        - Develop recommendations for quality improvement and monitoring to improve accuracy of e-prescribing systems.

- Secure reimbursement of transactional costs through federal (CMS) support for Medicaid.

- Develop a plan for a multi-payer single web portal.
  - Provide access to formulary information assuring consistency with Vermont's Health Information Exchange (HIE) development.
  - Provide information about formulary drug lists, drug status, alternatives, and limitations.
  - Provide information about provider call centers, prior authorization (PA) or specialty drug forms, PA criteria, and PA appeals processes.
    Ensure portal accommodates electronic PA submittal.
  - In addition, the workgroup responsible for portal evaluation will consider and explore the following capabilities:
    - Enable providers to access payer portals with a single set of secure credentials.
    - Use single web portal to perform identity management, authentication, and digital identification.
    - Pre-populate the information needed by payers for prior authorization as much as possible.

- Identify or develop, and communicate common features of all payers' formularies. Some of the state's larger insurers utilize the same PBM which could be helpful in designing a phased-in approach to a single formulary.
  - Evaluate which insurers share a common formulary.
  - Create a list of formulary drugs and features common among all payers' formularies (i.e., "common multi-payer formulary").
  - Evaluate the feasibility of using common PA forms.

- Identify and evaluate for adoption, best practices among insurers and other states that promote administrative simplification and quality improvement processes for formulary support services. Some of these practices include:

- Developing a common measurement tool for assessing provider satisfaction.
- Promoting a more seamless interface for the provider community.
- Assuring that drug PA decisions are made on a timely basis.
- Assuring that drug management rules are established via evidence-based medicine and include evidence-based guidelines and key criteria that will be used to make a final determination on prior authorization request.

- Closely monitor development of national electronic prior authorization EHR standards and electronic PA pilots. Align Vermont's electronic PA development with the development and approval of appropriate and workable national standards.
  - According to the Office of the National Coordinator for Health Information Technology (ONC), there is a lack of fully vetted standards to support electronic prior authorization and no capability to support electronic prior authorization in implemented EHR systems (Frisma, 2011).
  - DVHA, in collaboration with other states, is participating in a focus group for entities that are serious about testing electronic PA's. The group is sponsored by the National Council for Prescription Drug Programs (NCPDP).
  - Refer to Appendix A for the current impact of the PA process and Appendix B for proposed electronic PA processes.

- Expand the University of Vermont's Area Health Education Centers' Academic Detailing program to promote the use of generics on all formularies and educate providers about appropriate prescribing.

- Include pharmacists on the Blueprint's Community Health Teams (CHT) to facilitate the PA process.
  - Develop role of CHT pharmacists to guide prescribing decisions, assuring optimal drug therapy and formulary compliance.

- Provide protocol, training, and authorization to CHT pharmacists to submit PA requests on behalf of physicians.

Several states are implementing initiatives designed to streamline the prior authorization process for outpatient medications [refer to Appendix C for examples].

2. ***Intermediate-Term Goal (2014-2017):*** Begin to implement a "single formulary" with the early adopters of a single-payer system.
   - Continue work on 2012-2013 initiatives.

   - Implement single formulary for certain single-payer groups:
     - Duals (SFY 2013)
     - Medicaid (new MES procurement SFY 2013)
     - State employees, subject to labor agreements and/or statute

   - Facilitate incorporating electronic prior authorization into EHR systems for all payers.

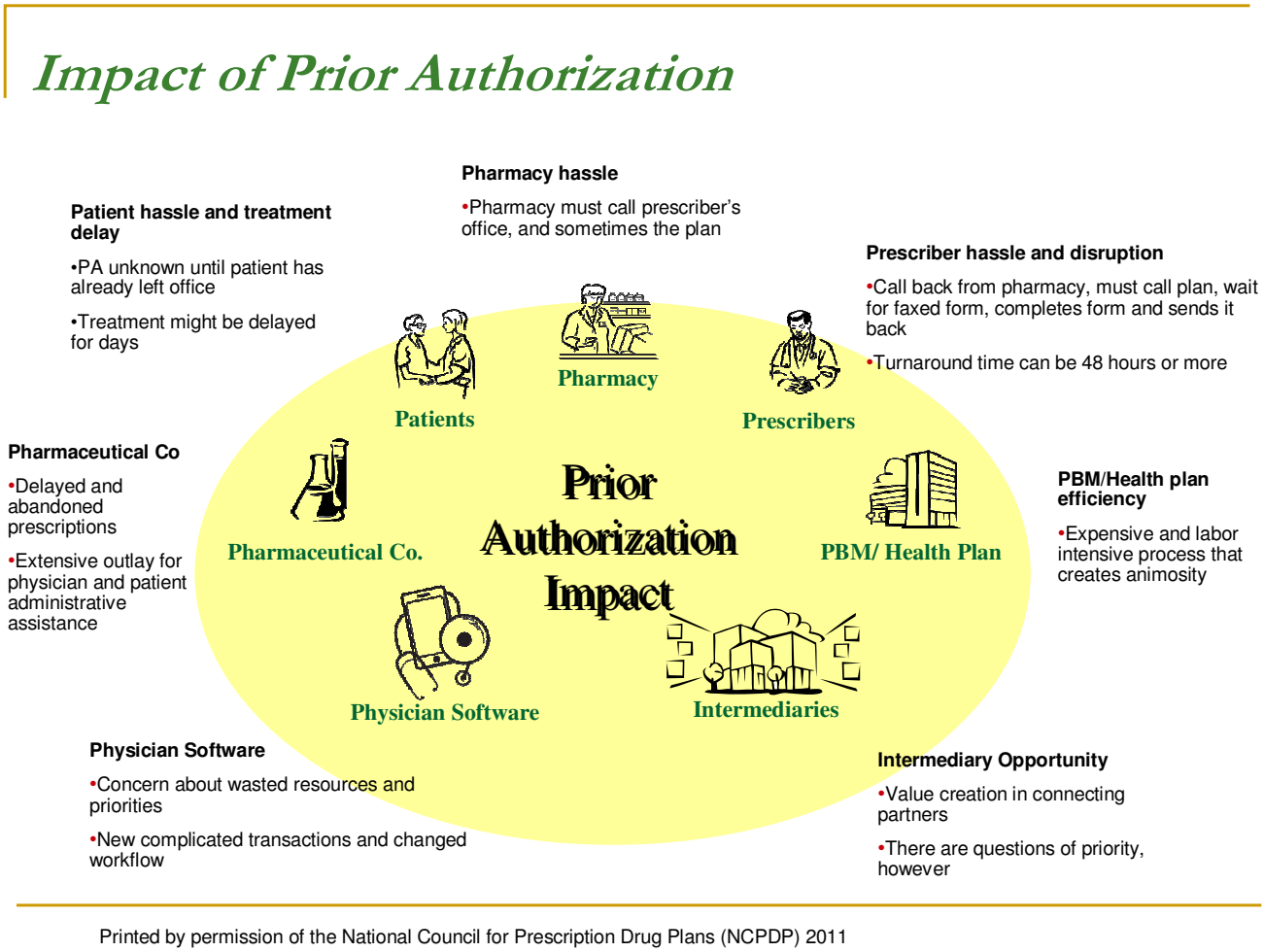
   - Continue to develop and refine a multi-payer provider portal to facilitate formulary and electronic PA process for all payers, consistent with HIE development.

3. ***Long-Term Goal (2017 and beyond)***: Continue to implement single formulary to single-payer expansion groups.
   - Align with single-payer strategies to increase population under a single formulary.

VI. APPENDICES

Appendix A

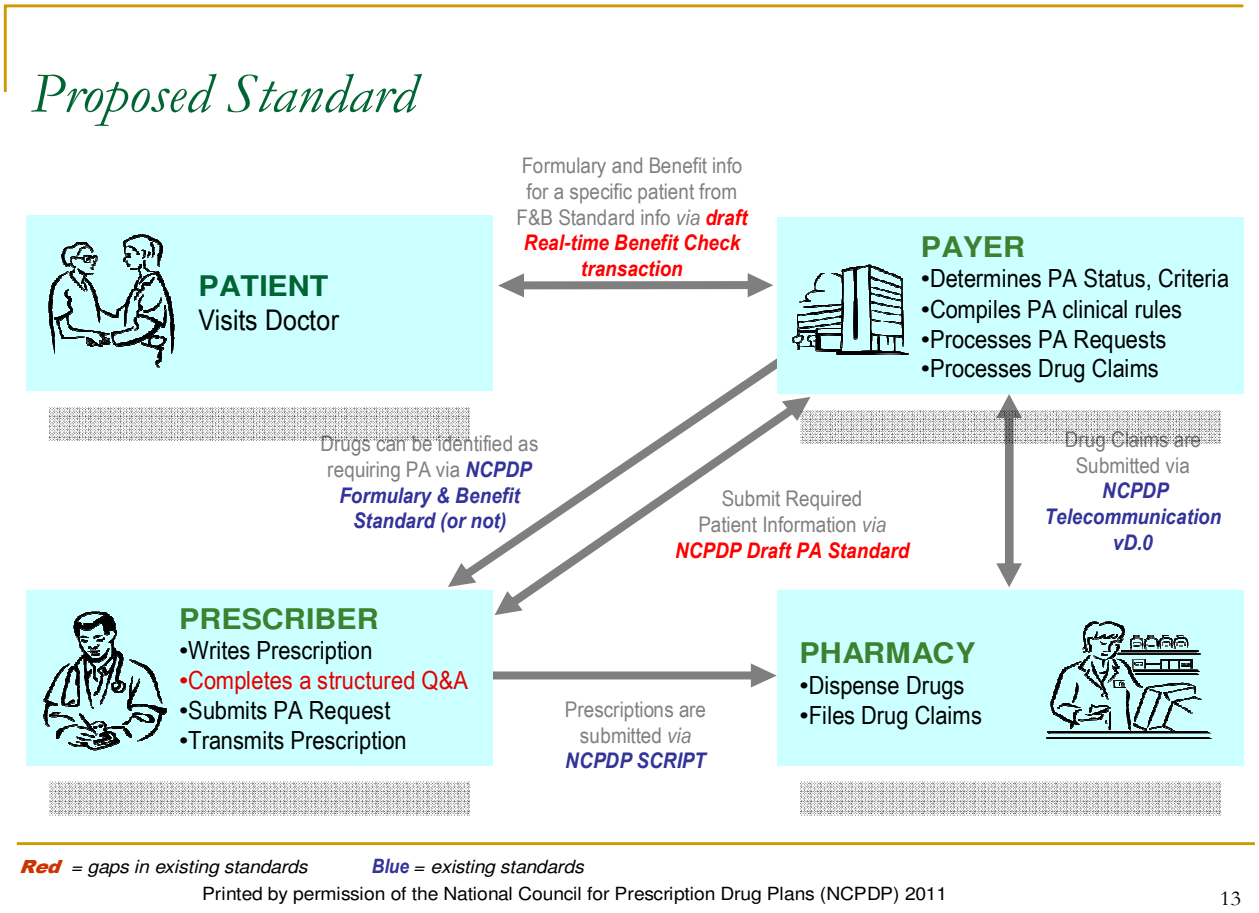
Impact of Current Prior Authorization Process



(National Council for Prescription Drug Programs, 2011)

Appendix B

Proposed Electronic Prior Authorization Standards



(National Council for Prescription Drug Programs, 2011)

NCPDP National Electronic Prior Authorization Standards

According to the Office of the National Coordinator for Health Information Technology (ONC), there is a lack of established and fully vetted standards to support electronic prior authorization and a current lack of capability to support electronic prior authorization in implemented EHR systems. There are draft standards not yet tested in pilots, but pilots are being developed. The National Council for Prescription Drug Programs (NCPDP) is a not-for-profit ANSI-Accredited Standards Development Organization representing virtually every sector of the pharmacy services industry. It convened a focus group October 2011 for entities that are implementing or serious about testing the electronic prior authorization (e-PA) transaction exchange (Fridsma, 2011).

The e-PA Task Group began conference calls again in December 2011, and the Department of Vermont Health Access is regularly participating in those calls.

APPENDIX C

Initiatives in Other States Related to Single Formulary, Administrative Simplification, and Electronic Prior Authorizations

Several states are implementing initiatives designed to streamline the prior authorization process for outpatient medications. Several types of initiatives have emerged:

- Single formulary:
  - No states have considered or are currently considering a statewide single formulary in the breadth and scope of Vermont's.
  - While Montana's governor announced in September of 2011 his intention to seek a "waiver from the federal health reform law's mandate for state-based health exchanges in favor of forming a unique universal system" (The Advisory Board Company, 2011), few details are available on the state's efforts other than that the governor's office is currently working on a position paper to be submitted to the Centers for Medicaid and Medicaid Services (CMS) (Rhoades, J., 2012).
  - Recent efforts involve states with managed Medicaid programs. The Affordable Care Act (ACA) allows states to collect federal rebates on the MCO utilization for Medicaid beneficiaries, which previously they were not allowed to do. A few states with managed Medicaid pharmacy benefits are requiring the MCOs to follow the state's Medicaid preferred drug list to maximize rebates. This creates a single formulary in the sense that all Medicaid lives operate under one drug list. Vermont already operates under one Preferred Drug list for all Medicaid lives.
  - A second initiative in Georgia attempted to implement a single formulary for Medicaid and state employees. However, this effort was abandoned due to

negative financial implications of state employee utilization not being subject to federal Medicaid rebates, making it impossible to align the two formularies cost-effectively. Georgia's experience is an important consideration as Vermont moves forward with a single formulary. Ultimately, two formularies may be needed, as closely aligned as possible, to allow the state to take advantage of each market's dynamics (Georgia Medicaid Program, 2012).

- Single multi-payer web portals:
  Several states are attempting to create a single portal for providers to access information from multiple payers. For example, Washington and Oregon are developing OneHealthPort. Although it appears there is access to the plans' formularies, there is no immediate plan to incorporate drug prior authorizations (Maryland General Assembly Joint Commission on Health Care Delivery and Financing, 2011).

- Prior authorization:
  - Some states have pursued the use of a uniform prior authorization form to be accepted by all payers. Those states are in various stages of design, development, and uptake by the provider community.
  - There is considerable focus on electronic submission of prior authorization requests. A major limiting factor is the lack of national standards for transmitting electronic prior authorization through electronic medical records.

Individual State Initiatives

Single Formulary

Montana

In September of 2011, Governor Brian Schweitzer announced that he is urging the state to adopt a single-payer system in Montana based on the health care system in place in neighboring Saskatchewan, Canada, "which has reduced costs by negotiating fees with drug companies and limiting access to high-cost non-emergency care." The neighboring province has similar demographics but spends 50% less than Montana on per-capita health care costs. This would require a waiver from the federal health reform law's mandate for state-mandated health insurance claims (The Advisory Board Company, 2011).

Texas

Texas is moving most of its Medicaid beneficiaries and all of its CHIP beneficiaries to managed care plans effective March 1, 2012. The state is contracting with 19 managed care organizations (MCOs) using seven different pharmacy benefit managers (PBMs), so having providers adhere to one preferred drug list (PDL) is important to the effectiveness of the prior authorization process and allows for greater negotiation by the Texas Medicaid program with manufacturers for supplemental rebates (Vasquez, 2012). In addition to several other requirements, recent Texas legislation requires that Medicaid MCOs:

- adhere to the state's Medicaid preferred drug list;
- not negotiate or collect rebates with manufacturers for drugs provided to Medicaid beneficiaries; and
- not implement prior authorization clinical criteria that are more stringent than the state's criteria.

The single PDL provisions expire August 2013 unless the legislature extends them in the March 2013 session (Texas Senate, 2011).

Kansas

Currently, Kansas is waiting for bids (due at the end of January 2012) for the RFP it released for managed Medicaid services. Kansas is requiring that bidders utilize the state's preferred drug list (Kansas Department of Administration).

Georgia

Georgia consolidated Medicaid and state employee health insurance programs in 2001, looking to achieve common program administration. It was an unsuccessful attempt, and in 2006 the administration of the two plans was again separated. One issue identified was the lack of expertise that PBMs have in both commercial and Medicaid markets, so there were challenges for their PBM that were difficult to overcome. Often the Medicaid PDL decisions had a negative financial impact on the state employee plan. For example, the state employee plans lost some commercial (i.e., non-Medicaid) rebates due to more restrictive criteria on the Medicaid PDL. More importantly, since the state employees' claims were not subject to federal rebates, there was a significant negative financial impact.

Additionally, when new generics enter the market, Medicaid programs often continue to prefer the brand drugs for a short period of time after they go off patent. Significant federal and supplemental rebates make them much less expensive for Medicaid programs. However, the same benefits do not exist for the state employees' plan. Because Georgia's single formulary legislation required the state employees to use the Medicaid drug list, they were financially impacted by the employees' plan having to pay for the brand drug without realizing the benefits of the rebate advantages. Savings on the administrative side were also believed to be minimal (Georgia Medicaid Program).

Ohio

Prior to October 1, 2011, outpatient pharmaceuticals were "carved out" from the state's contracted Medicaid managed care plans to one pharmacy benefits manager with one preferred drug list and one point of contact, which was convenient and popular with

prescribers. Effective October 1, 2011, the state transferred management of managed Medicaid pharmacy services to seven managed care plans contracted with the state, each with their own pharmacy benefit manager.

Due to providers' positive experience with the state's carve-out plan, the state is attempting to align the formularies and utilization management rules for each of seven managed care plans and the fee-for-service Medicaid plan. This is being achieved by quarterly meetings with the state and the plans to align drug lists as must as possible. Currently, the managed care plans are in alignment on 63% of drugs on their respective drug lists, including agreement as to whether or not the drug requires a prior authorization. Based on utilization, the managed care plans are in alignment 83% of the time. Prescribers seem satisfied with the progress being made, although there is significant administrative burden on the plan and the state (Ohio Medicaid Program, 2011).

Single Multi-Payer Web Portal

Washington

Title 48.165 requires that a lead organization be appointed by the insurance commissioner to simplify and standardize administrative processes between providers and payers. The Washington Health Care Forum and OneHealthPort were appointed in 2009 to oversee the administrative simplification process.

The Maryland Health Care Commission, which was charged with the development of recommendations around best practices and standards for electronic prior authorizations for the state of Maryland, reported on the related initiatives of other states.

According to Maryland's report, Washington's Title 48.165 "…was written in such a way to allow the private sector to lead the simplification effort without regulation from the Insurance Commissioner. If the private sector fails to reach consensus on best practices and standards for simplification, or they fail to achieve widespread adoption of

the standards, the insurance commissioner has the authority to enact rules and regulations for all payers and providers in the state."

"When OneHealthPort began to look at the prior authorization process, it evaluated the American National Standards Institute ASC X12 278 transaction standard but determined that it was not ready for use; the timeline for when it would be ready was also unclear. Additionally, since prescription medication prior authorizations involve not only payers/TPAs and providers but also pharmacists; at this juncture, OneHealthPort has not included prescription medications in the simplification process." OneHealthPort is a for-profit, privately owned organization, based in the state of Washington (Maryland General Assembly Joint Commission on Health Care Delivery and Financing, 2011).

Oregon

Administrative Simplification Executive Committee of the Oregon Health Leadership Council (OHLC) is working with OneHealthPort on a "secure, single sign-on initiative." While not mandated by the legislature, the program is voluntary and provides health care providers with a single sign-on to the websites of multiple payers, with the provider's information pre-populated on each payer's site.

> "As of July 2011, seven health plans were participating in the initiative. As of June 2011, 4,731 provider organizations have registered with OneHealthPort, and 11,771 individuals were registered within those organizations. From March 2011 to June 2011, providers signed on using OneHealthPort approximately 302,000 times"

(Maryland General Assembly Joint Commission on Health Care Delivery and Financing, 2011).

Maryland

Single sign-on efforts are also taking place in Maryland, with the goals of real-time prior authorization capability by all insurers by July 1, 2013, and all prior authorizations being processed electronically by January 1, 2015, with some exceptions made for extenuating circumstances, such as a provider's lack of broadband access.

"This may be via online websites or portals or the provider's practice management, EHR, or e-prescribing system, if a national transaction standard has been established and adopted by the industry" (Maryland General Assembly Joint Commission on Health Care Delivery and Financing, 2011). This single sign-on authority may be the state-designated health information exchange (HIE).

Uniform Prior Authorization Forms, Electronic Prior Authorization Processing

California

California Senate Bill 0866 requires that a uniform paper prior authorization document be developed on or before July 12, 2012, which all providers must use and all insurers must accept. This form must be made available electronically and must be capable of electronic submission effective January 1, 2013, or six months after the form is developed. The bill requires that insurers review requests within 48 hours or the request is automatically deemed approved (Legislative Council, State of California, 2011).

Nevada

Nevada legislation from 2011 requires the completion of a study on how to create standards for electronic prior authorizations and that the Director of Health and Human Services (DHHS), "prescribe by regulation, in consultation with the state board of pharmacy, standards for the electronic transmission of prior authorizations for prescription medications using a health information exchange." The DHHS does not currently have a deadline for implementing an electronic prior authorization process. (Maryland General Assembly Joint Commission on Health Care Delivery and Financing, 2011).

Minnesota

Minnesota legislation from 2009 sets objectives to achieve the goal of full access to electronic submission of prior authorizations by January of 2015 (Minnesota Office of the Revisor of State Statutes, 2010).

"Minnesota Statutes 62J.497 was amended during the 2009 legislative session with requirements for the Minnesota Department of Health (MDH) to produce an "outline on how best to standardize drug prior authorization request transactions between providers and group purchasers with the goal of maximizing administrative simplification and efficiency in preparation for electronic transmissions." This requirement was fulfilled with a report, submitted 2/15/2010, which includes a section describing a form to be used for prescription drug PA requests. The form for PA requests was very similar to another form that MDH developed, for formulary exception requests. Because of the similarities between the two forms, MDH created a single, combined prescription drug PA and formulary exception request form: the Minnesota Uniform Form for Prescription Drug Prior Authorization (PA) Requests and Formulary Exceptions.

Minnesota Laws, Chapter 336, Sec. 5, requires that "No later than January 1, 2015, drug prior authorization requests must be accessible and submitted by health care providers, and accepted by group purchasers, electronically through secure electronic transmissions. Facsimile shall not be considered electronic transmission (Prescription Drug Prior authorization Standardization and Transmission Project, n.d.).

According Sara Drake, R.Ph., the Pharmacy Director for Minnesota Medicaid, in regard to this 2009 legislation, "A multi-payer and provider group met multiple times and developed a report to the Minnesota legislature in February 15, 2010. The Minnesota Administrative Uniformity Committee (AUC), which participated in the meetings, submitted a position statement expressing concerns with the report's recommendation of standardized web portals. The AUC concluded that the web portal approach would not reduce administrative burden or cost. Furthermore, the AUC concluded that true electronic PA would not be feasible until national transactional standards are developed,

tested and adopted. The legislation was ultimately amended so that the electronic PA requirement now aligns with the development of national standards." The state settled on a standard multi-payer PA and formulary exception pdf fillable form that all payers are required to accept for formulary exception requests (Drake, 2011).

North Dakota

North Dakota, effective August 1, 2013, requires that all insurers accept electronic prior authorizations. Within the same House Bill 1422 is a requirement for the health information technology committee "to establish an outline on how to best standardize drug prior authorization request transactions between providers and payers, insurance companies, and pharmacy benefit managers responsible for adjudicating the authorization or denial of the prescription request." The committee's recommendations are due by June 30, 2012 (North Dakota House of Representatives, 2011).

Michigan

Effective January 1, 2012, Michigan will begin requiring a uniform prior authorization form. This bill also requires that insurers review requests within 48 hours or the request is automatically deemed approved (Michigan Senate, 2011).

Massachusetts

Senate Bill 411: "The division shall provide to participating providers a prior authorization request form designed to permit the prescriber to make prior authorization requests in advance of the need to fill the prescription, and designed to be completed without unnecessary delay. The form shall be capable of being stamped with information relating to the participating provider and, if feasible, at least one form capable of being copied shall contain known patient information" (Massachusetts Senate, 2008).

APPENDIX D

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