

Date Received	Sender	Affiliation	Single Formulary	Administrative Simplification	Electronic Prior Authorization
12/7/2011	Mongan, Madeleine	Deputy Executive Director, Vermont Medical Society			Here's a link to an interesting new California law that mandates use of a standardized prior authorization form that is made available electronically and that can be electronically submitted, and that takes into consideration CMS' existing prior authorization forms for Medicare Part D. http://leginfo.ca.gov/pub/11-12/bill/sen/sb_0851-0900/sb_866_bill_20111009_chaptered.pdf
12/28/2011	Mongan, Madeleine	Deputy Executive Director, Vermont Medical Society	<p>VMS' comments on DVHA's recommendations required by Act 48 concerning a single formulary and administrative simplification:</p> <p>I. Implementation of a Single Formulary</p> <p>The current multiple formulary system, where each payer has its own formulary, creates a tremendous burden for physician practices.</p>	<p>II. Minimizing Administrative Burdens and Promoting Uniformity for Pharmacy Benefit Management</p> <p>Section 18 of Act 48 requires DVHA to provide recommendations by January 15, 2012 addressing:</p> <p>A uniform set of drug management rules aligned with Medicare to the extent possible, to minimize administrative burdens and promote uniformity of benefit management. The standards for pharmacy benefit management shall address timely decisions, access to clinical peers, access to evidence-based rationales, exemption processes, and tracking and reporting data on prescriber satisfaction.</p>	

			<p>This system requires physician practices to manage multiple formularies, multiple prior authorization forms, multiple contact numbers, and multiple processes to obtain prior authorization and appeal denials. One result of this proliferation of administrative activities is noted in an AMA report that found that administrative employees outnumber the clinical staff at many physician practices in the United States.</p> <p>Plans' complex benefit management programs and the confusion created by multiple formularies can delay patients' access to care that they need. On an AMA survey, more than two-thirds (69%) of physicians report typically waiting several days to receive preauthorization for drugs while one in ten (10%) wait more than a week. Likewise, more than two-thirds (67%) of physicians report it is difficult to determine which drugs require preauthorization by insurers' pharmacy benefit managers (PBMs).</p>	<p>Section 4 of Act 51 requires DVHA to evaluate the use of electronic means for requesting and granting prior authorization for prescription drugs and make recommendations to the legislature regarding processes to develop standards for electronic prior authorizations. DVHA is in its presentation to stakeholders in December made a number of recommendations to reduce administrative burdens including a proposal to promote physician access to formularies and e-prescribing through provider incentives for adoption of e-Rx and Electronic Health Records (EHR), through development of formulary interface using EHRs, and through reimbursement of transactional costs. DVHA also recommended evaluating the feasibility of developing a web-based multi-payer portal that would identify plan formularies, contain information on how to contact plan call centers and obtain plan prior authorization forms and would allow real-time electronic prior submittal and approval.</p>	
			<p>The legislature first attempted to address this issue in Act 127 in 2002 when it recommended creation of a Medicaid preferred drug list and contemplated joint purchasing agreements with health benefit plans, the state employees' benefit plans and private plans. The legislature again addressed this issue in Section 18 of Act 48 (2011) which requires DVHA to make recommendations with respect to "a single prescription drug formulary to be used by all payers of health services." In its presentation to stakeholders, DVHA proposed a timeline to develop a statewide single formulary that begins by implementing a single formulary for the dual eligibles in January of 2013, assuming the state receives a dual eligibles waiver from CMS. The timing of state employees' participation in a single formulary will be governed by the state's contract and DVHA does not envision rolling out the single payer to fully insured plans until 2017, when Vermont expects to receive the ACA waiver that will allow it to implement a single pay plan.</p>	<p>Other DVHA recommendations included including pharmacists on Community Health Teams and expanding the Academic Detailing program. In general, VMS is supportive of these recommendations although they are not likely to offer physicians any relief from administrative complexity in the near term. VMS is interested in investigating the concept of a web-based single portal. On the positive side, a single portal, if well-maintained, up to date and consistent would be a place where prescribers could obtain phone fax and email contact information for insurers' PBMs that handle drug prior authorization, exceptions and appeals. Prior authorization forms could also be obtained from the single portal. A single portal would not, however, reduce the administrative burden created by the overwhelming plethora of formularies, prior authorization forms and appeal processes that prescribers must deal with to ensure that their patients receive medically necessary drugs. This complexity and multiplicity of forms, phone numbers, fax numbers, user IDs</p>	

			<p>Several states have begun to streamline administration for drug authorization by requiring single state paper forms and options for electronic transmission of the forms. At least one other state has already successfully implemented a PDL for use by multiple government health plans. In Washington State an evidence-based single formulary, the Preferred Drug List (PDL) was created by a Pharmacy and Therapeutics (P&T) committee similar to DVHA's Drug Utilization Review (DUR) Board, which created the Vermont PDL. The Washington PDL is used by three state agencies, Medicaid, the state employees' plan and workers' compensation plans.</p> <p>Based on the work done in other states, VMS believes that there are steps Vermont can take prior to establishing a single-pay, single-PBM system.</p>	<p>Achieving meaningful administrative simplification through DVHA's recommendations will take time and VMS believes that there are steps that can be taken now that would be helpful. Three states, Minnesota, California and Massachusetts have enacted legislation requiring the use of a single prior authorization form by health plans. Minnesota, the first state to pass the single form requirement, has developed a uniform form – the Minnesota Uniform Form for Prescription Drug Prior Authorization (PA) Requests and Formulary Exceptions.</p>	
			<p>VMS Recommendations on Single Formulary</p> <p>As you know, VMS strongly supports efforts to move to a single formulary. As intermediate steps, VMS recommends the following:</p> <ul style="list-style-type: none"> • Working to broaden the use of a single state formulary (PDL) to include all plans subject to state government regulation as soon as possible, such as the state employee benefit plan, teachers, municipal employees, and workers' compensation plans; • Initiating discussions with health plans to identify and address specific obstacles to their participation in a single formulary. At the same time, VMS recommends that DVHA work with plans to identify the common drugs on all of their formularies, and develop a common preferred drug list that can be provided to prescribers; and • Requesting a waiver from CMS for the dual eligible project to authorize Vermont to use the Medicaid preferred drug list for dual eligible Medicare patients. 	<p>and passwords remain evident in the single portal used by the State of Washington. The recently enacted California legislation also includes specific requirements for a single prior authorization form. It requires state agencies to develop a prior authorization form for use by every health plan that provides prescription drug benefits, with limited exceptions. Prescribers must use and plans must accept the form 6 months after the form is developed. The form must be made available electronically and the completed form may be electronically submitted. In developing the form, the agency is required to consider the existing CMS forms, such as the Medicare Part D forms and national standards for electronic prior authorization. If a plan does not respond to a prior authorization request within two days the law deems prior authorization to be granted as requested.</p>	

			<p>In Massachusetts, Section 57 of Chapter 288, enacted in 2010 requires the division of insurance, in consultation with the secretary of health and human services, to promulgate regulations to promote administrative simplification in the processing of claims. Among other things, the regulations must establish a standard authorization form to be submitted by a health care provider to obtain authorization to provide health care services to a member.</p> <p>Washington State took another approach to streamlining pharmacy benefit management, when it established the Therapeutic Interchange Program (TIP), a process that allows physicians and other prescribers to endorse the Washington State Preferred Drug List (PDL), an evidence-based formulary created by a pharmacy and therapeutics (P & T) committee. When a prescriber endorses the PDL and prescribes a drug for a patient covered by Medicaid, the Department of Labor & Industries, or the Uniform Medical Plan, pharmacies automatically interchange a preferred drug in the therapeutic class for any non-preferred drug.</p>	
			<p>If the prescription is for a refill of an antipsychotic, antidepressant, chemotherapy, antiretroviral, or immunosuppressive drug, however, the pharmacist dispenses the prescribed non-preferred drug. An endorsing practitioner can also indicate "dispense as written" (DAW) on a prescription and no substitution will be made at the pharmacy. This program reportedly saves time for physicians seeking authorization for non-preferred drugs. About 7500 of 18,000 active prescribers in Washington have voluntarily endorsed the preferred drug list and participate in the TIP program.</p>	
			<p>In its presentation, DVHA expressed concern that even if there were a single PDL, in a multi-payer setting, administration of the formulary would be fragmented and the plans' multiple P & T committees would be difficult to manage. VMS believes that standardization across health plans is possible in the multi-payer environment. BISHCA has taken a number of steps to standardize administrative activities across private health plans. These include a common credentialing form, a common set of questions for plans' provider satisfaction forms, a single explanation of benefits, and a requirement that health plans participate in joint quality improvement projects with other health plans.</p>	

				<p>VMS Recommendations for Minimizing Administrative Burdens and Promoting Uniformity for Pharmacy Benefit Management:</p> <ul style="list-style-type: none">• VMS recommends that the state, with input from the DUR Board, create a single standard prior authorization form for drugs. All public and private health plans should be required to use the form, which should be usable in paper and electronic formats.• VMS recommends that DVHA and the Green Mountain Care Board convene a group of stakeholders to investigate the potential benefits of therapeutic interchange and dispense-as-written program similar to the one in Washington State.• VMS recommends that Medicaid reimburse physicians for the time they spend obtaining prior authorization for drug benefits for their patients using the 99499 code for unlisted evaluation and management services.	
				<ul style="list-style-type: none">• VMS recommends that DVHA, in consultation with the DUR Board, establish a "gold card" process to exempt physicians from obtaining prior authorization for drugs when they have a documented record of prescribing drugs consistently with the evidence-based PDL. VMS supports focusing outreach and education efforts on prescribers who are less familiar with the evidence-based PDL.	

12/16/2011	Mongan, Madeleine	Deputy Executive Director, Vermont Medical Society	The California prior authorization bill and some background information are attached above. The bill requires a California state agency to develop a prior authorization form for use by every health plan that provides prescription drug benefits, with limited exceptions. It also requires prescribers to use and plans to accept the form 6 months after the form is developed. The form must be made available electronically and the completed form may be electronically submitted. In developing the form, the agency is required to consider the existing CMS forms and national standards for electronic P/A. If a plan does not respond to a P/A request within two days the law deems P/A to be granted as requested.		
			Attachments:		
			Senate Bill No. 866, Chapter 648		
			Article entitled: What Does It Cost Physician Practices To Interact with Health Insurance Plans?, Health Affairs, published online on May 14, 2009		
			Article entitled: New AMA Survey Finds Insurer Preauthorization Policies Impact Patient Care, November 22, 2010, http://www.ama-assn.org/ama/pub/news/news/survey-insurer-preauthorization.page		
12/27/2011	Garand, Lucie	Government Relations Specialist, Downs, Rachlin, Martin on behalf of Pfizer, Inc.			Summary Recommendations: Using laws passed in Minnesota and California as references, legislation should be passed in Vermont that outlines the following: 1) short-term goal of developing and implementing a standardized, paper prior authorization form across all payers in Vermont; 2) Long-term goal of integrating the prior authorization process with electronic prescribing systems for real-time adjudication; and 3) Defined prior authorization review period to protect the patients of Vermont.

					<p>Full Comment</p> <p>Pfizer appreciates the opportunity to submit comments on Act 51 – Electronic Prior Authorizations.</p> <p>Pfizer’s mission is to discover and produce branded and generic medications that improve both human and animal health. As part of our mission, we believe access to innovative medicines and quality health care can be achieved by working in partnership with all stakeholders, including patients, health care providers, managed care organizations, governments and non-governmental organizations.</p> <p>Like patients, employers and policymakers, we recognize the need to reign-in health care costs while improving the quality care for patients. Pfizer supports patient-centered cost containment mechanisms that maintain patient access to care and therapies, and believes that standardizing the prior authorization process would significantly reduce unnecessary administrative burden currently placed on providers and patients.</p>
					<p>Prior authorization requests, which insurers and pharmacy benefits managers (PBMs) require before allowing enrollees to access specific medications, consume excessive resources across the health care system. Personnel must be dedicated to manually reviewing requests, and, similarly, providers must dedicate staff to navigating the complex web of requirements to complete requests, which differ for each insurer and PBM.</p> <p>To be clear, Pfizer is not promoting the elimination of cost-containment mechanisms that improve physician or patient awareness of cost and value of care options. We support the elimination of administrative waste through standardization and modernization. Our recommendations are not intended to, and will not, eliminate prior authorizations. Rather, we believe there are important and highly feasible opportunities to reform the current processes that will ultimately save money and benefit patients.</p>

					<p>A study published in Health Affairs in 2009 estimated that physicians spend between \$23.2 and \$31 billion a year on administrative issues such as prior authorizations. And in May of 2010, a survey from by the American Medical Association (AMA) found that 20% of physician staff time is spent communicating with pharmacies and payers for issues such as prior authorizations.</p>
					<p>And in May of 2010, a survey from the AMA found that 20% of physician staff time is spent communicating with pharmacies and payers for issues such as prior authorizations. In other words, staff spends one out of every five work days on unnecessary administrative tasks. The same survey identified the following issues physicians have with the current prior authorization process.</p>
					<ul style="list-style-type: none"> • 67% had trouble determining whether a prior authorization is required; • 69% of physicians reported typically waiting several days to receive prior authorization from an insurer for drugs; and • "Nearly all physicians surveyed said that streamlining the prior authorization process is important and 75% believe an automated process would increase efficiency." <p>Vermont is already a leader in the movement towards electronic prescribing and is well positioned to benefit from electronic prior authorizations. From 2006 to 2008, the percentage of physicians sending prescriptions electronically increased dramatically from 13% to 62%, while the percentage of eligible prescriptions sent electronically increased from 5% to 28%. In 2010, Vermont ranked 14th in the nation in the electronic prescribing according to the SureScripts Safe-Rx™ ranking criteria.</p>

					<p>Vermont's transition to electronic prescribing is likely to continue with passage of the HITECH Act, which injected over \$34 billion into the US health care system to promote universal adoption of HIT systems. Under the Act, eligible health care professionals and hospitals can qualify for Medicare and Medicaid incentive payments when they adopt certified EMR technology and use it to achieve specific objectives. In order to be eligible for incentives, medical providers must demonstrate "meaningful use" of EMRs, which must include an electronic prescribing function.</p>
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					<p>The expansion of electronic prescribing will improve patient safety, but without reforming the prior authorization system, administrative waste will continue unchecked. In fact, the current prior authorization process short-circuits the electronic prescribing process by only allowing paper or telephonic requests.</p> <p>The current system is depicted in Figures 1 and 2 (attached). Figure 1 represents a generalized model of the current prior authorization process, if no complicating factors arise (e.g., incorrect forms supplied, fax submissions lost, etc.), developed from interviews with medical office staff responsible for prior authorizations. It demonstrates that even if a prescription is submitted electronically, prior authorizations initiate a long and complicated series of steps that must be completed manually by the prescriber and their staff.</p>
					<p>Figure 2 was developed the National Council on Prescription Drug Programs (NCPDP), a not-for-profit ANSI-Accredited Standards Development Organization representing multiple sectors of the pharmacy services industry. It also provides a visual depiction of the current prior authorization process, including the multiple points of information exchange that increase time and cost. Figure 3 highlights the benefits of an electronic model of prior authorizations as envisioned by NCPDP. The model shows a much more efficient process that should be the ultimate goal for the State.</p>

					<p>We recognize the challenges to streamlining administrative processes in a multi-payer environment where payer and cost containment interests must be balanced against provider and patient interests. Therefore, we support a phased transition from the current, overly burdensome system of multiple forms and telephonic systems to a single, standardized paper process and eventually to an electronic process that is fully integrated with electronic health record (EHR) systems. Reducing administrative burden will increase time available for patient education, care and coordination, the hallmarks of high quality health care and key elements to preventing unnecessary and high cost hospitalizations and emergency room visits.</p> <p>We recommend Vermont pass legislation that tackles the three primary challenges faced by providers when completing prior authorization requests: 1) non-standard processes; 2) antiquated procedures; and 3) variation in review duration. Several states have passed legislation that would provide a sound starting point for model legislation in Vermont.</p>
					<p>In 2009, Minnesota passed legislation requiring the Minnesota Administrative Uniformity Committee to develop a "uniform formulary exemption form that allows health care providers to request exceptions from group purchaser formularies using a uniform form. The standardized form became available January 1, 2011, and according to the statute "all health care providers must submit requests for formulary exceptions using the uniform form and all group purchasers must accept this form from health care providers."</p>

					<p>The statute also requires the Minnesota e-Health Advisory Committee and the Minnesota Administrative Uniformity Committee to "outline how best to standardize drug prior authorization request transactions" with the goal of "maximizing administrative simplification and efficiency in preparation for electronic transmissions," and that by January 1, 2014 an electronic prior authorization system is developed that must be available by January 1, 2015.</p> <p>Minnesota stakeholders identified several potential solutions before electronic systems are implemented including developing a standard set of drugs requiring prior authorization across payers and payer prior-authorization 'web portals' meeting minimum standards set by the State. However, concerns over "new administrative costs and burdens," and concerns that eventual transition to fully integrated electronic systems would render such investments unwise, led the State to conclude that a standardized form that could be completed online represented the best interim option available.</p>
					<p>In 2011, California passed Senate Bill 866 into law, which, unlike the Minnesota law, addresses each of the three prior authorization challenges. It deals with non-standardized processes by requiring a uniform paper form to be developed that providers must use and insurers must accept. It modernizes the process by requiring that the form be made available for completion and submission electronically (fax is not considered an electronic submission). Lastly, it addresses variation in review time by requiring insurers to review requests within 48 hours or the request is automatically deemed approved.</p>

					<p>Taking a phased approach to wading out of the current administrative quagmire that begins with a standardized paper form then moves to electronic solutions will address the challenges providers and patients face today, while providing sufficient time for national standards for electronic prior authorization data exchange to be approved by the NCPDP.</p> <p>Despite releasing XML language in 2009, NCPDP has not finalized a "standard" since pilots were not conducted. The NCPDP Prior Authorization Work Group has reconvened and is working on updating the 2009 draft standard, which is expected to be released in the coming months. Recognizing the need for these national standards to be piloted and approved, legislation in Vermont should require adoption and implementation of the new standards when they are released by NCPDP.</p>
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					<p>Conclusions</p> <p>Current prior authorization systems unnecessarily deplete health care resources and delay patient care. As part of Vermont's efforts to move to a health care system that best serves patients and reduces costs through administrative simplification, prior authorization processes should be reformed through statute.</p> <p>Using laws passed in Minnesota and California as references, legislation should be passed in Vermont that outlines the following:</p> <ul style="list-style-type: none"> • Short-term goal of developing and implementing a standardized, paper prior authorization form across all payers in Vermont; • Long-term goal of integrating the prior authorization process with electronic prescribing systems for real-time adjudication; and • Defined prior authorization review period to protect the patients of Vermont. <p>Pfizer appreciates the opportunity to comment on Act 51 and looks forward to working with the Department of Vermont Health Access on the direction and focus of efforts to improve the prior authorization process in Vermont.</p>
					Attached are three diagrams:
					FIGURE 1: Current Paper Prior Authorization Process
					FIGURE 2: NCPDP Prior Authorization Flow Diagram
					FIGURE 3: NCPCP Model for Electronic Prior Authorization