Implementing Electronic Prior Authorizations

Overview

In July 2011, the Maryland General Assembly Joint Committee on Health Care Delivery and Financing requested the Maryland Health Care Commission (MHCC) to develop recommendations around best practices and standards for electronic prior authorizations of prescription medications and medical services.

The MHCC convened a multi-stakeholder workgroup (workgroup) to develop recommendations focusing on short-term solutions that incrementally reduce the burden on providers, state-regulated payers (payers), and third party administrator (TPAs).[1] Workgroup participants included: representatives from the following organizations; Aetna, CareFirst BlueCross BlueShield, CIGNA, Community Health Integrated Partnership, CVS CAREMARK, Delta, Kaiser Permanente, League of Life and Health Insurers of Maryland, MedChi, Medco, United Healthcare, Venable, and WellPoint. The workgroup focused on developing solutions to implementing electronic prior authorizations for adoption by providers, payers, and TPAs that would require minimal rework once national standards are adopted. National standards for electronic prior authorizations are expected to be in place by January 2016.

Background

Prior authorization is required by many payers and TPAs before certain prescriptions for medications may be filled or medical services may be undertaken. Each payer has its own set of services and each TPA has its own set of medications that need prior authorization, requirements for approving prior authorizations, and workflow for processing prior authorizations.

Prior authorization review is generally needed to confirm that services are provided in the most cost-effective manner. Prior authorizations may be required for reasons such as the availability of low-cost generic alternatives, age restrictions, ensuring medical necessity, and higher than normal dosages. In general, providers view the process for submitting and tracking prior authorizations as onerous and time consuming.

Generally, the current prior authorization process is nonstandard and typically manual, requiring providers to print and fax prior authorization forms.

National Activity

To date, six states have passed legislation or implemented systems to support electronic prior authorization:

- Minnesota
- Nevada
- Oregon
- Utah
- North Dakota
- Washington

A number of states have legislation pending that define requirements for electronic prescribing (e-prescribing), which includes an electronic or automated prior approval process. States with such pending legislation include:

- California
- Georgia
- New Mexico
- North Carolina
- Massachusetts
- Oklahoma
- Missouri
- New Jersey
- New York
- South Carolina
- South Dakota

A few states have requested further study to develop recommendations on how to standardize the prior authorization process and make it an electronic or automated process, including Hawaii, New Mexico and Vermont.

Maryland Landscape

The largest payer market shares in Maryland are held by CareFirst BlueCross BlueShield and United Healthcare. Approximately 26 TPAs operate in the state. Little consistency exists in how the payers and TPAs have

[1] 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). State mandated health insurance benefits affect around 25 percent of insured Maryland residents. Additional information is available from the U.S. Department of Labor at: http://www.dol.gov/dol/topic/healthplans/erisa.htm. Third party administrators are identified based on their Maryland Corporation Income Tax Statement.

implemented prior authorizations. A number of payers and TPAs offer an online portal for requesting prior authorizations. The predominant method for requesting a prior authorization in Maryland continues to be a paper form that is faxed by the provider to the payer and TPA.[2]

- Most payers make prior authorization forms available on their websites; at least five TPAs require providers to call and request the prior authorization form be faxed to their office.

Recommendations

The consensus of the workgroup was to focus on shortterm solutions for implementing electronic prior authorizations that incrementally reduce the burden on providers, payers and TPAs, and require minimal rework once national standards are adopted. The goal of the recommendations is to reduce the administrative burden on providers, payers, and TPAs. The work group developed four recommendations[3]:

1. *Provide a single sign-on option to payers and TPA websites.* Payers with an annual premium of $1 million or more and TPAs with $1 million or more in net income allocable to Maryland must accept provider or clinical staff authentication for their prior authorization website or portal from a single sign-on authority, such as the state designated health information exchange.

2. *Payers and TPAs will follow a phased approach to implement electronic prior authorization requests.*
   - ***Phase 1****:* Payers and TPAs will include on their website, and/or within their other customized online tool, the medical services and prescription drugs that require prior authorization, as well as the key criteria that are used to make a final determination of a provider's prior authorization request. Phase 1 must be completed by July 1, 2012.
   - ***Phase 2***: Payers and TPAs will develop an online process to accept provider prior authorization requests that include the ability to identify a request by a unique number across their systems, i.e. electronic, call centers, and fax systems. Phase 2 must be completed by December 1, 2012.
   - ***Phase 3***: Electronic pharmacy prior authorization requests, where no additional information is needed and that meet the established criteria for approval, should be approved in real time. Phase 3 must be completed by July 1, 2013.

3. *Payers and TPAs will report to the MHCC.* Payers and TPAs will submit a report to the MHCC by December 1, 2012, which includes an update on the status of the implementation of Phase 1 and Phase 2, as well as an outline of their plan for achieving Phase 3. State-regulated payers and TPAs will submit an additional report to the MHCC by December 1, 2013, which includes information related to the implementation of the recommendations, along with other performance monitoring information related to electronic prior authorizations. The MHCC will provide payers and TPAs guidelines of what to include within each report.

4. *Require providers to utilize an electronic prior authorization process.* By January 1, 2015, providers must utilize the online prior authorization process for their practice management, electronic health record or electronic prescribing system to submit all prior authorization requests. Providers will have the option of applying for an exception in extenuating circumstances, such as the lack of broadband Internet access, etc.

Next Steps

Rather than legislating the electronic prior authorization recommendations, the general consensus among payers and TPAs is to voluntarily support the recommendations and timeframes. Over the next two years, the MHCC intends to monitor payer and TPA progress with implementing the recommendations and meeting the

[2] *Prior Authorization: Impact on Patient Care in Maryland, A Survey of the Members of the Maryland State Medical Society,* July 20, 2011. The survey was issued to 3,966 members, and results are based on 249 responses.

[3] The full report is available on the MHCC website at: http://mhcc.maryland.gov/mhcc/pages/hit/hit/documents/HIT_State_Regulated_Payor_PBM_Preauth_Rpt_20131001.pdf

established timeframes. The MHCC will reconvene payers and TPAs on an as-needed basis in an effort to obtain feedback on progress made and facilitate information sharing between payers and TPAs as they work to meet the recommendations. The MHCC also plans to periodically reporting to stakeholders on progress made by payers and TPAs.