
# Drug Prior Authorization Compliance

## REPORT TO THE MINNESOTA LEGISLATURE

07/14/2021

**Drug Prior Authorization Compliance Report to the Legislature**

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# Executive summary

Minnesota Statutes, Section 62J.497, sets the standards for an electronic prescription drug program and includes a requirement for group purchasers to accept electronic drug prior authorization (PA) requests submitted by health care providers. PA requests are an administrative process whereby healthcare providers request approval from health plans to provide a medical service, prescription, or medical supply for a patient. Drug prescription requests can be made at the time of prescribing (prospectively) or at the time the medication is dispensed by the pharmacist (retrospectively). The prospective model allows for better communication between the prescriber, health plan, and pharmacists, and is expected to decrease the time from when a medication is prescribed to when a patient can receive and begin taking the medication.

During the 2020 legislative session the legislature passed SF3204/HF3398, which directs the Minnesota Department of Health (MDH) to complete and submit a one-time report in 2021 on electronic PA. This report addresses this requirement using data collected from health plans offering commercial fully-insured and/or self-insured health insurance in Minnesota regarding electronic prescription drug PAs processed in 2020.

## Key findings:

- Three-fourths of PA requests are submitted electronically.
- Turnaround time for electronic PAs is faster than for manual PAs on average.
- There is no difference in denial rates between electronic and manual PAs.
- Many providers struggle to use electronic PA because these systems are not necessarily integrated into the electronic health record systems or prescribing systems.
- Health plans do not all use a common electronic PA system for requests, requiring prescribers to adapt to each health plan's system and requirements.
- Forthcoming federal rules will help improve adoption of electronic PA standards.
- Other standards relating to prescribing and benefits are under development.

Electronic PA is in common use and is shown to offer faster turnaround time than PAs that are submitted via manual (non-electronic) means such as fax or email, which has the potential to improve patients' experience of care. However, current technology and standards create inefficiencies. Achieving universal electronic PA requires patience as standards are developed and a commitment to using a standard solution when it is available. The development of real-time prescription benefits standards will further enhance the process. Federal policies will drive this effort by requiring these standards as a condition of payment from the Centers for Medicare and Medicaid Services.

Stakeholders in Minnesota need to work together to ensure that all prescribers, pharmacists and health plans will be able to adopt national standards and meet federal requirements with the goal of delivering optimal care to Minnesotans. The Minnesota e-Health Initiative has convened stakeholders to address issues related to adoption and use of health information technology, including electronic prescribing and electronic PA. The initiative continues to provide a forum to address barriers that obstruct optimal electronic prescribing and PA communications. Minnesota policy makers can continue to support this effort through actions and levers that align with the national activities and federal incentive programs.

# Introduction

Minnesota Statutes, Section 62J.497, sets the standards for an electronic prescription drug program and includes a requirement for group purchasers to accept electronic drug prior authorization (PA) requests submitted by health care providers in Subdivision 5. PA requests are an administrative process whereby healthcare providers request approval from health plans to provide a medical service, prescription, or medical supply for a patient. For prescriptions, requests can be made at the time of prescribing (prospectively) or at the time the medication is dispensed by the pharmacist (retrospectively).

Under state law (MN Statutes, Section 62J.497) prior authorization information is required to be exchanged electronically as of January 1, 2016 (see Appendix A). The goal of electronic PA includes modifying the current information flows so that the prescriber is requesting and obtaining PA before the prescription is sent to the pharmacy. Transitioning to this prospective model allows for the prescriber to communicate with their patient about the PA process, reduces the volume of claims rejected because the PA hasn't been obtained, reduces calls between pharmacies and prescribers, and improves patient satisfaction with the process. This model of electronic PA is expected to decrease the time from when a medication is prescribed to when a patient can receive and begin taking the medication.

During the 2020 legislative session the legislature passed SF3204/HF3398, which directs the Minnesota Department of Health (MDH) to complete and submit a one-time report in 2021 on compliance with the requirements outlined in MN Statutes, Section 62J.497, subdivision 5 (see Appendix B). This report addresses this requirement using data collected from health plans offering commercial fully-insured and/or self-insured health insurance in Minnesota regarding electronic prescription drug prior authorizations processed in 2020 (see Appendix C).

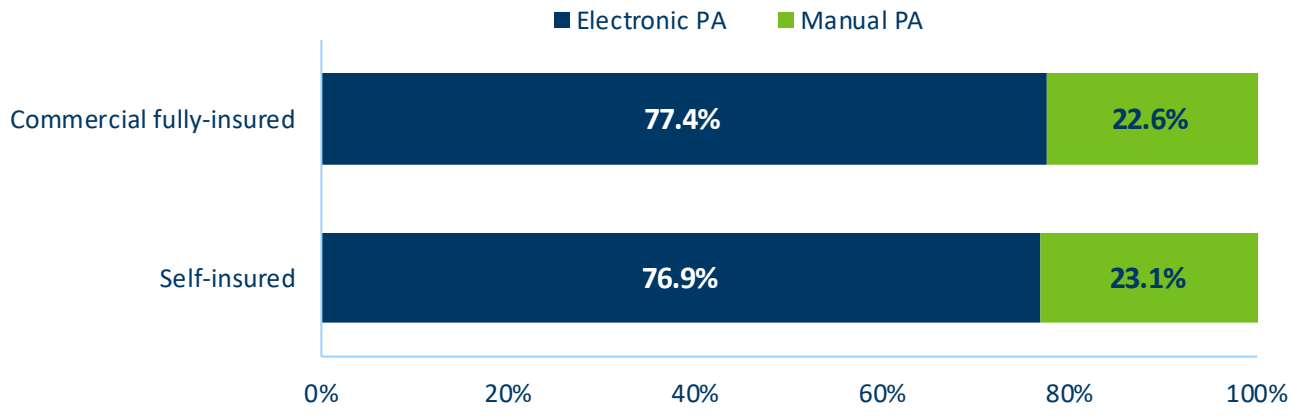
# Findings

Health plans collectively represent 3,165,144 individuals covered by health carriers licensed in Minnesota as of December 31, 2020. This includes fully and self-insured health insurance markets, but excludes state and federal public programs. Commercial fully-insured enrollees represent 38% of these enrollees, and self-insured represent 62%. For these enrollees, the health plans collectively received 114,879 drug prior authorization requests in 2020, for an average of 0.036 requests per enrollee. The health plans received notably more prior authorization requests per enrollee for the commercial fully-insured (0.071) than for self-insured enrollees (0.033).

## Characteristics of prior authorizations

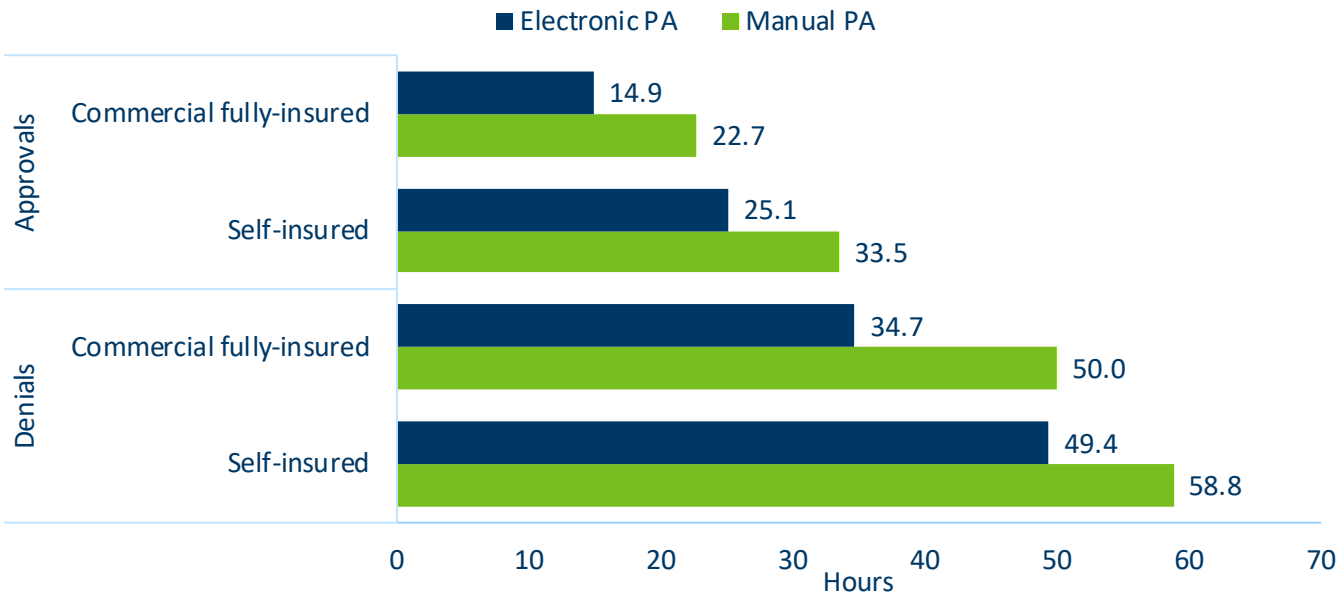
PA requests can be submitted electronically or manually. Electronic PAs are typically submitted to the health plans using a tool within the provider's electronic health record systems, through the health plan's electronic portal, or using a third-party vendor. Manual PAs are typically submitted by fax or phone. Collectively, health plans reported that 77% of PA requests are received electronically, with effectively no difference between commercial fully-insured and self-insured enrollees (see Exhibit 1 below).

### Exhibit 1. How PA requests are submitted, Minnesota 2020




Health plans report that the turnaround time is shorter for electronic PAs compared to manually submitted PAs in all categories. Approvals are granted about two-thirds of the time for electronic PAs processed by commercial fully-insured plans compared to manual PAs, or at 14.9 hours for electronic compared to 22.7 hours for manual. For the self-insured market, electronic PAs are granted in about three-fourths the time of manual, or at 25.1 hours compared to 33.5 hours. This pattern is nearly the same for PA denials, although the total time for denials is almost twice as long as for that of approvals.

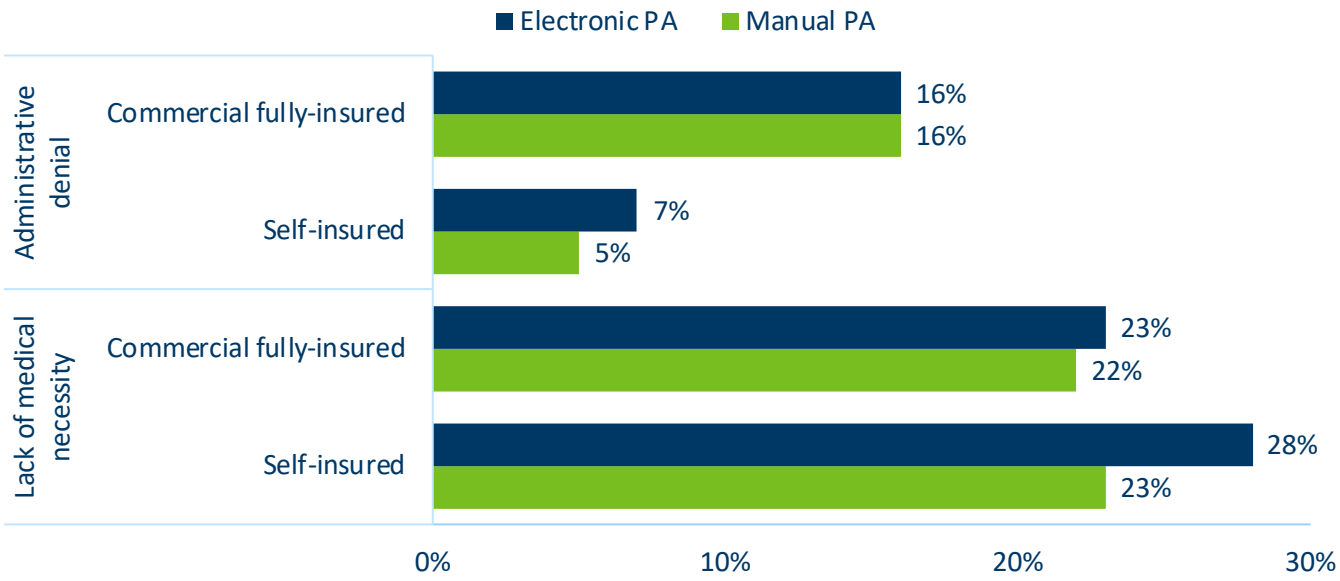
## Exhibit 2. Average PA turnaround time, Minnesota 2020




There is minimal difference in the reason for denial between electronic and manual PA requests and between plan types reported by health plans. However, PAs are denied more often due to lack of medical necessity than for administrative issues (e.g., lack of information, excluded benefit). For administrative denials, there is no difference in administrative denials for commercial fully-insured submitted electronically vs manually (16% each), and only a slight difference among self-insured, with 7% of electronic compared to 5% of manual PAs having an administrative denial.

For denials based on lack of medical necessity, there was no substantive difference between electronic (23%) and manual PA requests (22%) among commercial fully-insured plans. Among self-insured plans, a higher percent of these denials were electronic (28%) compared to manual (23%).

**Exhibit 3. Reasons for PA denial, Minnesota 2020**




## Anticipated effect of universal electronic PA

In addition to providing the data on turnaround time and denials, health plans were asked, "What would you anticipate the effect on denials and turnaround times to be if all providers in Minnesota were to submit drug prior authorizations electronically?" In general, the plans that had enough data to make a reliable estimation noted that turnaround times for electronically submitted requests were, on average, faster than manual requests. This faster turnaround time is a benefit to patients and providers. However, for denied requests the reason for denial did not vary by type of submission. A such, there would be no expected impact on denial rates.

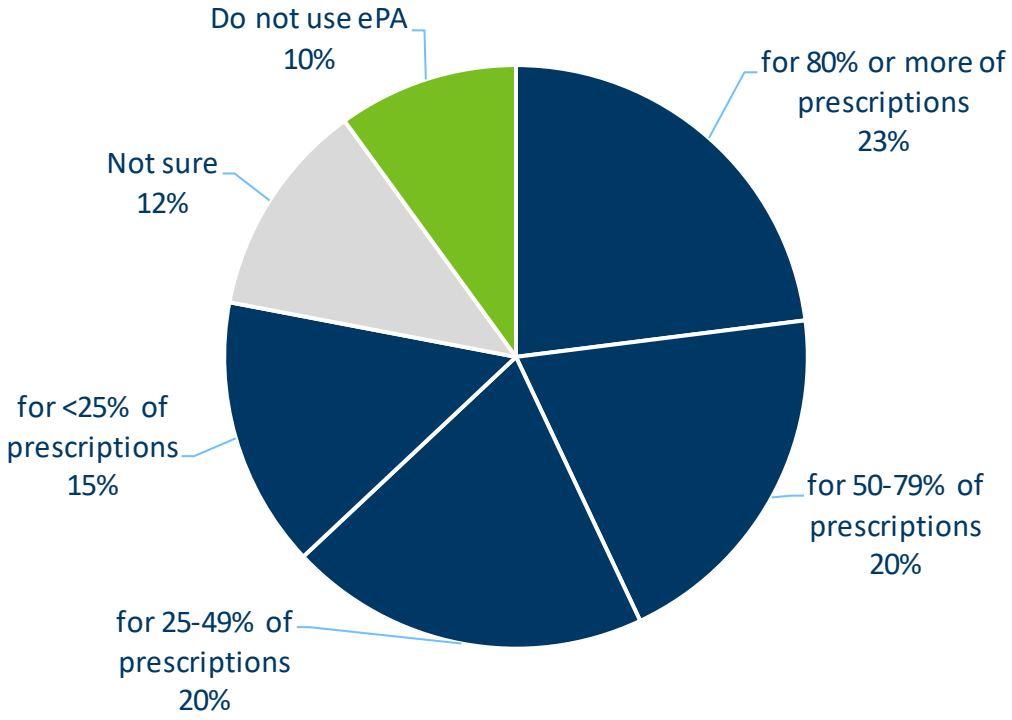
Select comments describe the reported health plan perspective:

> *"We anticipate a significant decrease in turnaround times while no significant impact on the denial rate. Faster turnaround times are a benefit to consumers and providers."*
>
> *"Faster turnaround times will result in quicker access to appropriate care for our members. Faxed submissions require more administrative work on both the part of the provider and the health plan. They are also less reliable and subject to technical failures requiring rework or denials."*
>
> *"[Electronic PA] provides the necessary criteria in the form of a decision tree allowing for a more precise process and clear responses which may result in a shorter turnaround of the prior authorization. Lastly, our implementation of smart coverage technology is more easily facilitated through the electronic prior authorization process. This technology permits the auto-answering of some question types based on available system data. If all criteria can be auto-answered the result is approval with a significantly shorter turnaround compared to standard prior authorization."*

## Provider compliance with electronic PA

To balance the health plan perspective with that of the provider, we reviewed data from the 2020 Minnesota Clinic Health Information Technology survey (see Appendix C). Under state law (MN Statutes, Section 62J.497), prior authorization information is required to be exchanged electronically as of January 1, 2016. Survey results showed that nearly all clinics use electronic systems for prescribing and health record management and at least 78% of clinics in Minnesota used electronic PA for drug requests to health plans and pharmacy benefit providers at least some of the time (see Exhibit 4 below). Nearly half of clinics use electronic PA for 50% or more of prescriptions.

### Exhibit 4. Clinics' use of electronic prior authorization, Minnesota 2020




## Barriers to using electronic PA

The Clinic Health Information Technology survey asked an open-ended question to describe barriers to using electronic PA. The most common barriers for providers were inefficient integration with the electronic health record (EHR) system or that their EHR system does not have the capability. Another reported problem is that the health plans and pharmacy benefit managers (PBMs) do not use a common platform, so the clinic staff need to adapt to multiple submission processes, in some cases not even starting with an electronic process.

Comments from the prescriber perspective indicate that they face technology and workflow issues that require them to adapt to each health plan's process. This lack of uniformity and standards is a burden for the electronic PA process. Select comments from the prescriber perspective include:

*"Not all insurance companies use the same system. Not all insurance cards have the pharmacy benefit manager and all that information listed on the insurance card. Difficult to find the correct forms more than half the time, so end up doing double to triple the work for just one prior authorization."*

*"Different requirements and platforms per payer create barriers. Interface with our EHR would be an improvement."*

*"Issues include technology barriers of different EHRs being used in different care groups, staffing and resource prioritization to implement the technology changes needed, differing payer requirements."*

*"Data interoperability, tracing documents, using multiple forms, not having up-to-date formulary information."*

*"The process requires too much practitioner time. Writing a response and having a staff person respond is much faster than going to a new site and logging on."*

*"Its cumbersome due to all the repetitive questions."*

*"Not all insurance is onboard with CoverMyMeds, the system we use most often. Some require us to login to their portal, which is not as convenient."*

*"Not all insurances have information to support electronic prior authorizations."*

*"EHR makes it difficult to locate needed information. We must search through different areas of the chart to complete."*

*"Name of patient not listed when a medication is approved."*

# Conclusion and opportunities

Effective and patient-centered prescribing practices rely on efficient and complete communication between providers (prescribers), health plans, pharmacist dispensers and PBMs. Electronic prescribing has become common practice in Minnesota, but the evolution of standards is just now including processes such as prior authorizations and benefit checks. Therefore, while electronic PA solutions exist, they did not necessarily use common standards nor integration into the prescribing workflow. Now that electronic standards exist, they need to be adopted by all stakeholders. In the meantime, exceptions and nuances still require ad hoc communication methods.

The report shows that, while electronic PA is in common use and is shown to offer faster turnaround time than PAs that are submitted manually, there are nonetheless inefficiencies with current technology and standards. Achieving universal electronic PA in Minnesota – and nationally – requires patience as standards are refined and stakeholders commit to using the standards. The development of standards for real-time prescription benefits will further enhance the process. Federal policies will also drive this effort by requiring these standards as a condition of payment from CMS. Progress at the national level includes:

- The National Council for Prescription Drug Programs (NCPDP) is the standards-development body for electronic transactions relating to prescribing. The NCPDP prior authorization standards call for a fully electronic means for determining whether PA is required for a particular medication and particular patient. The standards support both prospective (prescriber-initiated) and retrospective (pharmacist-initiated) prior authorization requests and allow for cancellations and appeals. Further, these standards present the PA information needed to the prescriber in a consistent format while enabling each health plan to request the particular information it requires. NCPDP is also developing a real-time prescription benefit standard, which will complement the electronic PA process by providing real-time information on product coverage/restrictions, alternative products, and alternative benefits. The beta version was published in January 2020 and an update is under development in 2021.
- In late 2020 the Centers for Medicare and Medicaid Services (CMS) proposed rules to help make the PA process more efficient and transparent.[1] The comment period closed on January 4, 2021 and final rules have yet to be announced. In the past, rules such as these have been effective in shifting stakeholders toward use of a common standard.

Stakeholders in Minnesota need to work together to ensure that all prescribers, pharmacists and health plans will be able to adopt national standards and meet federal requirements with the goal of delivering optimal care to Minnesotans. Since 2004 the Minnesota e-Health Initiative has convened Minnesota's stakeholders to address issues related to adoption and use of health information technology. The electronic prescribing workgroup of the e-Health Initiative has monitored the evolution of electronic PA standards and adoption, and identified specific barriers as well as opportunities to address those barriers. During the 2021 session the Minnesota Legislature extended the sunset of the Minnesota e-Health Advisory Committee to 2031, which will provide the forum for this work to continue in alignment with final rules from CMS. The electronic prescribing workgroup traditionally has strong representation from pharmacists, and going forward will need to specifically engage health plans, PBMs, and health systems to address barriers that obstruct optimal electronic prescribing and PA communications. Minnesota policy makers can continue to support this effort through actions and levers that align with the national activities and federal incentive programs.

[1] https://www.cms.gov/files/document/121020-reducing-provider-and-patient-burden-cms-9123-p.pdf

# Appendix A: Statutory Language

**Minnesota Statutes, section 62J.497, subdivision 5**[2]

Subd. 5. **Electronic drug prior authorization standardization and transmission**. (a) The commissioner of health, in consultation with the Minnesota e-Health Advisory Committee and the Minnesota Administrative Uniformity Committee, shall, by February 15, 2010, identify 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.

(b) By January 1, 2014, the Minnesota Administrative Uniformity Committee shall develop the standard companion guide by which providers and group purchasers will exchange standard drug authorization requests using electronic data interchange standards, if available, with the goal of alignment with standards that are or will potentially be used nationally.

(c) No later than January 1, 2016, 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.

[2] Subdivision 5 of Minnesota Statutes, 62J.497 was originally passed in Minnesota Session Laws of 2009, Chapter 79, Article 4, Section 6. Modifications to this subdivision were subsequently made in Minnesota Session Laws of 2009, Chapter 173, Article 1, Section 1; Minnesota Session Laws of 2010, Chapter 336, Section 5; and Minnesota Session Laws of 2014, Chapter 291, Article 6, Section 1.

# Appendix B: 2020 Session Law Language

**Minnesota Session Laws of 2020, Chapter 114, Section 21 (SF3204/HF3398)**

**Compliance report on drug prior authorization**

"By April 1, 2021, the commissioner of health shall submit to the chairs and ranking minority members of the legislative committees with jurisdiction over health care policy and finance a report on compliance with the requirements for providers in Minnesota Statutes, section 62J.497, subdivision 5. The report must include the following information from health plans offered in the commercial fully insured and self-insured health insurance markets:

(1) the total number of drug prior authorization requests;

(2) the frequency with which drug prior authorization requests are submitted electronically. Electronic submission does not include facsimile or e-mail requests;

(3) the turnaround times for health plans when drug prior authorizations are submitted electronically;

(4) the turnaround times for health plans when drug prior authorizations are not submitted electronically;

(5) the reasons electronic drug prior authorizations are denied;

(6) the reasons non-electronic drug prior authorizations are denied;

(7) the anticipated effect on denials and turnaround times if all providers in Minnesota were to submit drug prior authorizations electronically;

(8) the differences between the commercial fully insured and self-insured markets for clauses (1) to (7); and

(9) the reasons providers are not able to comply with Minnesota Statutes, section 62J.497, subdivision 5."

# Appendix C: Data Collection

## Health plan data

MDH requested and received the following prior authorization data from these health plans, broken out by commercial fully-insured and self-insured enrollees.

**Total number of enrollees as of December 31, 2020 by health plan**

| Health Plan | Commercial fully-insured | Self-insured | Total |
|---|---|---|---|
| Blue Cross Blue Shield of Minnesota | 241,768 | 1,303,815 | 1,545,583 |
| Health Partners | 287,558 | 403,473 | 691,031 |
| Medica | 203,982 | 160,875 | 364,857 |
| Optum | 365,740 | - | 365,740 |
| Preferred One | 39,297 | 106,246 | 145,543 |
| Quartz | 660 | - | 660 |
| Sanford | 1,673 | - | 1,673 |
| UCare | 50,057 | - | 50,057 |
| Total | 1,190,735 | 1,974,409 | 3,165,144 |

**Data collection specifications**

For calendar year 2020 provide the following information, broken out for your commercial fully-insured from self-insured business. For purposes of this request, "electronic" or electronically" does not include facsimile or email transactions.

- Include PA requests for individuals covered by health carriers licensed in Minnesota.
- Include fully and self-insured health insurance markets, but exclude the Federal Employee Group.
- Include only retail drugs.
- Include partial denials.
- Exclude post-service reviews.
- Exclude step therapy.

1. Total number of enrollees as of December 31, 2020
2. Total number of drug prior authorization requests
3. Total number of drug prior authorization requests that were submitted electronically
4. For those prior authorizations **submitted electronicall**y, the average response turnaround times in number of hours for:
    a. Approvals
    b. Denials

5. For those prior authorizations **not** submitted electronically, the average response turnaround times in number of hours for:
    a. Approvals
    b. Denials
6. For drug prior authorizations **submitted electronically**, the number of requests that are primarily denied for each the following reason categories:
    a. Administrative denials (drug is an excluded benefit, lack of sufficient information)
    b. Lack of medical necessity (does not meet medical criteria)
7. For drug prior authorizations **not** submitted electronically, the number of requests that are primarily denied for each the following reason categories:
    a. Administrative denials (drug is an excluded benefit, lack of sufficient information)
    b. Lack of medical necessity (does not meet medical criteria)
8. What would you anticipate the effect on denials and turnaround times to be if all providers in Minnesota were to submit drug prior authorizations electronically? (open-ended response)

## Provider data

MDH used the 2020 Minnesota Clinic Health Information Technology Survey to inform provider use of and barriers to using electronic PA. This survey was sent on September 15, 2020 to 229 medical groups representing 1,400 clinics. Data were collected through October 2020, with responses from 193 medical groups representing 1,143 clinics in Minnesota (82%).

Questions from the survey used to inform this report include:

To what extent do prescribers in your clinic use electronic prior authorization (ePA) to request medication prior authorizations requests with payers and pharmacy benefit managers?

- ○ For 80-100% of prescriptions
- ○ For 50-79% of prescriptions
- ○ For 25-49% of prescriptions
- ○ For less than 25% of prescriptions
- ○ We do not use electronic prior authorizations
- ○ Not sure

Describe issues and/or barriers your clinic faces in using electronic prior authorization. How can this be improved? (open response)