COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

CYNTHIA B. JONES
DIRECTOR

SUITE 1300
600 EAST BROAD STREET
RICHMOND, VA 23219
804/786-7933
800/343-0634 (TDD)
www.dmas.virginia.gov

December 1, 2015

TO: The Honorable Walter A. Stosch
Co-Chairman, Senate Finance Committee

The Honorable Charles J. Colgan
Co-Chairman, Senate Finance Committee

The Honorable S. Chris Jones
Chairman, House Appropriations Committee

FROM: Cynthia B. Jones, Director

SUBJECT: Report on Progress of the Implementation of Budget Language for Pharmacy Prior-Authorization

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The 2015 Appropriation Act, Item 301 SSSS requires:

"The Department of Medical Assistance Services (DMAS) shall amend its July 1, 2016, managed care contracts in order to conform to the requirement pursuant to House Bill 1942/Senate Bill 1262, passed during the 2015 Regular Session, for prior authorization of drug benefits. The Department shall report the necessary amendments to the Chairmen of the House Appropriations and Senate Finance Committees by December 1, 2015."

This amendment adds language directing the Department of Medical Assistance Services (DMAS) to conform its managed care contracts to the provisions in House Bill 1942/Senate Bill 1262, which simplifies, streamlines and applies consistency to the prior authorization process used for drug benefits that is required by carriers in health insurance provider contracts. Language requires DMAS to report on such changes by December 1, 2015.

After initial analysis of this section, the Department does not foresee any significant obstacles to meeting this requirement. To implement this provision, the Department shall amend its managed care contracts to require MCO compliance effective July 1, 2016. A copy of the proposed MCO contract language is attached.

Should you have any questions or need additional information, please feel free to contact me at (804) 786-8099.

Att.
cc: The Honorable William A. Hazel, Jr., MD, Secretary of Health and Human Resources

PROPOSED MCO CONTRACT LANGUAGE TO BE EFFECTIVE 7/1/16

7.2. **Prior Authorization SCRIPT Standards:**

Effective July 1, 2016, the Contractor shall follow prior authorization procedures pursuant to the *Code of Virginia* § 38.2-3407.15:2 and incorporate the requirements into its provider contracts. The Contractor must accept telephonic, facsimile, or electronic submissions of prior authorization requests that are delivered from e-prescribing systems, electronic health records, and health information exchange platforms that utilize the National Council for Prescription Drug Programs' SCRIPT standards for prior authorization requests.

Pharmacy services which are denied for children must be afforded a secondary review in accordance with the EPSDT requirements set forth in Section 7.1.D.

The Contractor's response to prior authorization requests must include whether the request is approved, denied, or requires supplementation or additional information limited to items specifically needed on the prior authorization request, necessary to approve or deny the prior authorization request... If coverage is denied, the Contractor shall inform the member of his or her rights and the procedures for filing an appeal via the timeframes below, as applicable, including the reasons for denial. If the drug is prescribed for an "emergency medical condition," the MCO must pay for at least a 72-hour supply of the drug to allow the MCO time to make a decision. The Contractor shall respond to prior authorization requests as follows:

- Urgent Requests: If the prior authorization request is submitted to the Contractor telephonically or in an alternate method directed by the Contractor for urgent requests, the Contractor must respond to the prescriber or designee within 24 hours of an urgent prior authorization request.
- Fully Completed Requests: The Contractor must communicate electronically, telephonically, or by facsimile to the prescriber or designee within two (2) business days of a submission of a fully completed prior authorization request.
- Provider Responses for Supplementation to Contractor: The Contractor must communicate electronically, telephonically, or by facsimile to the prescriber or designee within two (2) business days of a submission of a properly completed supplementation from the provider or designee, that the request is approved or denied.

The Contractor shall honor approved prior authorizations from other contractors or health plans for at least the initial thirty (30) days of a member's prescription drug benefit coverage, subject to the provision of the Contractor's evidence of coverage, upon the Contractor's receipt from the prescriber or designee (or other means as determined by the Department), a record demonstrating the previous health plan prior authorization approval. The Contractor must have a tracking system in place for all prior authorization requests, and that such information be provided to the prescriber or designee upon the Contractor's response to a prior authorization request.

The Contractor must also publicize all drug formularies, drug benefits subject to prior authorization by the Contractor, the Contractor's prior authorization procedures, and prior authorization request forms accepted by the carrier. This information should be available through a central location on the Contractor's website, and must be updated within seven (7) days of any approved changes to such information.