Presented at

CBI Conference:
Specialty Product Distribution and Dispensing Optimization

October 14, 2015

By: Tony Schueth

Streamlining Access for Patients — Utilize ePrior Authorization and Benefit Verification

POINT-OF-CARE PARTNERS
Health IT Management Consultants

Learning Objectives

- Assess the shift to ePrior authorization (ePA) utilization and the impact on the healthcare process
- Gain insight into data supporting the efficiencies and positive experiences with ePA
- Discuss challenges with eligibility, automating the determination process and converting existing coverage criteria
- Evaluate future capabilities of ePA and how stakeholders will adapt to this technology

Specialty Medications: A Force of Health Care

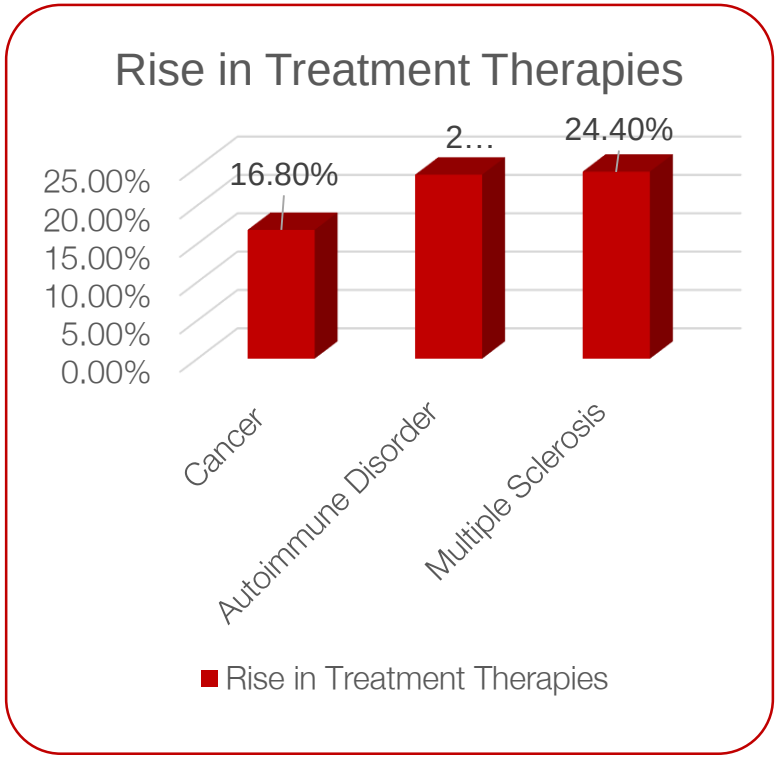
- Administered to small populations with **rare and chronic diseases**.
- **Expanding to larger populations** and therapeutic areas.
- Complex, large molecule and biologic drugs distributed through **multiple pharmacy models**.
- Majority require **clinical management** and **special handling**.

- **Specialty** medications are a growing and significant part of the nation's drug spend.

$374 billion in 2014 (IMS, April 2015)

$12.3 billion Hepatitis C

Health plans and PBMs can better monitor and control specialty drug spending through ePrescribing, electronic prior authorization and formulary data improvements.



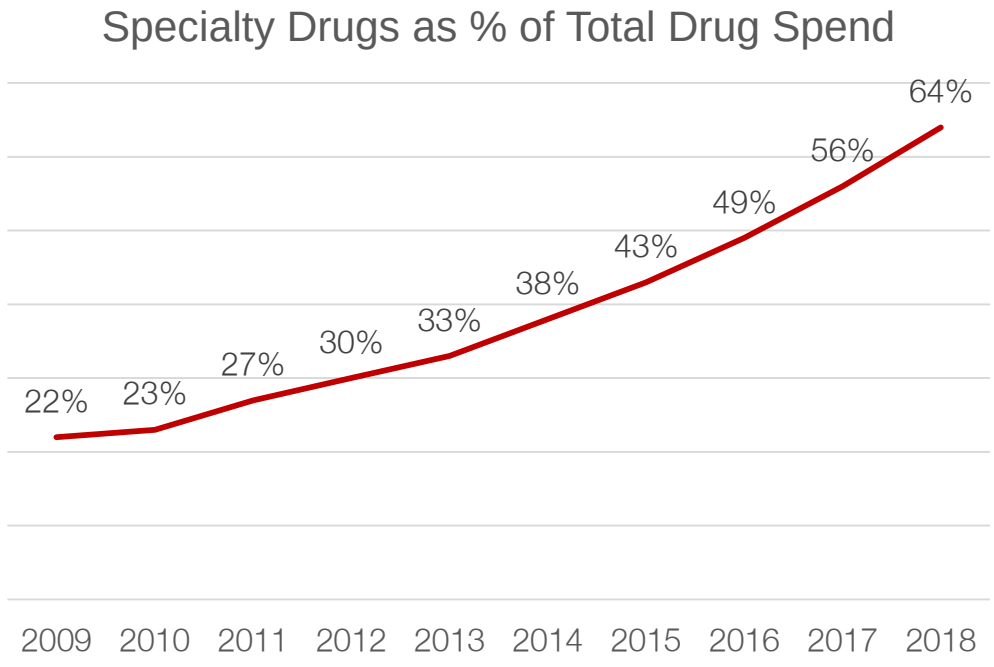
Specialty drugs continue to grow

While the volume of specialty medications is less than 1% of total prescriptions, US spending on specialty drugs is projected to **grow 67% by the end of 2015.**

Specialty medications are the fastest-growing sector in the American healthcare system, expected to jump two-thirds by 2015, and **account for half of all drug costs by 2018.**

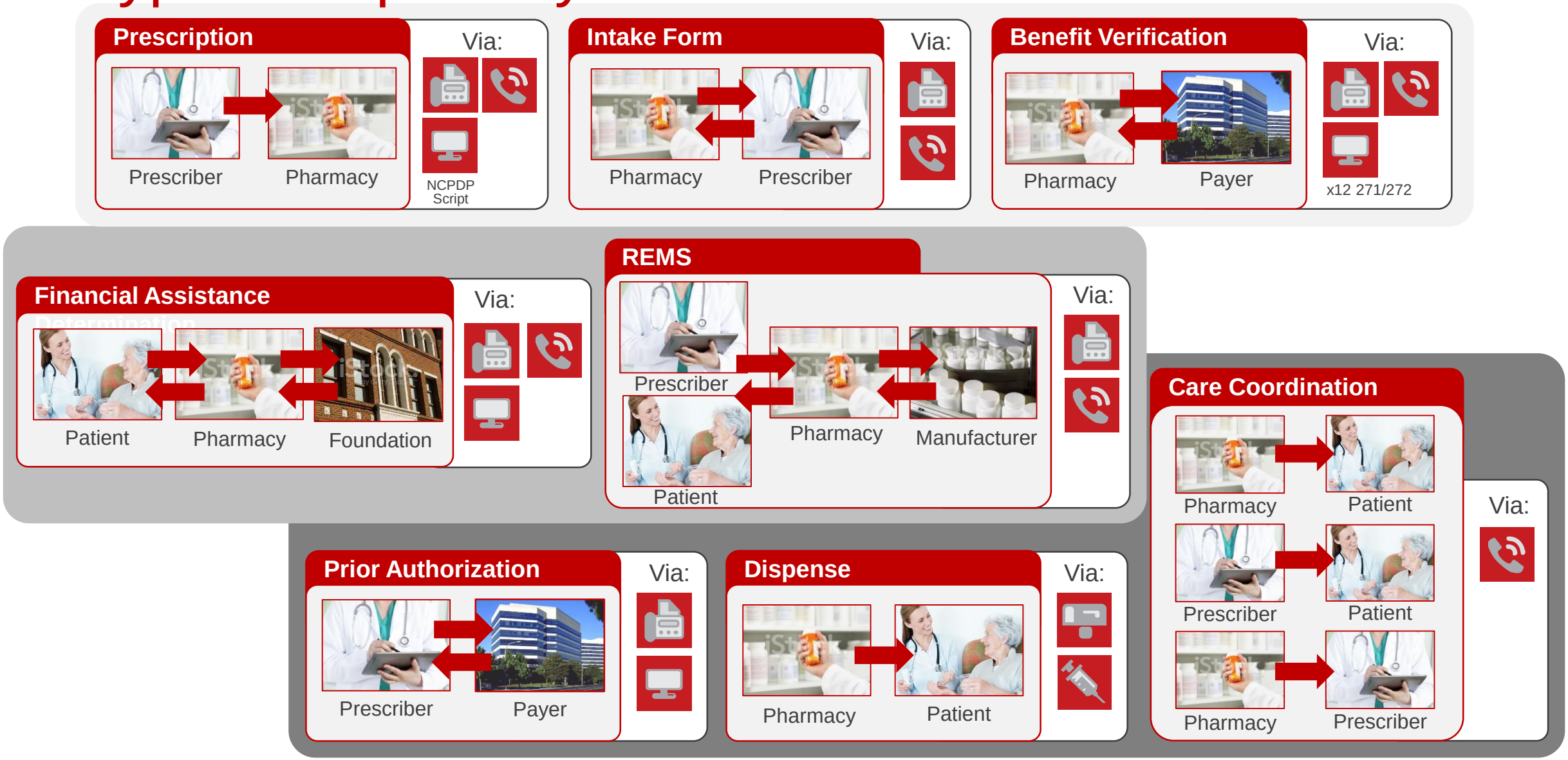
Specialty medications can run at $2,000 per month per patient; **those at the high-end cost upwards of $100,000 to $750,000 per year.**

Specialty Med Spending: **67%** growth end 2015



Source: Prime Therapeutics

Types of Specialty Processes/Transactions



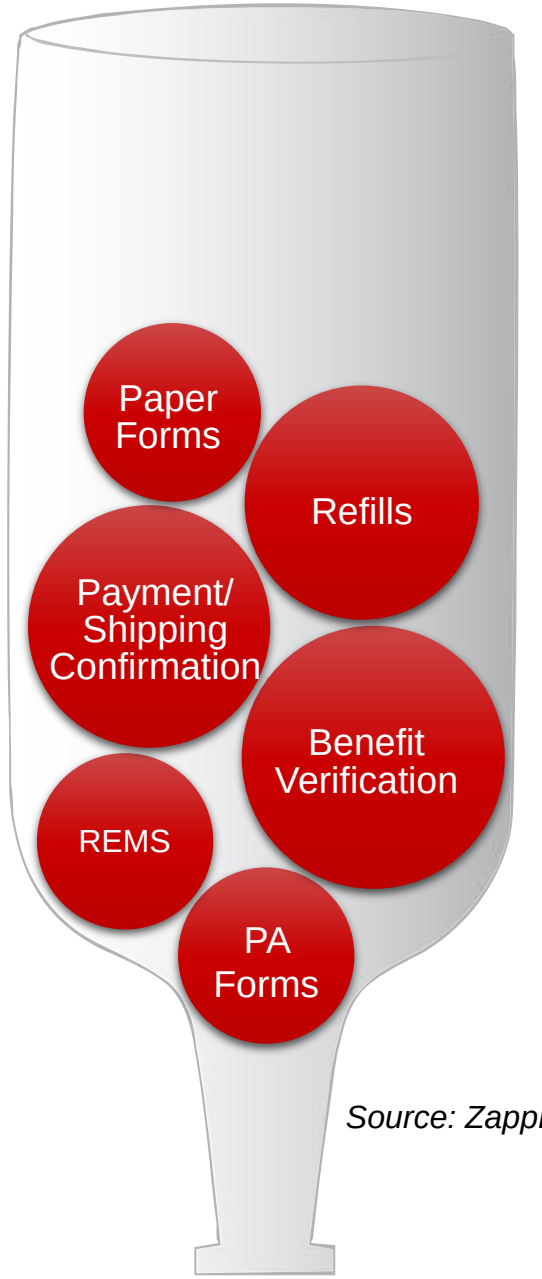
Challenges in Specialty Processes

Manual processes cause excess time delays*

- Paper Forms: **19.2 minute** manual input
- Benefits Verification: **1 week** backlog; 60% accuracy
- PA Forms: **1 week** submission to results delay
- REMS: 1/3 orders delayed **7+ days** by patient sign-off
- Payment/Shipping: **2 day** delay for patient confirmation
- Refills: **10 day** average turnaround

Delays result in fewer patients served

Bottlenecks accumulate –
It currently takes an average of **3-6 weeks** for a patient to receive their specialty medication after it is prescribed.



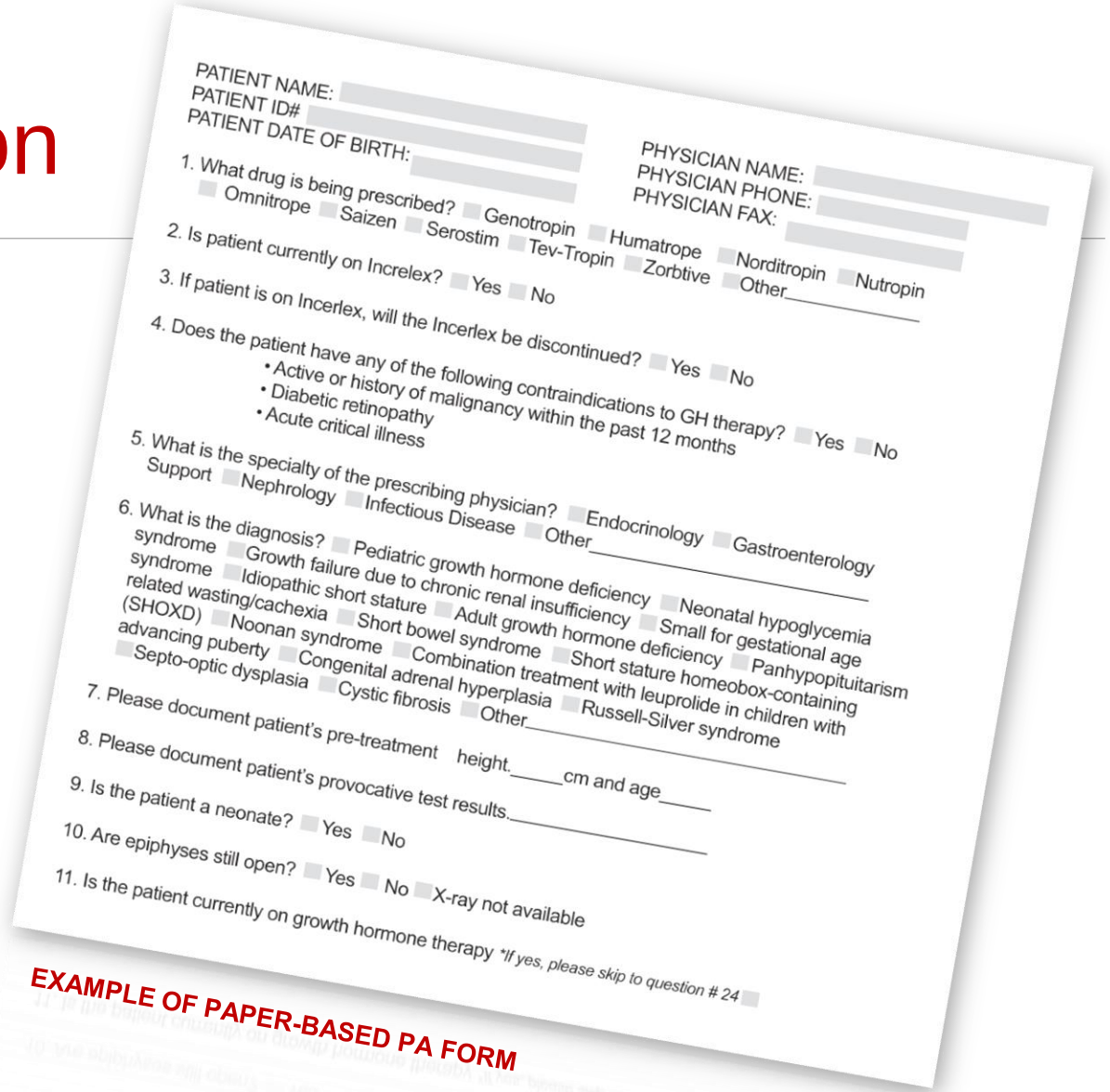
Source: ZappRx, Inc.

Electronic Prior Authorization (ePA)

Defining Prior Authorization

Prior Authorization is a cost-savings feature that helps ensure the safe and appropriate use of selected prescription drugs and medical procedures.

- Criteria based on clinical guidelines and medical literature
- Selection of PA drug list and criteria can vary by payer



PATIENT NAME:
PATIENT ID#
PATIENT DATE OF BIRTH:

PHYSICIAN NAME:
PHYSICIAN PHONE:
PHYSICIAN FAX:

1. What drug is being prescribed? Genotropin Humatrope Norditropin Nutropin Omnitrope Saizen Serostim Tev-Tropin Zorbtive Other_____
2. Is patient currently on Increlex? Yes No
3. If patient is on Incerlex, will the Incerlex be discontinued? Yes No
4. Does the patient have any of the following contraindications to GH therapy? Yes No
   - Active or history of malignancy within the past 12 months
   - Diabetic retinopathy
   - Acute critical illness
5. What is the specialty of the prescribing physician? Endocrinology Gastroenterology Support Nephrology Infectious Disease Other_____
6. What is the diagnosis? Pediatric growth hormone deficiency Neonatal hypoglycemia syndrome Growth failure due to chronic renal insufficiency Small for gestational age syndrome Idiopathic short stature Adult growth hormone deficiency Panhypopituitarism related wasting/cachexia Short bowel syndrome Short stature homeobox-containing (SHOXD) Noonan syndrome Combination treatment with leuprolide in children with advancing puberty Congenital adrenal hyperplasia Russell-Silver syndrome Septo-optic dysplasia Cystic fibrosis Other_____
7. Please document patient's pre-treatment height._____cm and age_____
8. Please document patient's provocative test results._____
9. Is the patient a neonate? Yes No
10. Are epiphyses still open? Yes No X-ray not available
11. Is the patient currently on growth hormone therapy *If yes, please skip to question # 24*

EXAMPLE OF PAPER-BASED PA FORM

Current Manual Prior Authorization

Rx Pended/Manual PA Begins

Doctor submits the prescription though normal ePrescribing flow.

Pharmacists spend an average of 5 hours/week on prior authorizations.

If denied, pharmacist calls doctor who notifies patient, prescribes alternate therapy or submits as cash Rx.

After approval, doctor submits electronic prescription with authorization # to pharmacy.

Pharmacy processes Rx, bills payer, dispenses or administers medication.

Source: 2015 ePA National Adoption Scorecard

40%

OF PRESCRIPTION ARE ABANDOND

Prior Authorization Impacts All Healthcare

PATIENT HASSLE AND TREATMENT DELAY

- PA unknown until patient has already left office
- Treatment might be delayed for days

Patients

PHARMACY HASSLE

- Pharmacy must call prescriber's office, and sometimes the plan

Pharmacy

Pharmaceutical Co.

PRESCRIBER HASSLE AND DISRUPTION

- Call back from pharmacy, must call plan, wait for faxed form, completes form and sends it back
- Turnaround time can be 48 hours or more

Prescribers

PBM/ Health Plan

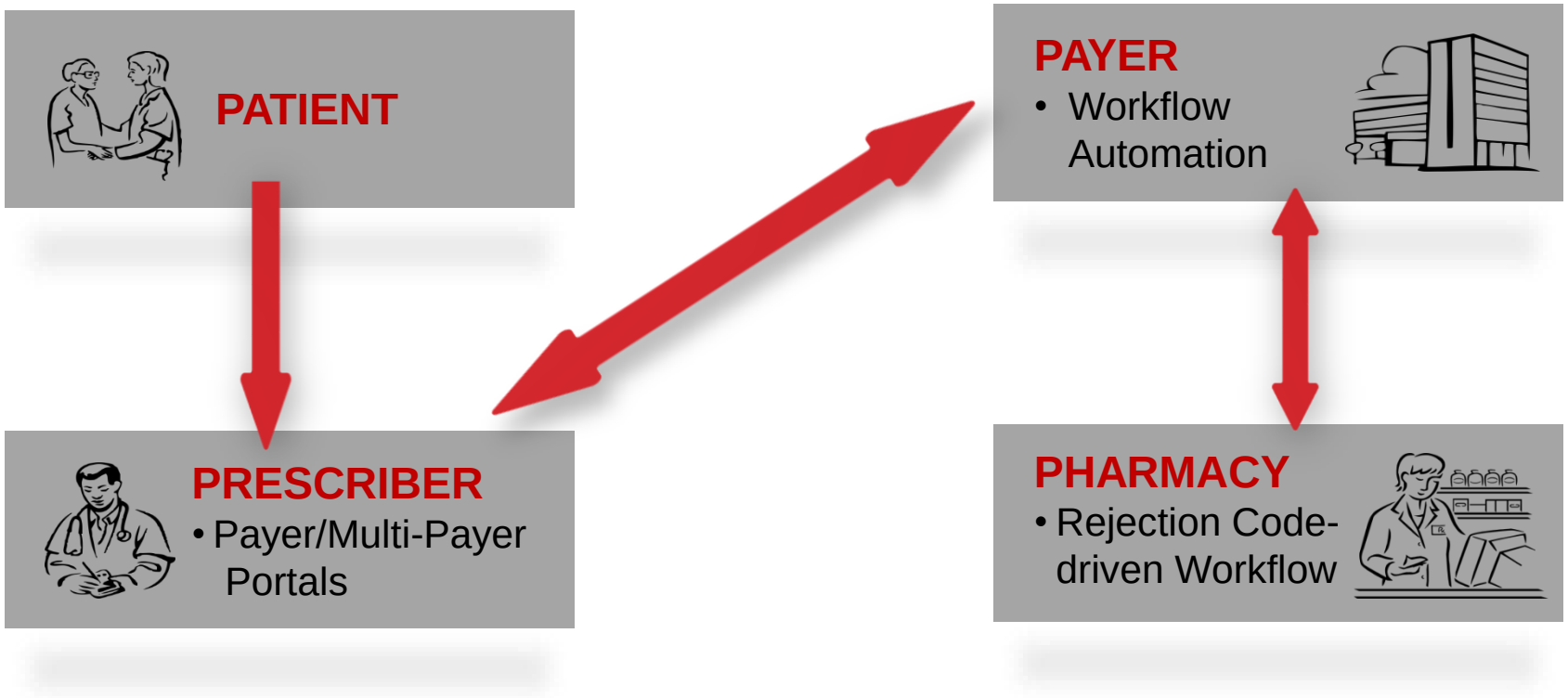
PHARMACEUTICAL OBSTACLES

- Delayed and abandoned prescriptions
- Extensive outlay for physician and patient administrative assistance

PBM/HEALTH PLAN INEFFICIENCY

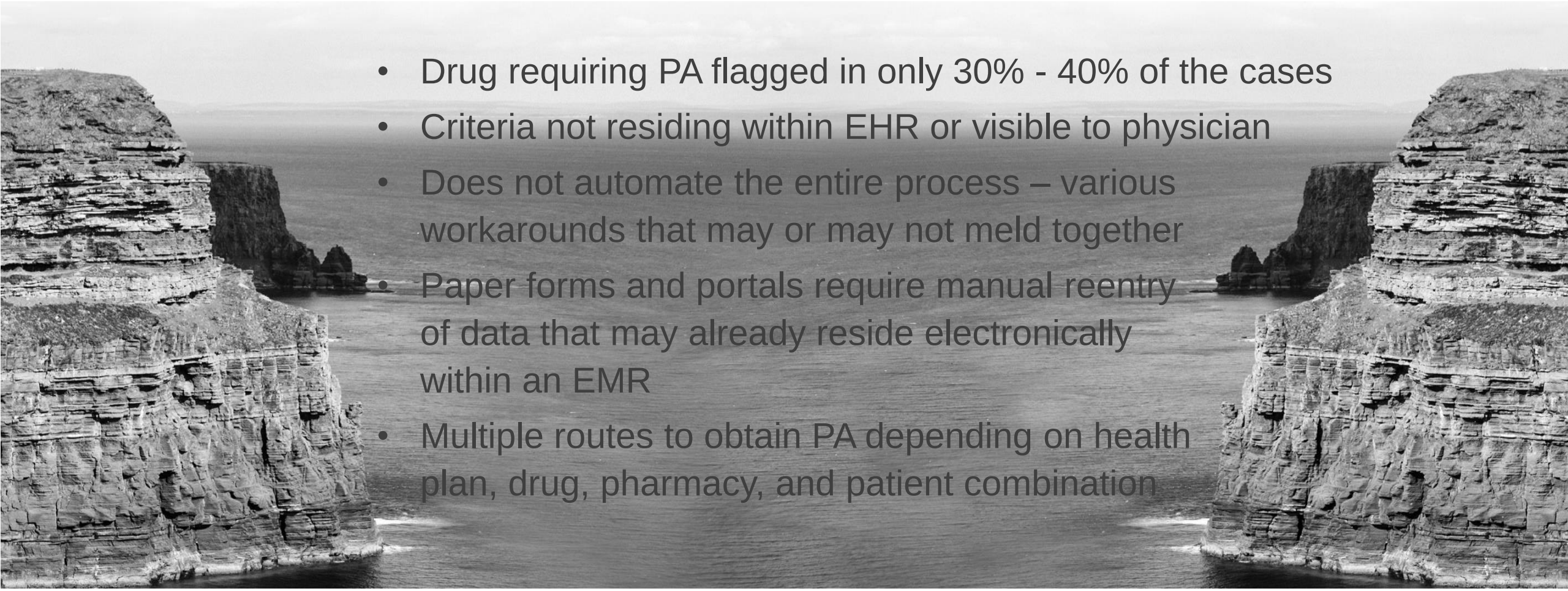
- Expensive and labor intensive process that creates animosity

Interim PA Automation (non-ePA)



Until today, automation largely replicated the paper process requiring duplicate entry of information.

Gaps in Current PA Activities



- Drug requiring PA flagged in only 30% - 40% of the cases
- Criteria not residing within EHR or visible to physician
- Does not automate the entire process – various workarounds that may or may not meld together
- Paper forms and portals require manual reentry of data that may already reside electronically within an EMR
- Multiple routes to obtain PA depending on health plan, drug, pharmacy, and patient combination

A look at the ePA road so far

1996	HIPAA Passes, names 278 as standard for ePA
2003	MMA Passes
2004	Multi-SDO Task Group Formed
2005	NCVHS Hearings
2006	MMA ePrescribing Pilots involving ePA
2007	Report to Congress recommending a new standard
2008	Expert Panel Formed/Roadmap Created
2009	Minnesota Law Passes New ePA Standard Created using SCRIPT
2011	CVS Caremark Pilot
2013	New Standard Published
2015	Implementation of SCRIPT-based Standard

Electronic Prior Authorization:

The Infrastructure is in place

80%

Physicians Today

Nearly 80% of physicians ePrescribe today

700

EHRs Enabled

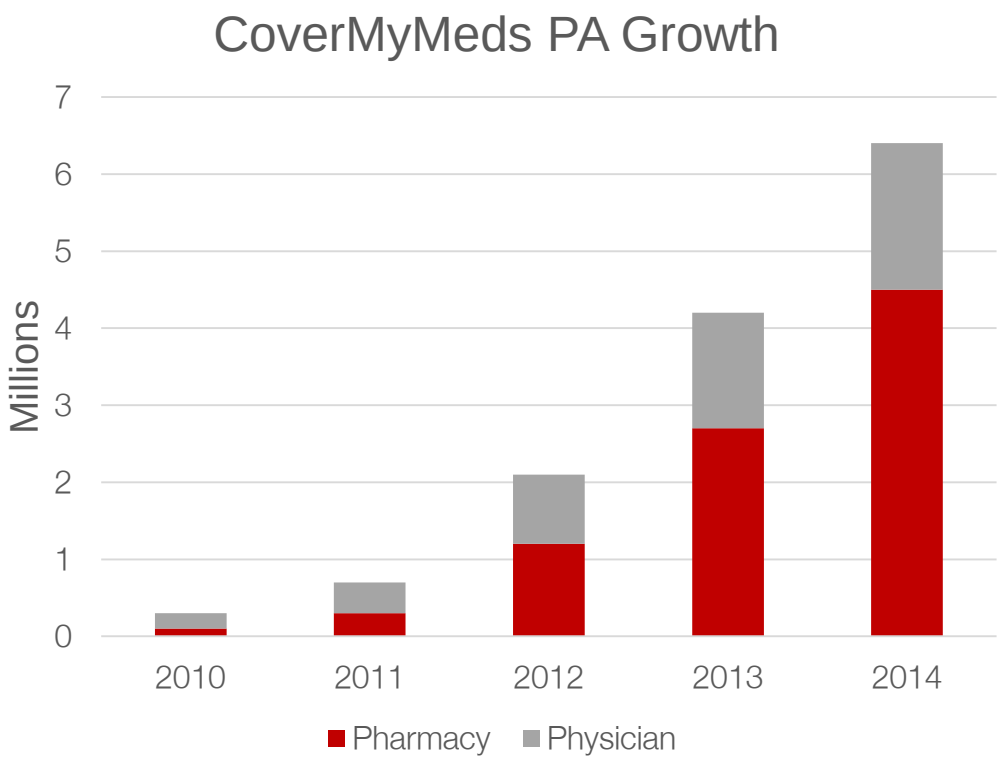
Approximately **700** EHRs enabled for ePrescribing

100%

Retail Pharmacies

Nearly **100%** retail pharmacies

Electronic Prior Authorization



Source: CoverMyMeds

- Retrospective and prospective models emerging in the marketplace
- Retrospective being conducted in a proprietary manner
- Industry movement toward **prospective**
- Prospective ePA officially approved as part of the SCRIPT standard in July, 2013
- Standardized retrospective process on-hold
- Standardized questions being addressed
- Need for standardization, evidence-based PA criteria

ePA Represents a Win-Win for All Stakeholders

PATIENT BENEFITS

- Improves medication access by days to weeks
- Drugs requiring PA can be approved at doctor's office
- Reduces prescription abandonment

PHARMACY BENEFITS

- Time Savings – manual PA takes 5 hours per week per pharmacist[1]
- Improves patient access to medications

Patients

Pharmacy

Prescribers

Prior Authorization Impact

PRESCRIBER BENEFITS

- Significant time savings: 20-60 minutes per PA[2]
- Seamless workflow integration with EHR/immediate notification of drugs requiring PA before ePrescribing
- Reduced prescription abandonment; improved medication adherence

PHARMA BENEFITS

- Increases medication adherence
- Eliminates physician calls
- Improves patient access to programs and quality of formulary data

Pharmaceutical Co.

PBM/ Health Plan

PBM/HEALTH PLAN BENEFITS

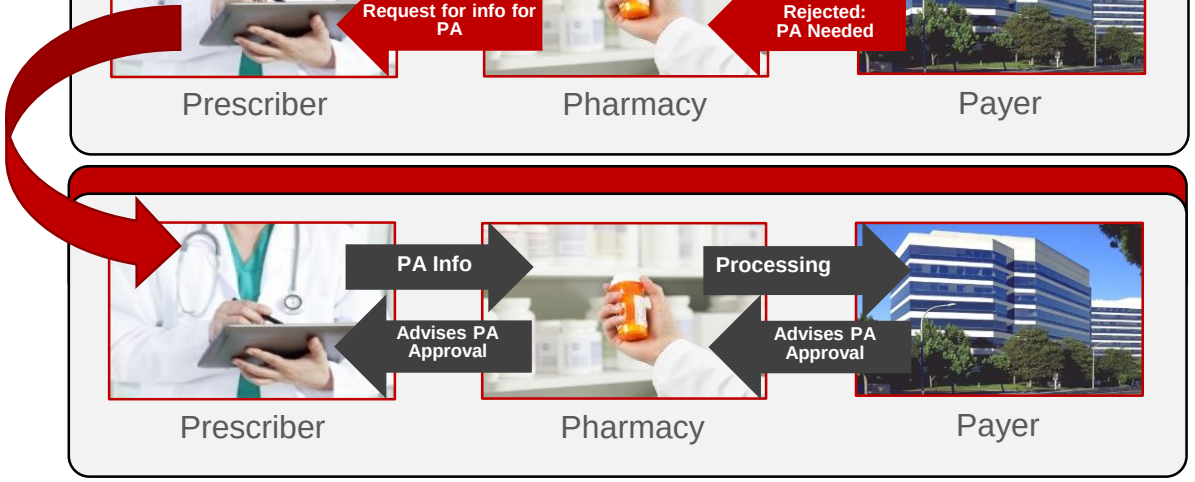
- Eliminates manual PA processing costs estimated at $20-$25 per submission[3]
- Improves provider and patient relations
- Reduced prescription abandonment; improved medication adherence

1. 2015 ePA National Adoption Scorecard
2. Medical Economics: The Prior Authorization Predicament, July 8, 2014
3. American Journal of Managed Care, *A Physician-Friendly Alternative to Prior Authorization for Prescription Drugs*, Published Online, Dec. 2009

New Standard Enables Multiple Workflows

Retrospective vs. Prospective

Retrospective PA – without PA info at time of prescribing



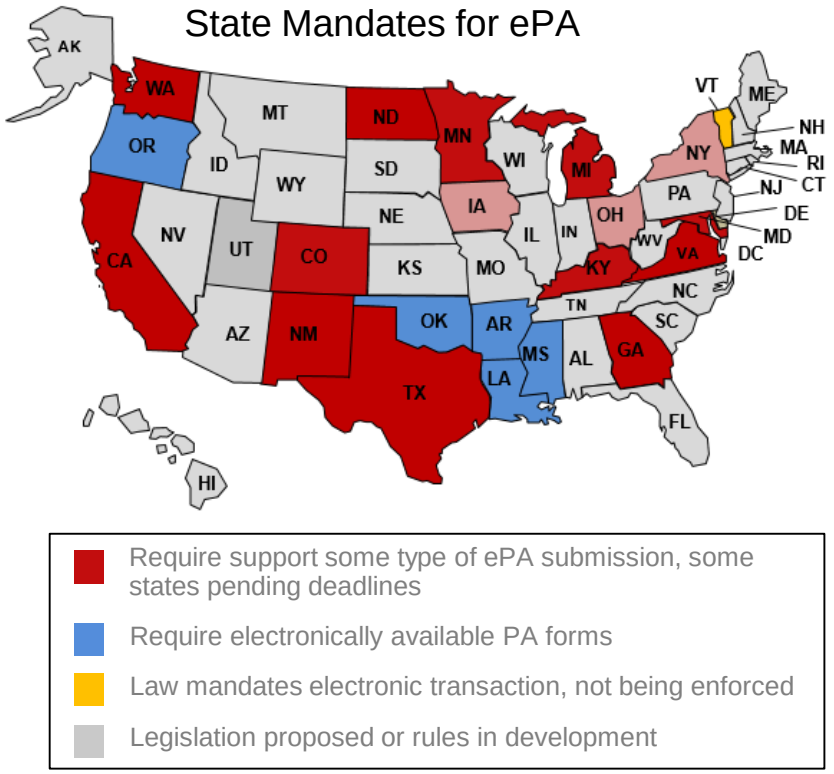
Prospective PA – with PA info at the time of prescribing

ePA being Implemented Nationally

ePA standard currently being implemented nationally

- Task Group DERFs all about clarifying standard and adding new, unanticipated data elements
- Payers/PBMs required to be able to support ePA or a universal PA form in 14 states by July 2015
- Turn-around times for forms return improving
- Retrospective is most used means of ePA, though adoption is sub-optimal
- Adoption of prospective dependent on PA flag in formulary or RTBI and is consequently sub-optimal

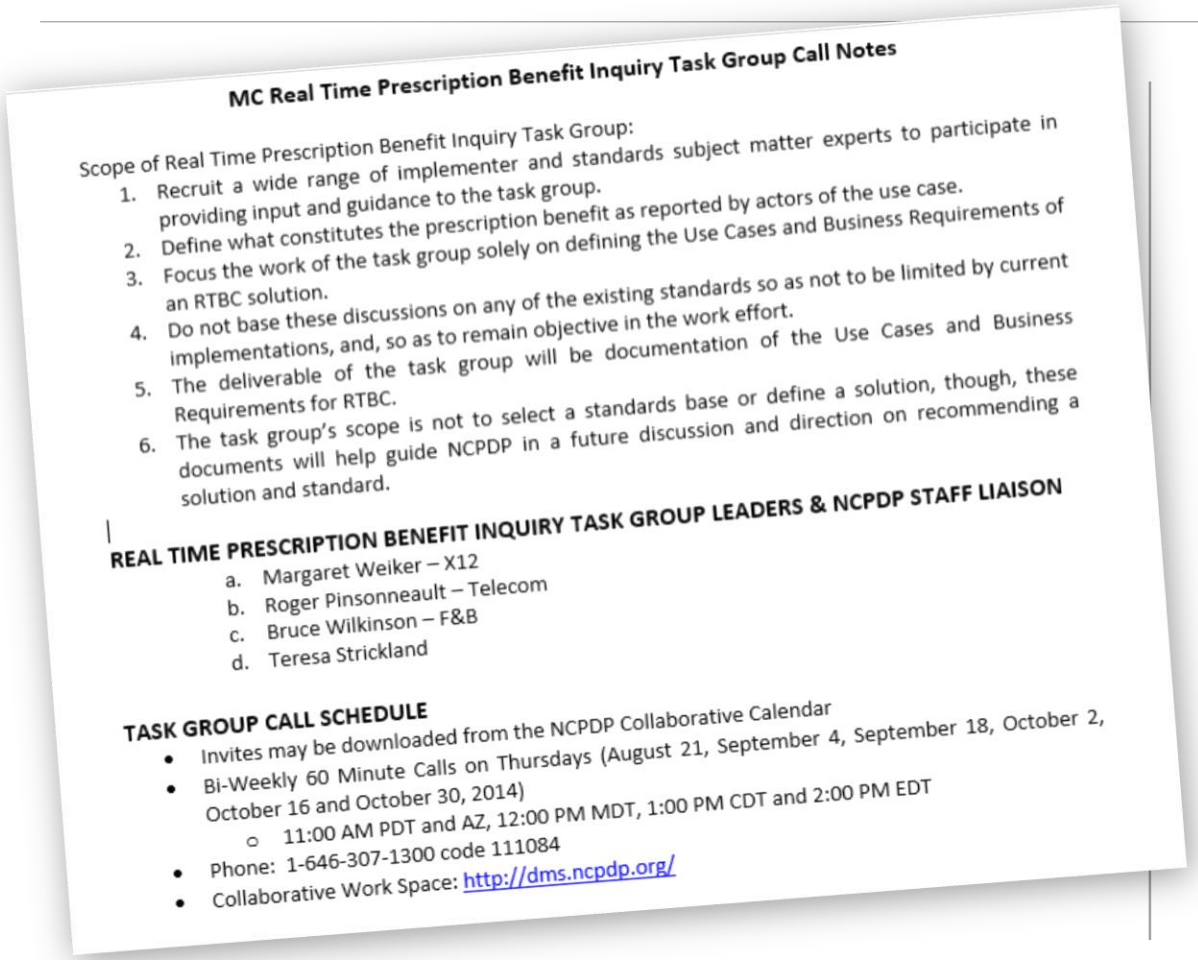
For ePA to reach wide adoption, HCPs need integration within the EHR workflow, and auto-completion of ePA request with existing EHR data



Map SOURCE: Point-of-Care Partners, www.pocp.com, Revised 7/15/2015

Electronic Benefit Verification (eBV)

Benefits Verification



MC Real Time Prescription Benefit Inquiry Task Group Call Notes

Scope of Real Time Prescription Benefit Inquiry Task Group:

1. Recruit a wide range of implementer and standards subject matter experts to participate in providing input and guidance to the task group.
2. Define what constitutes the prescription benefit as reported by actors of the use case.
3. Focus the work of the task group solely on defining the Use Cases and Business Requirements of an RTBC solution.
4. Do not base these discussions on any of the existing standards so as not to be limited by current implementations, and, so as to remain objective in the work effort.
5. The deliverable of the task group will be documentation of the Use Cases and Business Requirements for RTBC.
6. The task group's scope is not to select a standards base or define a solution, though, these documents will help guide NCPDP in a future discussion and direction on recommending a solution and standard.

REAL TIME PRESCRIPTION BENEFIT INQUIRY TASK GROUP LEADERS & NCPDP STAFF LIAISON

a. Margaret Weiker – X12
b. Roger Pinsonneault – Telecom
c. Bruce Wilkinson – F&B
d. Teresa Strickland

TASK GROUP CALL SCHEDULE

- Invites may be downloaded from the NCPDP Collaborative Calendar
- Bi-Weekly 60 Minute Calls on Thursdays (August 21, September 4, September 18, October 2, October 16 and October 30, 2014)
  - 11:00 AM PDT and AZ, 12:00 PM MDT, 1:00 PM CDT and 2:00 PM EDT
- Phone: 1-646-307-1300 code 111084
- Collaborative Work Space: http://dms.ncpdp.org/

- Today still done via **phone/fax**
- Effort to bring a **standardized** electronic benefit verification to the market via the Real-Time Benefit Inquiry

Options include using:

- NCPDP Telecommunications D.0 Standard
- X12 270/271 Eligibility Request
- NCPDP SCRIPT Standard

Transition to Real-Time Benefits Verification

- EMR systems, PA Portals, Intermediaries are implementing the NCPDP ePA Standard and transmitting ePAs to Plans and PBMs that support ePA.
- Benefit Verification from a prior authorization perspective is available in real-time from certain PBMs
- Not all health plans and PBMs have completely automated the prior authorization process
- Regulatory processes

Source: Agadia

Real Time Benefit Inquiry Milestones

The ONC Notice of Proposed Rule Making (NPRM) released in Feb 2014 was the catalyst for NCPDP efforts around RTBI. In subsequent meetings, a request for demonstration projects was made by ONC leading to additional industry efforts.

Feb 2014

ONC NPRM

- ONC Solicits comments on NCPDP Telecom and Formulary and Benefit Standard to support expanded use cases such as real-time benefit checks

June 2014

NCPDP Task Group Created

- NCPDP Task Group created under maintenance and control workgroup

Aug 2014

Subgroups created for Use Case Development

- Larger task group split into subgroups focused on specific Use Cases.
- Use Cases included: Alternatives, patient pay amount and coverage restrictions

Sept 2014

HITSC Meeting

- NCPDP presents at Health IT Standards Committee meeting.
- Requests for additional demonstration projects are made

Apr 2015

Subgroups dissolved

- Use Case Subgroups dissolved due to overlap of efforts
- NCPDP work will continue in single task group

Real Time Benefit Inquiry Today and Pilots

One Target, but currently **many paths…**

- NCPDP workgroup efforts
  - Use Case Development
- Industry Stakeholder Pilots
  - Modification of D.0 Telecommunications standard
  - Modification of SCRIPT standard
  - Proprietary connection
- ONC and CMS requests for pilots

Industry Efforts and Pilots

Surescripts Real-Time Benefit Check Product

- Product based on NCPDP SCRIPT standard (ePA Request and Response transaction)
- Pilots completed – 2010; General Availability of Transaction set and implementation guide - 2013
- RTBC 3.0 discussed at NCPDP in 2014 as part of SCRIPT standard; no consensus on implementing as standard
- Slow uptake due to vendor costs and uncertainty of industry standard

Relay Health Apollo Project

- Implementing as part of ONC NPRM demonstration project requests
- Slow progress on release due to slower than expected contracting process with PBMs and Payers
- Pilot based on NCPDP Telecom Standard D.0

Additional Industry Pilots VirMedica Pilot: Portal based eBV

- **Pilot Setup:**
- HUB services company hired by manufacturer to conduct 7 state pilot designed to measure accuracy and completeness of an eBV related to coverage of medical injectable
- compared manual BVs vs. eBV solution provided by VirMedica; 800+ cases reviewed over 3 month period.
- Data elements analyzed: Insurance eligibility status, Product coverage status, Patient cost share, Step edits and/or PA required, Specialty Pharmacy restrictions, Dosage restrictions

- **Key Findings:**
- Results of manual BV and eBV were virtually identical in accuracy and completeness (coverage status, cost share, restrictions)
- eBV produced more accurate results in “no call states” (i.e., states that do not allow 3rd party manual benefit verification. Example: Michigan)
- If data provided by HCP was inaccurate, the automated transaction could not produce a result, whereas the manual BV could capture the correct information

Are we truly “Real-time” yet?

- ONC demonstration projects are slow to launch due to contracting and implementation issues
- NCPDP workgroup progress slow due to competing stakeholder priorities
- Industry efforts are moving forward through various pilots and direct connections between EHRs and PBMs/Payers
- eBV in the form of prior authorization available in real-time from the larger PBMs
- Nearly all efforts are focused on pharmacy benefit side only; need to incorporate view of medical benefit for comprehensive solution

Next Steps and Expected Path Forward – CY2015

Activity for remainder of CY2015:

- NCPDP August Workgroup Meeting:
- RTBI Task Group to present “happy path” Use Case (Bi-Weekly calls leading up to Workgroup meeting)
- NCPDP November Workgroup Meeting:
- Work based on results of August workgroup meetings and continued work on Use Cases
- Continued industry efforts on pilot projects: RelayHealth, Humana, Surescripts

NCPDP and industry efforts through the end of the year will determine the direction and potential timelines of an industry standard.

Next Steps and Expected Path Forward – CY2016

Activity for CY2016:

- NCPDP February Workgroup Meeting:
- Work based on results of November Workgroup Meeting
- NCPDP to report to ONC & CMS per requests
- Expected results from pilot projects

Brands will need to continue to evaluate progress of NCPDP as well as industry efforts to anticipate the impact and exposure of RTBI to a particular brand.

Thank You.

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