Update on the Electronic Prior Authorization Landscape

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AMCP MANAGED CARE & SPECIALTY PHARMACY ANNUAL MEETING 2016

AMCP Academy of Managed Care Pharmacy®

Learning Objectives

At the completion of this activity, participants should be able to:

1. Explain how advanced payer portals can improve the prior authorization process and patient access to medication.
2. Discuss the financial and clinical impact of payer portals.
3. Describe how industry front-runners are using technology to manage prior authorization for medications and therapy covered under both the pharmacy and medical benefits.
4. Summarize key prior authorization trends, costs and options available to automate prior authorization of medications.

Continuing Pharmacy Education Credit

- Log-in to AMCP Learn at http://amcplearn.org/
  - *PLEASE NOTE: USE THIS EXACT URL
- Follow instructions available on amcpmeetings.org
- Have available:
  - NABP e-profile ID
  - Birth month and birthday
  - Session-specific attendance code
- Complete and submit session evaluation no later than May 23, 2016 (5:00 PM ET)
- Information in CPE Monitor approximately 72 hours after submission completion

Financial Relationship Disclosures

- James R. Lang reports having no financial relationships with any commercial interests during the past 12 months.

- Tony Schueth is the owner of Point-of-Care Partners, LLC and reports having no other personal financial relationships with any commercial interests during the past 12 months.

This slide deck was peer reviewed to mitigate any risk of bias.

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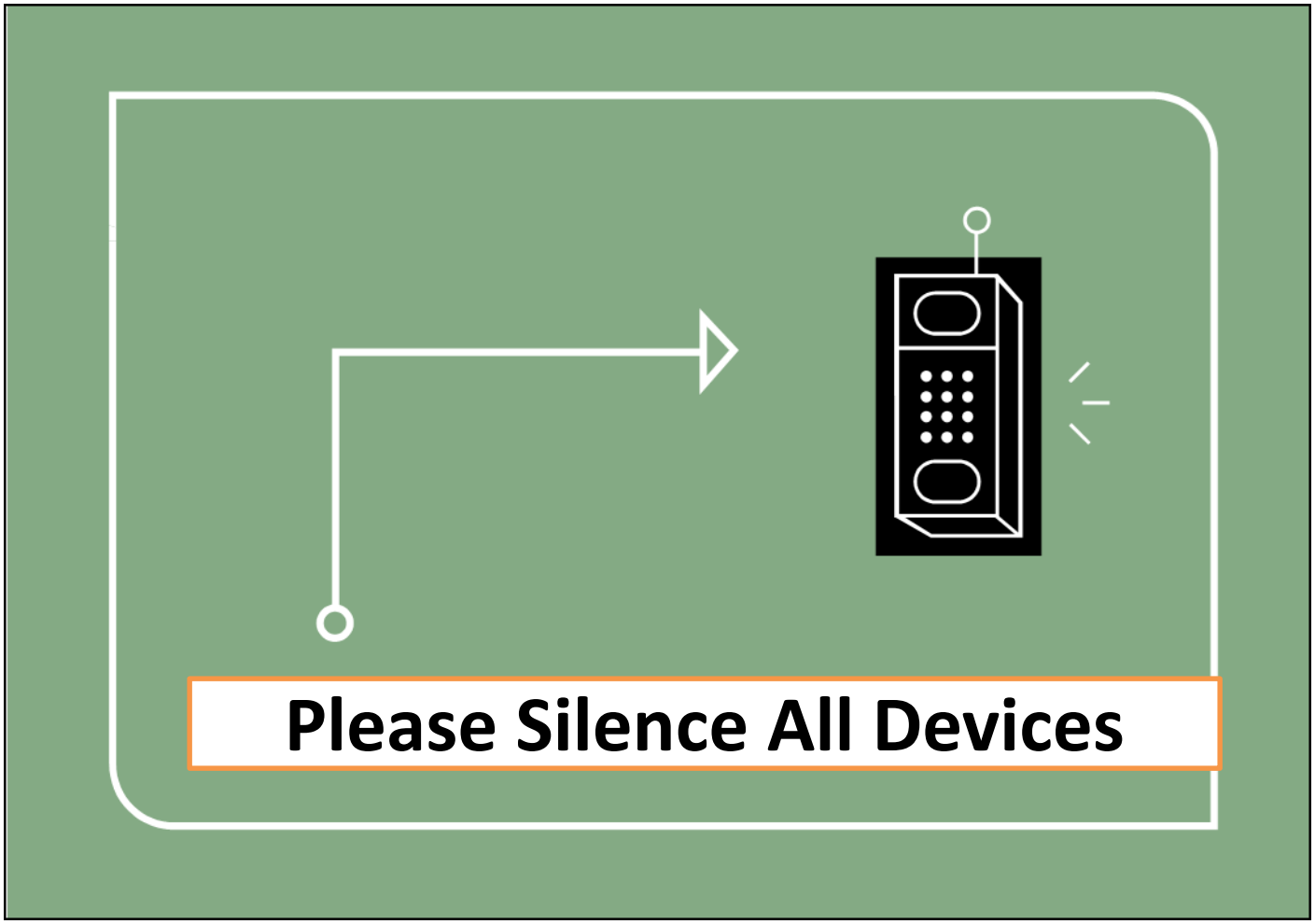
Please Silence All Devices

Faculty

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PRE-TEST

Learning Assessment Question #1

How can web-based utilization management (UM) solutions improve the prior authorization process?

a. PA approval delivered in real-time, improving patient access to medications
b. One solution for all distribution channels
c. Approval is automatically entered into the claim system
d. All of the above

TEXT TO 22333

a. 22133
b. 22138
c. 23224
d. 23784

Learning Assessment Question #2

Which of the following is not needed to ensure clinical relevance of web-based UM programs?

a. Deep dive into the medical data to identify opportunities for improvement
b. Evaluation of the specialty pipeline
c. Implementation of Specialty Drug Workgroup to manage the clinical criteria development
d. Coordination with EHR vendors

TEXT TO 22333

a. 24665
b. 27842
c. 27843
d. 27846

Learning Assessment Question #3

Which of the following are stakeholder benefits for electronic prior authorization (ePA)?

a. Reduced prescription abandonment; improved medication adherence
b. Saves prescribers 20-60 minutes per PA; saves payers $20-$25 per submission
c. Immediate notification of drugs requiring PA before ePrescribing
d. All of the above

TEXT TO 22333

a. 30071
b. 30414
c. 30535
d. 31143

Learning Assessment Question #4

Which of the following are considered best practices for automating prior authorization of medications?

a. Implement applicable NCPDP message types
b. Transition from retrospective to prospective ePA
c. Monitor ePA legislative mandates
d. All of the above

TEXT TO 22333

a. 28081
b. 29943
c. 29944
d. 29946

Agenda

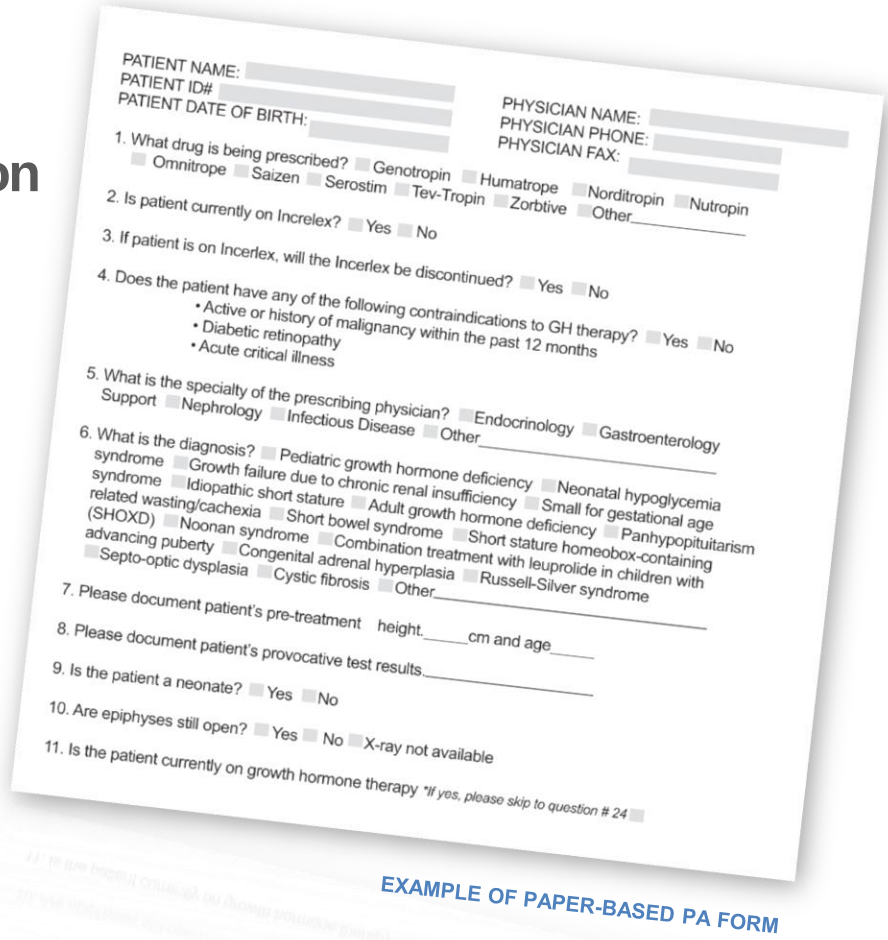
- **Prior Authorization Landscape**
  - Definition and Gaps
  - Interim PA Automation
- **Case Study: Blue Cross Blue Shield of Michigan**
- **Implementing ePA in Prescriber Workflow**
  - ePA Roadmap
  - Use of Transaction Standards
  - Real-Time Formulary and Benefit Data

The Prior Authorization Landscape

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**
- ***For our purposes, PA here does not include quantity limits, step therapy or other protocols***



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

Traditional Manual Prior Authorization Process

Doctor submits the prescription though normal ePrescribing flow.

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

Rx Pended/ Manual PA Begins

40%

OF PRESCRIPTIONS ARE ABANDOND

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.

1. 2015 ePA National Adoption Scorecard
2. Point-of-Care Partners' Internal Data

Prior Authorization Impacts All Healthcare

PATIENT HASSLE AND TREATMENT DELAY

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

PHARMACY HASSLE

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

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

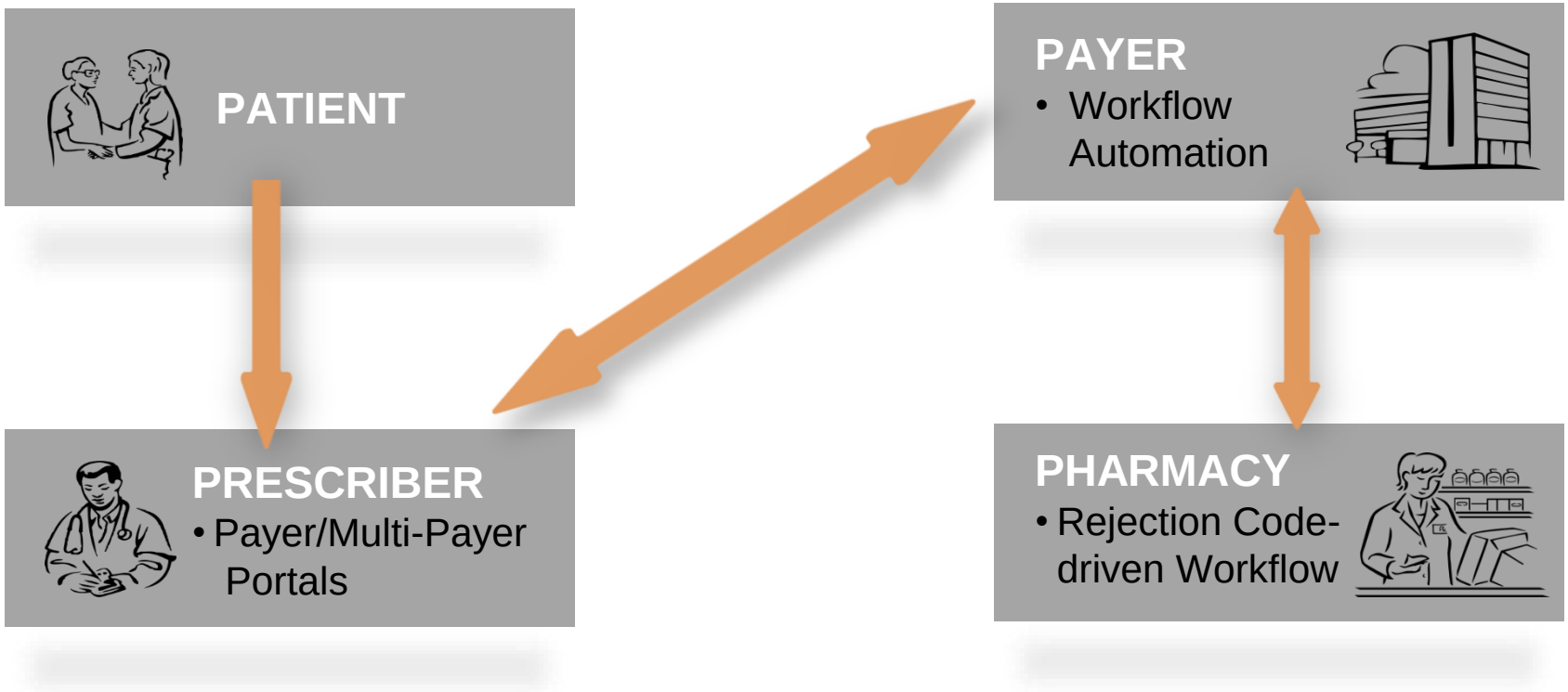
PHARMACEUTICAL OBSTACLES

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

PBM/HEALTH PLAN INEFFICIENCY

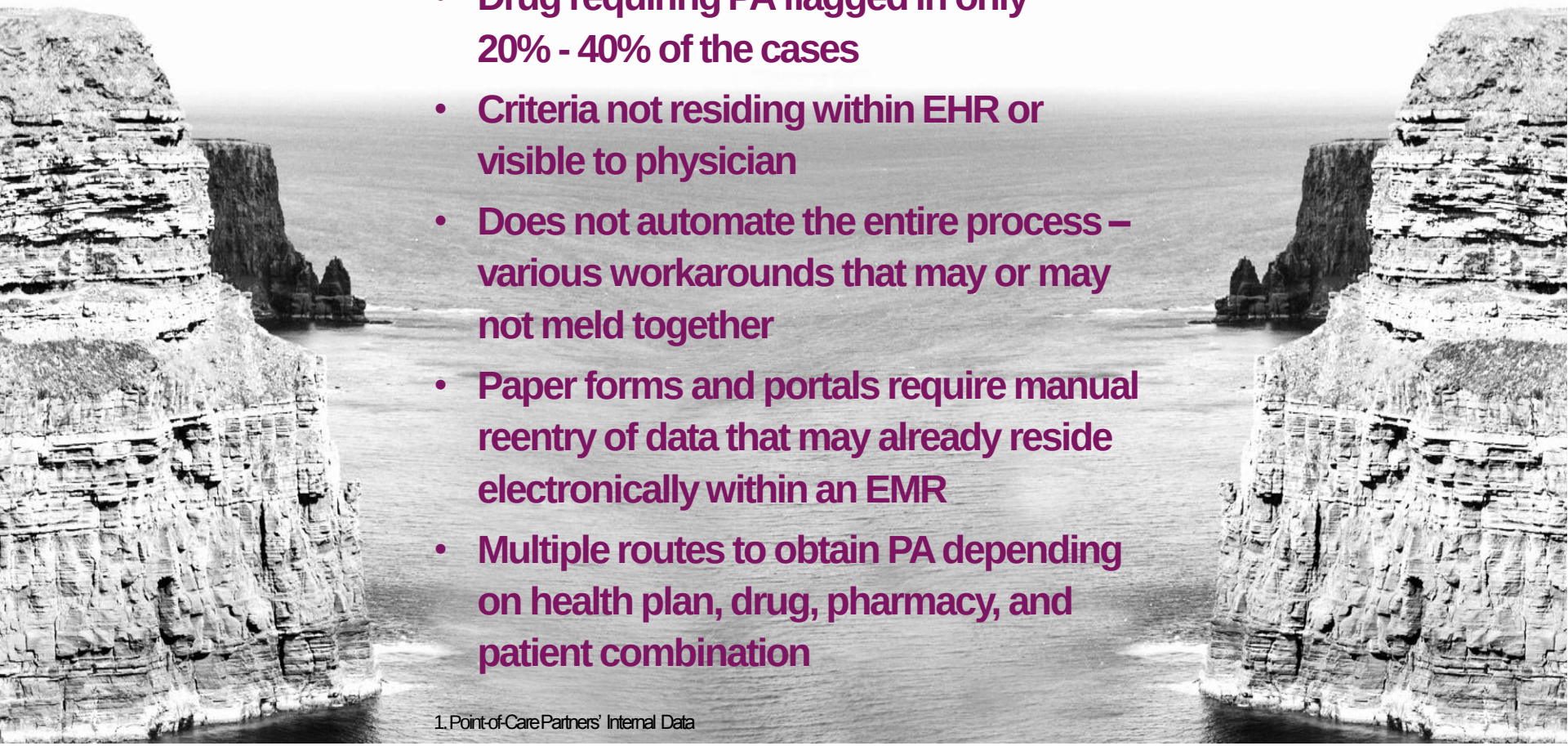
- Expensive and labor intensive process that creates animosity

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 20% - 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

1. Point-of-Care Partners' Internal Data

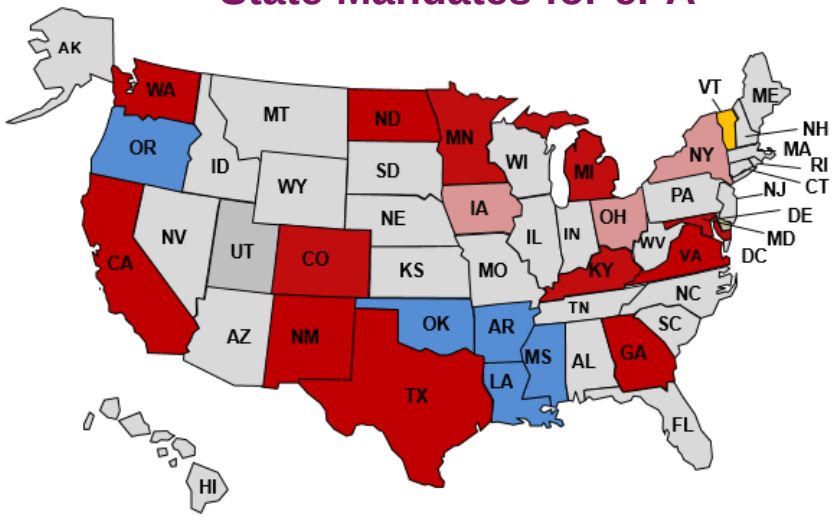
ePA Being Implemented Nationally

Ongoing Legislative and Regulatory Momentum

- Demand seems to be high to reform the entire prior authorization process and workflow
- Standard forms and ePA are a key component of this effort
- Payers are required to accept electronic submission of ePA– HCPs are not required to use ePA
- A separate website, portal or unconnected solution would meet these requirements

Sessions have begun and legislative activity has picked up in 2016

State Mandates for ePA



Map SOURCE: Point-of-Care Partners, www.pocp.com, Revised 1/15/2016

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

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

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

Case Study: Blue Cross Blue Shield of Michigan

Industry Trends in Prior Authorization

- **Electronic prescribing (NCPCP format)**
  - Decades long ramp up
  - Many years of physician incentives at BCBSM
  - Necessary pre-cursor to ePA
- **Same trajectory with electronic prescribing of controlled substances**
  - Difficult and confusing regulatory response
  - Very slow adoption
  - New incentive program for adoption at BCBSM

Industry Trends in Prior Authorization

- Expansion of health plan involvement in medical drug spend
- Need for PA on professional and facility claims on medical drugs
- Development of health plan portals to support medical drug PA's

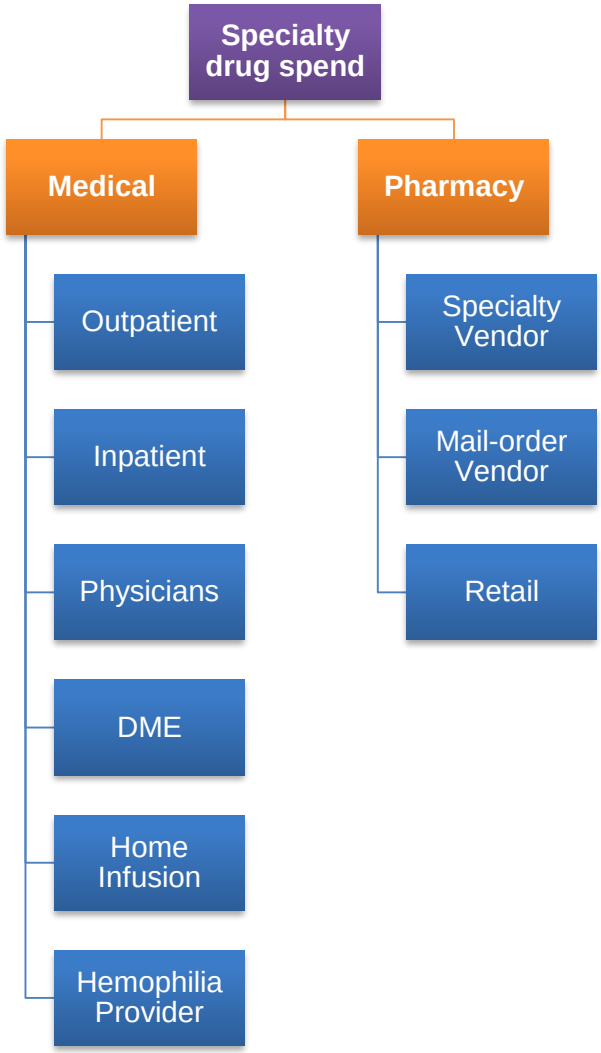
BCBSM Response to Medical Spend

- **Wanted to leverage available technology for medical drug management program**
- **Decided on a process to:**
  - Develop necessary requirements for program
  - Request for proposal for vender
  - Oversee the complex implementation
- **Review and update on implementation of medical specialty drug program**

Strategy requires new abilities to manage medical specialty drug distribution channels

New cross-functional distribution channel management abilities:

- Benefit design
- Claim editing
- Expansion of vendor management
- Reimbursement enhancements to take advantage of the most cost effective care setting
- Physician Group Incentive Program
- Utilization Management (UM) programs:
  - Prior authorization
  - Off-label review
  - Pipeline monitoring
- Provider services
  - Electronic prescribing
  - Medication adherence



Medical Specialty Drug UM Program Development

- Stages from analysis to implementation
  - 2-3 year effort
- Multi-departmental effort
- Leadership approval and buy in
- Focus resources
- Process development
- Training and communication is key

Analysis:

- **Deep dive into the medical data to identify opportunities for improvement**
- **Evaluation of the specialty pipeline**
- **Brainstorming answers to the following:**
  - How can we effectively manage
  - What are other plans doing to control utilization/cost
  - Do we need assistance of a consultant
  - How can we leverage technology to facilitate clinical reviews

Pre-RFP:

- **Presentations of different companies management software/program/vendor demo's**
  - Identify industry best practices
  - Assimilate information to be incorporated into the RFP
  - Describe the "must have" capabilities including web-based prior authorization capabilities
- **Interdepartmental team meetings**
- **Implementation of Specialty Drug Workgroup to manage the clinical criteria development**
- **Continued communications with Executive Leadership**

Strategy Development:

- **Identify components of the ideal medical specialty utilization management program including administration locations to consider**
  - Office infusion
  - Home infusion
  - Outpatient facility
- **Internal partner discussions to identify potential challenges and barriers**
- **Estimation of IT requirements to support electronic prior authorization web portal**
- **Development of timeline of program component implementation**
- **Initial budget estimations**

RFP Time Period:

- **Procurement process**
  - Review/selection
  - Contracting
- **Clinical process**
  - Developing clinical criteria and branch tree logic
  - P & T approvals
- **Operational process**
  - Secure funding for project
  - Staffing review
  - Review and update of provider contract/certificate
  - Socializing strategy internally

Project Implementation:

- Initial time frame 120 days from signing of contract for web-base tool to be up and running for internal staff
- Rolled out web-base tool to providers in waves over 6 months based on types of specialty drugs
- Ongoing development of clinical criteria and branch tree logic for future additions

Vendor Selection

- **Non-negotiable vendor requirements:**
  - Vendor capability for 11- digit NDC pricing
  - Web-based prior authorization capability for providers utilizing branch-tree logic
- **Case meets criteria based on programmed clinical logic**
  - Approval is automatically entered into the claim system
  - Provider obtains instant feedback

Provider Response to Technology

- Few providers obtained the web login access to the prior authorization system
- Physicians who utilize the web-based prior auth process have provided feedback that it is efficient and appreciated
- Provider consulting teams have identified that despite training, many providers are reluctant to utilize another tool in their workflow

Lessons Learned

- Adoption of electronic prior authorization may be slower than anticipated
- Continued communication with providers is essential for a successful utilization management program
- Internal resources need to be aligned to make sure all aspects of medical claims systems are working synergistically

Implementing ePA in Prescriber Workflow

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

1. Point-of-Care Partners' internal data; ePrescribing State Law Review
2. NCPDP website

Electronic Prior Authorization

The Infrastructure is in place

80%

Physicians Today

Greater than 80% of physicians ePrescribe today

700

EHRs Enabled

More than **700** EHRs enabled for ePrescribing

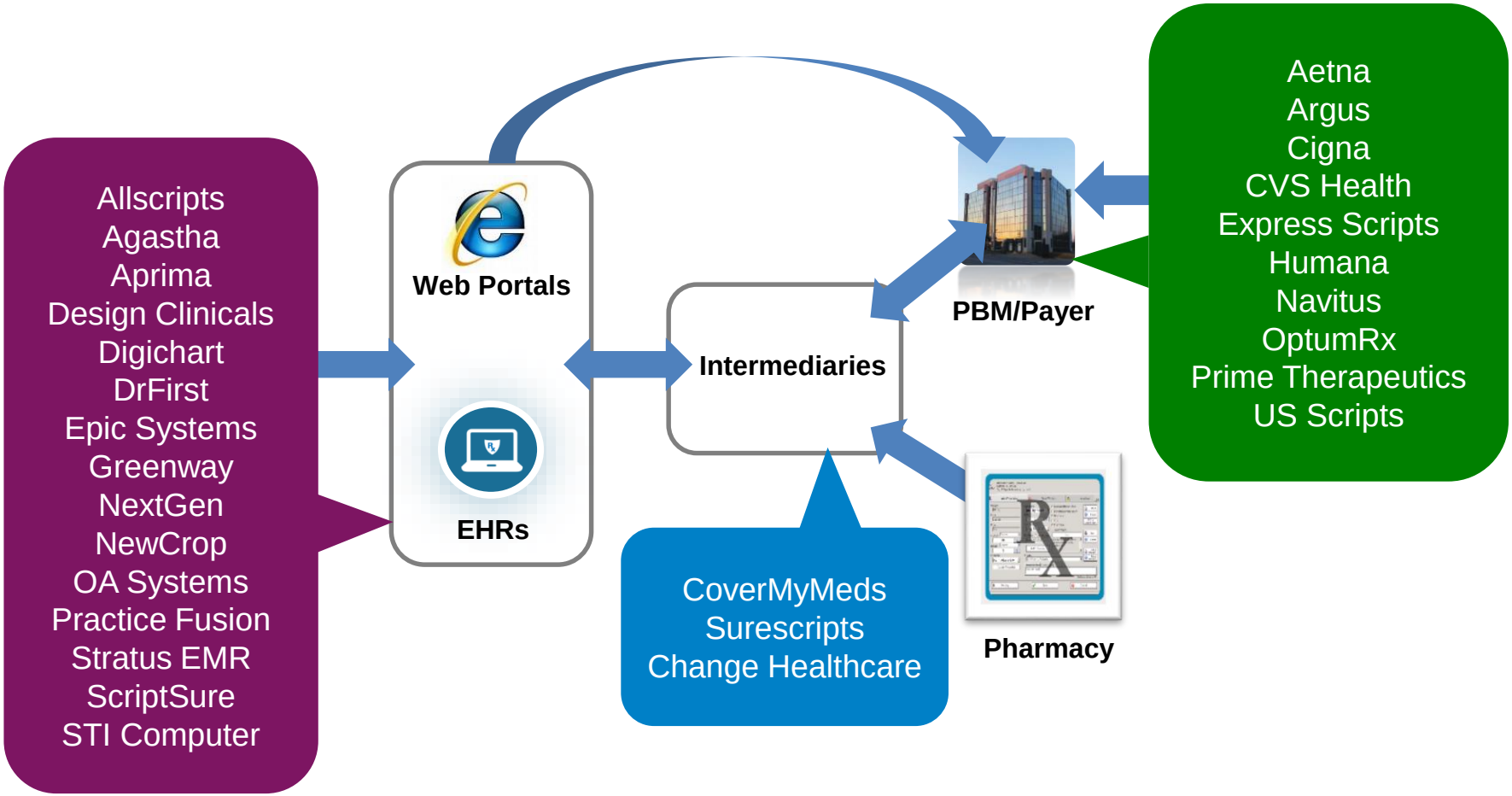
100%

Retail Pharmacies

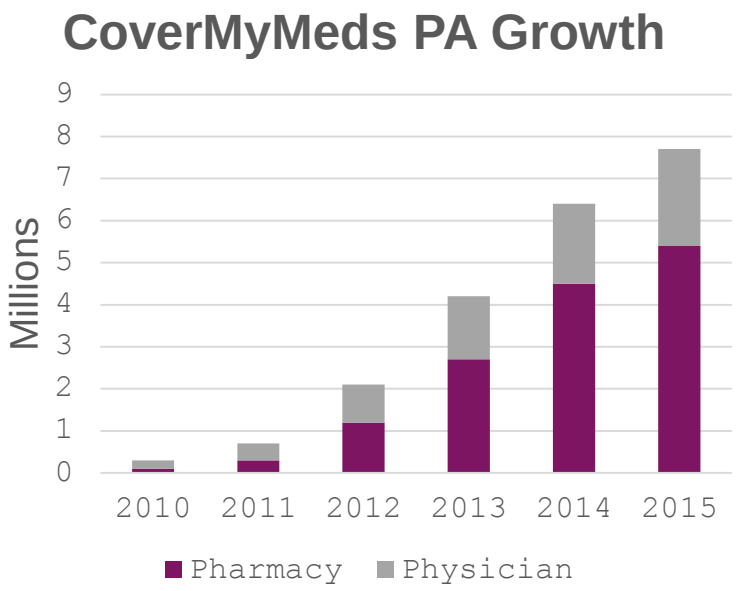
Nearly **100%** retail pharmacies

1. Surescripts
2. Point-of-Care Partners' internal data

Current Landscape



Electronic Prior Authorization

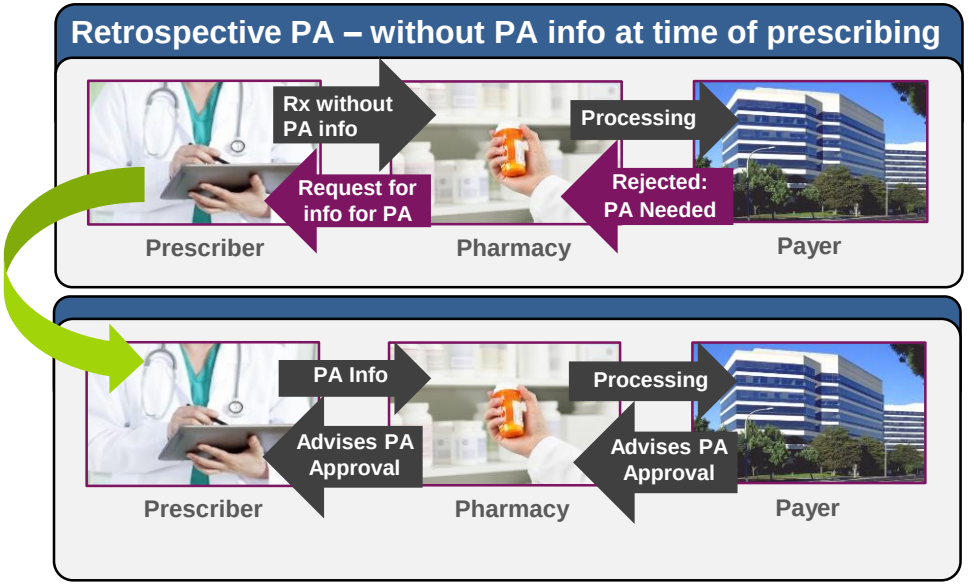


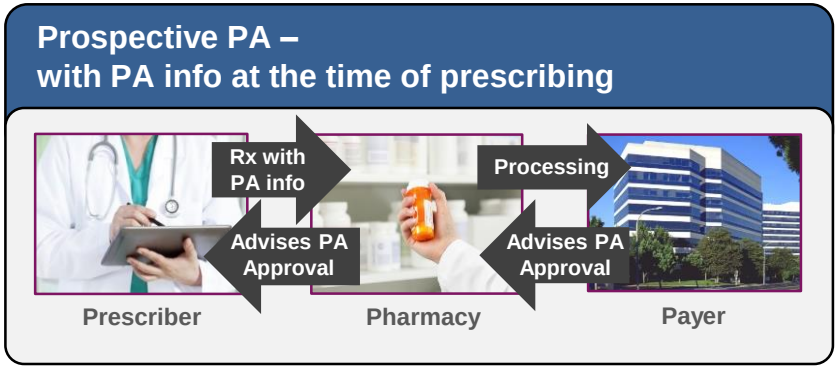
Source: CoverMyMeds

- **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

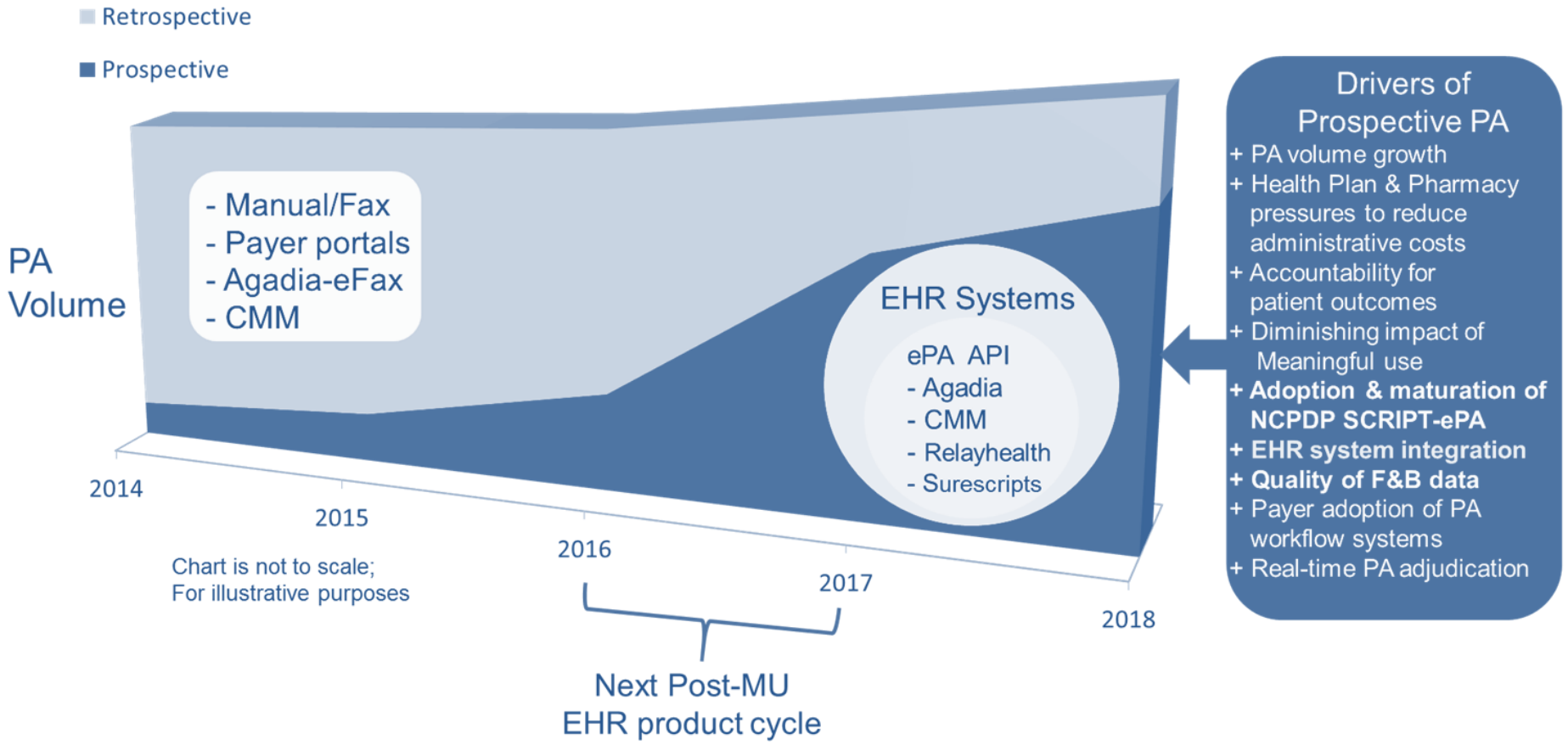
New Standard Enables Multiple Workflows

Retrospective vs. Prospective





Transition from Retrospective to Prospective Prior Auth



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

1. NCPDP Real-time Benefit Check Briefing
2. NCPDP website

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**

Post-Test

Learning Assessment Question #1

How can web-based utilization management (UM) solutions improve the prior authorization process?

a. PA approval delivered in real-time, improving patient access to medications
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d. All of the above

TEXT TO 22333

a. 30773
b. 35736
c. 37160
d. 37950

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Which of the following is not needed to ensure clinical relevance of web-based UM programs?

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TEXT TO 22333

a. 30532
b. 31150
c. 31290
d. 31291

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TEXT TO 22333

a. 30774
b. 37951
c. 45707
d. 50195

Learning Assessment Question #3

Which of the following are stakeholder benefits for electronic prior authorization (ePA)?

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Learning Assessment Question #4

Which of the following are considered best practices for automating prior authorization of medications?

a. Implement applicable NCPDP message types
b. Transition from retrospective to prospective ePA
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d. All of the above

TEXT TO 22333

a. 32664
b. 50198
c. 50201
d. 51208

Learning Assessment Question #4

Which of the following are considered best practices for automating prior authorization of medications?

a. Implement applicable NCPDP message types
b. Transition from retrospective to prospective ePA
c. Monitor ePA legislative mandates
d. All of the above

QUESTIONS?

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