Electronic Prior Authorization Situation Review and Level-Set

National Council for Prescription Drug Programs
NCPDP

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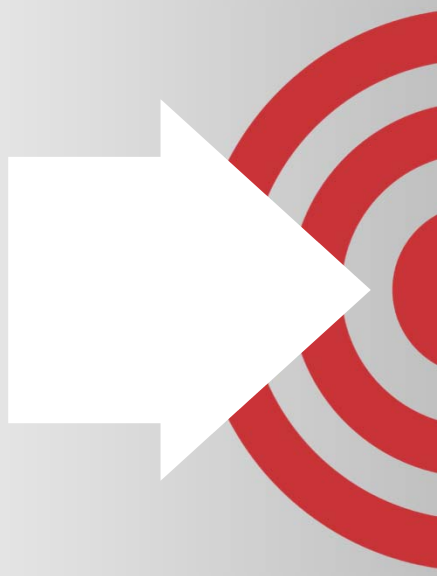
October 6, 2011

Agenda

- Prior Authorization today
- Current Drivers
- Standardized electronic Prior Authorization

Prior Authorization Today



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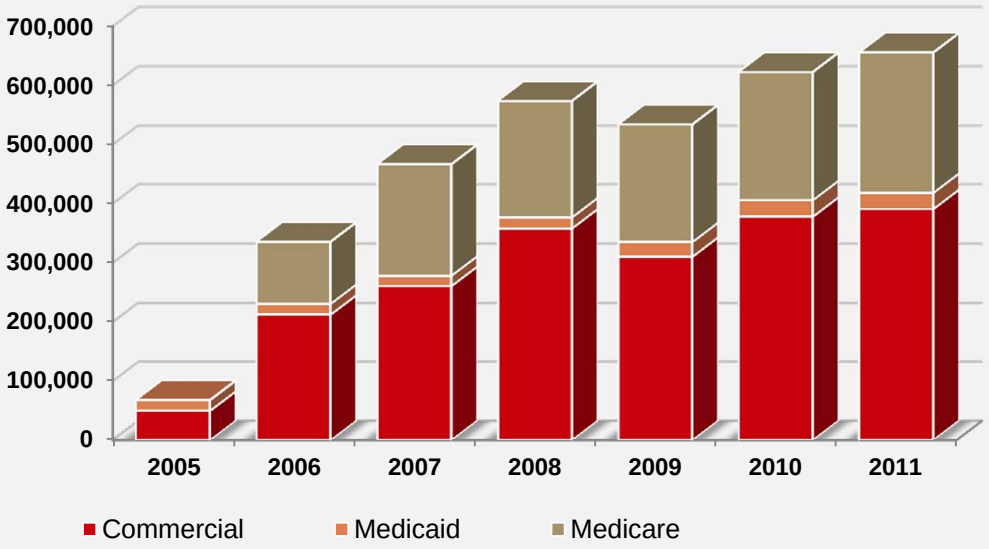
Growth in PA (2005 – 11)

- Advances in medication therapy management, biotechnology, designer drugs, specialty pharmacy, and the cost of the pharmacy benefit, has increased the number of PA'd medications
- From 2005 to 2011, the number of prior authorizations have increased nearly six-fold.
- Among commercial plans, the number of PAs have increased dramatically.
- Among *Medicaid* programs, the number has been fairly consistent.
- The largest jump in *Medicare* was after the Part D program was introduced in 2006.



Source: MediMedia analysis of formulary database, October 2011

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

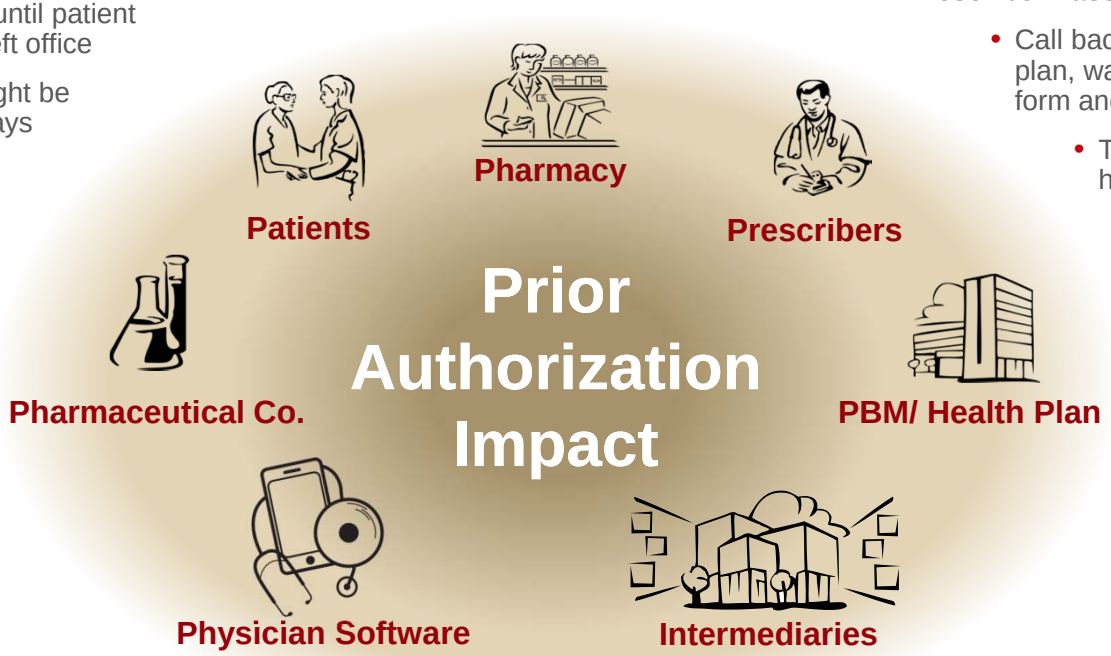
- Pharmacy must call prescriber's office, and sometimes the plan

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 Cos

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



PBM/Health plan efficiency

- Expensive and labor intensive process that creates animosity

Physician Software

- Concern about wasted resources and priorities
- New complicated transactions and changed workflow

Intermediary Opportunity

- Value creation in connecting partners
- There are questions of priority, however

Tension in Prior Authorization

Streamline Process

Simplify & Standardize

Health Plans & PBMs

- Present a consistent format while maintaining particulars of drug's clinical assessment by the company
- Reducing administrative barriers for prescribers may:
  - generate a higher volume of PA transactions – requiring automation to handle the increased volume
  - Increase utilization of drugs requiring PA
  - Allow an increase number of drugs requiring PA

Doctors

- Full Transparency of rules; ie clearly articulate the criteria for the decision
- Same set of rules and data requirements across all health plans
- Eliminate duplicate data entry from EHR
- Make prescription process for drugs requiring PA easier and less time consuming

Prior Authorization Today… Largely a paper process

- Some plans use a generic form:
  - May require basic info: demographics, Dx, Med Hx,
  - Shares no criteria or specific drug information
  - Results in added calls or communication
- Some plans use forms specific to drug/class:
  - Organized by therapeutic area
  - May require lab values, other relevant parameters, etc
  - Previous medications (med Hx) required
  - Guidelines for approval may be included on form
- Criteria varies by plan, wording non-standard
  - Criteria for approval usually not apparent to prescriber

Current Automation in PA

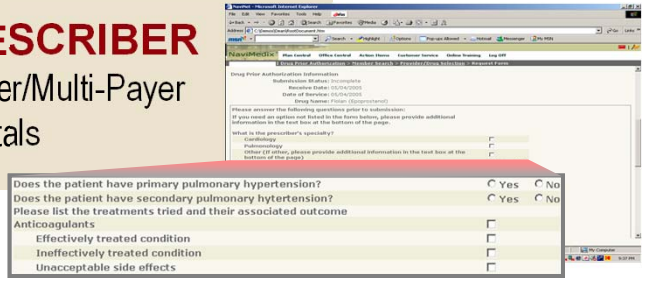
PATIENT

PAYER

- Workflow Automation

PRESCRIBER

- Payer/Multi-Payer Portals



PHARMACY

- Rejection code-driven Workflow

Automation today largely replicates the paper process requiring duplicate entry of information

Gaps in Current Activities

- Criteria not residing within physician's application 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

Current Drivers

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Electronic Prior Authorization Milestones

Federal government (HIPAA, MMA, CMS/AHRQ) efforts to encourage development and adoption of ePA has brought us to an inflection point. The industry must now take over.

Aug 1996

HIPAA passes
- X12 278 named "prior authorization" transaction standard

Nov 2004

NCPDP ePA Task Group Formed
- Standard transactions mapped
- Gaps identified
- HL7 PA Attachment created (2005)

2006

MMA ePrescribing Pilot Tests
- "Menagerie of ePA standards" pilot tested
- One standard – not X12 278 -- recommended

2008

CMS/AHRQ pushes forward
- Resolution of which SDO would own ePA
- Exception to HIPPA resolved
- Value model created

2009

New Standard Created
- Housed in NCPDP
- Compatible with emerging technology
- No pilot test

2011

Renewed Interest
- More pilots
- Economic value
- State legislation

ePA Drivers

- In 2009, State of Minnesota passed a bill mandating electronic prior authorization
  - *No later than January 1, 2011, drug prior authorization requests must be accessible and submitted by health care providers, and accepted and processed by group purchasers, electronically through secure electronic transmissions. Facsimile shall not be considered electronic transmission."*
  - Implementation pushed back to January 1, 2015
- In December 2010, "Electronic Prescription Adoption Act" surfaced in many states
  - Numerous versions of the bill found in the states running from 1 to 8 pages
  - Requirements vary from state to state
  - Would require the use of a real-time electronic prior authorization process
  - No intervening person language
  - State insurance agency would set standard
- In April 2011, CVS Caremark announced ePA pilot at AMA meeting
- West Virginia Request for Quotation (bid opening date: 11/4/11)

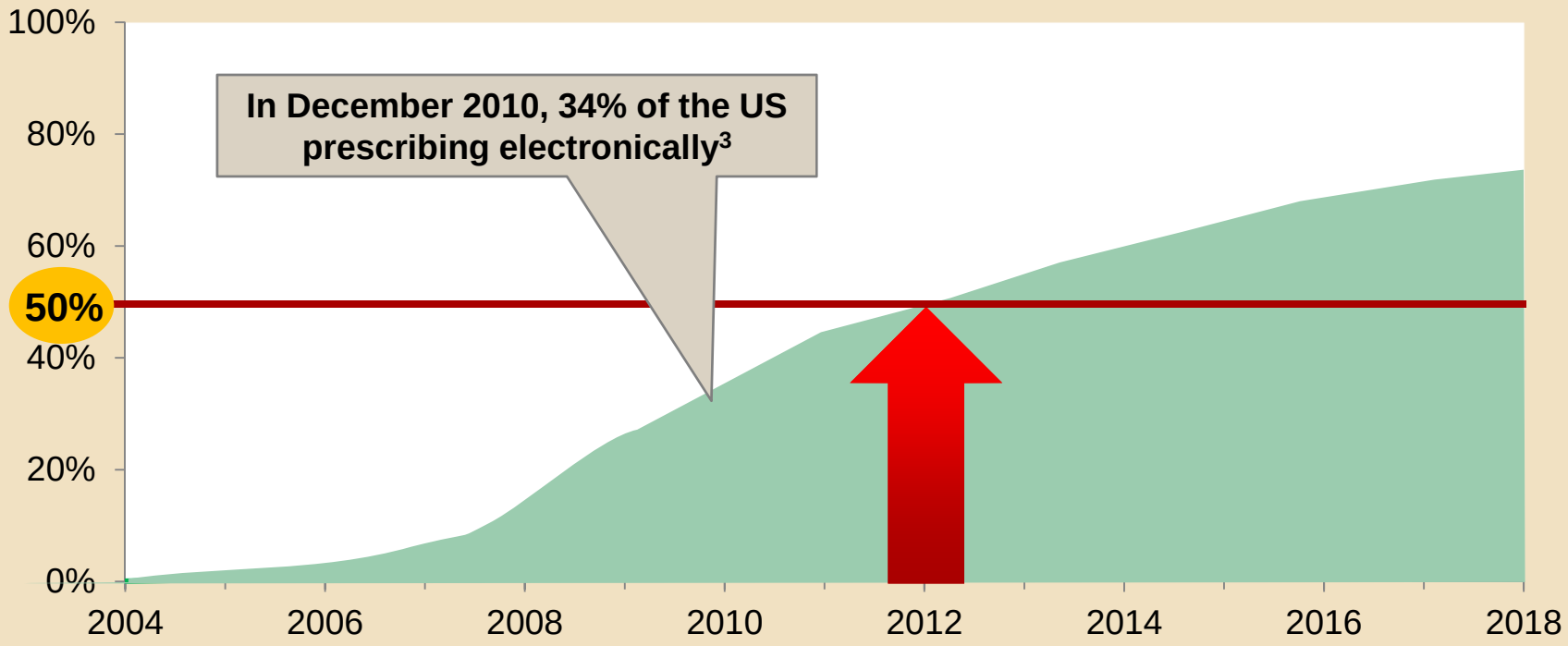
Current State Legislative Status

- ND is the only state in which the ePrescribing/ePA bill has passed, and that law doesn't take effect until 2013
- NJ's bill is technically still in play, but it's moving very slowly and could stall
- MI still has a bill in play
- Still pending NC, GA, NE, OK, TN, VT, MA and NY.

ePrescribing Can No Longer Be Ignored

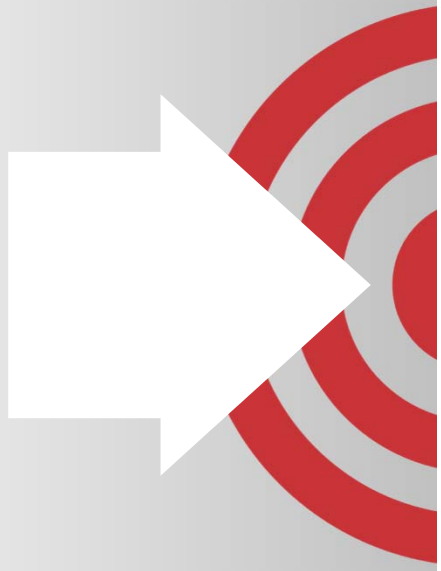
50% of prescribers[1] will soon be prescribing electronically[2]

ePrescribers as a Percentage of Total Ambulatory Prescribers



[1] Defined by as ambulatory prescribers less practitioners that are not regular prescribers, e.g., radiologists
[2] Based on Surescripts historical data and Point-of-Care Partners projections
[3] Surescripts 2011, National Progress Report on E-Prescribing and Interoperable Healthcare

Standardized ePA



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Where We Are (per ONC)

Proposed Standard

PATIENT
Visits Doctor

PAYER
- Determines PA Status, Criteria
- Compiles PA clinical rules
- Processes PA Requests
- Processes Drug Claims

Drugs can be identified as requiring PA via *NCPDP Formulary & Benefit Standard (or not)*

Submit Required Patient Information *via* *NCPDP Draft PA Standard*

Drug Claims are Submitted via *NCPDP Telecommunications vD.0*

PRESCRIBER
- Writes Prescription
- Completes a structured Q&A
- Submits PA Request
- Transmits Prescription

Prescriptions are submitted *via* *NCPDP SCRIPT*

PHARMACY
- Dispense Drugs
- Files Drug Claims

Red = gaps in existing standards *Blue* = existing standards

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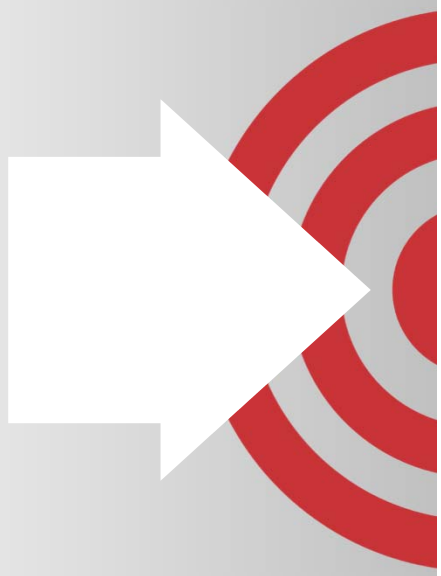
Appendix



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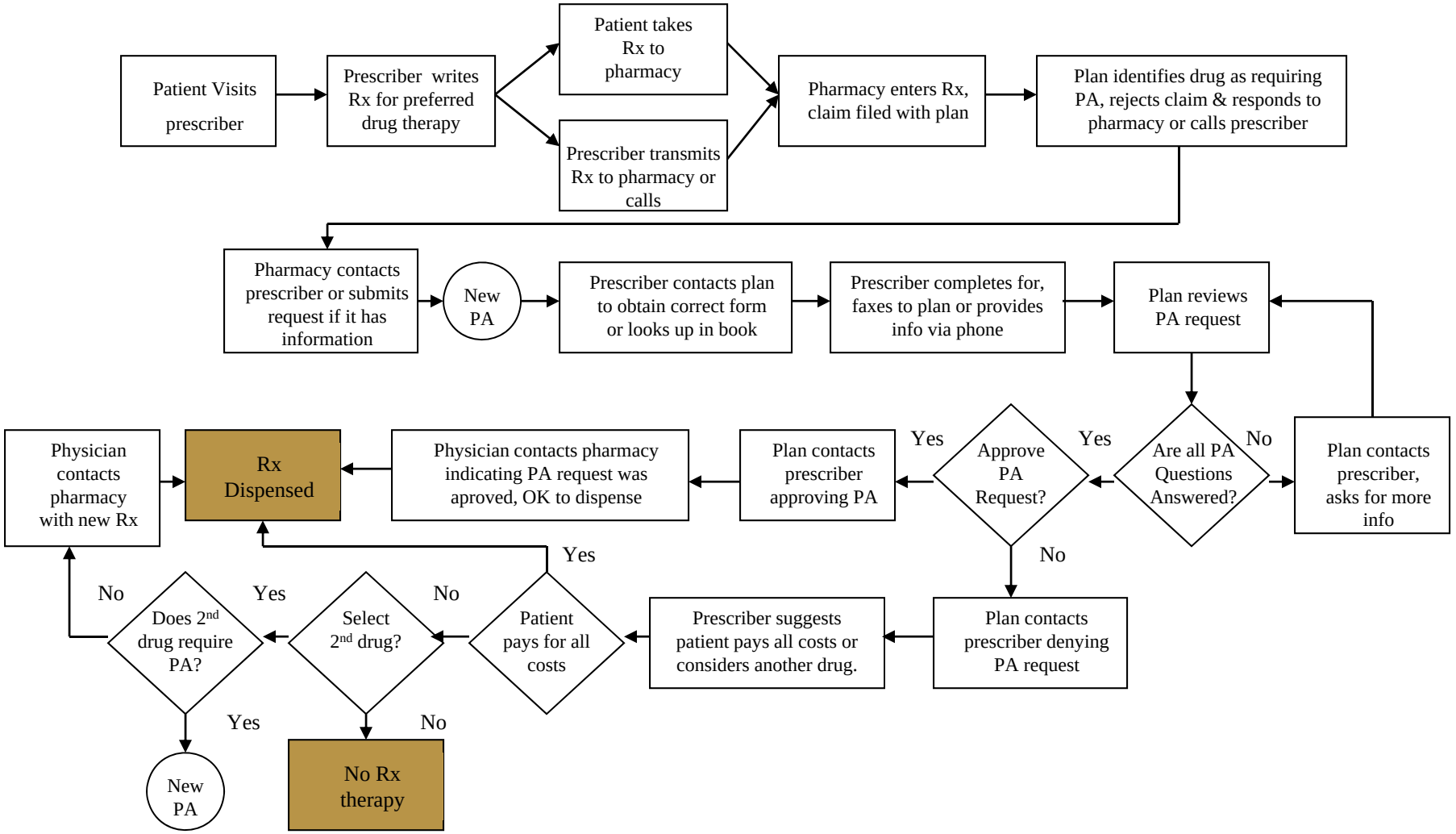
Paper-based Prior Authorization Today (cont.)



Medical and Pharmacy PA

Medical PA

- Includes admissions, procedures and medications
- Destination is the insurer or administrator of the medical benefit
- No standard for PA in practical use today

Pharmacy PA

- Medication only
- Destination is either pharmacy benefit or insurer
- Proposed but untested standard

From the physician perspective there is little difference and increasing confusion about the process.

How a Standard is Created*

1. Workgroup within SDO identifies a problem
2. Volunteer task group within the workgroup is formed
3. Plan established and sub-taskgroups are formed
4. Task group comes to consensus and brings recommendation back to workgroup
5. Standard is proposed by workgroup
6. Standard is pilot-tested
7. Standard is modified based on test
8. Standard is re-tested if needed
9. Standard is balloted at SDO and voted on
10. Standard is released to the industry

Each item listed take 1-3 months each; approval to move on requires unanimous agreement

Bottom Line: Standards development is a slow process because everyone must agree

New Pilot Components

- Ideal large-scale pilot would involve more than one payer/processor, more than one vendor (representing several prescribers/prescriber specialties) and an intermediary
  - Highly complex, multi-stakeholder initiative
  - Need experienced project lead and/or principal investigator
  - Experienced administrative organization ideal
- Required multi-million dollar investment
  - 2006 MMA pilots were $1.2M to $2M
- Timeline of 18 to 24 months
  - 6 months to put program in place (contracts with each stakeholder, financial flows, study design, etc.)
  - 6 to 12 months to pilot test standard
  - 3 to 6 months to analyze findings and write report