Electronic Prior Authorization Overview

April 4, 2011

POINT-OF-CARE PARTNERS
HIT Strategy & Management Consultants

Tony Schueth | CEO & Managing Partner | Point-of-Care Partners
Laura Topor | President | Granada Health

Agenda

- Introductions
- ePA Overview
- Historical/Current Status
- Options/Implications

Tony Schueth

- CEO & Managing Partner, Point-of-Care Partners, a HIT Strategy & Management Consulting firm (see appendix for overview)
- Taskgroup leader, NCPDP Prior Authorization Workflow-to-Trans-actions Task Group, 2004-2010
- Currently engaged to project manage CVS Caremark ePA pilot (to be described later)
- In 2010, assisted technology companies in assessing ePA opportunity
- Currently and previously engaged with pharmaceutical manufacturers to assess ePA situation, potential go-forward strategies
- Engaged by CMS Office of eHealth Standards and Services (OESS) and Agency for Healthcare Research and Quality (AHRQ) to work on ePA, 2008-09
- Project lead for 2006 MMA-mandated ePrescribing pilot that assessed ePA opportunities, challenges (as subcontractor to Rand Corp.)

Laura Topor

- President, Granada Health, LLC
- NCPDP
  - Member, Board of Trustees
  - Co-Chair, ePrescribing and Related Transactions Work Group
  - Lead, Structured and Codified Sig Task Group
- Participant/SME
  - 2006 and 2009 AHRQ/CMS funded electronic prescribing pilots
  - Minnesota eHealth Advisory Committee workgroups
    - ePrescribing
    - Standards and Interoperability
    - Privacy and Legal Policy
    - Health Information Exchange
    - Adoption and Meaningful Use

Agenda

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- ePA Overview
- Historical/Current Status
- Options/Comments

Medication Prior Authorization

- Medication prior authorization (PA) is the process of obtaining pre-approval from a payer for specified medications or quantities of medications, with the goals of:
  - Improving patient safety and quality
  - Containing costs
- Each payer has its own set of PA criteria, which vary by drug, indication, gender and other factors.
- Some payers consider step therapy and quantity limits to be part of PA, some do not

.

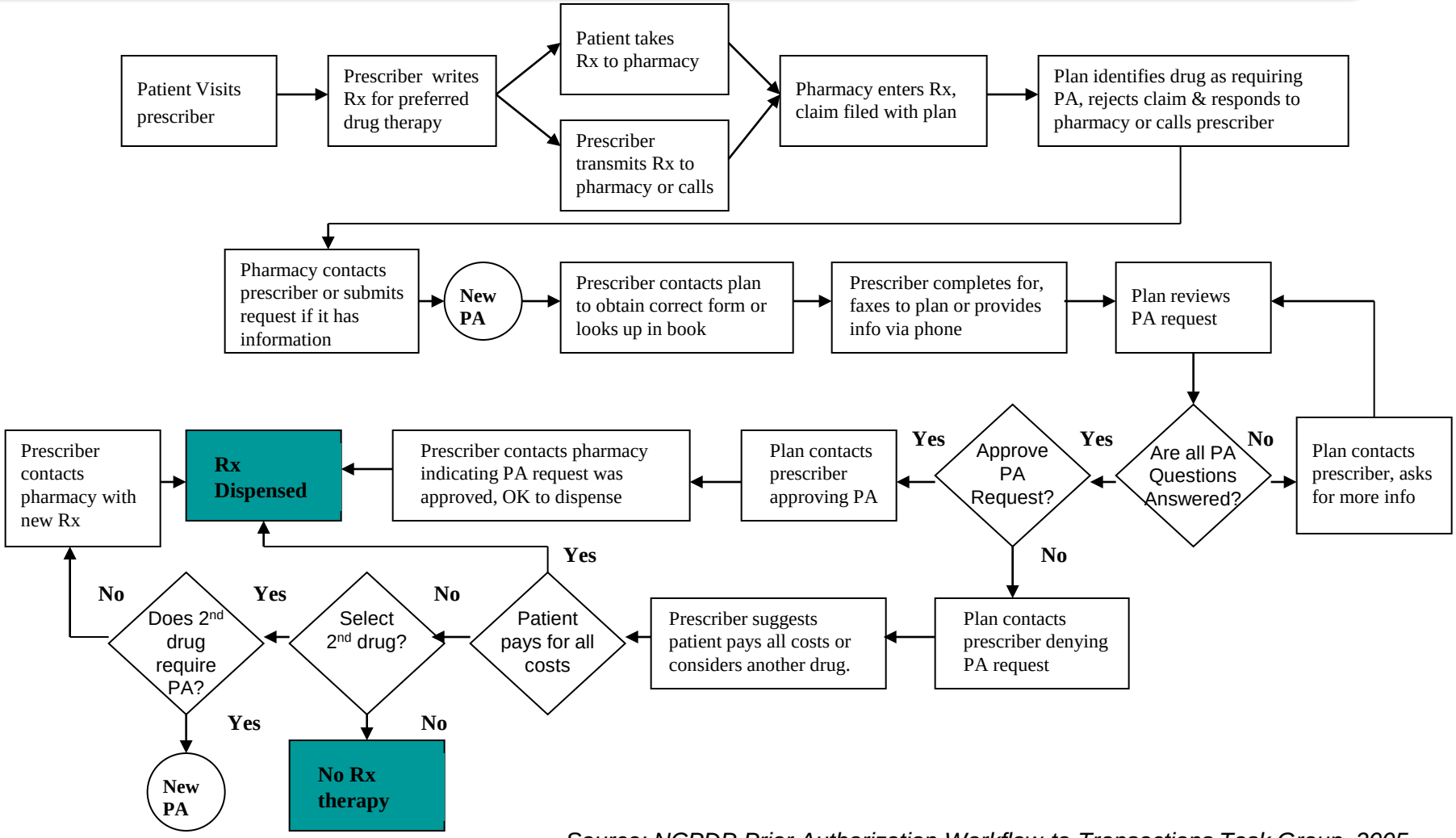
Medication Prior Authorization Today

- Today's PA is not automated, requiring the prescriber and pharmacy to determine the patient's benefit plan and identify the appropriate PA form.
- Once the form is obtained, the prescriber must fill it out and fax a paper copy to the payer, sometimes with the assistance of pharmacy facility staff.
  - Some payers have transitioned this process to one that is web-based either through direct data entry or the acceptance of the form electronically, but manual intervention is still required by the prescriber and the payer to complete the process.
- Once obtained, the payer's PA staff must review the information provided for clarity and completeness.
  - One plan estimates that 80% of PA requests require follow-up
  - Another estimates that 20% of their staff is dedicated to PA

Medication Prior Authorization Today (cont'd.)

- The payer then evaluates the request, and responds with a faxed approval or denial.
  - Evaluation is often done by non-clinical staff.
  - More complex cases may be brought to a clinician or, in some cases, a committee.
- If approved, the PA drug will be covered, and a pharmacy claim will process successfully.
  - The process can take several days to complete.

Medication Prior Authorization Today (cont'd.)



Source: NCPDP Prior Authorization Workflow-to-Transactions Task Group, 2005

Sample Form: Celebrex

- Observations
  - Organized by therapeutic category
  - Patient, physician data required should be in vendor system
  - Previous medications (med hx) required
  - Rules included on form
  - Conditions required

CONTAINS CONFIDENTIAL PATIENT INFORMATION

Celebrex (celecoxib) Prior Authorization of Benefits (PAB) Form

Complete form in its entirety and fax to:
Prior Authorization of Benefits (PAB) Center at (888) 831-2243

BlueCross of California

1. PATIENT INFORMATION

Patient Name: _____
Patient ID #: _____
Patient DOB. _____
Date of Rx: _____
Patient is: ❑ Female ❑ Male

2. PHYSICIAN INFORMATION

Prescribing Physician: _____
Physician Specialty: _____
Physician DEA#: _____
Physician Phone#: _____
Physician Fax#: _____

3. INDICATE DIAGNOSIS

Diagnosis:	❑ Osteoarthritis	❑ Rheumatoid Arthritis	❑ Primary Dysmenorrhea	❑ FAP Familial Adenomatous Polyposis
Strength:	Celebrex 200mg	Celebrex ❑ 100mg ❑ 200mg	Celebrex 200mg	Celebrex 400mg
Max Qty Limit:	30 per 30 days	60 per 30 days	11 per 30 days	60 per 30 days
	OA or RA: Must meet criteria below in 4A OR 4B OR 4C		Must be female and meet criteria below in 4A OR both 4B AND 4C	Only diagnosis required

4. APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY

Any areas that are not filled out will be considered not applicable to your patient AND MAY AFFECT THE OUTCOME OF THIS REQUEST

A. ❑ Yes ❑ No **Patient has major NSAID-induced GI complication risk factors: ONE OF THE FOLLOWING MUST BE PRESENT**

- ❑ Yes ❑ No Active non-menstrual bleeding or bleeding disorder
- ❑ Yes ❑ No Concurrent anticoagulation therapy Please note: bleeding events and increased prothrombin time have been reported in patients taking COX-II Selective NSAIDs concurrently with warfarin. INR monitoring is still necessary in COX-IIs.
- ❑ Yes ❑ No Patient has previous documented history of NSAID-induced gastropathy

B. ❑ Yes ❑ No **Patient has other NSAID-induced GI complication risk factors: TWO OR MORE OF THE FOLLOWING MUST BE PRESENT**

- ❑ Yes ❑ No Age ≥ 65 years old
- ❑ Yes ❑ No Chronic major organ impairment _____ (please specify) or active Rheumatoid Arthritis
- ❑ Yes ❑ No Concomitant chronic systemic corticosteroid therapy
- ❑ Yes ❑ No Chronic high-dose NSAID therapy (e.g. 2-3 times the standard dose to achieve therapeutic effect)
- ❑ Yes ❑ No Anti-platelet agents for vascular prophylaxis

C. ❑ Yes ❑ No **Patient has documented trial and failure of 2 or more prescription-strength NSAIDs (Must specify trials below)**

NSAID #1: _____ NSAID #2: _____

5. PHYSICIAN SIGNATURE

_____ _____
Prescriber or Authorized Signature Date

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician, only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions.

IMPORTANT WARNING: This message is intended for the use of the person or entity to which it is addressed and may contain information that is privileged and confidential, the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient, or the employee or agent

8.5 x 11 in

Sample Form: Growth Hormones

- Add'l Observations
  - Laboratory test results required
  - Data that might be in EMR requested

BlueCross of California

CONTAINS CONFIDENTIAL PATIENT INFORMATION

Growth Hormone Prior Authorization of Benefits (PAB) Form

Complete form in its entirety and fax to:
Prior Authorization of Benefits Center at (888) 723-5479

1. PATIENT INFORMATION

Patient Name: _____
Patient ID #: _____
Patient DOB: _____
Date of Rx: _____

2. PHYSICIAN INFORMATION

Prescribing Physician: _____
Physician Specialty: _____
Physician DEA#: _____
Physician Phone#: _____
Physician Fax#: _____

3. MEDICATION REQUESTED (Maximum quantity limit allowed: 28 injections per 28 days)

☐ Genotropin ☐ Humatrope ☐ Nutropin, Nutropin AQ ☐ Serostim ☐ Tev-Tropin
☐ Geref ☐ Norditropin ☐ Protropin ☐ Saizen ☐ Zorbtive

4. DIAGNOSIS

☐ Short Stature ☐ Prader-Willi Syndrome ☐ Short Bowel Syndrome
☐ HIV Wasting Syndome ☐ Panhypopituitarism ☐ Turner's Syndrome
☐ Idiopathic Growth Hormone Deficiency
☐ Other (please specify): _____

5. PROVIDE THE FOLLOWING INFORMATION AS APPROPRIATE Please note: Any areas that are not filled out will be considered not applicable to your patient AND MAY AFFECT THE OUTCOME OF THIS REQUEST

	List **and attach** copy of Growth Hormone Stimulation Test Results **and** Reagents Used	
Date:		
Patient's Height:	Reagent 1:	Reagent 2:
Patient's Bone Age:	Results #1:	Results #1:
Patient's Chronological Age:	Results #2:	Results #2:
Growth Velocity:	Results #3:	Results #3:
IGF-1 Results:	Results #4:	Results #4:
	Results #5:	Results #5:

6. PHYSICIAN SIGNATURE

_____ _____
Prescriber or Authorized Signature Date

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician, only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions.

Industry Analysis (NSAIDs/Cox2s)

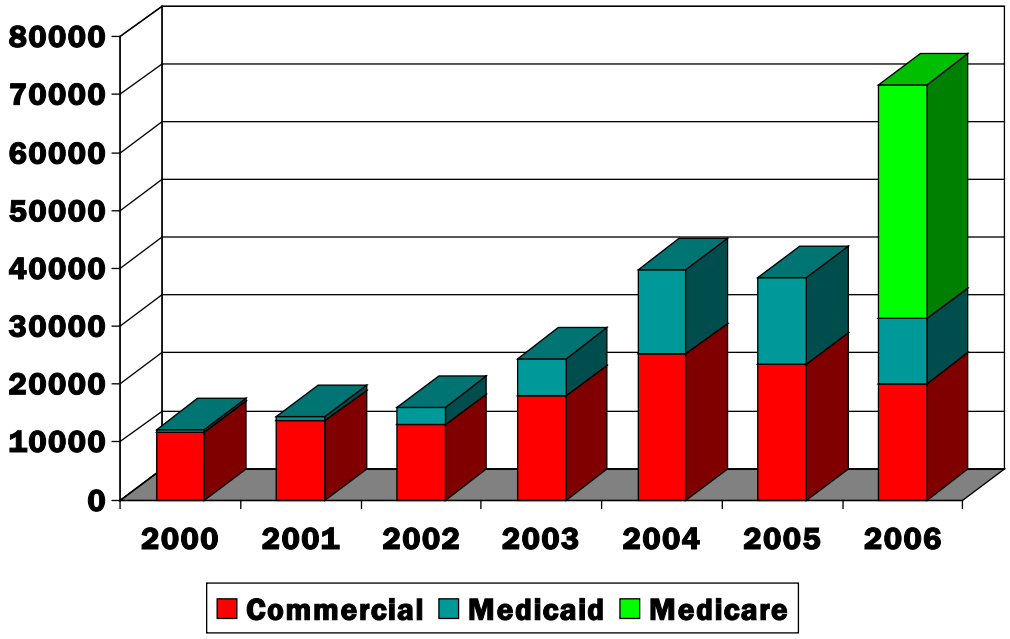
Criteria varies by plan, wording non-standard

Drug/Criteria	Health Plan A	Health Plan B	Health Plan C	Health Plan D	Health Plan E	Health Plan F	Health Plan G
NSAIAs							
[Celebrex, Bextra] - COX2 Inhibitors							
Drug			*N/A*				
Strength	●	●		●	●	●	●
Dose	●	●		●	●	●	●
Diagnosis	●	●		●	●	●	●
Expected duration	●	●		●	●	●	●
Previous therapy and dates	●	●		●	●	●	●
Response to previous therapy (inadequate response, adverse effects, comments)	●			●		●	●
Pt age: 65 or older				●	●	●	●
Pt has documented Hx of ulcer disease or prior evidence of GI hemorrhage (ICD-9 if available)	●					●	●
Pt has concurrent use of corticosteroids		●			●	●	●
Pt has concurrent use of anticoagulants or antiplatelets (Ticlid, Aggrenox, Plavix)	●	●		●	●	●	
Pt has concurrent use of NSAIDs	●	●		●	●	●	
Pt has anti-ulcer agent (H.Pylori eradication agents) - Helidac or Prevpac		●					
Pt requires NSAID use > 21 days (list drug and dose)	●						
Pt previously unable to tolerate 2 different NSAIDs	●					●	●
Shrt-trm Tx (<21d) hi-risk pts NSAID induced adv GI event w/2 different	●				●		
Shrt-trm Tx (<21d) hi-risk pt anticoag, antiplatelet, chronic oral corticosteroid	●						
Hx of PUD, NSAID-related ulcer or clinically significant GI bleed	●					●	●
Pt has hereditary or acquired coagulation defect (eg: hemophilia or Von Willebrand's, protein C or S deficiency, thrombocytopenia or chronic renal failure)	●			●			
Celebrex coverage for reducing number of adenomatous colorectal polyps in pts w/Familial Adenomatous Polyposis (FAP)	●						●
Coverage not provided for prevention of cancer, prev or tx of Alzheimer's or in presence of ASA >325 mg/day	●						
Benefit approval duration: 12 months (grandfather existing users)	●						

Source: NCPDP Prior Authorization Workflow-to-Transactions Task Group, 2005

Growth in PA (2000 – 06)

- Advances in MTM, biotechnology, designer drugs, specialty pharmacy, and the cost of the pharmacy benefit, has increased the number of PA'd medications
- From 2000 to 2006, *commercial* plans doubled the number of medications requiring PA.
- Among *Medicaid* programs, the number increased steadily.
- But the most dramatic impact was in *Medicare* Part D plans that designated more than 40K drugs as requiring PA



Source: MediMedia analysis of formulary database, October 2006

In Summary: The Problem

- Patient hassle and treatment delay
  - No one knows the drug requires PA until patient has already left prescriber's office
  - Treatment might be delayed for days
- Pharmacy hassle
  - Pharmacy must call prescriber's office, and sometimes the plan
- Prescriber hassle and disruption
  - Gets called back from pharmacy, must call plan, wait for faxed form, completes form and sends it back
  - Turnaround time can be 48 hours or more
- Health plan inefficiency
  - Expensive and labor intensive process that creates animosity

Is Investing in ePA worth it?: Key Dimensions of Value

- Streamline a multi-step process that is presently disjointed and labor-intensive
  - As medication management (e.g. electronic prescribing) becomes increasingly automated in doctors' offices and pharmacies, PA moves even further outside the workflow, exacerbating an already inefficient process
- Improve quality and safety
  - Prescribers' reluctance to endure PA process and delays in filling patient prescriptions may have undesirable affect of compromising clinical quality and patient safety (the "sentinel effect")
- Contain costs
  - Increase productivity of doctors, pharmacists and their support staff; also call center staff of Health plans and PBMs reduces admin. costs
  - However, reduction in drug utilization costs ***using ePA compared to traditional, forms-based PA*** is unclear

Bottom Line: ePA promotes the prescribing of the right drug for the patient for the right reason *at the right time*

Shared Value of ePA

Prescriber

↓ Calls from Pharmacies

↓ Calls to/from Health Plans & PBMs

Pharmacy

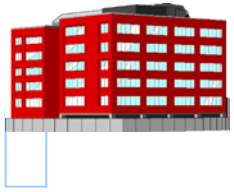
↓ Calls to Doctors

Streamlined Process with ePA

Consumer

↓ Walk-aways without filled Rx

Health Plan & PBM



↓ Calls to/from Doctors & Pharmacies

Strategic focus on enhancing Productivity & Customer service will yield the most traction during early stages of the ePA life cycle

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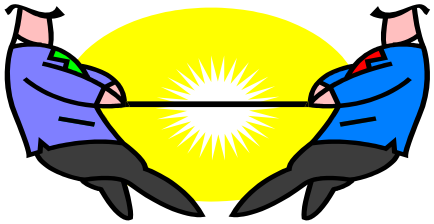
Potential Sources of Tension with ePA

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 to PA may generate a higher volume of PA approvals and have the unintended effect of increasing utilization of drugs requiring PA

Doctors

- Same set of rules and data requirements across health plans
- Make prescription process for drugs requiring PA easier and less time consuming

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Conclusions

- Doctors, Health Plans, and possibly PBMs are the principal beneficiaries of electronic Prior Authorization
  - Streamlining the PA process with an electronic transaction integrated into ePrescribing has the potential for delivering a concrete and compelling ROI based on reduced calls and interruptions
    - Economic impact to Health Plans and PBMs of reduced administrative costs will likely be significant
- Impact of ePA on drug utilization and compliance with clinical guidelines is unclear
  - Higher volumes of PA requests may result in increased drug utilization and improved quality and safety
  - A rise in near-term drug costs along with a reduction in medical costs is a plausible scenario

- Bottom line: New benefits emerge when migrating from traditional PA to ePA, creating a new set of business dynamics that are not well understood

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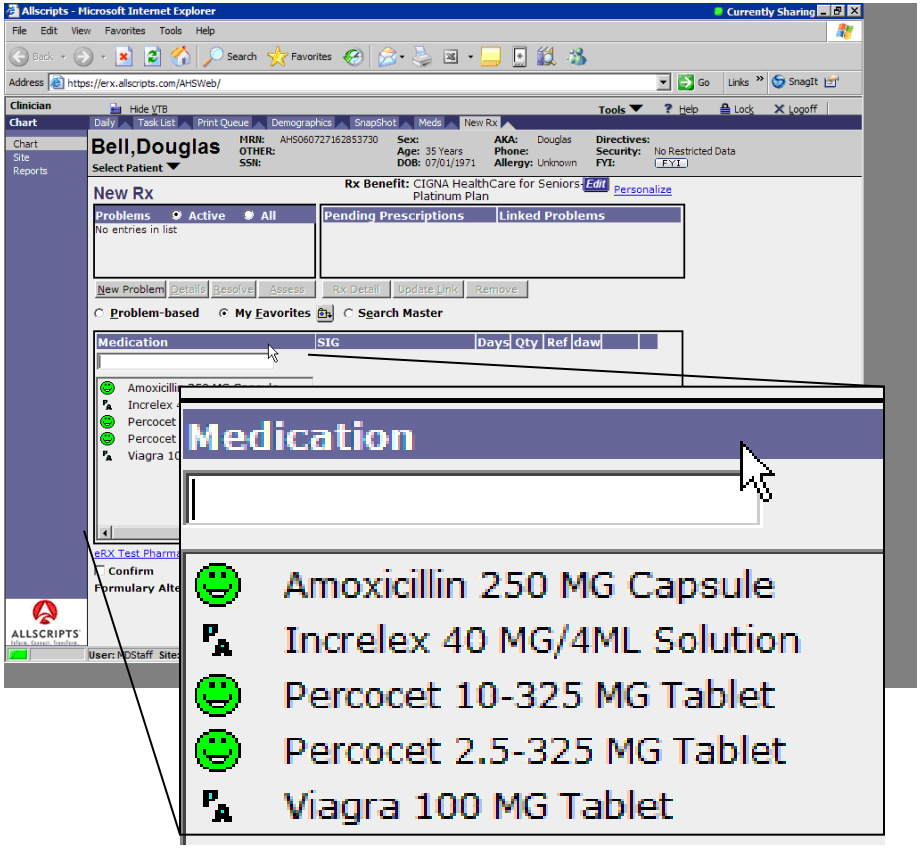
- Introductions
- ePA Overview
- **Historical/Current Status**
- Options/Comments

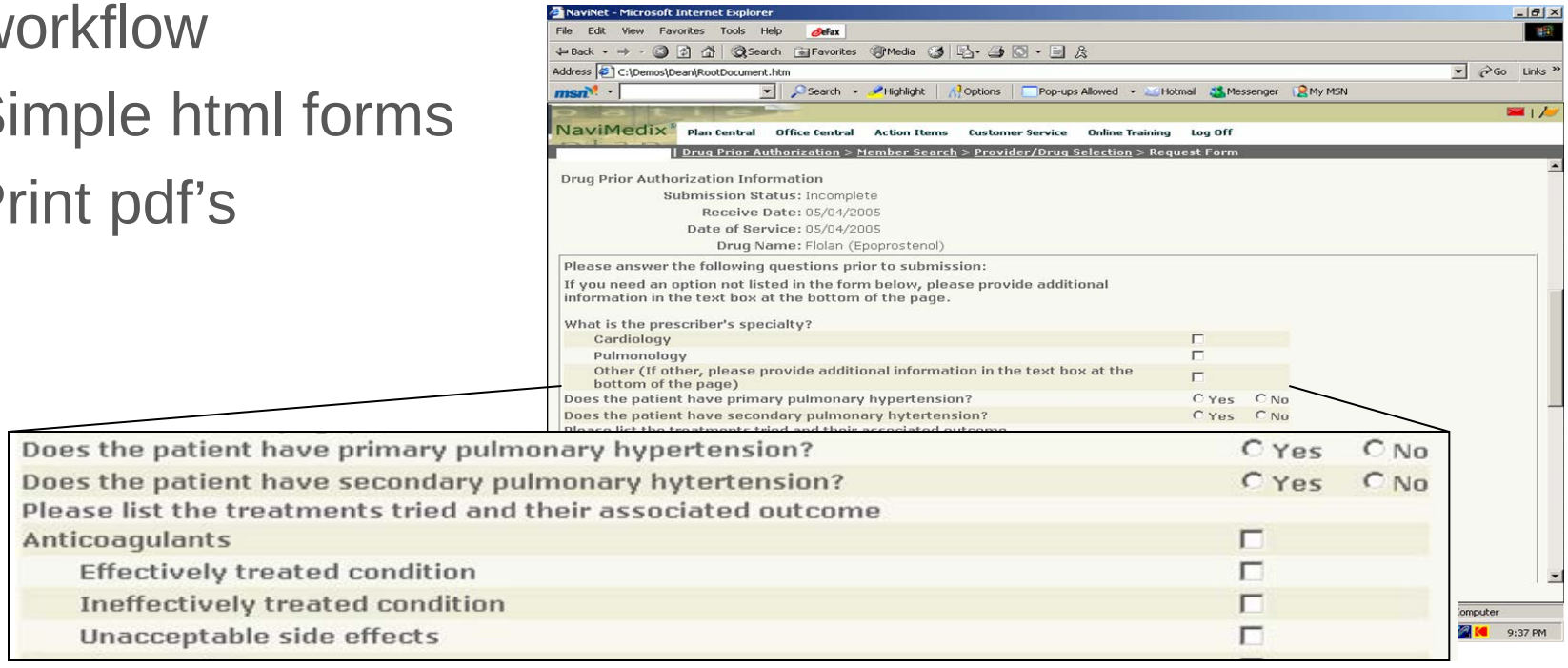
Component of Formulary Database

- For years, formulary aggregators (RxHub, MediMedia, Epocrates) have provided a PA flag
- ePrescribing, EMR companies use it to alert prescribers
- Vendors use different, symbols
- Some PBMs don't supply this data
- Sometimes data is at the group level



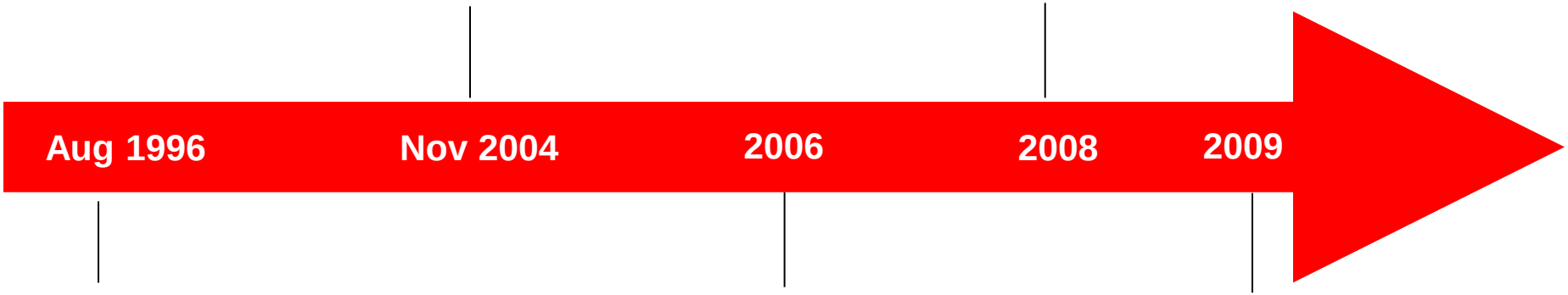
Custom, Non-Standard Solutions

- There are solution providers who have created custom, non-standard solutions for health plans
- Less than optimally effective because not in prescribing workflow
- Simple html forms
- Print pdf's



Electronic prior authorization timeline

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.



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

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

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

CMS/AHRQ pushes forward
- Resolution of where standard should reside
- Value model created

New Standard Created
- Housed in NCPDP
- Compatible with emerging technology
- Needs to be pilot tested

CVS Caremark Pilot

- ePA pilot allows the proivider to electronically request PA question set, return answers to CVS Caremark and receive a real-time response
- Flexible solutions deliver access through prescribers' and payers' preferred channel
  - ePA integrated into ePrescribing applications for prescribers using an ePrescribing or EHR
  - Portal solution available to provide prescribers single sign-on access from a client portal or direct access
- ePA launch 1/1/2012 with select group of vendors
- CVS Caremark is developing transactions using Surescripts platform
  - Pilot to prove value of ePA and move to industry as a new standard
  - Solution provides scalability to support ePA through any point-of-care tool

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Options/Comments

Options	Comments
1. Do nothing	One initiative has finally begun so there is some progress
2. Lobby CMS/AHRQ to allocate grant money for additional research - Leverage previous research, experience	Research could ensure that needs of all stakeholders taken into account and value to all quantified
3. Lead effort to form your own coalition to fund pilot or research - Multiple potential funding sources	Complex project would require experienced coordination and commitment; focus may be on different element of ePA
4. Encourage key stakeholders to take this on themselves - e.g. payers or intermediary	Important to be satisfied with the level of physician input
5. Other???	

The End

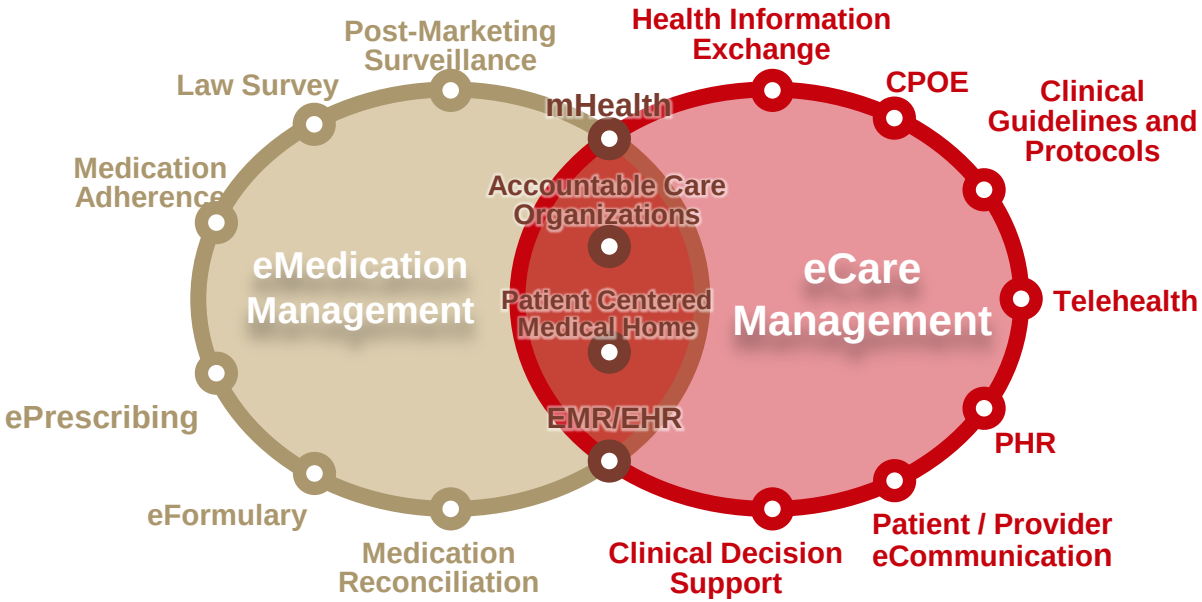

POINT-OF-CARE PARTNERS
HIT Strategy & Management Consultants

Appendix

POINT-OF-CARE PARTNERS
HIT Strategy & Management Consultants

Point-of-Care Partners' Practice Domains

- **Point-of-Care Partners (POCP)** is a health information technology (HIT) strategy and management consulting firm with two active practices: (1) eMedication Management and 2) eCare Management



- **POCP's standard areas of engagement** include:
  - ⇨ Business / Product Strategy
  - ⇨ Program Management
  - ⇨ Product Development
  - ⇨ Market Intelligence
  - ⇨ Business Development / Strategic Alliances
  - ⇨ Marketing

POCP Clients

- **POCP's clients** are a who's who of HIT Stakeholders, representing key areas of HIT. A partial list of clients include:

Pharmaceutical Manufacturers
- AstraZeneca
- Boehringer Ingelheim
- PhRMA
- *Five others, representing 7 of the top 15*

Providers
- American Medical Association
- Henry Ford Medical Group

Government
- Department of Defense (DoD)
- Centers for Medicare and Medicaid Services (CMS)
- Vermont Information Technology Leaders
- National Library Of Medicine (NLM)

Technology Companies
- AthenaHealth
- Allscripts
- Epocrates
- MedPlus

Employers
- General Motors
- Ford

Health Plans
- Cigna
- Blue Cross Blue Shield of Florida
- BlueCross Blue Shield of Michigan

PBMs
- Medco
- CVS Caremark

Connectivity Companies
- Availity
- eRx Network, an Emdeon company

> ***"It's not just about us. It's about understanding marketplace dynamics, which are constantly being shaped by events and key stakeholders. In working with those company's leaders, POCP gets to understand their motivations and aspirations in a profound way."***
>
> POCP client, July 2009

Multi-SDO Task Group

Founded	November 18, 2004 (NCPDP Fall Workgroup Meeting)
Objectives	• Promote standardized automated adjudication of prior authorization • Coordinate the further development and alignment of standards • Identify additional needed standards
Organizations Participating	Standards Development Organizations: NCPDP, X12, HL7 Health Plans/PBMs: Wellpoint, HealthNet, Excellus BCBS, BCBSMA, Express Scripts, Caremark, Medco, Argus, Prime Therapeutics Physicians/Providers: AAFP, Lifespan Others: Achieve (long-term care); Pfizer; Dr. First; ZixCorp; Allscripts
Task Group Leader	Tony Schueth, Managing Partner, Point-of-Care Partners, LLC

ePA-Related Standards (2005)

PATIENT

Visits Physician

Drugs can be identified as requiring PA via *NCPDP Formulary & Benefit Standard*

PAYER

- Determines PA Status, Criteria
- Processes PA Requests
- Processes Drug Claims

Required Patient Information can be submitted via *X12N-278*

Drug Claims are Submitted via *NCPDP Telecommunication*

PRESCRIBER

- Writes Prescription
- Submits PA Request
- Transmits Prescription

Prescriptions are submitted *via* *NCPDP SCRIPT*

PHARMACY

- Dispense Drugs
- Files Drug Claims

Solicited model *= eRx software makes request, payer id's criteria and responds; 2nd request is made*

Unsolicited model *= eRx software provides criteria/form and request is made to payer*

Straw Model

PATIENT

Visits Physician

Drugs can be identified as requiring PA via *NCPDP Formulary & Benefit Standard*

PAYER

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

Submit Required Patient Information *via* *X12N-278*

Transmission of Clinical data

(HL7 PA Attachment)

Drug Claims are Submitted via *NCPDP Telecommunication*

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 letters = gaps in existing standards

Value Model: Health Plans & PBMs

Value Proposition	Measures
Streamline authorization process and reduce administrative costs	1) Volume of calls to call center for PA 2) Percentage of PA requests requiring follow-up with doctors and/or patients
Reduce drug spend	1) Volume & cost of drugs having less expensive, equally effective substitutes 2) Volume & cost of equally effective drugs compared to more expensive brands
Improve drug utilization controls	1) Volume of drugs prescribed for inappropriate uses (e.g. low-risk patients where other drugs are just as effective). 2) Volume of drugs targeted for overuse
Improve quality by increasing propensity of prescribing the clinically appropriate drug	Clinician compliance with quality criteria for clinically appropriate medication therapies
Improve member satisfaction	1) Member/patient return visits to the pharmacy due to PA requirement 2) Delay (in days) of prescription fill due to PA requirement

Highest impact

Less but still significant impact

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ePA Value Prop: Health Plans & PBMs

- "Sweet spot" for realizing value with ePA is labor cost savings associated with a reduction in follow-up communications and disruptions in workflow
  - $10 -- $25 cost associated with each PA request to a health plan or PBM is a big target for potential cost reduction with ePA (Carroll et al., 2006)
  - Unclear what impact, if any, ePA would have on the volume of authorizations requested
  - Well-designed ePA application can be a platform for consistently capturing a comprehensive profile of clinical data necessary to accurately and promptly evaluate patients for drugs requiring authorization
    - A structured application prompts the clinician for information needed and does not accept the PA request unless all required data is entered
- Additional source of value may be in promoting clinically appropriate prescribing and discouraging overuse of particular drugs
  - Primary care physicians report being discouraged from prescribing the most appropriate medication because of PA requirements (PDR.net, 2004)

ePA Value Prop: Health Plans & PBMs

- Change in drug utilization and costs when using ePA instead of traditional (i.e. forms-based) PA methods is unknown
  - The same dynamic leading to more clinically appropriate prescribing (eliminating reasons prescribers avoid drugs requiring PA) may actually result in more PA requests and therefore authorizations
  - Perceived risk of ePA increasing rather than decreasing utilization of medications requiring authorization (ESI, 2004)
  - However, this may be offset by the inherent "sentinel effect" of reduced utilization when doctors know PA is required (Kahan et al., 2006)
    - - Is the "sentinel effect" as pronounced when ePA is in place? An important question for ePA pilot studies to answer
  - PA approval rates are high for certain drugs (Edlin, 2005); Savings realized primarily when a large low-risk population exists (Carroll, 2006)

ePA Value Prop: Health Plans & PBMs

Bottom Line

- Potential for concrete ROI in two specific areas:
  - 1) Reduce follow-up required due to authorization requests containing errors or incomplete information
  - 2) Eliminate labor for manual data entry of PA request into payer computer systems
- Use of ePA may also be a factor in producing better clinical outcomes
  - Higher compliance of doctors with clinical guidelines by prescribing the most appropriate drug regardless of whether PA is required
  - Proactive and interactive communication of PA rules and clinical guidelines to doctors as an integral component of the prescription writing process
- ePA may produce the unintended consequence of higher volumes of prior authorization requests and approvals relative to traditional forms-based PA processes

Value Model: Doctors

Value Proposition	Measures
Simplify the administrative process.	Number of steps in prior authorization review process
Make prescribing of appropriate drugs easier and less time-consuming when prior authorization is required.	1) Avg. time spent by doctor and support staff to complete the prior auth. process 2) Number of call-backs to the doctor's office for additional information
Standardize prior authorization procedures	Variation in prior auth. approval criteria and data requirements among payers
Reduce the frequency of denials	Frequency of denials because approval criteria not met
Facilitate staying current with the latest payer prior authorization rules	Frequency of denials because of outdated prior authorization procedures or approval criteria
Improve quality and safety by increasing propensity of prescribing the clinically appropriate drug	Frequency of avoidance of most clinically appropriate drugs because of PA requirements

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ePA Value Proposition: Doctors

- ePA may mitigate Doctors' negative perceptions of Health Plans' prior authorization policies
- "Sweet spot" for ePA is reducing administrative burden to doctors and their support staff
  - Opportunity to improve health plan – doctor relations
  - ePA is a vehicle for more timely and accessible communication of new and changed PA rules, education, clinical trials, etc.
- Doctors' desire for consistent PA rules across health plans will most likely encounter resistance from health plans and PBMs
  - Health Plans & PBMs want to reflect the particulars of the assessment by their clinical teams in the approval criteria (Source: POCP on MMA pilots, 2007)
- Presentation of approval criteria in the context of the patient's problem could have educational value (NJEPAC, 2007)
  - ePA application could serve as a vehicle for delivering evidence-based information to clinicians, e.g. drug protocols for particular diseases
  - Not perceived as a significant area of value today, but has potential as ePA applications are developed

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ePA Value Proposition: Doctors

<u>Bottom Line:</u> Doctors' central role in the prescription process requires their participation in PA process improvement efforts. Easing the administrative burden by reducing the complexity and number of steps involved is the main attractor of ePA to doctors

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Value Model: Pharmacies

Value Proposition	Measures
Streamline and accelerate the authorization process between prescriber, health plan and/or PBM	Number of prescriptions placed in a “hold” status due to lack of proper PA
Reduce doctor callbacks due to lack of prior authorization	Frequency of calls to doctor offices requesting submission of PA to health plan
Reduce the frequency of denials	Frequency of denials because approval criteria not met
Reduce returns to inventory	Frequency of inventory returns due to PA denials and Rx. changes
Enable patient to receive medications when needed	Time elapsed between initial filing of prescription claim and PA approval

ePA Value Proposition: Pharmacies

- Primary benefit to pharmacists of ePA is a reduction of calls to doctors' offices informing them of need to submit (or re-submit) PA request to Health plan or PBM
- Drugs requiring PA represent a small but growing proportion of all prescriptions (NJEPAC, 2007)
- ePA will have a minor but positive effect on improving Pharmacy workflow for processing eRx transactions in general

Bottom Line: Value of ePA to Pharmacies relative to Healthplans, PBMs, and Doctors is less significant and should be viewed as a collateral benefit from investing in ePA for these other stakeholders

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Value Model: Consumers

	Value Proposition	Measures
?	Mitigate non-compliance events caused by patient walk-aways when PA is required but incomplete	Ratio of prescriptions to prescriptions filled/paid
?	Reduce risks to health from delays in receiving prescriptions requiring prior authorization	Time elapsed between PA request and prescription fill
?	Improve effectiveness of treatment regimen by using the clinically appropriate drug	Appropriate intermediate and clinical outcome measures
?	Avoid unexpected out-of-pocket costs associated with drugs not properly authorized	Member/patient out-of-pocket costs associated with denied authorizations
?	Improve patient experience with the healthcare system	Number of time patients must leave pharmacy without their prescription because of PA

? – Relative importance of value propositions is unknown;
Requires Voice of the Consumer research

ePA Value Proposition: Consumers

- Value of ePA to consumer benefits Healthplans and Doctors
  - Improves the care experience, which is increasingly important as consumers assume more control of health insurance and healthcare choices
- Demonstrating ePA value in terms of improving quality and safety depends on obtaining empirical evidence that doctors' avoidance of drugs requiring PA is a significant factor influenced by ePA

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Possible Baseline Benchmarks (for future research)

Study	Benchmark
Bell et al. (2007) Rand & Horizon BCBS study	Provider estimates of time spent on PA: 36 minutes (Doctor: 13 minutes; Staff: 23 minutes) Workflow Simulation Model assumptions: - Time consumed to complete authorization using ePA within ePrescribing is 50% of traditional methods
Carroll et al. (2006) ACS Heritage study	Changes in number of prescriptions and dollar expenditures for COX-2 inhibitors of control group (no PA) significantly higher than intervention group (ePA) Estimated a significant reduction of calls with use of ePA
NJEPAC (2007)	Time elapsed between PA request and approval: 48 – 72 hours Provider estimates of time spent on PA: 40 minutes (Doctor: 11 minutes; Staff: 29 minutes) Number of steps in PA process: 5 steps

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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

Health Plan Perspective

- Findings from survey of AMCP pharmacy directors, 92% of whom manage PA (2004 POCP n=25)
  - 96% support automation of prior authorization to:
    - Increase clinically appropriate prescribing (76%)
    - Decrease administrative costs (76%)
    - Increase member satisfaction (40%)
  - 84% expected no/small increase in PA'd drugs as a result
  - Just 44% believed the drugs requiring PA would ↑
  - Barriers to automating prior authorization:
    - Lack of physician office technology (88%)
    - Lack of electronic standards (84%)
    - Lack of PBM business model (60%)
    - Organizational buy-in (24%), Insufficient ROI (36%)

Other Perspectives

- “We recommend that there be standards associated with requests or authorization codes” (Medco executive, NCVHS, July 29, 2004)
  - “What’s (complicated) is the discussion on how to qualify the Rx”
- “The crafters of the MMA took care to insist the ePre-scribing pose no undue burden on physicians, but current transactions do little to address some areas where physicians feel the greatest administrative burden (e.g. PA).” (Pfizer exec, NCVHS testimony, July 29, 2004)
- “Automating processes like PA is what computers were designed for.” (MediMedia exec, NCVHS testimony, Aug 22, 2004)