[F5] Leveraging Technology for Patient-Level Formulary & Benefit Information at the Point of Care

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LEARNING OBJECTIVES

- Describe the landscape of formulary & benefit (F&B) and real-time benefit inquiry.
- Discuss the outcomes observed from a real world implementation of point of providing formulary, benefit and out-of-pocket cost information at the point of prescribing.
- Discuss strategies payers can employ to facilitate the communication of patient-level F&B at the point-of-care.
- Describe lessons learned and best practices in implementing a point of prescribing integration initiative.

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Financial Relationship Disclosures

- Michael J. Anderson is an employee and shareholder with United Health Group.
- Kimberly Hansen is an employee and shareholder with United Health Group.
- Anthony Schueth is an employee of Point-of-Care Partner.

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PRE-TEST

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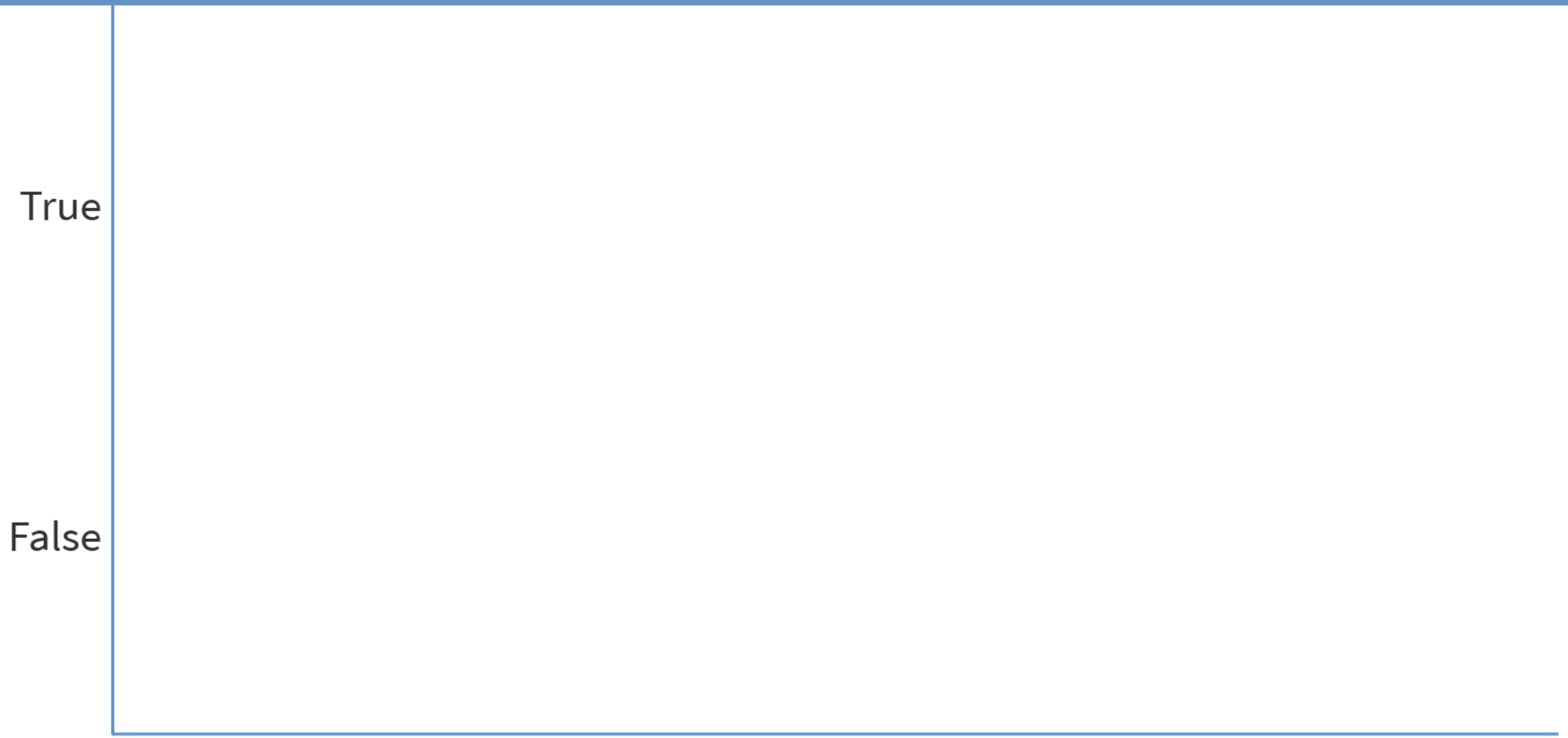
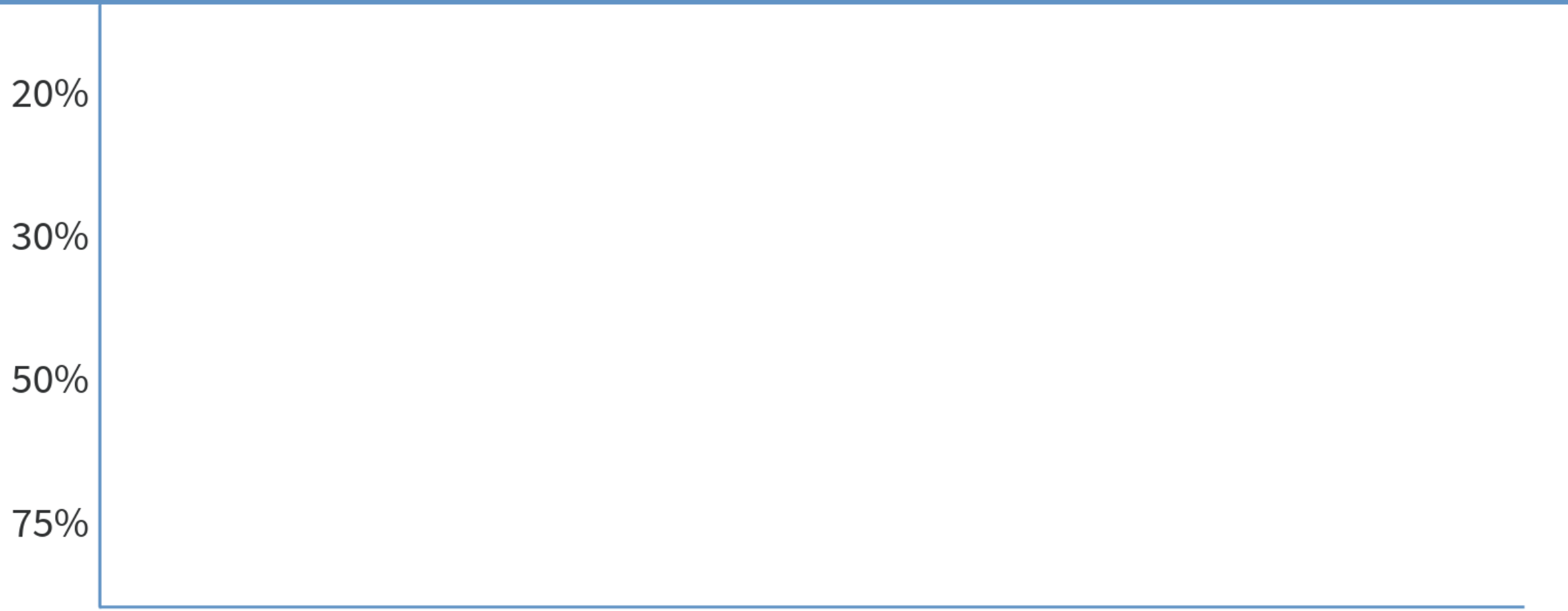
LQ1: Real-Time Benefit Check is intended as a replacement for formulary & benefits.



LQ2: Prior to implementing real-time benefit check, what percentage of UHG's Help Desk calls were due to pharmacy claims rejections from PA Required/not known until claim rejection and Drug is Non-Formulary/not known until claim rejection?



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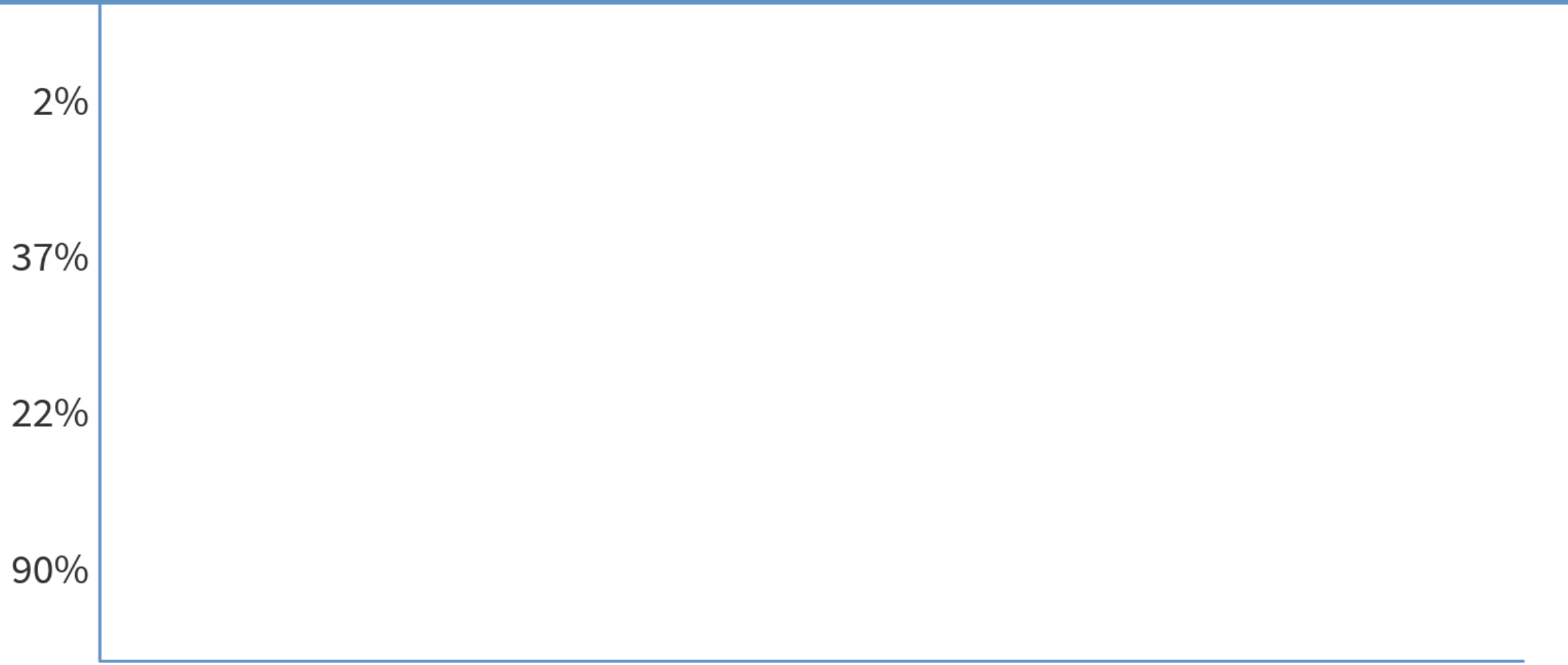
LQ3: In the first 120 days, what percentage of prescribing decisions were influenced by UHG's real-time benefit check point-of-prescribing initiative?



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LQ4: Which of the following were lessons learned from UHG's real-time benefit check point-of-prescribing initiative?

When poll is active, respond at **PollEv.com/amcp3** Text **AMCP3** to **22333** once to join

Establish EMR Technical Readiness at the onset of the initiative/before assigning resources

User Interface is a critical component

Business segment customization is time-consuming

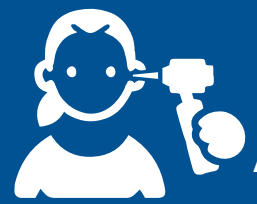
All of above

Real-Time Benefit Check: Background & Drivers

Eligibility-Informed Formulary Information Flow

Current Workflow

Links an eligibility response with downloaded formulary data files



Appointment

270: Eligibility Request

- First Name
- Last Name
- Gender
- Birth Date
- ZIP Code

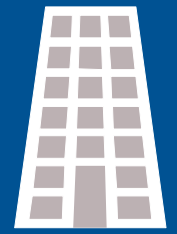
271: Eligibility Response

- Formulary List ID
- Coverage List ID
- Copay List ID
- Alternatives List ID

Intermediary

Formulary & Benefit Data

Plan Membership



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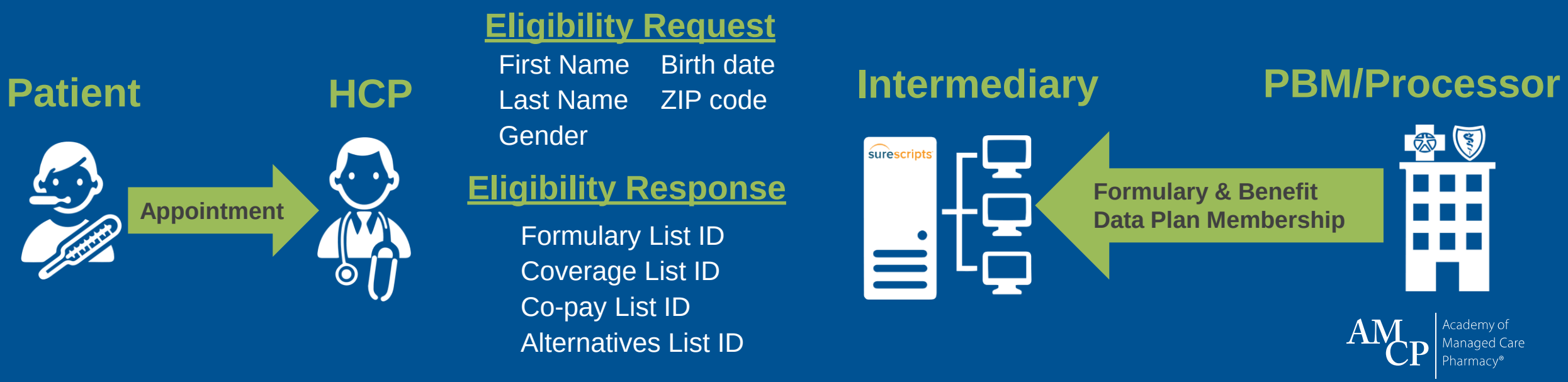
Deficiencies in Eligibility-Informed Formulary & Benefits

Challenges with accuracy of current Formulary & Benefit data led to a search for a better solution

- Formulary data is based on “Plan-” or “Group”-level; not patient specific
- Prior Authorization flag often missing or inaccurate
- Formulary tier/preferred level often not accurately displayed for HCP
- Issue is payer providing the data, not the standard



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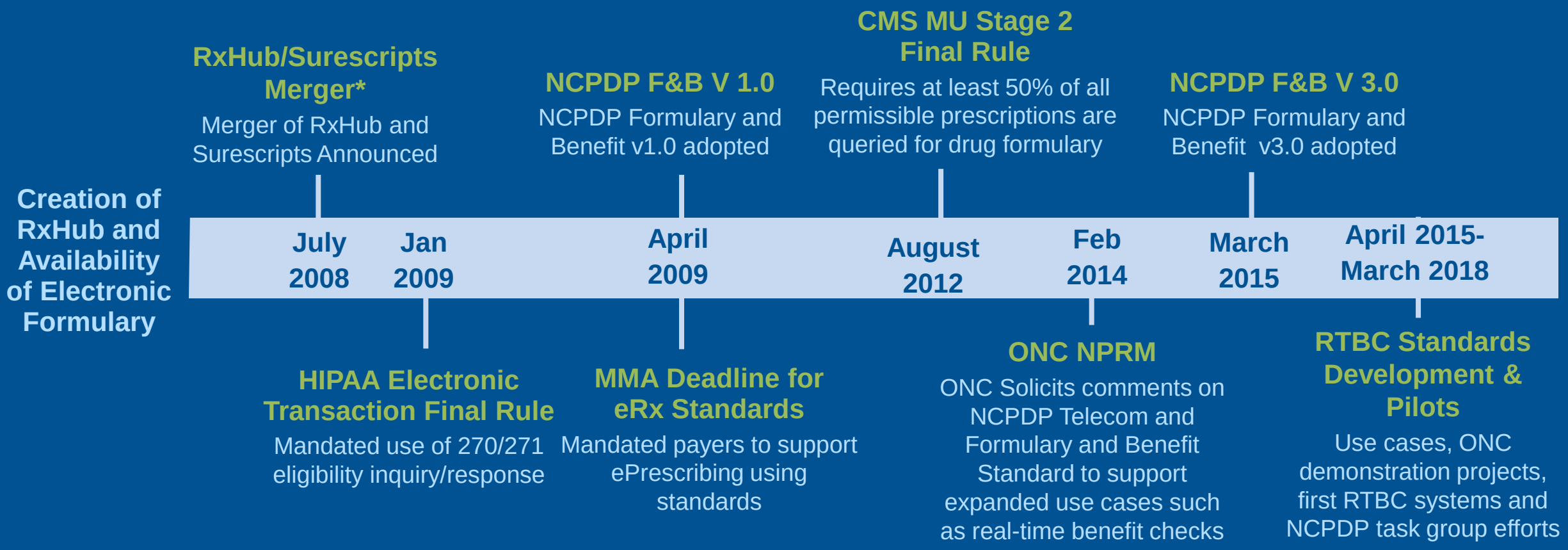
Formulary & Benefits/Real-Time Benefit Check (RTBC) Timeline



1. The merger of RxHub and Surescripts was a major catalyst in connecting patient identities with a specific formulary
2. NCPDP developed a standard format in which PBMS/payers should send formulary data to EHRs
3. Government regulations helped to push along mandatory use of electronic formulary data by physician practices
4. ONC NPRM released in Feb 2014 was the catalyst for NCPDP efforts around RTBI and subsequent demonstration projects.

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RTBC Provides Patient Specific Benefit Information

Real-Time Benefit Check (RTBC) provides **patient specific** benefit information, improving transparency and ensuring accurate display of tier/preferred information to health care professionals (HCPs)

Formulary status	**Tier or Preferred Level**
Coverage alerts	**Age & Quantity Limits, Prior Authorization (PA), Step Therapy**
Channel options	**Retail, Mail Order, Specialty**
Member Price	**Member Copay and Cost Sharing Details**
Alternative drugs	**Preferred Formulary/ Lower Cost Options**

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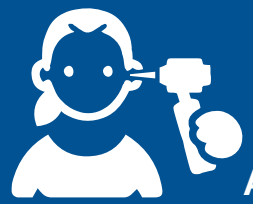
RTBC-Informed Formulary Information Flow

RTBC Workflow

Enables a prescriber to send a real-time inquiry directly to the PBM/ Payer for a patient's prescription coverage information.

PATIENT



Appointment

HCP
Using EHR

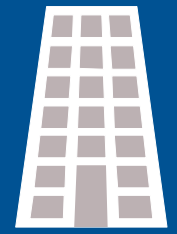
RTBC Request

- Last Name
- Gender
- Birth Date
- ZIP Code
- Prescription Info

RTBC Response

- Coverage
- Copay
- Alternatives

PBM/ PROCESSOR



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Real-Time Benefit Check (RTBC) – Why, How, When

- Real Time Benefit Check (RTBC) solves data issues surrounding formulary and benefit information including:
  - Inaccurate display of preferred status and tier level
  - PA indicator missing or incorrect
  - Benefit information at plan, not patient level

- RTBC data pulled in real-time and direct from payer
  - Provides for more detailed benefit information at patient level
- Formulary and Benefit files will not be replaced
  - Provides “directional” guidance during the initial prescription decision
    - On/Off Formulary -> Formulary Status
    - Tier Level - > Copay Tier, Dollar or Percentage Co-pay
    - PA required
- Can help determine if a RTBC is even necessary

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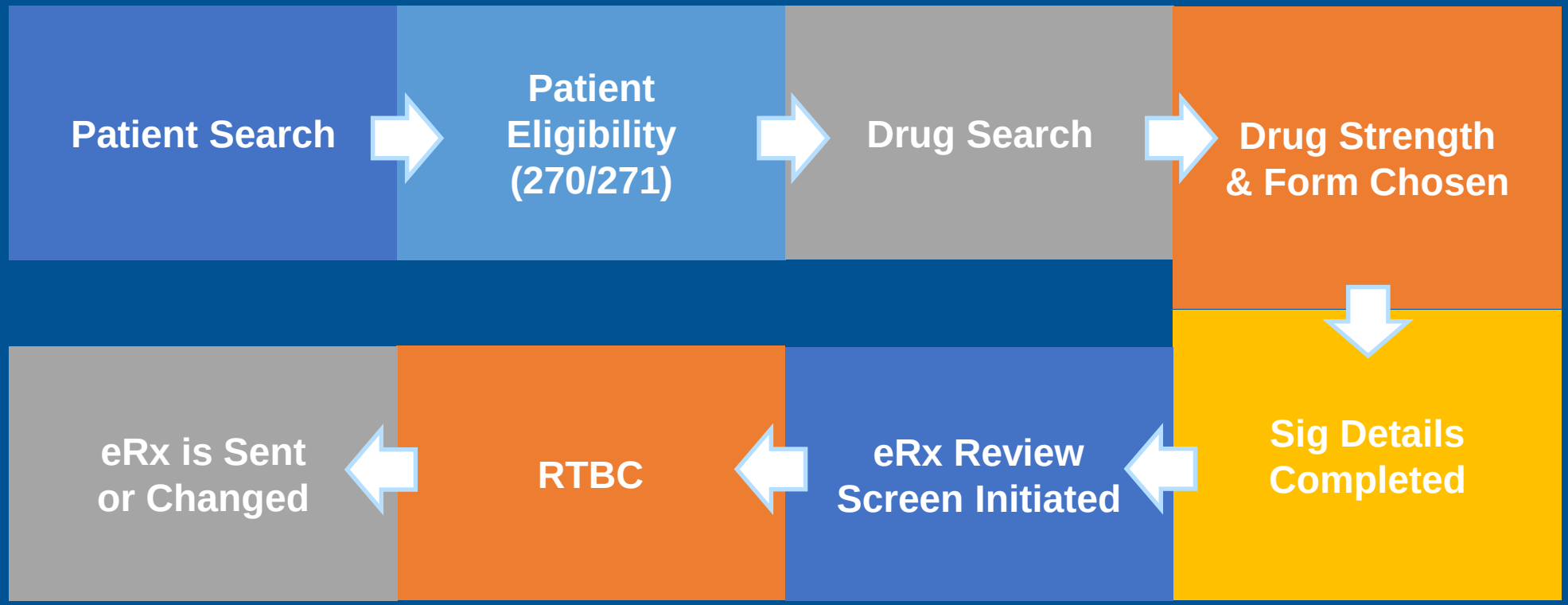
RTBC in e-Prescribing Workflow



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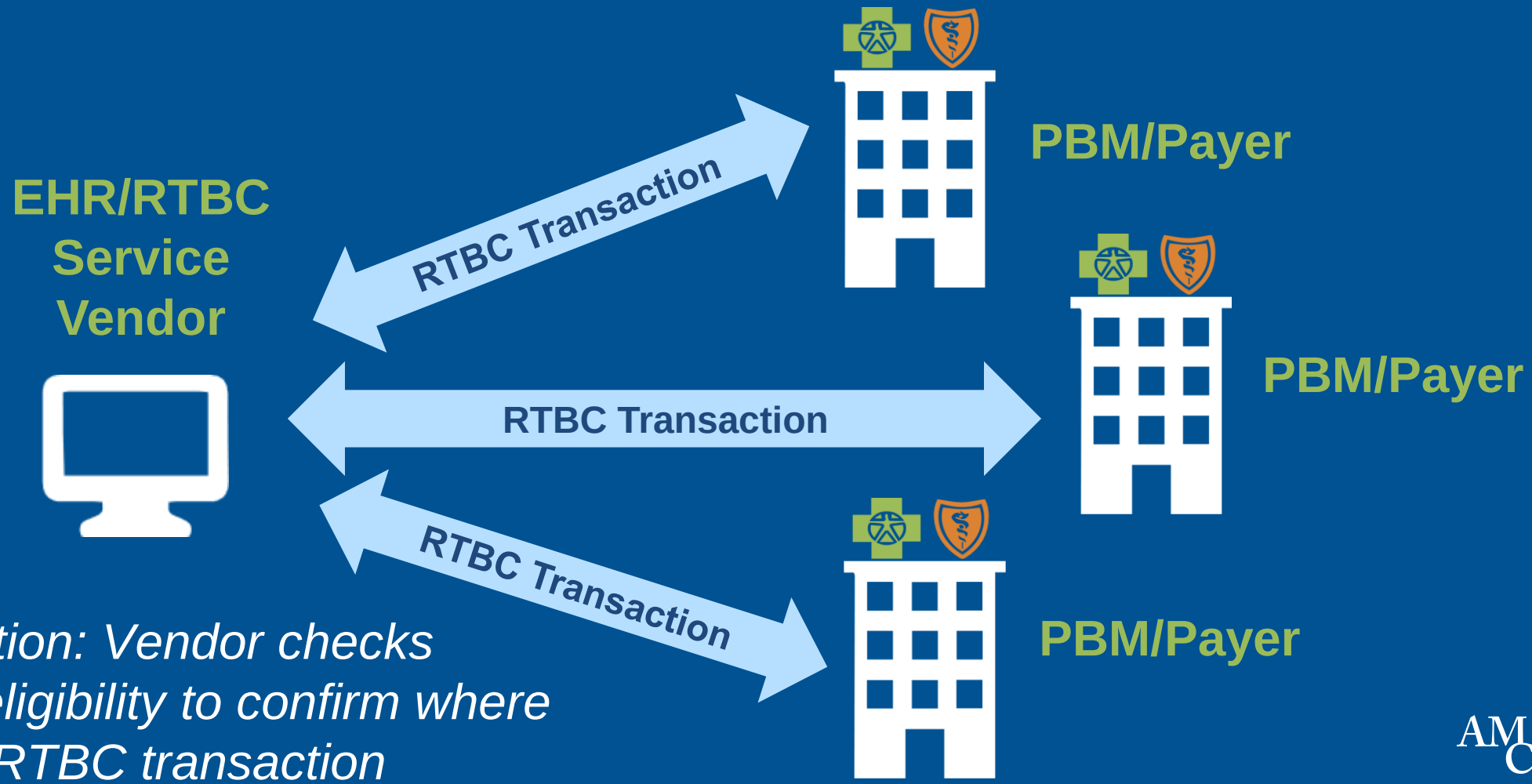
RTBC Direct Connection

With a Direct Connection, prescription benefit information comes directly from the PBM/Payer to the EHR or RTBC Service Provider. The EHR/RTBC Service Vendor needs to connect directly to multiple PBMs



Assumption: Vendor checks patient eligibility to confirm where to send RTBC transaction

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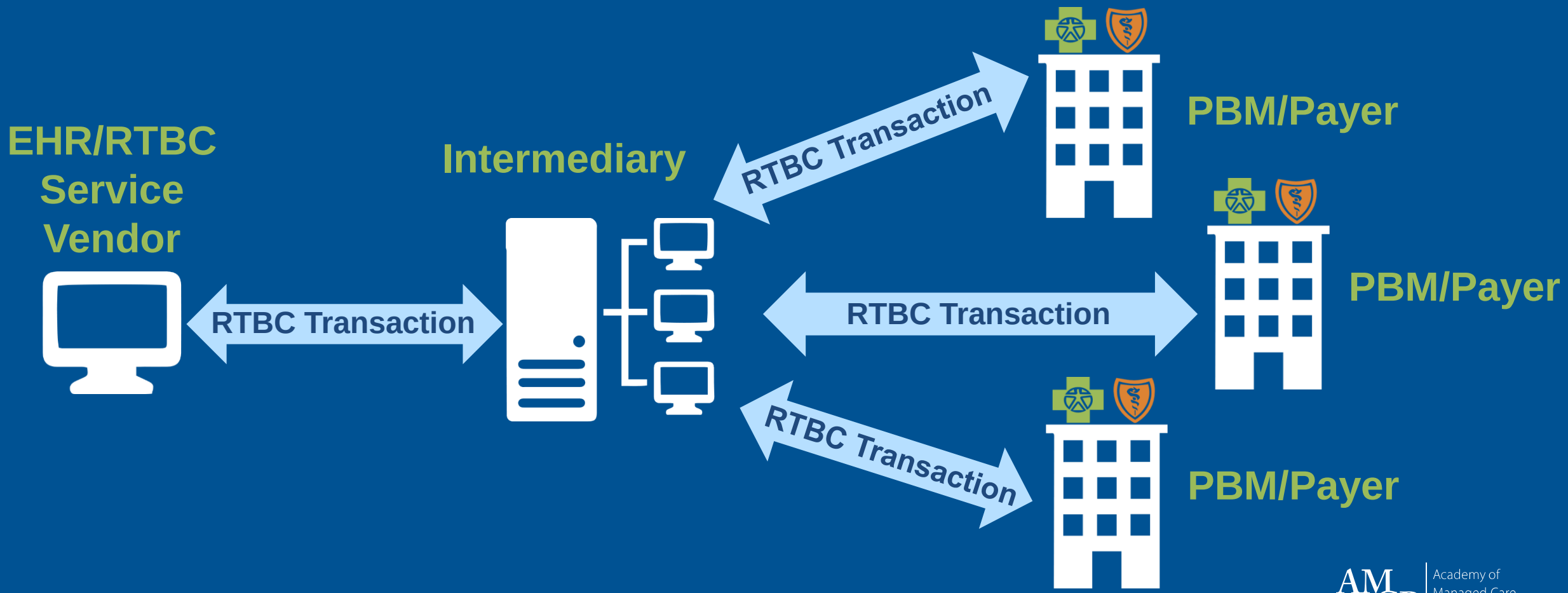
RTBC Intermediary Solutions

Intermediaries already have connections to PBMs/Payers for formulary information. The existing connections are used to send and receive an RTBC transaction



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RTBC: Benefits & Limitations

Benefits

- **Transparency**
  - Provides **patient-specific benefit information** to help provider make informed decisions at the point-of-care
  - Identifies cost barriers before patient arrives at pharmacy
- **Clinical Outcomes**
  - Improves **formulary adherence** by knowing drug coverage
- **Consumer Experience**
  - Improves **speed to therapy** by reducing prescription delays and claim denials

Limitations

– **Scope of Information**
  - Provides benefit information **for prescription benefit only –** no medical coverage

– **Benefit Plan Complexity**
  - Complexity of prescription benefit plans may be **difficult to communicate** (e.g., limited networks, lock-in, etc.)

– **Eligibility**
  - Limited options for intermediaries and/or solution providers as an **eligibility check is still required**

– **Assumptions**
  - **RTBC transaction occurs after a drug is selected and the PBM/Payer must assume pharmacy, quantity and days supply, if not provided**

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Considerations, Drivers, Future

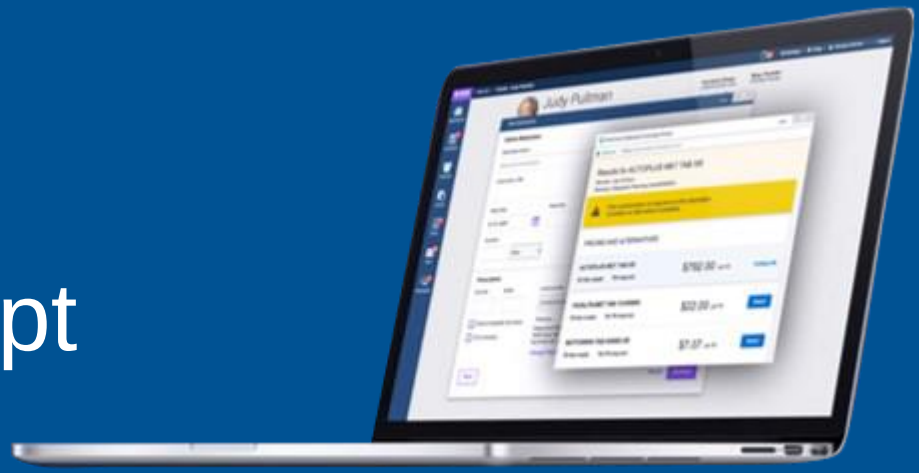
- Innovators/Early Adopters will help determine the value and lessons learned/best practices
- There are costs to both the payers/PBMs and EHRs
- Formulary and Benefit (F&B) will not go away with introduction of RTBC; both are needed
- What will drive wide-spread adoption of RTBC?
  - Regulations
  - Business model

CASE STUDY
United Healthcare's Real-Time Benefit Check Initiative

Note: The following case study is used for illustrative and educational purposes only and is not intended for promotional purposes. The solutions available were discussed in the previous section.

e-PA and e-Prescribing Solution Suite for Providers

UnitedHealthcare PreCheck MyScript



Outcomes, Strategies, Lessons Learned

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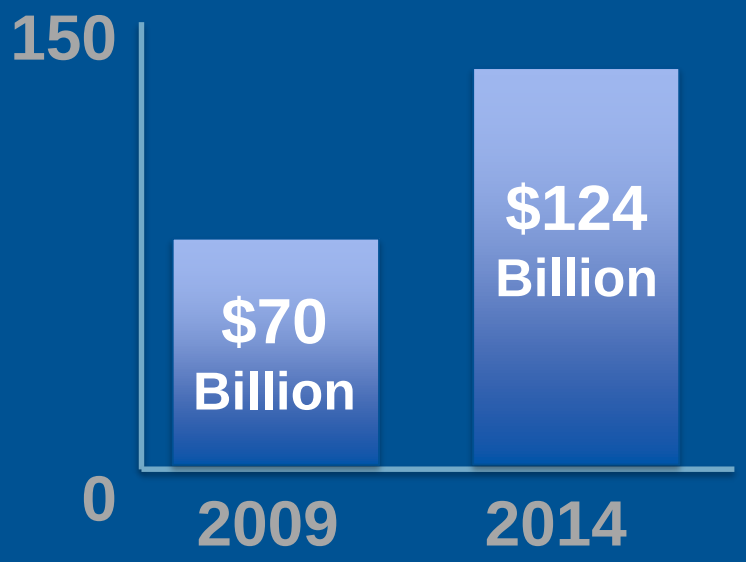
Industry Trends

E-Prescribing & electronic-Prior Authorization

1. On average, physicians spent more than **49%** of their time on administrative work and **62%** of the U.S. healthcare dollar is spent on administrative expenses according to the MGMA.

2. In 2014, more than $124 billion was spent on specialty medication, a $54 billion increase since 2009, driving the volume of PAs up.

3. Practices spend an average of 19 hours of physician and staff time per week on prior authorization requests.



Source: Modern Healthcare, April 2015

Sources:
1. Annals of Internal Medicine and Medical Group Management Association
2. Modern Healthcare, April, 2015
3. Medical Economics, March 25, 2017

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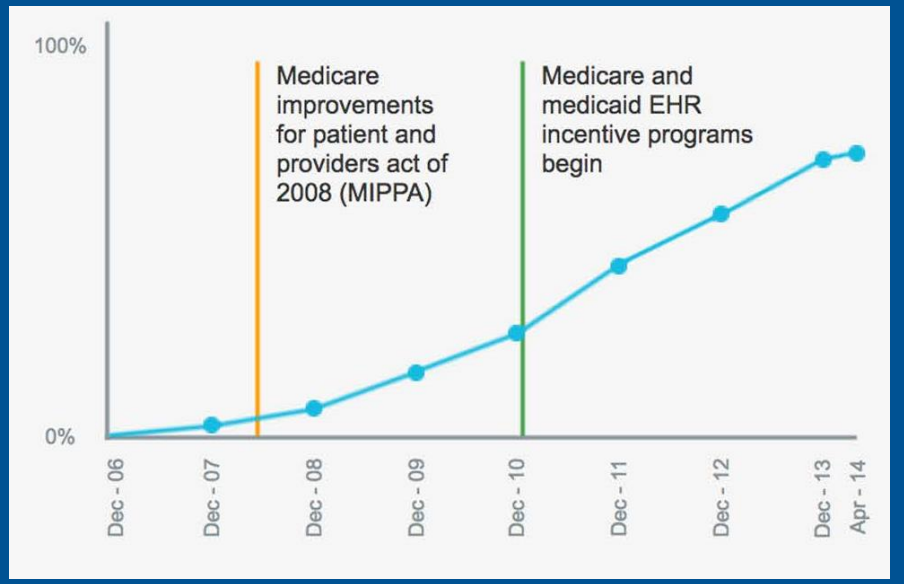
Industry Trends

E-Prescribing & electronic-Prior Authorization

4. Approximately **10%** of all prescription drug claims per year are rejected resulting in re-work or abandoned prescriptions.

5. Prescription drug spending increased **8.9%** in 2015, accounting for 10.1% of total healthcare spending and adding continued pressure to control costs.

6. The percent of physicians e-prescribing using an EMR/EHR has rapidly increased since 2008.



ONC Data Brief No. 18, July 2014. E-Prescribing Trends in the United States.

Sources:

4. CoverMyMeds 2018 ePA National Adoption Scorecard
5. cdc.gov
6. ONC analysis of physician prescriber data.

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UHG Current State

7.5 Million PAs/Annually

Rx PA transactions generated on Fax

Rx PA transactions on Phone

Of all Optum Rx calls are due to Pharmacy Claims Rejection

PA required

Drug is non-formulary

Provider Feedback

- Need to limit unnecessary PAs
- Need accurate patient and formulary data
- Needs to be in the physician's current work flow
- Need ability to save for later or assign task to administrative personnel
- Need to reduce member frustration with unexpected PAs
- Want to handle both Medical and Prescription PAs within the same application (link)

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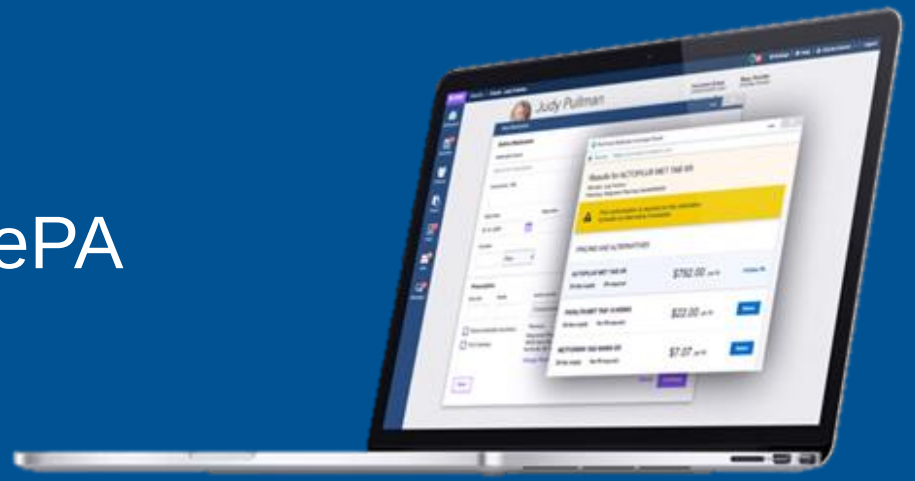
PreCheck MyScript Solution – Key Roles

- Patient-specific, real-time accurate data and coverage information at point of prescribing
- Immediate alerts for PA required and non-formulary prescriptions
- Lower cost therapeutic alternatives
- Electronic intake and adjudication of ePA and e-prescribing (EMR version)



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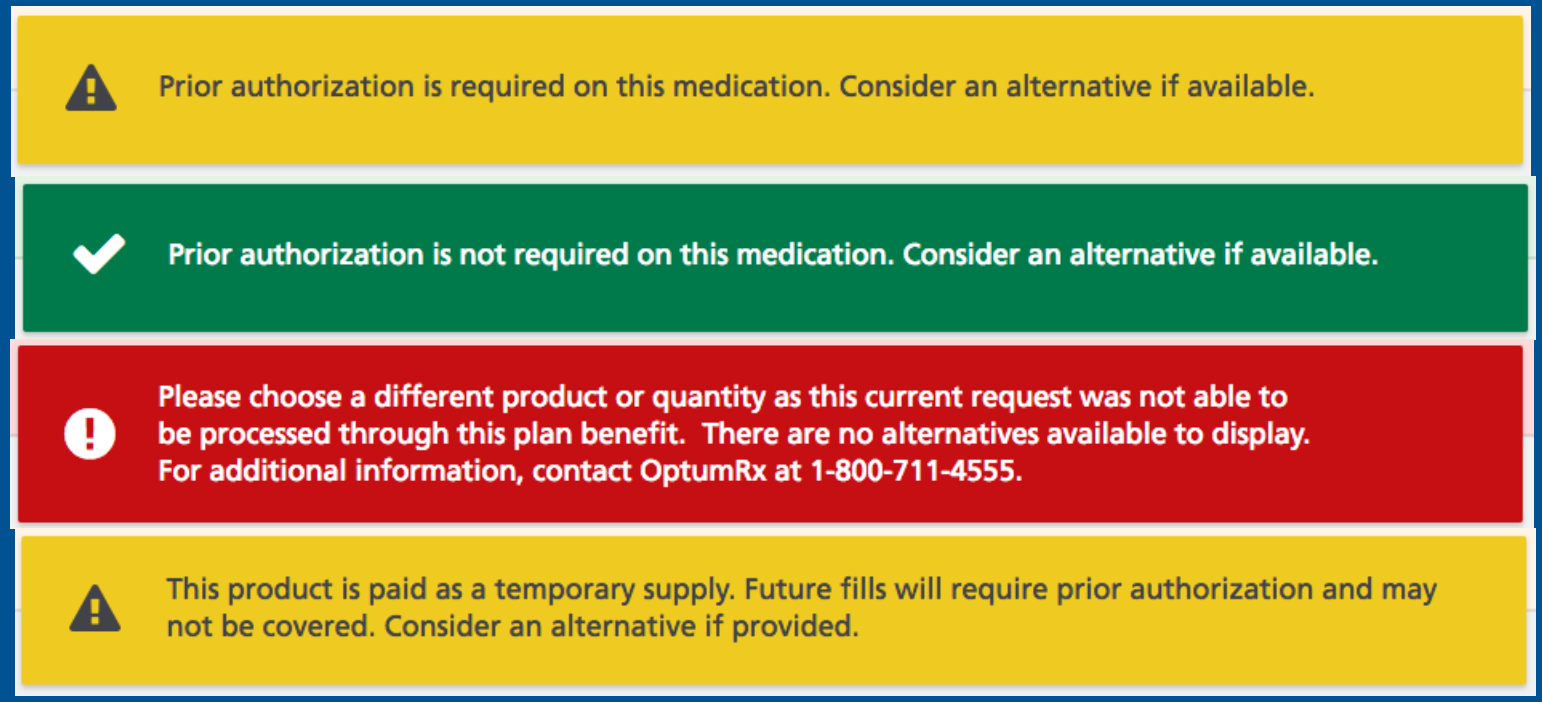
Coverage/Pricing/Messaging Overview

Pharmacy Benefit Plan Coverage & Messaging consists of:

- Patient Pay Pricing
- Pricing for covered medications and those medications requiring prior authorization (only)
- NCPDP messages translated into physician specific messaging



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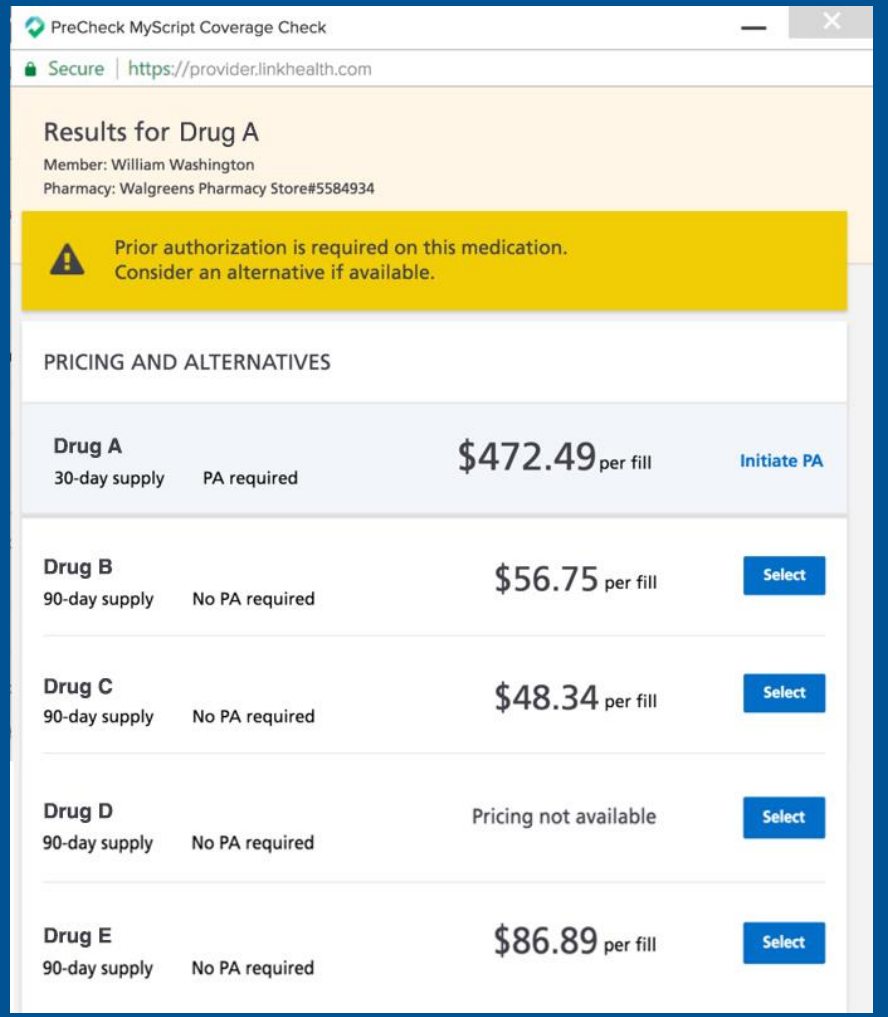
Preferred Alternatives

- Preferred Alternatives will be provided when a prescriber selects a non-preferred product based on a patient's pharmacy benefit plan.
- Preferred alternatives provided will contain patient pay pricing , coverage messaging and an prior authorization indicator when required.
- A maximum of three preferred alternatives will be provided within one transaction.
- Preferred Alternatives are returned in a pre selected order (1,2,3) and should be presented in the same order as provided



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Prior Authorization Functionality

Find out when prior authorization is needed.

Request prior authorization within the app.

Typically receive a response immediately* or in 24-72 hours.

PreCheck MyScript also shows:

Alternative medications that don't require prior authorization, if available.

The cost to the member per fill.

*Immediate PA determinations apply to some qualifying criteria. Standard turn around times of 24-72 hours apply to most PA determinations.

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40

UHG Goals with PreCheck MyScript

- Reduce overall volume of Rx PAs
  (4M annual call volume related to UHC Rx PAs)
- Provide real time accurate data at time of prescribing
  (currently transact 300 million UHC Rx eligibility requests annually)
- Provide price transparency at time of prescribing
- Avoid disruption in member access to prescriptions
  (nationally only 30% of Rx PAs result in the initial physician-prescribed choice of therapy*)
- Reduce pharmacy claim rejections
  (nationally, 265M claims per year are rejected, resulting in 74M abandoned prescriptions)
- Less time spent on Rx transactions with UHG, more patient time
- Fewer surprises and hassles for the member, builds trust and patient satisfaction for the Care Provider and for UHG

*Sources:

1. Frost & Sullivan The Impact of the Prior Authorization Process on Branded Medications
   CMM National ePA scorecard

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Why Should Providers Consider Using a Program Like This?

For your patients:

- Increases satisfaction by providing real-time medication costs and lower-cost alternatives, if available.
- Reduces frustration and delays at the pharmacy when prior authorization is needed.

For your office staff:

- Designed to integrate with your online workflow.
- Saves time by reducing the need to fax or call for prescription coverage information.
- View prescription alternatives that don't require prior authorization, if available.

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Results in the First 120 Days

22%

transactions where the solution influenced prescription decisions

34%

prior authorizations avoided/electronic prior authorizations initiated

1M

Transactions generated

1/2M

Members impacted

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Lessons Learned

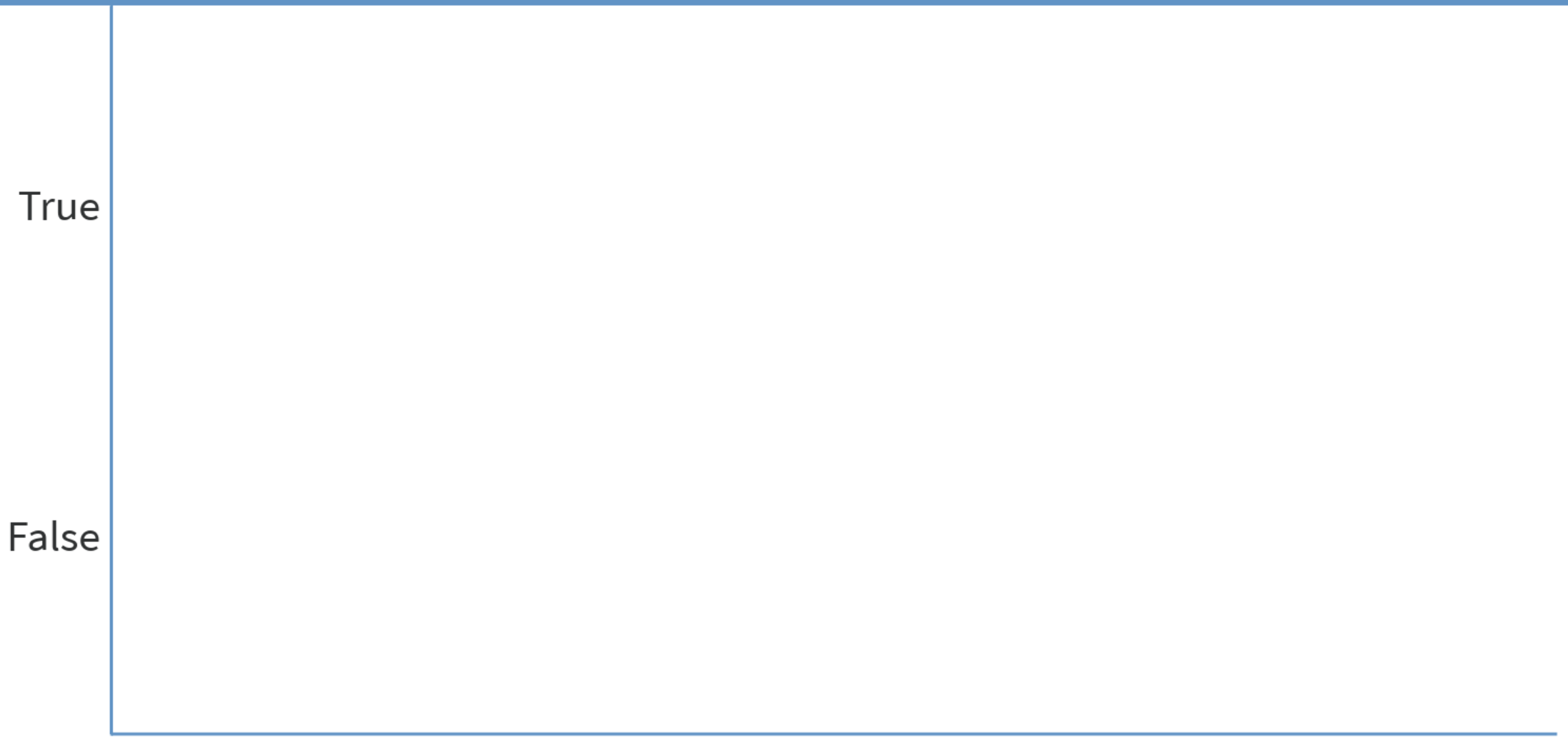
- EMR Technical Readiness
- User Interface Critical Components
- Business Segment Customization
- Market Activity and Noise vs. Reality

Early Clinical Engagements

- EMR platforms use drug names – RTBC requires NDC 11 specificity
- Government lines of business require different NDC 11 than Commercial due to State & Federal Guidelines
- EMR platforms have drug names that allow ‘ease of prescribing’ but may not exist in the real world
  - Diabetic Test Strips
  - Albuterol Inhaler
- Having RTBC mimic automatic generic substitution (unless DAW 1 designated) done at the pharmacy streamlines process

POST-TEST

LQ1: Real-Time Benefit Check is intended as a replacement for formulary & benefits.

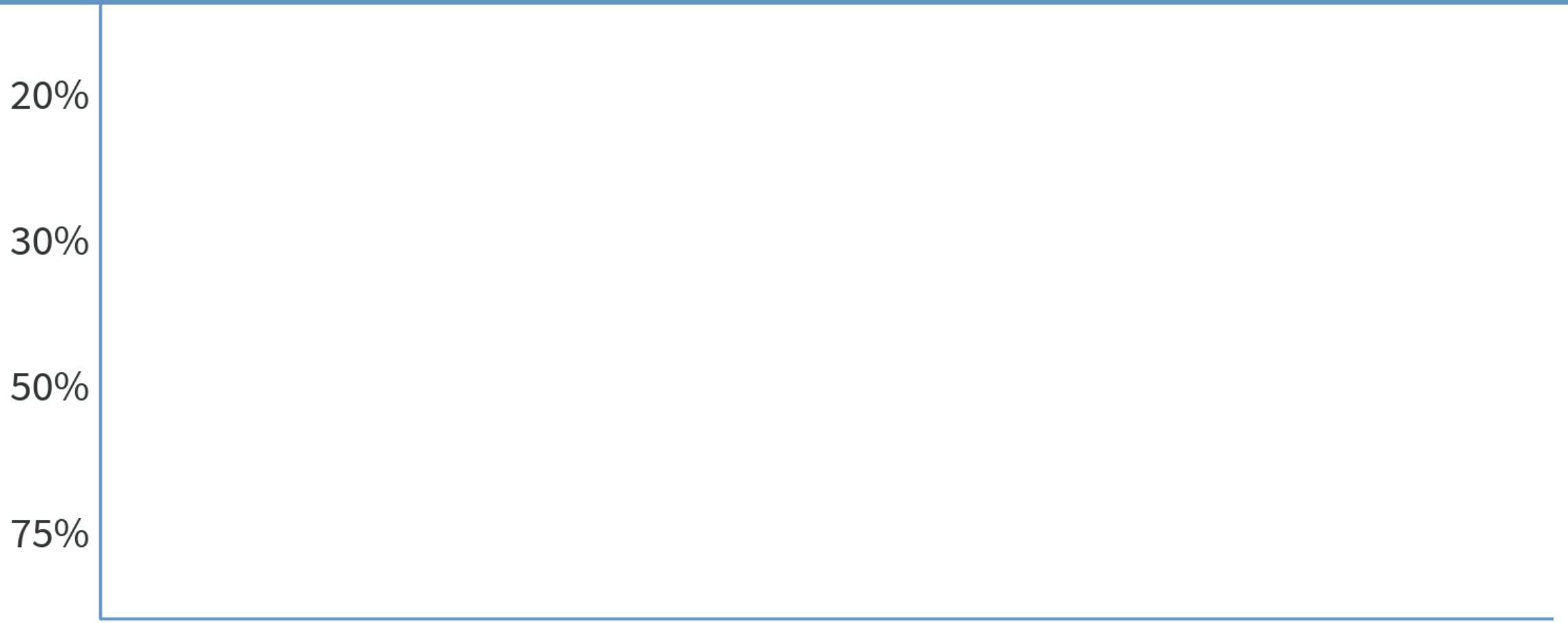


LQ1: Real-Time Benefit Check is intended as a replacement for formulary & benefits.

a. True

b. False

LQ2: Prior to implementing real-time benefit check, what percentage of UHG's Help Desk calls were due to pharmacy claims rejections from PA Required/not known until claim rejection and Drug is Non-Formulary/not known until claim rejection?



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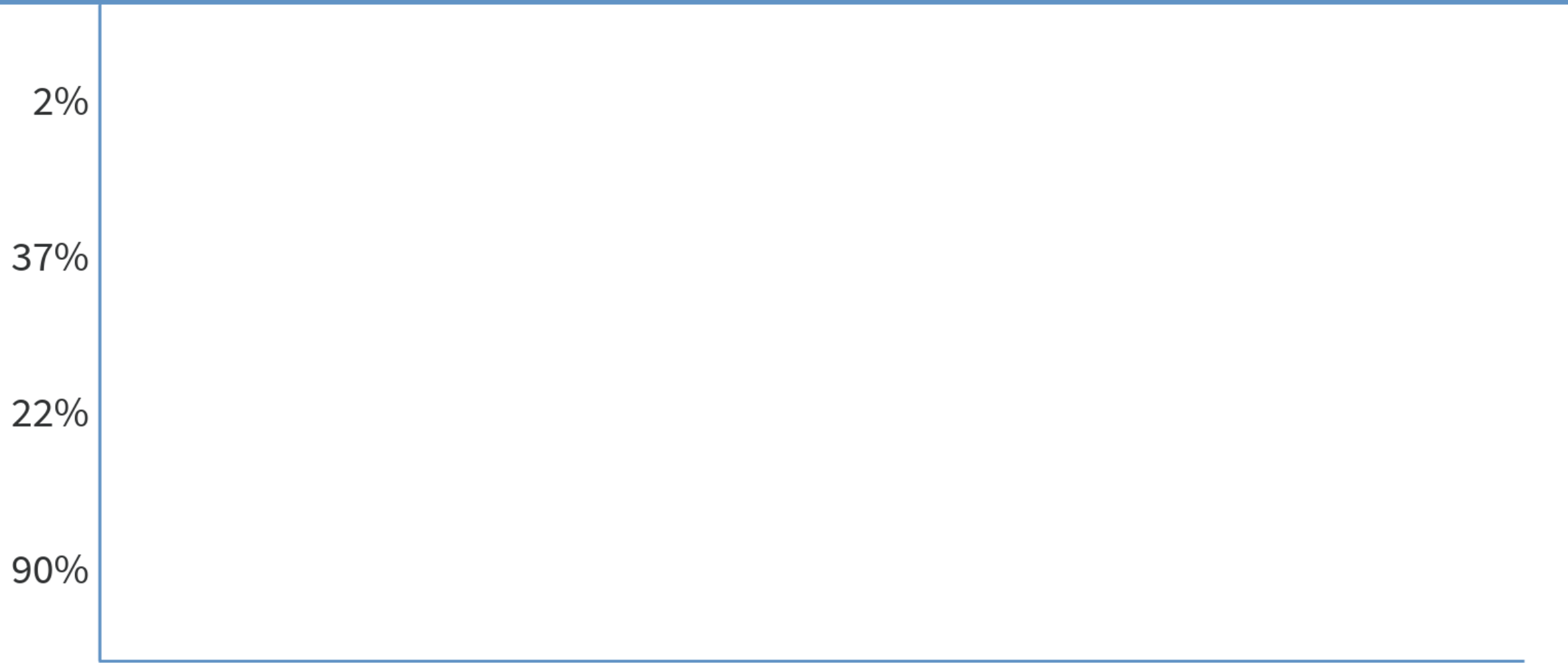
LQ2: Prior to implementing real-time benefit check, what percentage of UHG's Help Desk calls were due to pharmacy claims rejections from PA Required/not known until claim rejection and Drug is Non-Formulary/not known until claim rejection?

a. 20%
b. 30%
c. 50%
d. 75%

LQ3: In the first 120 days, what percentage of prescribing decisions were influenced by UHG's real-time benefit check point-of-prescribing initiative?



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LQ3: In the first 120 days, what percentage of prescribing decisions were influenced by UHG's real-time benefit check point-of-prescribing initiative?

a. 2%
b. 37%
c. 22%
d. 90%

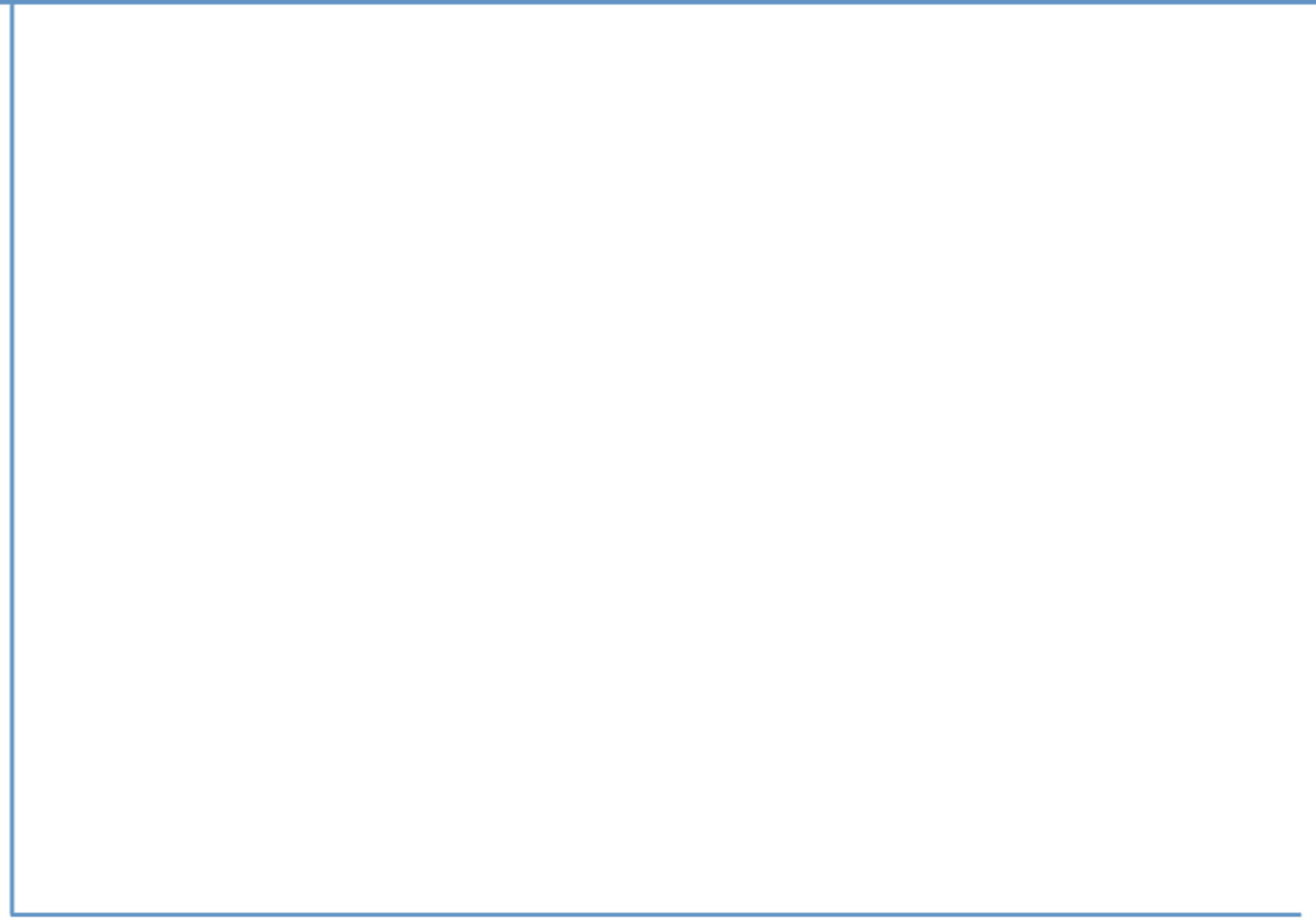
LQ4: Which of the following were lessons learned from UHG's real-time benefit check point-of-prescribing initiative?

Establish EMR Technical Readiness at the onset of the initiative/before assigning resources

User Interface is a critical component

Business segment customization is time-consuming

All of above



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a. Establish EMR Technical Readiness at the onset of the initiative/before assigning resources
b. User Interface is a critical component
c. Business segment customization is time-consuming
d. All of above

Questions?

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