Presented at

CBI Conference: Specialty Product Distribution and Dispensing Optimization

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Streamlining Access for Patients — Utilize ePrior Authorization and Benefit Verification
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 for Hepatitis C

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

Rise in Treatment Therapies

- Cancer: 16.80%
- Autoimmune Disorder: 2...
- Multiple Sclerosis: 24.40%
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.
Types of Specialty Processes/Transactions

**Prescription**
- Via: NCPDP Script

**Intake Form**
- Via: Pharmacy to Prescriber

**Benefit Verification**
- Via: Pharmacy to Payer

**Financial Assistance**
- Via: Patient to Pharmacy to Foundation

**REMS**
- Via: Prescriber to Pharmacy to Manufacturer

**Care Coordination**
- Via: Pharmacy to Patient

**Prior Authorization**
- Via: Prescriber to Payer

**Dispense**
- Via: Pharmacy to Patient
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.*
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
Current Manual Prior Authorization

Doctor submits the prescription though normal ePrescribing flow.

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

Rx Pended/Manual PA Begins

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.

40% of prescription are abandoned

Source: 2015 ePA National Adoption Scorecard

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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
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
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

<table>
<thead>
<tr>
<th>PATIENT BENEFITS</th>
<th>PHARMACY BENEFITS</th>
<th>PHARMA BENEFITS</th>
<th>PRESCRIBER BENEFITS</th>
<th>PBM/HEALTH PLAN BENEFITS</th>
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<tbody>
<tr>
<td>• Improves medication access by days to weeks</td>
<td>• Time Savings – manual PA takes 5 hours per week per pharmacist¹</td>
<td>• Increases medication adherence</td>
<td>• Significant time savings: 20-60 minutes per PA²</td>
<td>• Eliminates manual PA processing costs estimated at $20-$25 per submission³</td>
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<td>• Drugs requiring PA can be approved at doctor’s office</td>
<td>• Improves patient access to medications</td>
<td>• Eliminates physician calls</td>
<td>• Seamless workflow integration with EHR/immediate notification of drugs requiring PA before ePrescribing</td>
<td>• Improves provider and patient relations</td>
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<td>• Reduces prescription abandonment</td>
<td></td>
<td>• Improves patient access to programs and quality of formulary data</td>
<td>• Reduced prescription abandonment; improved medication adherence</td>
<td>• Reduced prescription abandonment; improved medication adherence</td>
</tr>
</tbody>
</table>

1. 2015 ePA National Adoption Scorecard
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

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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

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Electronic Benefit Verification (eBV)
Benefits Verification

- 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*
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.

**NCPDP Task Group Created**
- NCPDP Task Group created under maintenance and control workgroup

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

**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**
- 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

**Aug 2014**
- Subgroups dissolved
  - Use Case Subgroups dissolved due to overlap of efforts
  - NCPDP work will continue in single task group

**Sept 2014**
- Subgroups dissolved

**Apr 2015**
- Subgroups dissolved
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

<table>
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<tr>
<th><strong>Surescripts Real-Time Benefit Check Product</strong></th>
<th><strong>Relay Health Apollo Project</strong></th>
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<tr>
<td>• Product based on NCPDP SCRIPT standard (ePA Request and Response transaction)</td>
<td>• Implementing as part of ONC NPRM demonstration project requests</td>
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<tr>
<td>• Pilots completed – 2010; General Availability of Transaction set and implementation guide - 2013</td>
<td>• Slow progress on release due to slower than expected contracting process with PBMs and Payers</td>
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<tr>
<td>• RTBC 3.0 discussed at NCPDP in 2014 as part of SCRIPT standard; no consensus on implementing as standard</td>
<td>• Pilot based on NCPDP Telecom Standard D.0</td>
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<td>• Slow uptake due to vendor costs and uncertainty of industry standard</td>
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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.
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.