

Electronic Prior Authorization Update

NCPDP Workflow-to-Prior AuthTask Group (AKA ePA Task Group)
December 8, 2011

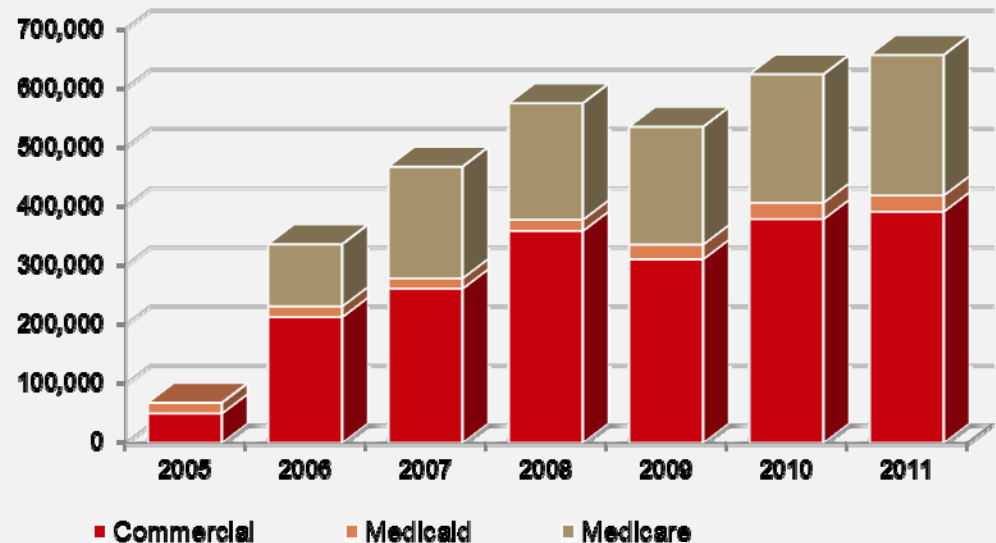
Agenda

- **Level-Set**
 - Prior Authorization Today
 - Current Drivers
 - Standardized ePA
- **October NCPDP Focus Group**
- **Next Steps**

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 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

Prior Authorization Impacts All Healthcare



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

Patient hassle and treatment delay

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



Patients



Pharmacy



Prescribers



Pharmaceutical Co.



PBM/ Health Plan



Physician Software



Intermediaries

Prior Authorization Impact

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

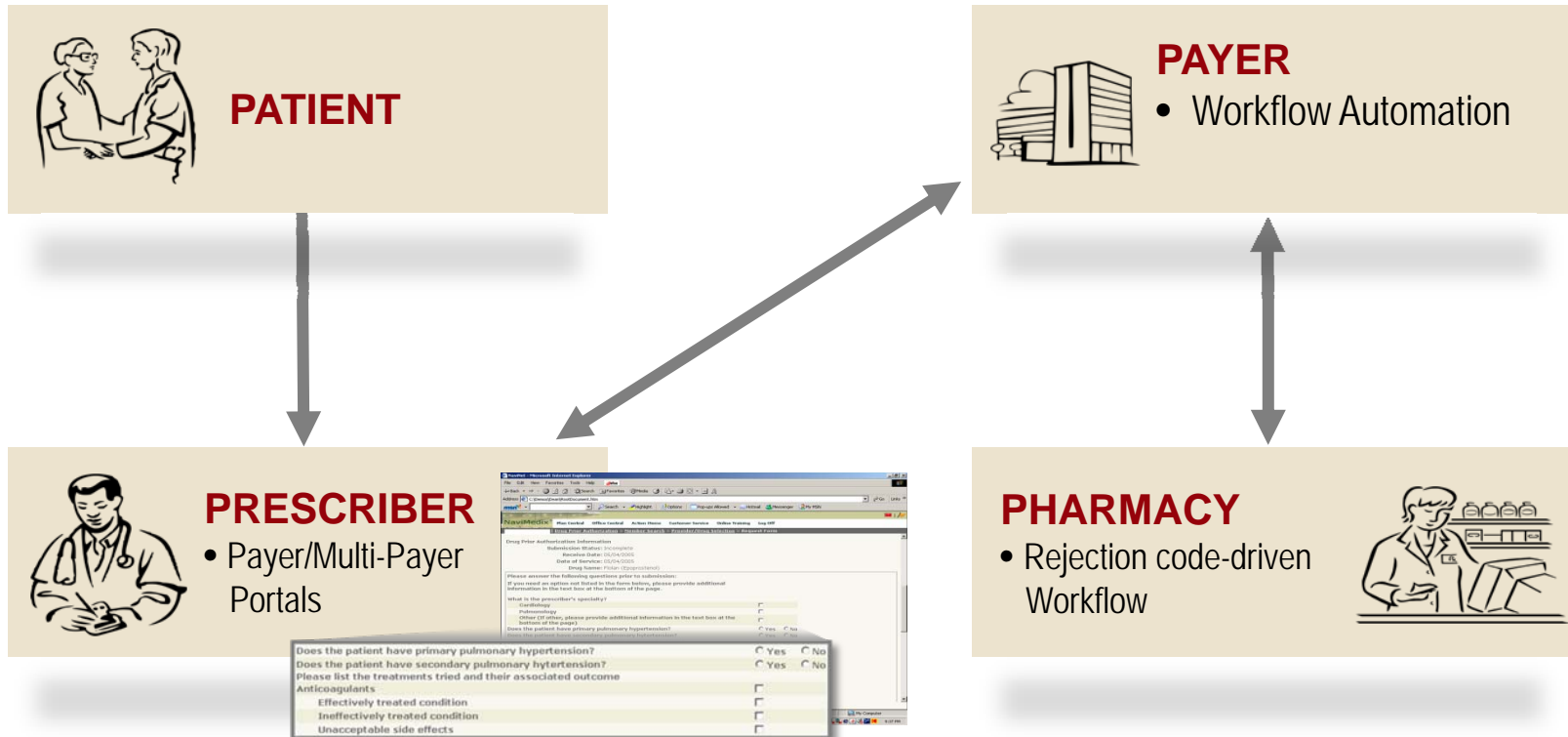
Health Plans & PBMs

- 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

Current Automation in PA



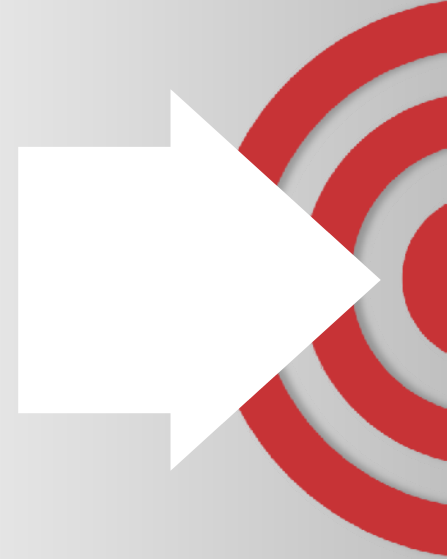
Automation today largely replicates the paper process requiring duplicate entry of information

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.

NCPDP ePA Task Group Formed

- Standard transactions mapped
- Gaps identified
- HL7 PA Attachment created (2005)

CMS/AHRQ pushes forward

- Resolution of which SDO would own ePA
- Exception to HIPAA resolved
- Value model created

Renewed Interest

- More pilots
- Economic value
- State legislation

Aug 1996

Nov 2004

2006

2008

2009

2011

HIPAA passes

- X12 278 named “prior authorization” transaction standard

MMA ePrescribing Pilot Tests

- “Menagerie of ePA standards” pilot tested
- One standard – not X12 278 -- recommended

New Standard Created

- Housed in NCPDP
- Compatible with emerging technology
- No pilot test



- 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



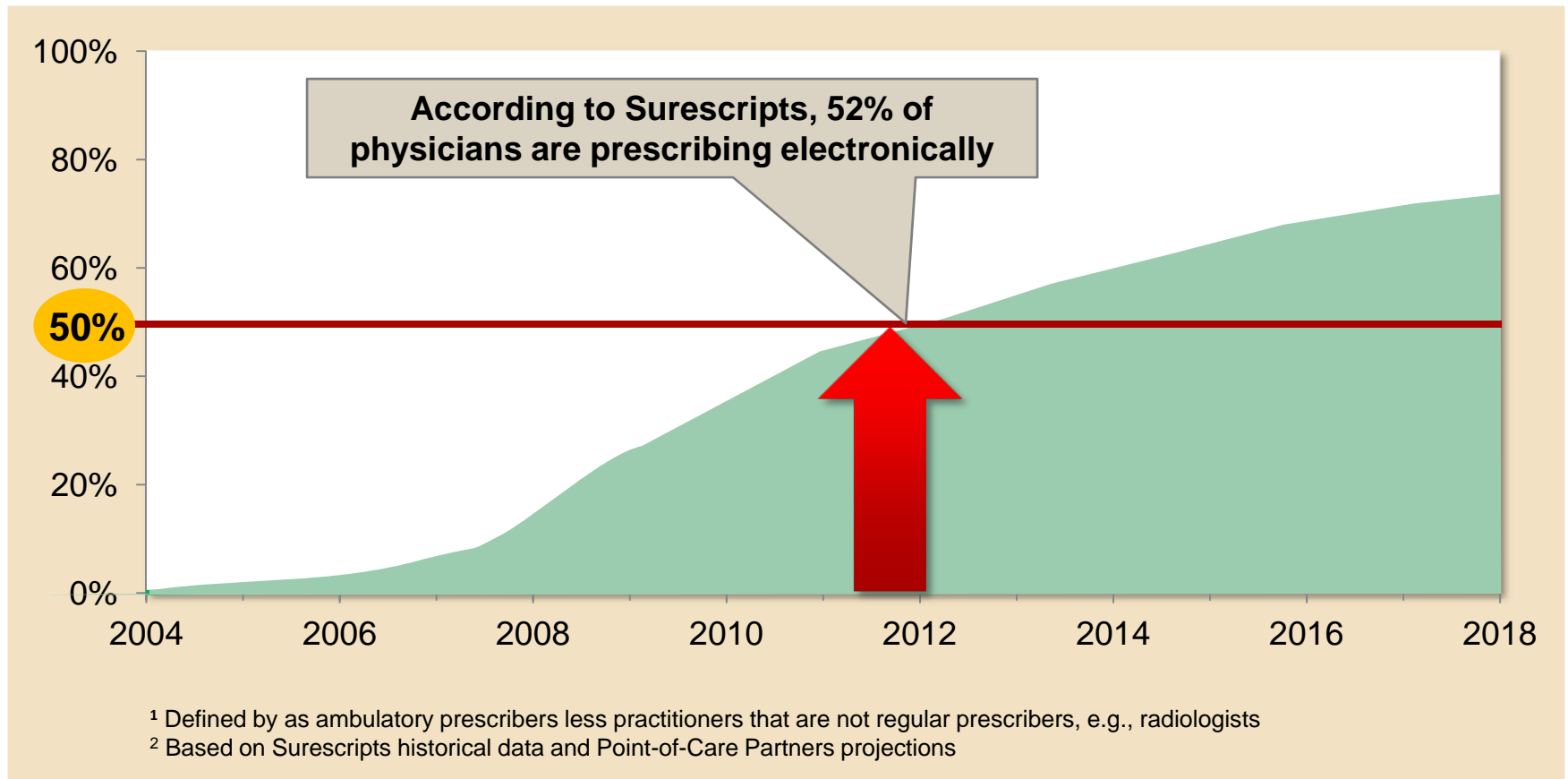
- ND is the only state in which the ePrescribing/ePA bill has passed, and that law doesn't take effect until 2013
- NJ's bill is technically still in play, but it's moving very slowly and could stall
- MI still has a bill in play
- Still pending NC, GA, NE, OK, TN, VT, MA and NY.
- Bill passed in CA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

ePrescribing Can No Longer Be Ignored

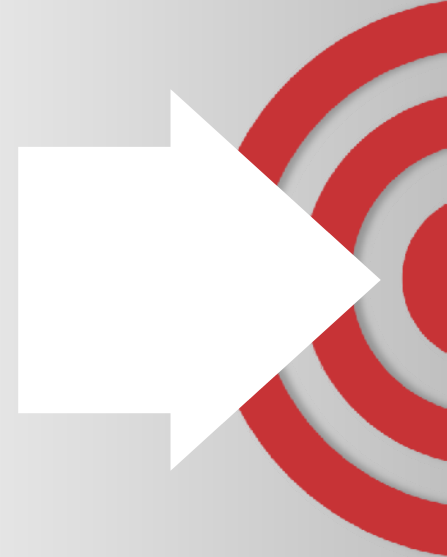
More than 50% of prescribers¹ are prescribing electronically²



ePrescribers as a Percentage of Total Ambulatory Prescribers



Standardized ePA



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Where We Are (per ONC)



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E-Prescribing and Standards for E-Prior Authorization

May 3, 2011, 9:58 am
Dr. Doug Frosina | Director Office of Standards and Interoperability

Recently, colleagues have raised questions about pending state legislation related to electronic prescribing (e-prescribing) and in particular the concept of electronic prior authorization (ePA) for medications. We thought it would be helpful to discuss what we know about the current state of e-prescribing and ePA. E-prescribing provides significant advantages in contrast to its paper analog. Coupled with other complementary technologies, such as drug-drug interaction checking, e-prescribing can improve patient safety, increase prescribing accuracy and efficiency, and lower costs by notifying providers of generic or preferred drug list alternatives.

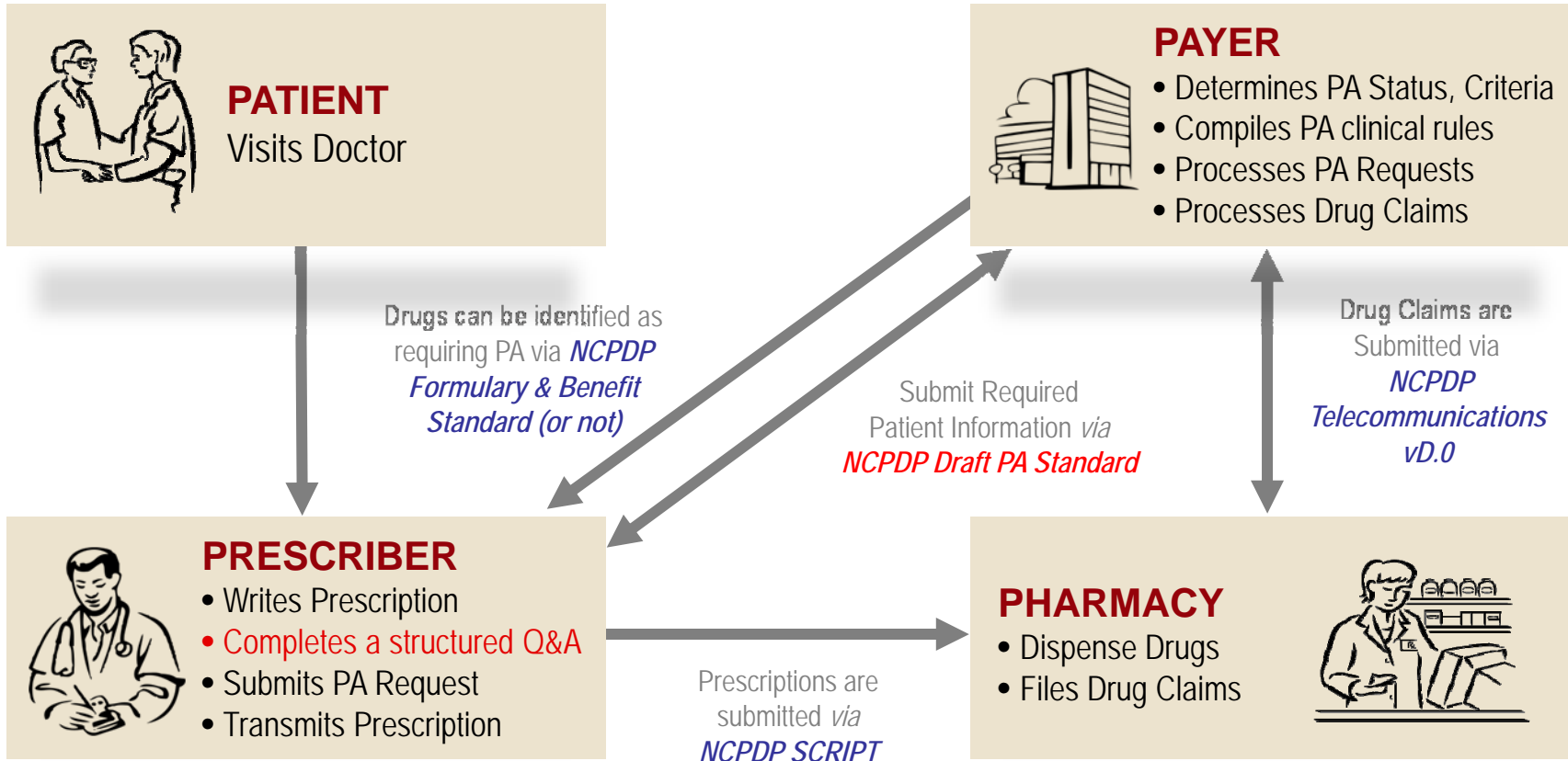
Over the past three years, Congress has signaled its support for e-prescribing by promoting its use in two major laws: Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) and the Health Information Technology for Economic and Clinical Health (HITECH) Act. The HITECH Act covers certain eligible professionals seeking to become meaningful users of certified electronic health record (EHR) technology in the Medicare and Medicaid EHR Incentive Programs. The HITECH Act specifically identified e-prescribing as a requirement for eligible professionals participating in the EHR incentive programs, and therefore it is part of the "core set" of meaningful use objectives and measures (which also includes objectives and associated measures for using computerized provider order entry (CPOE), maintaining active medication and medication allergy lists, and implementing clinical decision support). MIPPA focuses on Medicare eligible professionals to encourage e-prescribing with a separate incentive program requiring use of a qualified e-prescribing system. Below are a few points that address some of the questions raised by our state colleagues as they consider e-prescribing related legislation.

- It is useful to keep apprised of the technical requirements (capabilities and technical standards) that are currently part of Federal health IT programs to ensure consistency and avoid potential conflicts.
- While ONC requires as a condition of certification (for the purposes of meaningful use) that EHR technology be capable of generating and transmitting electronic prescriptions, certification does not require that EHR technology also be capable of performing electronic prior authorization.
- We are not aware of a widely adopted, common, industry transaction standard that has been demonstrated to support real-time ePA, nor are we aware of a common or universal electronic format that has been demonstrated to facilitate distribution of prior authorization forms. We are aware of work that has been done by the National Council for Prescription Drug Programs (NCPDP) to create an XML-based ePA messaging standard and a real-time eligibility check messaging standard. We understand that these are draft standards that have not yet been tested in pilots and have not been fully "balloted" (voted on) through NCPDP's process or been finalized as American National Standards Institute (ANSI)-accredited standards.
- There is a lack of established and fully vetted standards to support ePA and the current lack of capability to support ePA in implemented EHR systems. Therefore, requiring real-time electronic prior authorization as a prerequisite technical capability before health care providers could e-prescribe and/or access drug formulary information may be difficult to implement, and could otherwise prevent providers from being able to e-prescribe. If such requirements prevent providers from being able to e-prescribe, it could also keep them from being able to participate in the incentive programs noted above.

“We are not aware of a widely adopted, common, industry transaction standard that has been demonstrated to support real-time ePA, nor are we aware of a common or universal electronic format that has been demonstrated to facilitate distribution of prior authorization forms. We are aware of work that has been done by the National Council for Prescription Drug Programs (NCPDP) to create an XML-based ePA messaging standard and a real-time eligibility check messaging standard.”

“Therefore, requiring real-time electronic prior authorization as a prerequisite technical capability before health care providers could e-prescribe and/or access drug formulary information may be difficult to implement, and could otherwise prevent providers from being able to e-prescribe. ... it could also keep them from being able to participate in the incentive programs noted above.”

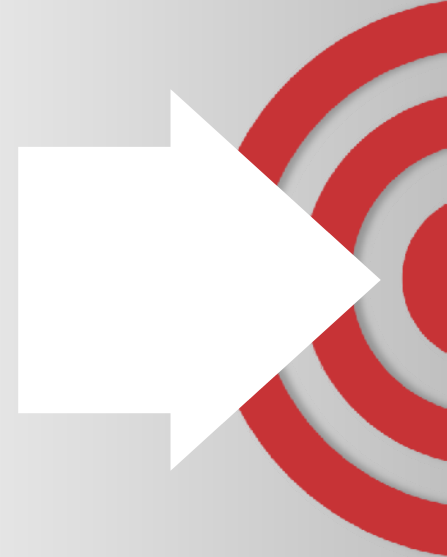
Proposed Standard



Red = gaps in existing standards

Blue = existing standards

NCPDP ePA Focus Group



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Meeting Overview



Meeting Date	October 6, 2011
Location	NCPDP Headquarters, Scottsdale, AZ
Stated Objectives	<ol style="list-style-type: none">1) To identify basic needs and issues for the industry related to electronic Prior Authorization.2) To implement a pilot project that uses the NCPDP standards that will address the concerns of all affected parties.3) To come away from this meeting with a basic project plan to create an ePA pilot.
Moderator	Rick Sage, Emdeon (NCPDP Workgroup 11 Co-Chair)
Presenters	Tony Schueth, Point-of-Care Partners (former Leader, NCPDP Prior Authorization-to-Workflow Task Group)
Pre-meeting Materials	<ul style="list-style-type: none">• Minnesota Department of Health work on ePrior Auth (current)• ONC Statement on ePrior Authorization standards (May, 2011)• “ePA Pilot Preparation Report,” by Point-of-Care Partners for AHRQ, (Feb, 2009)• Draft NCPDP ePrior Authorization Standards (2009)• Flow Diagrams (2009)• ePA Expert Recommendations (Feb, 2008)

NCPDP Facilitated Focus Group

Date/Location	October 6, 2011 NCPDP Headquarters, Scottsdale, AZ
Objectives	<ul style="list-style-type: none"> To identify basic needs and issues for the industry related to electronic Prior Authorization. To implement a pilot project that uses the NCPDP standards that will address the concerns of all affected parties. To come away from this meeting with a basic project plan to create an ePA pilot.
Organizations Participating	<p><u>PBMs/Payers</u></p> <ul style="list-style-type: none"> CVS Caremark, Express Scripts, Medco, Catalyst, Argus, SXC <p><u>Vendors</u></p> <ul style="list-style-type: none"> DrFirst, CoverMyMeds, Armada, Agadia, Ibeza, RxEOB <p><u>Intermediaries</u></p> <p>Surescripts, Emdeon, RelayHealth</p> <p><u>Physicians/Organizations</u></p> <p>AMA, Am College of Rheumatology, Heart & Vascular Center of Arizona</p> <p><u>Government</u></p> <p>CMS, AHRQ, Minnesota Department of Health</p> <p><u>Other</u></p> <p>Pfizer, Lilly, Center for Healthcare Transformation, AMCP</p>
Facilitator/ Speakers	<ul style="list-style-type: none"> Rick Sage, VP Clinical Services Emdeon; Co-Chair, NCPDP Workgroup 11 – ePrescribing & Related Transactions Tony Schueth, CEO & Managing Partner, Point-of-Care Partners; former leader, NCPDP ePA Task Group

Three Pilots, One Live Program Discussed



- Prospective vendor integration where PA is completed *within* the eRx process, *before* the patient leaves doctor's office
- Chose not to use NCPDP ePA draft standard although used elements
- Leverages the Real-time Benefit Check
- SCRIPT RxChange planned to be used for retrospective PA.
- Go-live planned for January, 2012 with Allscripts (other vendors to follow)



- Prospective orientation where PA is completed *within* the eRx process, *before* the patient leaves doctor's office
- Will use the NCPDP ePA draft standard
- Intent is to use ePrescribing software partner but vendor not announced
- Target is 4Q2011 for Phase 1 and 2Q2012 for Phase 2



- PA can be initiated before or after the claim rejection at the pharmacy (which is after leaving the physician office)
- Uses NCPDP Telecommunication Standard D.0 from pharmacy
- Will use the NCPDP ePA draft standard if applicable



- Retrospective orientation where PA is addressed *after* eRx is received (and it is determined that PA is required)
- Case/secure link is created, sent to physician via existing channel
 - Portal log-in not required
- Interim solution using NCPDP SCRIPT Change & Status functions

Key Takeaways



- New energy around standardized electronic prior authorization
- Recommendation to reform Task Group
- View that NCPDP standard was draft but that it could be modified to accommodate shortcomings
- CVS Caremark agreed to take concerns, lessons learned back to the task group to inform standards modifications
- Pioneer pilots (Humana/Agadia, Relay Health/CoverMyMeds) willing to share lessons learned and contribute to process

Next Steps/Action Items



- Checking to see if Surescripts will share the format for the Real-time Benefit Check (RTBC)
- Need to make announcement that NCPDP will reform the ePA task group
- NCPDP should consider making the RTBC a standard (if we're going to recommend use within the ePA standard, need to make sure the format is "standard.")
- Humana/Relay, CVS Caremark to compare formats, communicate the deltas
- Need to figure out how to provide a status back to the pharmacy and patient
- Consider other entry points to ePA such as the pharmacy