Electronic Prior Authorization and HIT Solutions to Improve Patient Care

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Objectives

1. Identify ePA transactions types and how transactions are communicated between payers and providers
2. Articulate the importance and value of implementing electronic prior authorization in the pharmacy and medical benefits
3. Recognize the value of leveraging electronic solutions to improve medication reconciliation during transitions of care
4. Understand the need for MTM research along with structured coding for MTM service documentation
About AMCP

The Academy of Managed Care Pharmacy (AMCP) is a national professional association of pharmacists, health care practitioners and others who develop and provide clinical, educational and business management services on behalf of more than 200 million Americans covered by a managed pharmacy benefit. AMCP members are committed to a simple goal: providing the best available pharmaceutical care for all patients. Some of the tasks AMCP’s more than 7,000 members perform include:

- Monitoring the safety and clinical effectiveness of new medications on the market
- Alerting patients to potentially dangerous drug interactions when a patient is taking two or more medications prescribed by different providers
- Designing and carrying out medication therapy management programs to ensure patients are taking medications that give them the best benefit to keep them healthy
- Creating incentives to control patients’ out-of-pocket costs, including through lower copayments on generic drugs and certain preferred brands.

Mission: To empower its members to serve society by using sound medication management principles and strategies to improve health care for all.

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Shift in AMCP Practice Activities

• Previously
  – White papers, practice advisories, website resources (presentations, industry guidance papers)

• Currently
  – Evolved to include expert panels with recommendations and action items
Shift in AMCP Practice Activities

• Technical Expert Panels
  – Partnership Forums, Summits, Task Forces
  – Select disease state, condition, challenge, or topic of high interest
  – Best in class examples – presentations “expert views”
  – Engaging group discussion – break out discussion
  – Identify challenges and opportunities – areas of engagement for AMCP
  – Publish proceedings in JMCP
  – Follow-Up/Next Steps – Steering Committees
Shift in AMCP Practice Activities

• Examples – Past Partnership Forums/Task Forces
  – Breaking the Link Between Pain Management and Substance Abuse
  – Improving Transitions of Care in ACOs: Leveraging MTM Network and Current HIT Capabilities In CHF and Other Cardiovascular Comorbidities
  – Biosimilar Collective Intelligence System: Utilizing Data Consortia to Prove Safety and Effectiveness of Biosimilars
  – NCPDP Electronic Prior Authorization Standards: Building a Managed Care Implementation Plan

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ePA Partnership Forum

• Presentations:
  – Physician and Patient Experience
  – Expectations of Managed Care Pharmacy
  – Lessons learned from the CVS Pilot and PBM readiness
  – ePrescribing Vendor Approach
  – Transaction hubs and EMR and Physician Readiness

• Discussions:
  – What are ePA capabilities in 2015?
  – Expanded capabilities in 2015/2016?
  – What are measures of success and how to champion ePA strategy?
Electronic Prior Auth. – Overview

• The impact of prior authorization (PA) today

• The New Standard for Electronic Prior Authorization

• Why Now? The Drivers of Standardized Electronic Prior Authorization (ePA)
Cost-savings feature that helps to ensure the safe and appropriate use of selected prescription drugs and medical procedures.

- Criteria based on clinical guidelines and medical literature
- PA drug list and criteria vary by payer
Manual Prior Authorization Impacts Everyone

- At pharmacy patient and pharmacist learn prior authorization (PA) needed
- Pharmacist phones or faxes prescriber to request PA initiation
- Provider and pharmacy benefit manager (PBM) exchange multiple calls, faxes, portal forms
- After waiting days—or even weeks—and more calls PA obtained and patient notified
“On average, physicians spent more time dealing with [drug prescriptions] than any other interaction”

Health Affairs
May 2009
“What Does It Cost Physician Practices To Interact With Health Insurance Plans?”
Prior Authorization Impact on Pharmacy

- **$11,440** cost per pharmacist per year\(^1\)
- **4 hours median time** spent on PAs per week

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NCPDP SCRIPT Standard for ePA Transactions

• Officially approved as part of the NCPDP SCRIPT Standard in July 2013
• Standard for communication between providers and payers
• Transaction types (Solicited Model):
  • PA Initiation Request
  • PA Initiation Response
  • PA Request
  • PA Response
  • PA Appeal Request/Response transactions
• Unsolicited model
  • Starts with prescriber sending a PA Request
  • EHR system would already have information for certain payers
Solicited Model - Visual

Prescriber is aware through F&B File

Prescriber (EHR/eRx)

PA Initiation Request

PA Initiation Response (question set delivered)

PA Request (question set completed)

Payer (HP/PBM)

PA Response*

*PA Appeal Request Transactions also supported
ePA Snapshot – select medication
ePA Snapshot – initiated ePA

[Image of ePA interface with highlighted option]

Send to ePA Task List

CS - Federal and state specific controlled substances cannot be sent electronically.
ABC Health Plan

Patient Name: Doe, John
Fentanyl (Medication)

Is the oral transmucosal fentanyl product being used for the management of acute or postoperative pain?

- Yes
- No

Expiration Date: 1/31/2013
Contact: (855) 323-3468

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ePA Snapshot – review and submit
ABC Health Plan

Patient Name: Doe, John

Please contact 555-555-5555 with any questions.

Thank you. Your ePA request is approved.

Fantom_DoeJ_Caremark_Approved.pdf

Expiration Date: 03/10/2014

ADD ATTACHMENTS

12MB Max

NEXT
CANCEL
START OVER
Pilot Experience

• Started in 2012
• Commercial, Medicare, Medicaid, and some specialty PA
• Involved PA, Step Tx, QLL, exclusions/exceptions
• Prescribers could complete “end-to-end” request in one session
  – Can also send ePA request to queue
• Observed less than 1% variance in approval rate between standard PA and ePA
• From ePA request to response – less than 5 minutes (approvals less than 60 seconds)
Some Lessons Learned

• Skip logic and decision trees are critical to providing the full, automated experience
  – Start with highest volume criteria

• Must understand workflow
  – How to work incoming PAs
  – Prepare for patient name mismatching
Preparing for the future

- Phase 1 – Transition from paper forms to electronic communication and submission
- Phase 2 – Coded reference support for criteria set
  - NCPDP ePA Transaction Standards recommend coded reference support
  - Allow for EHR to retrieve information
  - Payer would need to send coded references for applicable questions (i.e. SNOMED CT, LOINC, etc.)
Examples – Current / Future

“…Adalimumab (HUMIRA) is effective in the treatment of moderate to severely active Crohn’s Disease (CD)...”

Source: American Journal of Gastroenterology, ACG: 2009

What is the patient's diagnosis?

- Ankylosing Spondylitis
- Crohn's Disease
- Juvenile Idiopathic Arthritis
- Plaque Psoriasis
- Psoriatic Arthritis
- Rheumatoid Arthritis
- Ulcerative Colitis
- Other
“Adalimumab (HUMIRA) is effective in patients who have not responded despite complete and adequate therapy with a corticosteroid or an immunosuppressive agent (grade A).”

Source: American Journal of Gastroenterology, ACG: 2009
“Treatment with HUMIRA should not be initiated in patients…taking concomitant immunosuppressants,…(or) who have been exposed to tuberculosis.”

Source: Humira Prescribing Information, AbbVie, Inc.: September 2013
Potential Savings

• Council for Affordable Quality Healthcare (CAQH)
  – 2013 U.S. Healthcare Efficiency Index – not specific to retail pharmacy PA
    • Collected data from transactions
    • Health Plans representing 100 million lives
    • 1 billion claims / 3 billion transactions
    • Show the potential savings of migrating to electronic transactions

  – Nationwide - potential for plans to save $410 million from ePA alone. Healthcare providers and facilities could save $1.5 billion with ePA.
Potential Savings – CAQH Index Report

• Out of the six transaction types studied
  – Costs of manual prior authorization were the highest
  – Average Costs:
    • $3.95/transaction for health plan
    • $18.53/transaction for healthcare providers

• Report studied PA for medical and surgical benefits
  – Important due to growing trend of specialty drugs which typically fall under the medical benefit
More than 50% of the drugs in the pipeline are considered specialty medications, many of which require PA.

Recent studies project that specialty drug spending will increase 67% by 2015 and nearly half of all prescription drug sales will be for specialty medications by 2016.

Pharmacy and Medical Integration

Recommendations from AHIP
- Specialty and Medical integration is key
  - Utilization management strategy mismatch
  - Integrating allows for better tracking – manage cost
  - Pharmacy has more analytics and timely information

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Indicate which of the following factors present the greatest challenge to your organization.

- Variability in oncology treatment approach: 71%
- Determining value of therapy: 68%
- Limited internal health plan resources: 66%
- Shift in site of service: 53%
- Coordination within health plan departments: 49%
- Variability in reimbursement rate: 47%
- Obtain NDC-level data on medical claims: 47%
- Isolate specialty drug claims from hospital claims: 41%
Select your top 5 specialty drug management goals for the next 12-24 months.

- Manage drug cost trend
- Integrate specialty across RX and medical benefits
- Improve patient adherence
- Implement shared risk payment reforms with providers
- Align provider reimbursement across sites of care

% of plans: top 5 goals

- Manage drug cost trend: 75%, 71%, 78%
- Integrate specialty across RX and medical benefits: 65%, 59%, 67%
- Improve patient adherence: 64%, 62%, 65%
- Implement shared risk payment reforms with providers: 58%, 59%, 48%
- Align provider reimbursement across sites of care: 54%, 53%, 61%

Graph showing the percentage of plans for each goal across different categories: Commercial, MA-PD, Medicaid.
Current State of ePA

• Need for “critical mass”
  – Implementation Guide
  – Criteria Preparation
  – Scorecard

• Many large, national Health Plans/PBMs already “live”
  – Staged approach within each EMR – various offerings
  – Some will offer a separate update as an “add-on” to software, and others will need to take full software update

• Evolution of “PA Vendors or Processors” (transaction networks/intermediaries)
  – CoverMyMeds
  – Surescripts
Conclusions to ePA

• Significant opportunity
  – Lower administrative costs (plan/PBM, provider, pharmacy)
  – Speed up turn around time for PA approval/denial
  – Increase timely access to medications
  – Reduce steps required for physician (coded references and intelligent decision trees)

• Timeline
  – Some plans/PBMs live this month, many others will launch Q1 2015.
Electronic Solutions to Transitions of Care

• Result of a convened expert panel – Partnership Forum

• Report of the 2013 AMCP Partnership Forum on Electronic Solutions to Medication Reconciliation and Improving Transitions of Care (September 2014 – JMCP)
  – (http://www.amcp.org/JMCP/2014/September/18487/1033.html)

• Key Recommendations for AMCP:
  – Encourage the implementation of electronic solutions to the MedRec processes.
  – Work with MCO stakeholders and hospitals to pilot and measure different approaches to electronic solutions to MedRec.
Background

• Robert Wood Johnson Research Foundation report
  – Medicare patients alone
    • $26 billion in readmission costs
    • $17 billion was deemed avoidable if the right care was delivered

• CMS has identified readmissions as one of the top problems
  – Readmission reduction program
    • Target: CHF, AMI, Community Acquired Pneumonia
    • Considering expansion (COPD, post hip/knee replacement, asthma)

Background

• Lack of patient follow-up and adherence – major causes of readmission
• Changes in care settings should involve proper medication reconciliation (admission and discharge)
• “Garbage in, garbage out” – important to have strong data sources – avoid patient interviews
  – Surescripts database, health plan claim data, PDMP, HIE*
• Today – not leveraging electronic solutions and overuse of paper-based communication
Snapshot - Hawaii Pharm2Pharm Initiative

- CMMI grant* – University of Hawaii at Hilo, Daniel K. Inouye COP
- Launched in 4 counties
- Approximately 1,500 patients enrolled and “transitioned” that were high utilizers of acute care (Ave. $26,000/pt/year)
- MedRec Software – integration with HIE and available for use by community pharmacist for documentation
- All transition documents are sent from the hospital to community pharmacy through HIE (secure messaging)
- Available data/documentation by pharmacists is able to be pulled from HIE by providers – integration into EMR
- Lab data was also available to pharmacists – required provider authorization (many HIEs do not include)

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Snapshot - Hawaii Pharm2Pharm Initiative

• Results through July 2014
  – 84% of patients’ medications were reconciled by the Community Pharmacist within 30 days post discharge
  – >2,800 drug therapy problems were identified
  – 44% of drug therapy problems identified were resolved by the next patient visit
  – In 7% of visits with the Community Pharmacist, the patient reported medication access problems
  – 39% of medication access problems were resolved by the Community Pharmacist
  – 85% of patients were 55 yoa or older
  – 30-day pre/post PER PATIENT acute care cost decrease was approximately $11,000 (February 2014, n=1049)

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AMCP Activities

• Currently - one pilot program in development
  – Large national payer
  – Involves 2 hospital systems in KY and TN
  – Handoff of pertinent discharge information and MedRec from hospital to managed care MTM pharmacist
  – Document and record pharmacist intervention in software that will communicate with HIE (PCP, community pharmacy, hospital)
  – Target conditions with CMS Readmission penalty
  – Measure: impact on 30-day readmissions, utilization and costs at 3 and 12 months (all-cause ER and hospital visits, adherence, evidence based medications, avoidance of high-risk medications, number and cost of medications)
**IT Vendor**

- **Hospital**
  - Populate Admission MedRec Report
- **Patient**
  - Populate Discharge MedRec Report
- **Insurer**
  - Receive Discharge MedRec Report
- **Specialist**
  - MTM Service Documentation
- **Labs**
- **Pharmacy**
  - MTM Pharmacists

**Health Data Exchange/Direct Message Protocol**

*MTM Provider may be through vendor or insurer*
MTM and Research Gaps

• AHRQ – Draft Systematic Review of Medication Therapy Management – December 2013 (yet to release final report)
  – 5 Key Questions
    • Components and implementation features for MTM
    • Effectiveness on MTM for intermediate, patient-centered, or resource utilization outcomes
    • Intervention features
    • Patient characteristics that moderate the effect of an intervention on outcomes
    • Harms associated with interventions
  – Dearth of well-developed studies meeting inclusion criteria
  – Conclusion: “The evidence base is insufficient to address the effectiveness of MTM on most outcomes.”
MTM and Research Gaps

  – Study Effects of MTM on costs and outcomes, among high-cost Medicare patients with chronic diseases
  – Retrospective observational study

• Intervention Group (MTM)
  – Beneficiaries with CHF, COPD, or diabetes
  – Enrolled in Medicare Part D or Medicare Advantage with Part D
  – Eligible for and receiving MTM services
  – First year of enrollment

• Control Group
  – Beneficiaries eligible for MTM services in four largest Part D plans
  – Not actually receiving MTM services, because of different eligibility rules in plans in which they were enrolled
  – Additionally matched for relevant clinical and demographic characteristics
MTM Research – Acumen Continued

• Study findings
  – MTM improved medication adherence and quality of prescribing for CHF, COPD, and DM patients especially when CMR was provided
  – MTM initially improved the safety of drugs prescribed in new enrollees but positive effects diminished or reversed after 1 year of enrollment
  – MTM decreased hospital utilization and costs in DM and CHF patients receiving CMRs but not in COPD
  – Substantial variation in outcomes among Part D organizations

• High demand for robust research – potential in Medicaid plans currently offering MTM services
MTM Research Challenges and Opportunities

• Need continued flexibility for MTM eligibility criteria
  – Most health plans and MTM vendors are unsure which patients benefit most from services

• Need consistency in MTM documentation
  – MTM vendors – mostly free text
  – Uptake of standardized MTM service documentation codes
    • SNOMED CT Codes
    • Developed by Pharmacy HIT Collaborative - Work Group 2
    • Have an additional list of specific codes currently being developed
Conclusions

• New ePA transaction standards allow for a significant breakthrough in the efficiency of various utilization management strategies – Plans/PBMs, providers, and patients
• Beneficial for plans and PBMs to begin working with various EMR vendors as early as possible – make ePA a priority
• Electronic solutions to improve medication reconciliation and transitions of care exist – evaluate current strategies and consider best options to leverage technology to provide better electronic communication
• Request structured coding for MTM service documentation from your MTM vendor or begin to map your MTM services to available codes and partner with academic institutions to improve the body of evidence
Thank You

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