Medical vs. Pharmacy – Benefit Considerations for Benefit Checking and Reimbursement Models

Electronic Benefit Verification & Information Exchange May 18, 2016 | DoubleTree Center City | Philadelphia, PA



Speakers

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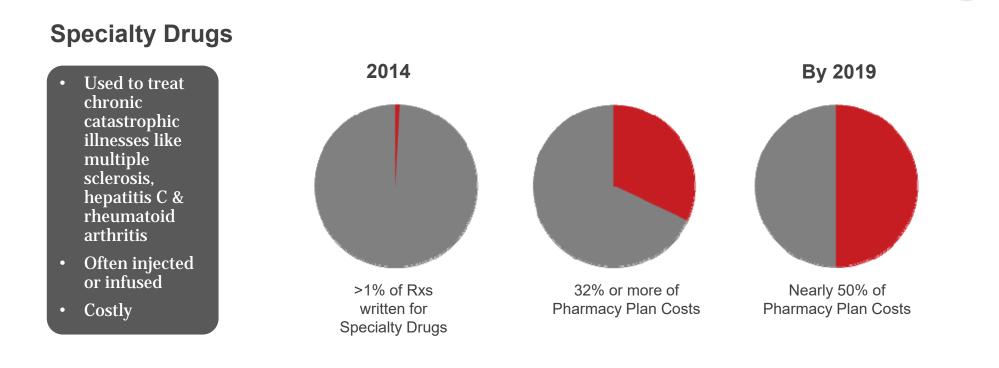
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Agenda

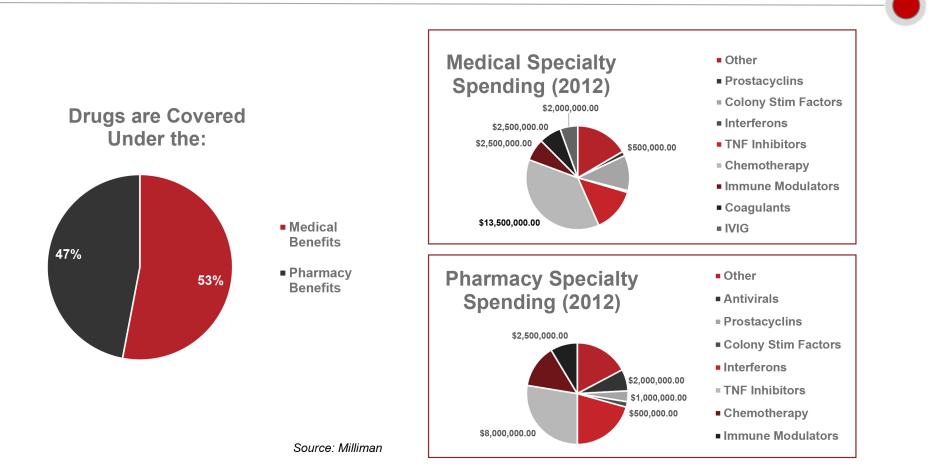
- The Current Environment
- Eligibility and Benefit Verification Today
 - Medical Benefit
 - Pharmacy Benefit
- Prior Authorization
 - Medical Benefit
 - Pharmacy Benefit
- Where We're Going

Growth of Pharmacy Specialty Spend



Source: Express Scripts Lab

Drug Coverage and Spending – Medical vs Pharmacy



The Differences Between Pharmacy and Medical

Medical **Benefit** Administration Intravenous Infusions, injections. Dispensing Physician, infusion channel center, home health. **Billing term** "Buy and Bill" Technology Can Bridge: Software/Tools Claims Batch or real-time Criteria using HCPCS codes. submission Route down Medical or Pharmacy benefit Utilization PA /medical review process management Member Copayment for office visit, coinsurance for cost-share drug product.

Pharmacy Benefit

Administration

Dispensing

Billing term

submission

Utilization

Member

cost-share

management

channel

Claims

Self-administered injections.

Specialty pharmacy dispenses drug and delivers to patient.

"Bill and Dispense"

Online using NDC.

PA, step therapies, concurrent DUR, formularies.

Copayment or coinsurance for drug.

The Current Environment – Pharmacy Benefit

7

How Does the Pharmacy Benefit Work?

- Self-Insured employers and health plans leverage third-party payers (TPAs) to manage the pharmacy benefit (called PBMs)
- Specific functions of PBMs include:
 - Main drug **formularies** to manage utilization and costs
 - Create **networks** of contracted/discounted retail pharmacies
 - Process pharmacy claims
 - Negotiate drug **rebates** with pharmaceutical manufacturers
 - Provide mail-order pharmacy dispensing
 - Administer programs to help reduce drug spend for clients, including Drug Utilization Review and Compliance Management Programs



Leveraging the ePrescribing Infrastructure



Office-Based

Physicians Use

Any EHR*



EHRs Enabled More than 700 EHRs enabled for ePrescribing

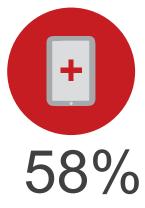


95%

Pharmacies Enabled for ePrescribing**



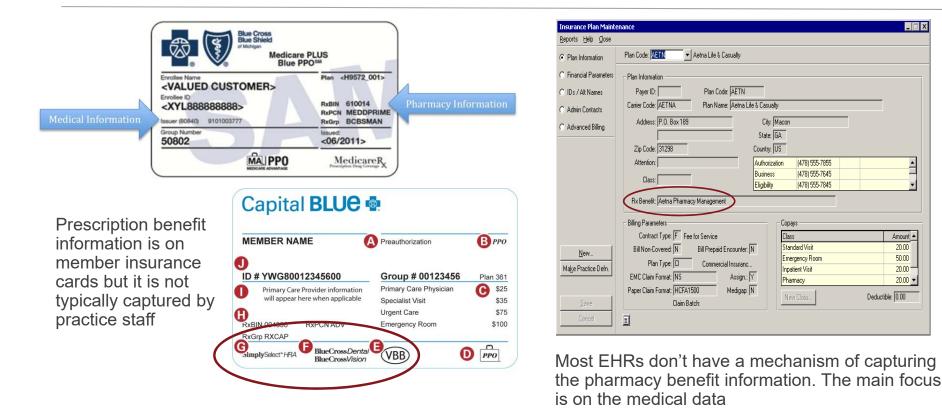
New Prescriptions Written Electronically**



Prescribers Utilizing Electronic Prescribing**

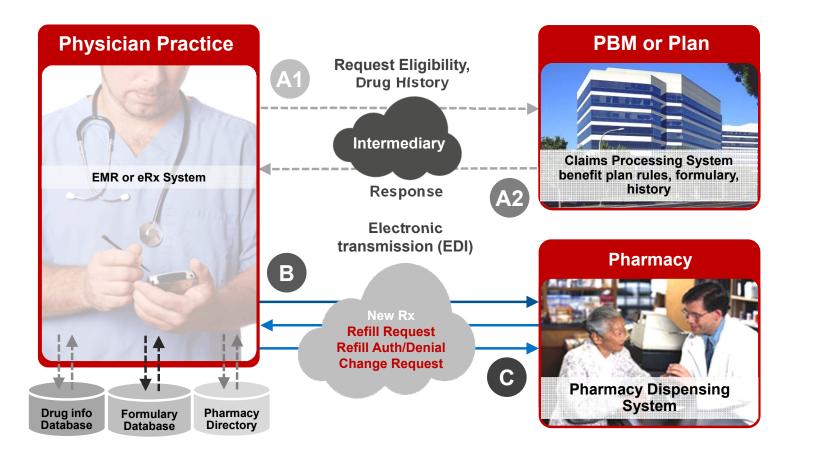
*HealthIT.Gov **Surescripts

Pharmacy Benefit Information not captured in the EHR



Despite significant progress with electronic formulary, practices still typically do not capture prescription benefit information from patients, as it is not used for the physician's billing

The Way ePrescribing Works



Challenges with Eligibility-informed Formulary



- Static data
- Inconsistent use of standard
- Potential inaccuracies
- Lack of appropriate granularity

M	Medicare Part DCommercial		Medicaid
	n=28	n=26	n=19
Formulary Status List	92.9% [26]	96.2% [25]	94.7% [18]
Copay (summary)	78.6% [22]	65.4% [17]	42.1% [8]
Coverage Detail: Prior Authorization	78.6% [22]	76.9% [20]	73.7% [14]
Coverage Detail: Step Therapy	75.0% [21]	76.9% [20]	68.4% [13]
Coverage Detail: Quantity Limit	71.4% [20]	61.5% [16]	68.4% [13]
Coverage Detail: Step Medication	64.3% [18]	57.7% [15]	42.1% [8]
Coverage Detail: Age Limit	60.7% [17]	57.7% [15]	57.9% [11]
Coverage Detail: Gender Limit	60.7% [17]	57.7% [15]	63.2% [12]
Coverage Detail: Coverage Exclusion	57.1% [16]	53.8% [14]	42.1% [8]
Alternatives	50.0% [14]	50.0% [13]	36.8% [7]
Copay (drug)	50.0% [14]	42.3% [11]	36.8% [7]
Coverage Detail: Coverage Text Message	50.0% [14]	50.0% [13]	42.1% [8]
Coverage Detail: Medical Necessity	39.3% [11]	46.2% [12]	21.1% [4]
Classification List	32.1% [9]	15.4% [4]	10.5% [2]
Coverage Detail: Resource Links (drug)	25.0% [7]	23.1% [6]	26.3% [5]
Coverage Detail: Resource Links (summar	y) 21.4% [6]	19.2% [5]	10.5% [2]

eFormulary Standard Adoption

Real-Time Pharmacy Benefit Inquiry Today and Pilots

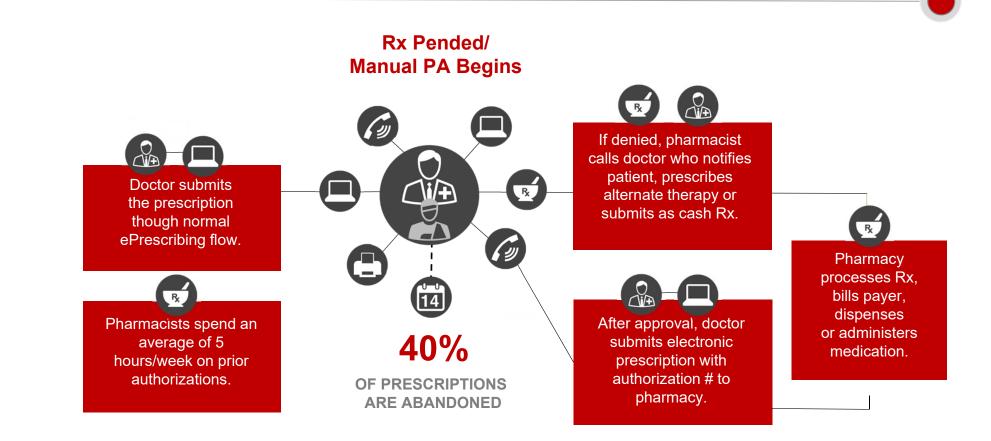


One Target, but currently many paths...

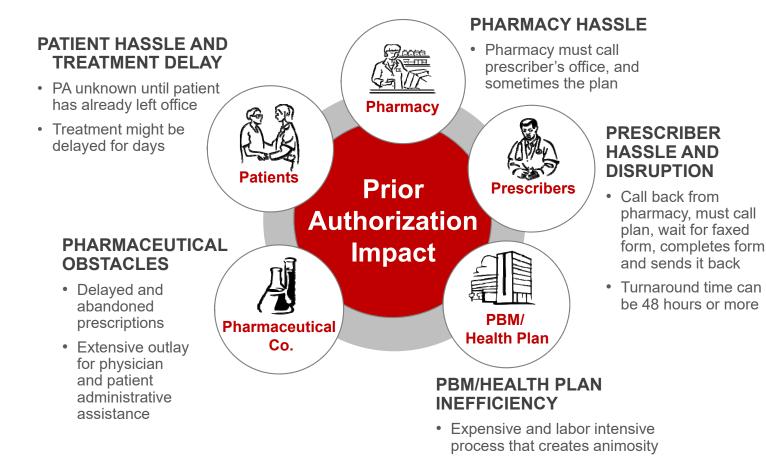
NCPDP workgroup efforts

- Use Case Development
- Industry Stakeholder Pilots
 - Modification of D.0 Telecommunications standard
 - Modification of SCRIPT standard
 - Proprietary connection
 - ONC and CMS requests for pilots

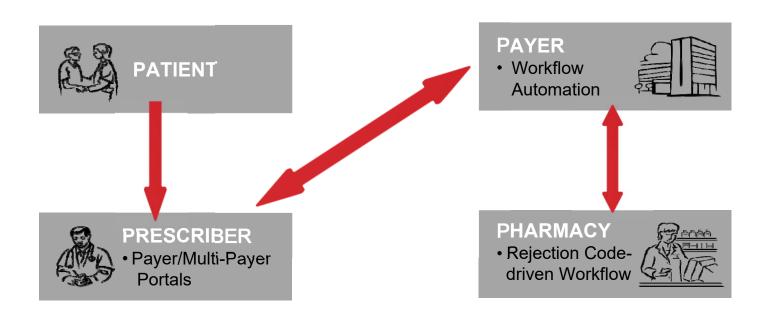
Current Manual Prior Authorization



Prior Authorization Impacts All Healthcare



Interim PA Automation (non-ePA)



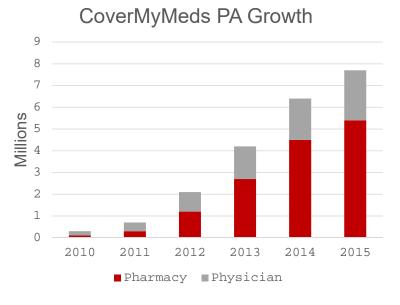
Until today, automation largely replicated the paper process requiring duplicate entry of information.

Gaps in Current PA Activities

Drug requiring PA flagged in only 20% - 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

HR pcess – ay or manual y reside AR ending acy,

Electronic Prior Authorization Update



Source: CoverMyMeds

- States driving adoption of ePA
- **Retrospective** and prospective models emerging in the marketplace
- 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, evidencebased PA criteria

The Medical Benefit

How Does the Medical Benefit Work?

- Employer/individuals pay premium to health insurance plan
- Drugs administered by a HCP are covered under the medical benefit
 - HCP may be MD office, hospital, home health or infusion provider, ambulatory infusion center
- Medical benefit drug costs built into deductible, cost share and max out of pocket
- · Health plan management of medical benefit drugs
 - May create formularies across RX and medical to manage utilization and costs
 - Create **networks** of contracted providers (HCPs) with variable reimbursement rates for same drugs: MD, home infusion, Hospital
 - Process drug claims on legacy medical claims systems not built for prospective adjudication; not directly linked to providers
 - Lag in time between drug administration, billing and reimbursement
 - May negotiate drug **rebates** with pharmaceutical manufacturers
 - May require **prior authorization** or adherence to medical policies



No e-Prescribing under Medical Benefit

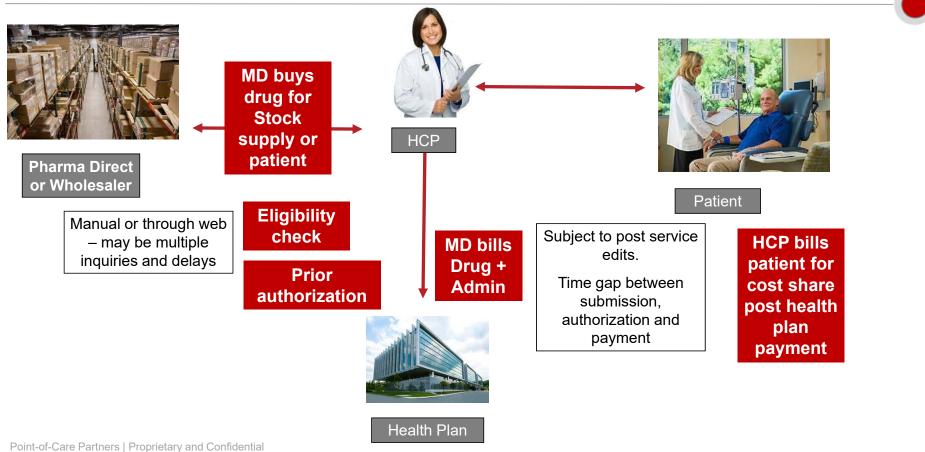
Buy and Bill

• Order may be entered into EMR, but no "prescription"

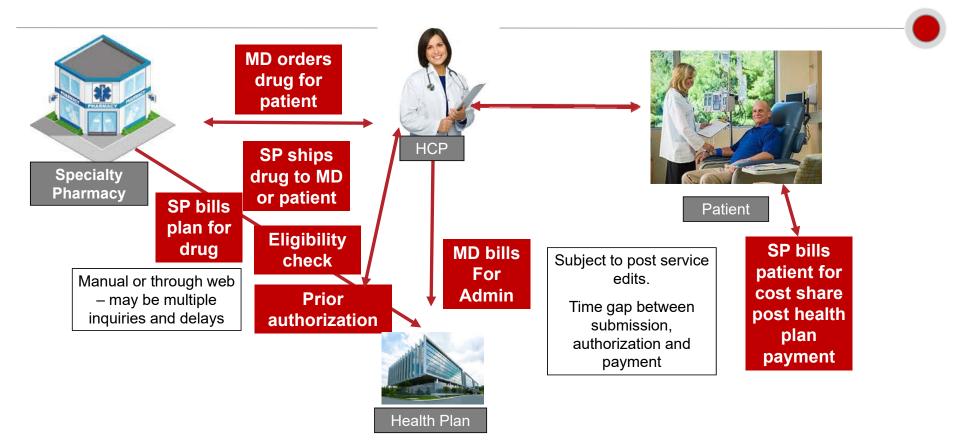
SP Distribution

- Order typically faxed along with a statement of medical necessity
- Either SP or MD will obtain Prior Authorization
- SP will typically try to bill under RX benefit first, then medical benefit
 - Most payers lock out infused drugs from RX benefit
 - SPs typically prefer RX benefit, as they get instant verification of payment information and copay (if applicable)

Medical Benefit Process Flow – BUY AND BILL



Medical Benefit Process Flow – SP Distribution



Mechanisms to Obtain PA for Medical Benefit Drugs

MD or SP calls or faxes health plan

- Labor intensive
- Significant lag time
- Patient often has to wait for treatment
- Follow-up difficult



- Questions relevant to condition
- Immediate authorization if criteria is met
- Treatment can begin immediately

Traditional Prior Authorization Example

> 50 questions, random order, not customized to diagnosis

Health Plan Avastin Medical Precertification Request

MEDICAL EDECEDTIES ATION DEO

Pa

MEDICAL PRECENTIFICATION REQ EOCID: Avatin (devadzumab) 29 Phone: 1-866-651-7273 Fax back to: 1-888-				
Humana manages the pharmacy drug benefit for your patient. Certa Please provide the following information and fair this form to the num process.				
Patient name:	Prescriber name:			
Memberisubscriber number:	Fax:			
Patient date of birth:	Office contact:			
Group number:	Tax D:			
Address:	Address:			
City state, ZIP:	City, state, ZIP: Specialty/facility n			
If the patient is a Medicare Private Pee-for-Genvice member, I an giving notification. Yes No I an requesting an advanced coverage determination. Yes,	which of the following apoly			
By checking this box, I am requesting multiple drug revi	ews for this pakent.			
Drug name and strength:	Dose per infusion/in			
Directions/SIG:	Number of Infusion			
Quantity/units:	Number of cycles/ft			
If yes, please provide date of service:	r this patient that may sup			
Yes No				
Q2. Please provide diagnosis: *				
Q3. Please provide J-Code, if applicable:				
Q4. Please provide ICD Diagnostic Codes:				
Q5. Please indicate which one of the following apple				
The drug is blied, dispensed and administered by infusion clinic on patient's behalf				
The drug is blied and shipped from a retail pham administered infusible drug)	nacy on patient's behalf to			
The drug is dispensed to the patient by a retail pt				
Home Health Service (supplied and administered	D			

G6. If Long-Term Care/Skilled Nursing Facility, is the patients stay cover

Avastn (bevacitumab) 29 Phone: 1-668-481-7273 Fax back to: 1-680-4					
atient Name:		Precoriber Name:			
Yes	No No				
07. "For facilities	other than the prescriber's offic	e, please provide where the drug			
	quested part of a clinical trial?				
_ Yes	N0				
	lease provide the registration of ClinicalTifals.gov identifier: NC	r identification number for the spe (T12345678);			
Q10. Is the reque	st for a reauthorization?				
Yes	No No				
Q11. Is the patien	i stable on the requested drug t	herapy?			
Yes	No No				
	's diagnosis one of the followin oular Rictinal Edoma, or Diaboti	g: Age related macular degerera o Mooular Edema?			
Yes	□ No				
Q13. Has the path	ent had significant disease prog	ression on previous Avastin thera			
_ Yes	No No				
Q14. IS Avastn be	ang used in combination with El	toitux (celuximab) OR Vectibix (p			
Yes	No No				
	ing used in the adjuvant or neo	adjuvant setting?			
] Yes	No No				
Q15. Has the path healed?	ent undergone major surgery in	the last 28 days OR have a majo			
Yes	No No				
	tent have untreated brain metas	stases (cancer that has spread to			
Yes	No No				
Q15. Has the path	ent recently had hemophysis (bit	ood in sputumor coughing up bio			
Yes	No No				
	tent have a fistula involving an i	internal organ?			
Yes	No No				
	ent experienced a severe artera	al thromboembolic event?			
Tes .	No No				
	fent have a gastroiniestinal per	foration?			
TYes 1	No No				
		risis or hypertensive encephalopa			
Yes	No No				

MEDICAL PRECERTIFICATION REQU

MEDICAL PRECERTIFICATION REQUEST COCID: Avastin (bevadurmati) 29		MEDIC	
Phone: 1-865-461-7273 Pap			Phone: 1
Patient Name:	Presoriber Name:	Patient Name:	
Q23. Does the patient have a diagnosis of recurrent Ovarian	Cancer (cancer that has retur	clear cell histo	biogy following progres
Yes No		Tes Yes	D No
Q24. Does the patient have a diagnosis of Non-Small Cell Lu	ng Canter (NSCLC) with non-	G40. Does the patie	ent have a diagnosis o
Yes No		□ Yes	
czs. Is the patient currently on antocaguation (blood the patient have a history of bleeding?	nimers such as Cournadin, vi		in being used after dis for METASTATIC dise
Yes No		Tes 1	No
026. Is Avastin being used as a single-agent continuati	on maintenance therapy?	Q42. Is Avast	in being used in comb
Q27. Was Avastin used as first line treatment for	recurrence or metastasis?		e patient have an East
Yes No		Ves.	
Q28. Does the patient have a performance statu	s of 0 - 1?		dagnosis anglosarco
Tes No		T Yes	
029. Is Avastin being used in combination with displatin	or cartoplatn?	Q45. Is Avast	in being used as a sin
Yes No		TYES	
Q30. Does the patient have unresectable, locally yes No	advanced, recurrent, or met	Q16. Is the patient's	dagnosis solitary fibr
Q31. Does the patient have a diagnosis of progressive or rec	umot olobiaciona or papela	□ Yes	No
Yes No	aren groudentrie or ellepte	Q47. Is Avast	in being used in comb
Q32. Will Arastin be used as a single agent or in combi	nation with innotecan, carmu	Ves Ves	No No
temozoiomide?		G48. Is the request	for persistent, recurre
Yes No		C Yes	□ N0
Q33. Does the patient have a CNS hemorrhage (bleed)	ng in the brain)?		sth be used in combin
Yes No		Ves Ves	No No
Q34. Does the patient have a diagnosis of metastatic polored	tal cancer?		for progressive endor
Ves No		□ Yes	□ No
Q35. Is Avastin being used in combination with hubropy chemotherapy for second-line therapy in patients who here and the second se			sth be used as a sing
Yes No	ave progressed on a literarie	Ves Ves	
Q36. Is Avastin being used in combination with 5-fluoro	ursel based chemotherany ft		e previous therapies u ew of the drug request
Yes No		personance to the reve	en or one originequesi
Q37. Does the patient have a diagnosis of unresectable meta Cancer?	istatic (stage IV) Renal Cell C	L	
Ves No		Prescriber signature	
Q38. Will the patient be using Avastin in combination w	th interferon alpha?	I declare under penalty ofper	ury under the laws of the United
Q39. Will Arasth be used as subsequent therapy forre	lacsed or unresectable stace	contraction being resignent of this information is	ping to the senderthet is legally prohibited from disclosing this is point in relevance to the conten
		copying, distribution or action i immediately to arrange for the	taken in reterence to the conten

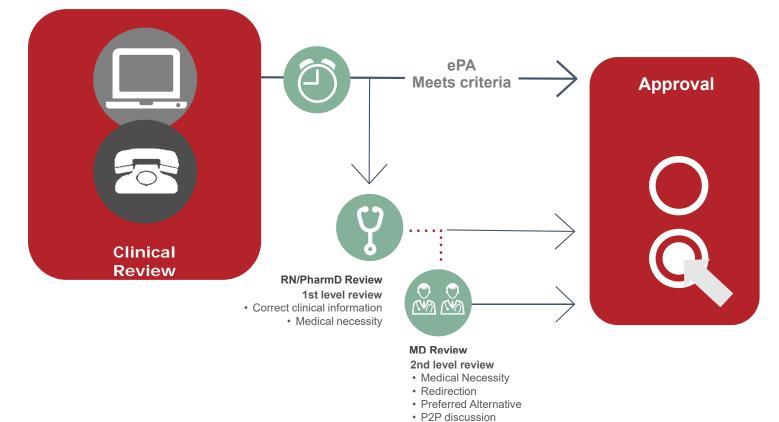
AL PRECERTIFICATION REQUEST FORM EDC ID: Avastin (bevacizumab) 29 866-461-7273 Fax back to: 1-888-447-3430 Precoriber Name ssion with cytokine therapy? metastatic (stage IV) or recurrent HER-2 negative Breast Cancer ease progression following antiracycline and taxane chemotherapy ination with Taxane (pacifaxel) for first line therapy tem Cooperative Oncology Group (ECOG) performance status of 0-2? de agent? sus tumor and hemanglopericytoms ination with terrozoiomide rt, or metastatic cervical cancer? nation with pacifizzel and displatin or pacifizzel and topolecan netrial cancer -agent sed with startierd dates and reason for discontinuing drug(s) that would be

internation provided in the and correct. This is intended only for the use of the individual of your are not be internated resident, you a copying, distribution or action taken in miler

eviCore data on file

Web-based Portal

3-5 minutes to complete authorization for entire course of therapy



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eviCore data on file

What's Next for Medical Benefit PA

- 1. NCPDP/AMCP development of ePA standard for medical benefit drugs (?)
- 2. Web link within EMR
- 3. Linkage between various PA programs if administered by the same company
 - a. Drugs
 - b. Laboratory/genetic testing
 - c. Imaging
 - d. Other modalities (radiation therapy, pathology, musculoskeletal management)
- 4. Full clinical Integration into EMR

Thank You.



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