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2018

ePA NATIONAL ADOPTION SCORECARD

Vol. IV

In the fourth edition of the scorecard, we continue to summarize the current state of electronic prior authorization (ePA) in the industry.

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As electronic prior authorization implementation continues to increase, the industry is looking for new ways to enhance ePA functionality to benefit industry stakeholders, continue fueling adoption from pharmacists and providers and benefit the patient.

Two areas of opportunity are real-time prescription benefit transactions (RTPB) and streamlined solutions for specialty medication. This edition of the scorecard highlights the current state of RTPB and specialty medications, and where the industry is headed.

View the full ePA Scorecard with real-time adoption statistics at **epascorecard.covermymeds.com**.

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TABLE OF CONTENTS

01

ABOUT ePA

About ePA

The industry continues to take note of the importance of an electronic prior authorization (ePA) solution and how it benefits all stakeholders.

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More states are adopting ePA language, more legislation is being proposed and electronic health record (EHR) systems are moving the needle forward on enabling PA.

While the market continues to grow and evolve, a natural focus is beginning to shift to more strategic and granular approaches to ePA to meet market need.

For example, how can ePA be of use for specialty medications? What other technology solutions are there to solve problems such as real-time prescription benefit check during the E-Prescribing process?

It is important for the patient and health care IT, as an industry, to tactically execute on solutions to solve existing problems, and to be deliberate in advancing future solutions.

NCPDP Transactions

Electronic prior authorization is the automated process of exchanging patient health and medication information required to help the patient's prescription coverage plan make a coverage determination.

Today, many prior authorization requests are completed through a manual process that involves phone calls and faxes between the pharmacy, provider and health plan. This is an inefficient, time-consuming process that leads to the patient abandoning the prescription 36 percent of the time.[1]

Electronic prior authorization automates this process by allowing the provider to initiate the ePA prospectively within their E-Prescribing workflow.

The most successful ePA strategies also connect the pharmacy to initiate an ePA that was missed at the point of prescribing, and allow the provider to complete a pharmacy-initiated PA electronically in their EHR or a designated ePA web portal.

The ePA process involves a four-part transaction established in the National Council for Prescription Drug Programs (NCPDP) SCRIPT Standard that enables patient and drug-specific prior authorization (PA) criteria and a real-time approval process.

NCPDP 4-PART TRANSACTION:

PART 1
Patient and drug information submitted to plan

PART 2
Questions provided based on patient, drug and plan

PART 3
Answers submitted to plan

PART 4
Determination returned to Provider

As ePA capabilities and adoption grow, particularly in the EHR space, there is often confusion as to the difference between ePA and electronic prescribing (E-Prescribing). A common misconception is that if a provider is E-Prescribing, they are also completing PA requests electronically.

E-PRESCRIBING

Electronic prescribing allows providers to write and submit prescriptions to pharmacies electronically through an EHR, rather than handwriting or calling it in to the pharmacy. It is beneficial to the patient in that they don't have to worry about bringing a paper copy to the pharmacy because the doctor submitted it electronically.
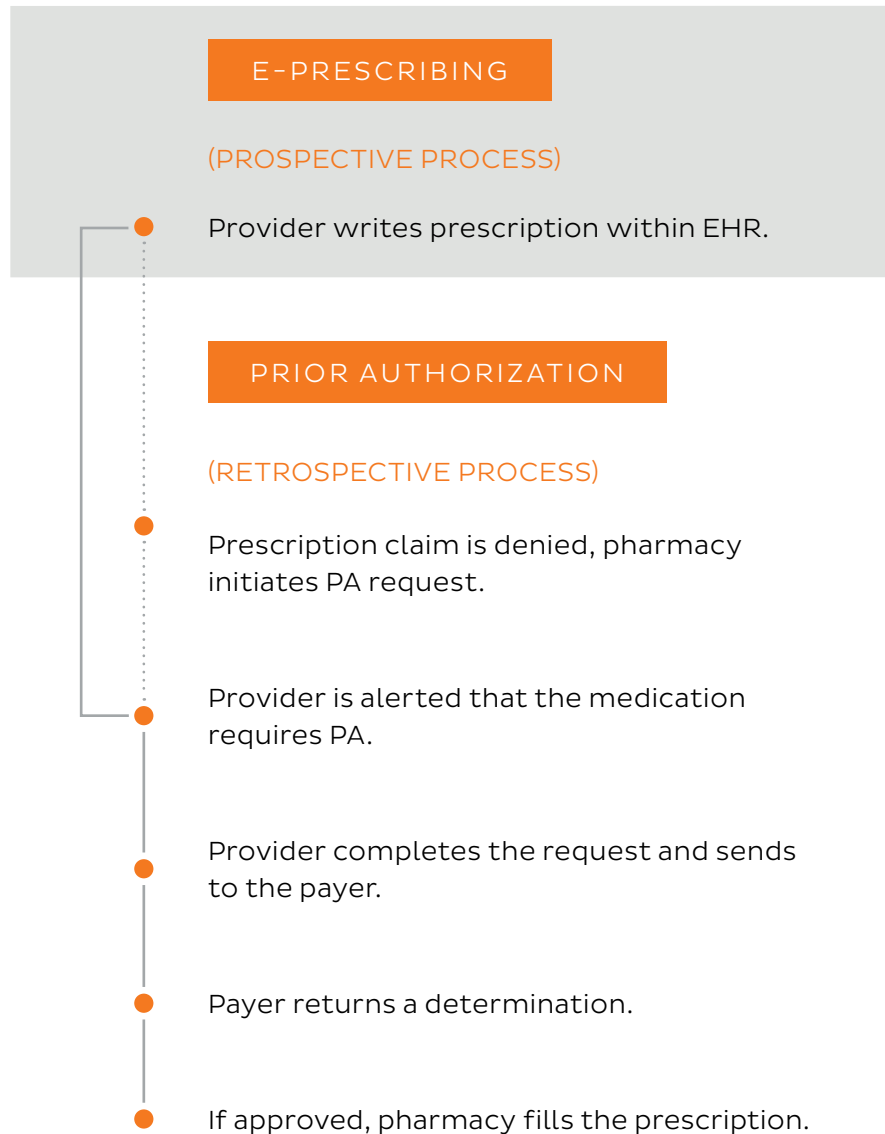
ePA

Electronic prior authorization occurs after a prescription is prescribed when a pharmacist or provider is notified that the patient's health plan requires PA to ensure coverage. Electronic prior authorization transforms the existing paper PA process into a real-time exchange of information that determines insurance coverage for a prescribed medication.

eFAX

While efax is not directly connected to the payer, it allows providers to submit a PA request using the same electronic workflow, regardless of the ePA capabilities of the payer. The pharmacy or provider may still initiate the PA and complete it electronically. It is then delivered to the payer via fax for processing.

While E-Prescribing and ePA will ideally occur in the same workflow within an EHR, they are not the same service.

E-PRESCRIBING

(PROSPECTIVE PROCESS)

Provider writes prescription within EHR.

PRIOR AUTHORIZATION

(RETROSPECTIVE PROCESS)

Prescription claim is denied, pharmacy initiates PA request.

Provider is alerted that the medication requires PA.

Provider completes the request and sends to the payer.

Payer returns a determination.

If approved, pharmacy fills the prescription.

02 IMPACT

Patient Impact

As the needle moves toward all stakeholders adopting an ePA solution, it's important to quantify the burden associated with PA and the benefits of an electronic solution. Those who report using an electronic method on average spend 2.5 fewer hours on PA per week, enhancing interoperability and medication adherence.

Approximately 10 percent of prescription claims are rejected at the pharmacy, and 66 percent of those prescriptions require PA; furthermore, 36 percent of those prescriptions will be abandoned due to the complex paper-based process.[1]

This increases the risk of future health problems or hospitalization for the patient. The utilization of an electronic solution may increase patient medication adherence by helping to ensure the patient leaves the pharmacy with a prescription in hand.

66% OF REJECTED PRESCRIPTION CLAIMS REQUIRE PA.[1]

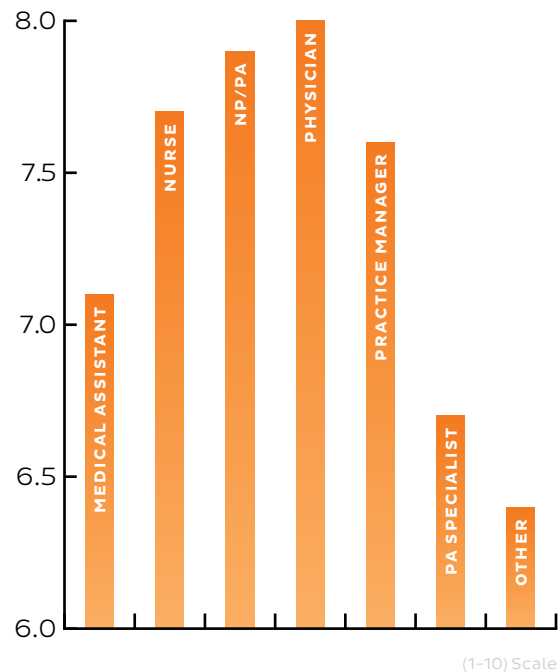**36% OF PRESCRIPTIONS REQUIRING PA ARE ABANDONED.**[1]

Provider Impact

Prior authorization has an immense effect on health care professionals of all types. Dealing with PA requests consumes a large number of hours for physicians, nurses and their staff, negatively impacting workflow and time spent with patients.

PERCEIVED BURDEN

There is a direct correlation between the perceived burden of PA and clinical responsibilities attached to the individual working on the request.[2]

A health care provider whose main focus should be on patient care and the prescribing of medication, perceives PA to be more of a burden than a PA specialist who has dedicated resources in assisting them with their workload.

(1–10) Scale

Fortunately, ePA can ease the burden for providers across the board.
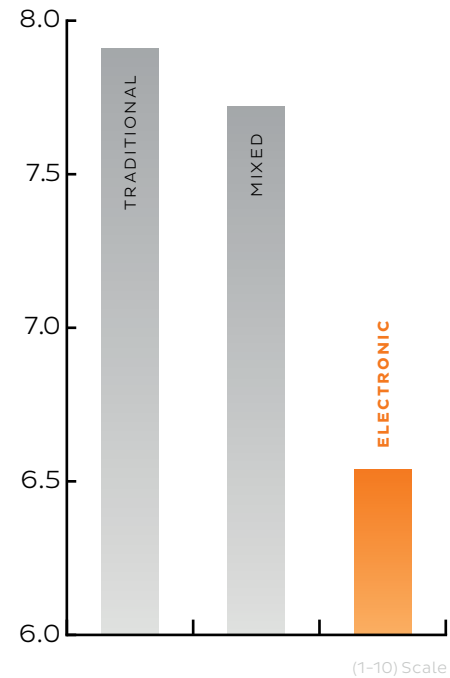

BURDEN BY SUBMISSION METHOD

The burden of PA is significantly lower for providers exclusively using an electronic method for PA versus those using fax and phone, or a combination of fax, phone and electronic channels.[2]

Those who report using an electronic method to submit PA, on average spend 2.5 fewer hours on PA per week.

There is an opportunity today for providers to exclusively use an electronic channel through utilization of an all-payer, all-medication ePA web portal.

8.0

7.5

7.0

6.5

6.0

TRADITIONAL

MIXED

ELECTRONIC

(1–10) Scale

As it stands, few providers exclusively use an ePA solution. Use of phone and fax channels to complete PA requests result in delays to therapy and additional administrative waste.
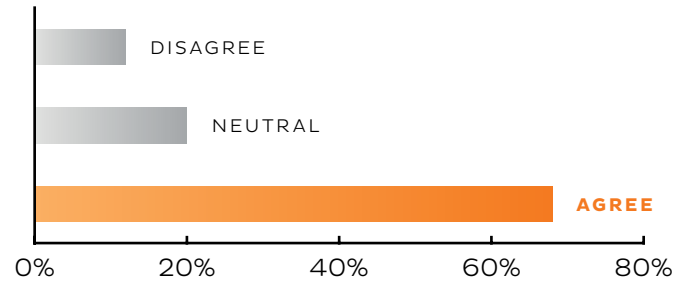
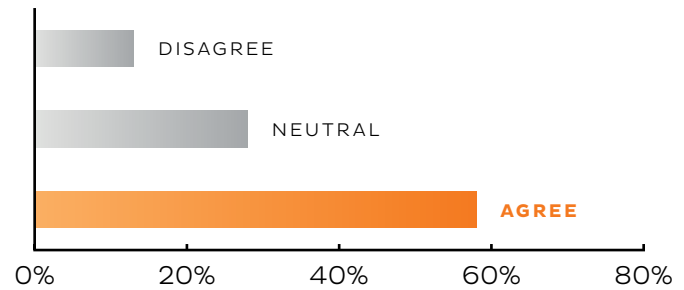**76% OF PROVIDERS USE MORE THAN ONE CHANNEL TO COMPLETE PA REQUESTS.**[2]

Across the board, providers agree that ePA can increase speed to therapy, positively impact their organization and decrease the likelihood of prescription abandonment.

Ninety-five percent of providers indicate they are likely to learn a new technology, such as ePA, if they agree with these benefits.[2]

ePA Increases Speed to Therapy
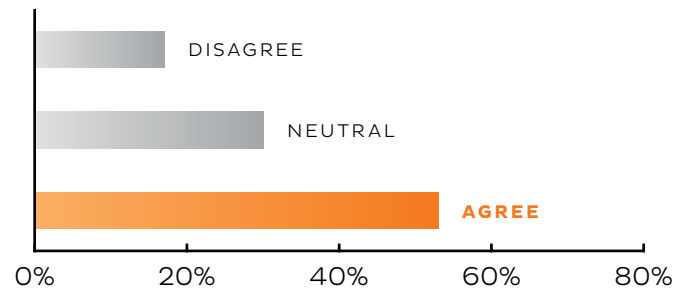
DISAGREE

NEUTRAL

AGREE

0%   20%   40%   60%   80%

ePA Has a Positive Impact on Health Care

DISAGREE

NEUTRAL

AGREE

0%   20%   40%   60%   80%

ePA Reduces Prescription Abandonment

DISAGREE

NEUTRAL

AGREE

0%   20%   40%   60%   80%

KEY TAKEAWAY

By leveraging ePA, providers greatly reduce paperwork, enable PA requests to be submitted in a secure environment and receive faster (often immediate) determinations. These benefits relieve the burden associated with the PA process, which is necessary to help ensure patients receive access to appropriate therapy.

03

SPECIALTY

Defining Specialty

While ePA for medication is quickly becoming more common, one area that has not yet reached its full potentiality is an electronic solution for all the elements required for specialty medications. As it stands, a patient may wait 3-6 weeks for treatment without a specialty solution.[3]

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The industry has yet to create one definition for specialty medication; however, as a rule they are often classified as high-cost drugs (on average, a wholesale acquisition cost of more than $670) which are used to treat chronic, complex or rare diseases.[4]

Their complexity is exacerbated due to the fact that they normally require unique administration (i.e. nebulizer, injections) and more consistent patient monitoring by way of labs or regular checkups, and more time-intensive up-front processes, enrollment documentation, REMS and PA. All of these requirements must be taken care of before the patient ever gets their specialty medication.

By 2020, a projected 90% of top-selling drugs by revenue will be specialty.[5]

Completion Time

In today's landscape, E-Prescribing can be challenging for providers due to the complexity of determining coverage and limited pharmacy distribution.

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The question is often asked if ePA can be used for a specialty medication, even when E-Prescribing does not offer the ideal solution. The answer is yes.

"The good news is that patients are being treated for rare and complex conditions and living healthier and happier lives." — PBMI drug report[6]
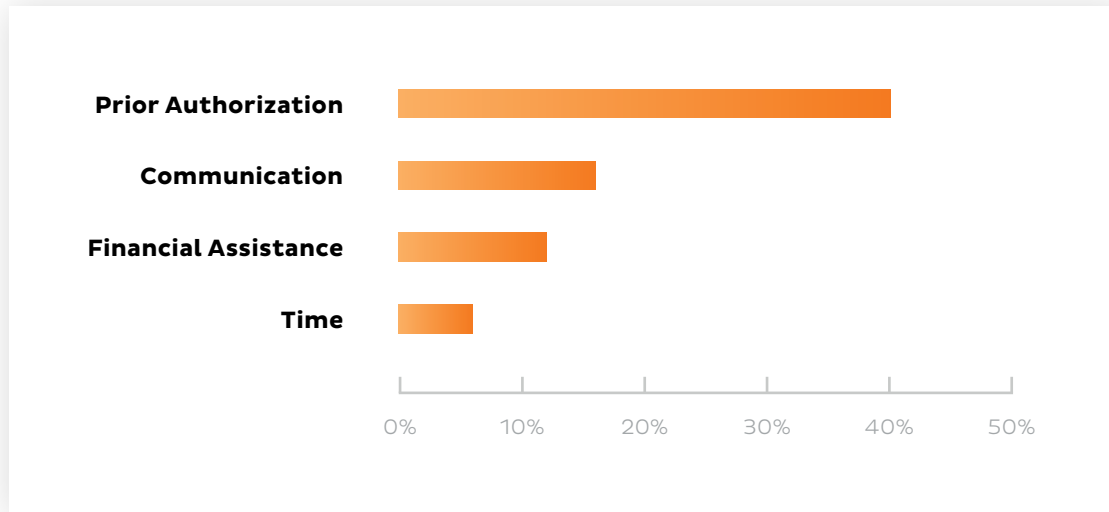
The current process of approval for specialty medication is extremely paper-heavy, similar to PA before the advent of ePA.

Forty percent of providers cite PA around specialty medications as the main pain point when prescribing the drugs, and 30-50 percent of specialty PA request denials involve administrative error.[7]

Additionally, there is little transparency for the provider to know which specialty pharmacy is authorized to fill the prescribed specialty medication for a specific patient.

Forty percent of providers cite PA around specialty medications as the main pain point when prescribing the drugs.[8]

A streamlined workflow for specialty medication benefits all stakeholders including the pharmacy, provider, payer and most importantly, the patient. A solution that allows the ability to monitor treatment is critical.

An integrated workflow can be used to understand the timeliness of medication delivery for the patient (i.e. how long it took from the prescription process to the patient actually commencing therapy),

adherence to their medication and how it impacted their health.

When a streamlined specialty solution is not incorporated into the provider workflow, a patient may wait 3-6 weeks for treatment.[3]

The seemingly endless cycle of communication and confusion with the provider, pharmacy and health plan puts the patient in danger of not receiving or adhering to this important medication.
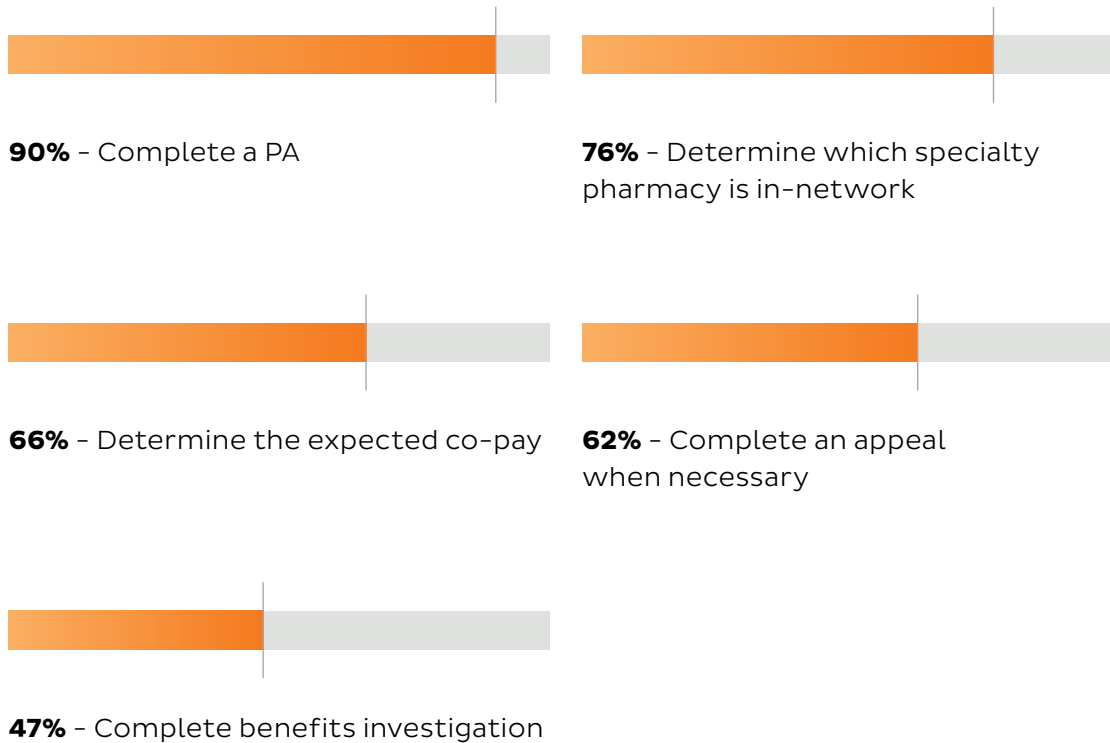
Ideal Workflow

The ideal workflow management tool will address gaps in communication and efficiently streamline and reduce back and forth between all stakeholders and provide more transparency on behalf of the patient.

Providers should be able to identify which specialty pharmacies can service the patient (from a neutral perspective), select an appropriate network pharmacy and complete the steps necessary to coordinate and monitor treatment within their normal workflow.

Specialty pharmacies would then receive a complete set of clinical questions required to process the patient's therapy. The solution should also provide personal support that encourages the submission of required information on the initial PA in an effort to prevent any unnecessary denials.

The top elements that specialty providers report they want to have in a specialty solution are as follows: [8]

90% - Complete a PA

76% - Determine which specialty pharmacy is in-network

66% - Determine the expected co-pay

62% - Complete an appeal when necessary

47% - Complete benefits investigation

A Closer Look

PROBLEM

A provider faxes the specialty medication enrollment form to the specialty pharmacy they think can fill the script, but unsure if the preferred pharmacy is correct.

The specialty pharmacy calls the provider to gather patient insurance and clinical information for the PA request, adding more time to the process.

A provider selects the specialty medication they want to prescribe with full transparency into the available specialty pharmacy network.

The provider, once understanding where they can send the script, can initiate the prescription electronically, including the patient benefit info, enrollment documentation and initiated PA.

SOLUTION

The provider and specialty pharmacy exchange a series of phone calls and faxes to complete enrollment, benefits investigation and PA.

The provider submits the PA to the plan. The plan reviews and makes a determination, but it's not communicated to specialty pharmacy and provider.

The specialty pharmacy and provider exchange more calls to communicate determination and fill the script. No dispense information is communicated.

The provider reviews and submits PA to plan, and completes E-Prescribing all in one streamlined workflow with no unnecessary back and forth.

The plan reviews and makes determination; the outcome is delivered electronically to provider and specialty pharmacy.

The specialty pharmacy fills the medication for the patient and sends dispense information electronically back to the provider.

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"There is a larger burden for ePA for a specialty medication. There is often many step edits that need to be addressed...Using ePA has definitely freed up a lot of time."

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–BARB ROBISON, DERMATOLOGY OFFICE MANAGER

KEY TAKEAWAY

In 2017, 300,000 NPIs submitted an ePA for specialty medication[9], indicating providers want to do these processes electronically. A PA can be submitted through web portals initiated at the pharmacy, or through a doctor's EHR. Unfortunately, it does not yet account for the additional factors that prescribers care about such as enrollment forms and pharmacy visibility. A pilot program is in progress to address these other barriers. CoverMyMeds is actively working to provide a solution that will be inclusive of all factors in the specialty prescribing process.

04

**REAL-TIME
PRESCRIPTION BENEFIT**

The landscape of health care IT continues to rocket toward a value-based care system. To remain viable in the changing market, companies are beginning to optimize and develop methods that allow providers to have full visibility into all aspects of a prescription.

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Functionality ranges from out-of-pocket costs, to whether medication will need a PA, and allows providers to have informed conversations with the patient before they ever leave the clinic.

When a provider is writing a prescription, their intent is to make clinically appropriate decisions based on the patient's needs.

Beyond what medication is most beneficial for the patient's health, a provider and their patient need to consider several aspects that contribute to adherence and reduce friction at the point of prescribing.

ADHERENCE CONSIDERATIONS

1. Is the medication covered by the patient's prescription benefits, or can it be covered through a PA request?

2. If not, what would be the cash amount?

3. Can the patient afford the co-pay?

4. Is the medication available at the patient's preferred pharmacy?

5. If not, is it available at a pharmacy that's convenient for the patient?

Feedback from providers and industry research indicates this information is lacking in the current prescribing workflow and a demand exists for it to be included.

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A study completed by AIS Health indicates that during the prescribing process, physicians have little visibility into benefit coverage and co-pay information.[10]

30% of physicians have access to co-pay information while prescribing.

31 % of physicians reported knowing if a PA will be required while prescribing.

50% of physicians have access to the correct formulary tier information while prescribing.

"Anticipating patient copays (in order to prepare assistance if needed) is made difficult by insurance imposed pharmacy restrictions. We usually have to obtain the authorization and then contact the contracted pharmacy who may or may not be willing to run a test claim.

If copays come back too high and provisions have not been made this usually keeps the medication out of the patient's hands."

– HEALTH CARE EMPLOYEE, ONCOLOGY

Increasing Provider Visibility for Better Patient Care

In order to narrow down the best possible option, providers need visibility into patient benefits.

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This will help to determine if a PA is going to be needed, accurate patient pay information, patient out of pocket cost and patient's preferred pharmacy, when applicable. In order to fully assist their patients, prescribers need access to this information in prescribing workflow.[11]

A workflow that provides these details enables the provider and patient to have an informed discussion and make the best decision on which therapy to prescribe.

It is also likely to increase the patient's ability to receive and adhere to the medication they need to successfully manage their drug therapy and improve their health.

The objective of RTPB solutions is to meet these needs and should be designed to support the provider and their patient at the point of prescribing.

It also eliminates various prescribing barriers that may lead to callbacks from the pharmacy and may help improve physician and patient satisfaction.

RTPB Benefits to Stakeholders

The benefits of a true price transparency RTPB solution are felt by all health care stakeholders but more importantly, the patient.

PROVIDERS

Instant visibility into benefits and pay information will allow a provider to have a real-time conversation with their patient, establishing the best path to therapy.

An informed decision at the point of prescribing will minimize further communication between the pharmacy and the provider's staff between the time of prescribing and when the medication is dispensed.

PAYERS

Less back and forth exists between the provider, pharmacy and health plan, when all needed information is provided up front for the patient. Some RTPB solutions also offer integrated ePA functionality, which will increase provider utilization.

04 — RTPB

PHARMACY

The pharmacy eliminates administrative calls and faxes to the provider when informed prescribing decisions are made proactively by the provider. Pharmacies will also have the ability to fill prescriptions faster and are more likely to have the medication picked up by the patient who is already aware of cost implications.

Instead of talking about costs with the patient, the pharmacy is also afforded the opportunity to counsel patients on how to appropriately take their medication.

PATIENTS

By allowing the provider to ask important information of the patient while they're still in the office, the patient has more say in variables that directly affect their health, such as cost and availability; thus, they are more likely to adhere to their prescribed therapy.

NCPDP and RTPB

The National Council for Prescription Drug Programs is in the process of developing RTPB standards. The uniqueness in RTPB, from a NCPDP standpoint, is the task group is working on a standard which can be utilized using either the Telecom or SCRIPT model. While no standard currently exists, progress is being made.

Available RTPB Solutions

There are several solutions currently available to the market. Similar to ePA, the success of RTPB solutions will be based on provider adoption.

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Ease of access to the provider is key; however, more critical will be delivering information in the RTPB transaction that reflects the data providers and their patients need to make informed clinical decisions. Based on conversations with providers, the following elements will be critical for adoption:

REAL-TIME, ACCURATE PATIENT BENEFIT AND PATIENT PAY INFORMATION

An indicator of patient coverage by a plan will not be enough. Providers will want to see data similar to what the pharmacy sees, which reflects real-time patient coverage and cost based on their specific plan and deductible.

AVAILABLE PATIENT ASSISTANCE PROGRAMS

Medication cost is a significant factor to adherence and should be part of the prescribing discussion. Visibility at the point of prescribing into patient assistance programs will support the provider and their patient making an informed decision on treatment options.

PHARMACY AVAILABILITY AND COST

Pharmacies are best equipped to provide accurate data on real-time medication availability and cost to help the provider and patient decide on a convenient pharmacy to fill the script, and the actual cost the patient will encounter when they arrive at the pharmacy.

ALL-PAYER COVERAGE

Similar to ePA, the need for RTPB solutions to have coverage for all payers is critical to provider adoption.

PA REQUIREMENTS AND OTHER COVERAGE RESTRICTIONS

An indicator of when a PA is needed to fill the script will enable the provider to initiate the PA automatically if they choose to prescribe therapy requiring PA. The most comprehensive solutions will include an indicator when PA is required and provide the option to proactively initiate an ePA to any health plan.

This capability increases the likelihood the PA is reviewed by the plan by the time the patient arrives at the pharmacy to pick up the prescription, bolstering adherence to their therapy.

KEY TAKEAWAY

The industry continues to implement RTPB solutions and quantify the impact on providers and patients. This report will track EHR, health system and provider adoption information as it becomes available.

05 LEGISLATION

Prior authorization legislation has been in consideration—and in some cases in effect—since 2013. Historically, mandates around PA legislation remained in the hands of individual states, but more recently the federal government has taken note of the importance.

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FEDERAL DEVELOPMENTS

In January 2018, H.R. 4841, the Standardizing Electronic Prior Authorization for Safe Prescribing Act, was introduced in the U.S. Congress.

This bipartisan bill is designed to move the needle on ePA usage in the Medicare Part D Program, improving prescription access for Medicare beneficiaries. It is a step forward to improving an outdated system and also improve efficiencies by standardizing the PA process.

PA Legislation Types:

ePA (NCPDP STANDARD)

Calls for the use of an electronic method for submitting medication PA in compliance with the NCPDP SCRIPT Standard.

ePA (NO STANDARD)

Calls for the use of an electronic method for submitting medication PA, but names no standard.
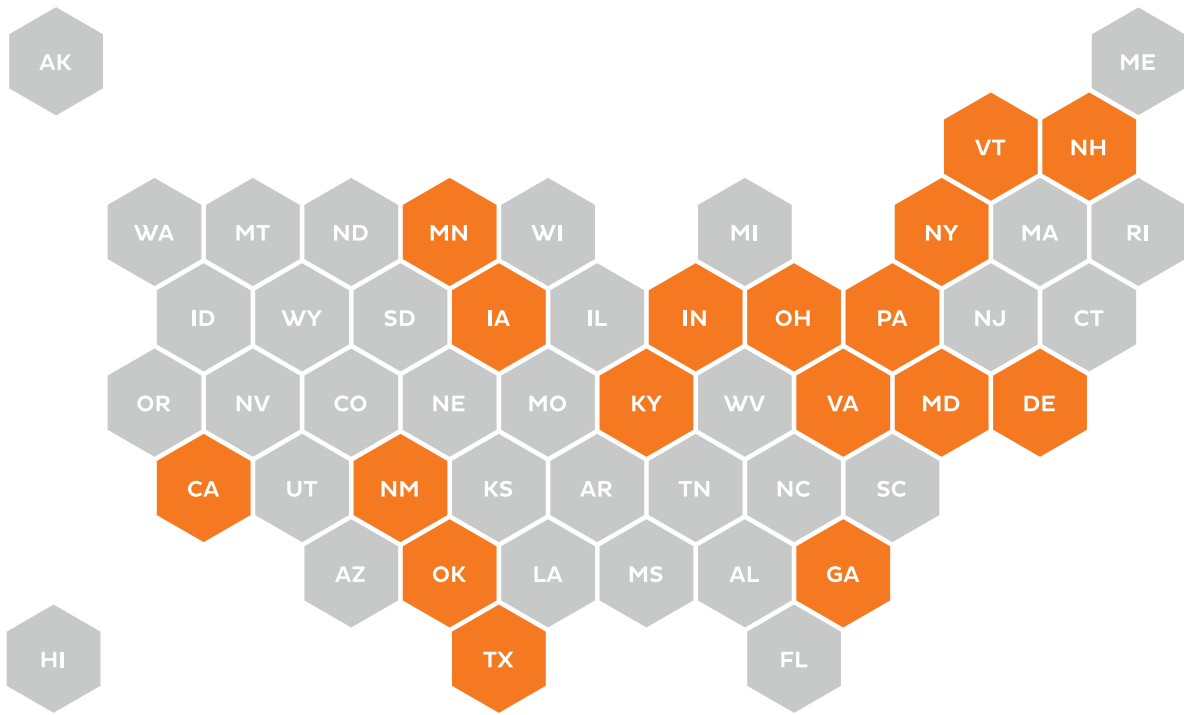
STANDARD FORM

Calls for the use of a universal or standard form for medication PA approved by the state's Department of Insurance.

STANDARD FORM & ePA

Calls for the use of a universal or standard form as well as the use of an electronic method for submitting medication PA.

ePA (NCPDP STANDARD)[12]

**CALIFORNIA
SB282**

The Department of Managed Health Care and the Department of Insurance jointly created a standard PA form, publishing rules effective July 1, 2017. The rule requires the use of the adopted standard form on or before January 1, 2018.

Every prescribing provider must use the adopted standard PA form, or an ePA process utilizing the NCPDP SCRIPT Standard ePA transactions to request PA. Every health insurer should accept that form or NCPDP SCRIPT Standard ePA transactions as sufficient to request PA for prescription drugs.

**DELAWARE
HB381**

The insurer must accept and respond to PA requests through secure electronic transmission using the NCPDP SCRIPT Standard for ePA transaction. Faxes, proprietary payer portals and electronic forms are not considered electronic transmissions.

**GEORGIA
SB416**

Electronic prior authorization requests must be accessible and submitted by providers to PBMs and health plans through secure electronic transmissions utilizing the current NCPDP SCRIPT Standard for ePA.

The health care provider is not required by adopted code to participate in ePA in order to obtain the necessary authorization for patient care; however, faxes are not considered an electronic submission except in the event that such ePA is temporarily unavailable due to system failure or outage.

**INDIANA
SB73**

Effective Jan. 1, 2018, the bill requires a health plan to accept and respond to a PA from a prescriber or a pharmacist through an electronic transmission using the NCPDP SCRIPT Standard. Encourages all entities to use a common form for PA but no standard form created or mandated.

**IOWA
ARC 2348C**

The regulation requires each insurer to create a PA form unique to that insurer, not to exceed two pages and to be approved by the Commissioner of Insurance. The form must be made available electronically by the carrier or PBM. The form to be submitted by the health carrier must take into consideration forms developed by CMS or U.S. Department of Health and Human Services and any national standards to include the NCPDP SCRIPT Standard.

The division recognized the importance of technology to the industry and modified the proposed rule to emphasize that the statutory language requiring a form does not preclude the use of or compliance with NCPDP SCRIPT Standards.

**KENTUCKY
SB144; KRS
217.211**

NCPDP adopted ePA standards in 2013. Within 24 months of NCPDP developing and making available national standards for ePA, each governmental unit of the Commonwealth communicating administrative regulations relating to E-Prescribing must consider E-Prescribing and ePA standards in its implementation of health information technology improvements as required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 and the Health Information Technology for Economic and Clinical Health Act, enacted as part of the American Recovery and Reinvestment Act of 2009.

**MARYLAND
HB1233**

Online, web-based process required by payers and PBMs. Providers are required to use payer web portal OR standard transaction that has been established and adopted by the health care industry via EMR. Additional requirements regarding Step Therapy were also added.

**MINNESOTA
62J.497**

Drug PA requests must be accessible and submitted by health care providers, and accepted by group purchasers, electronically through secure electronic transmissions. Fax should not be considered an electronic transmission.

The Minnesota Prescription Drug Companion Guide v1.1, names the NCPDP SCRIPT Standard for ePA transactions as the methodology for secure electronic transmissions. All health care providers must submit requests for formulary exceptions using the uniform form, and all payers must accept this form from health care providers.

**NEW
HAMPSHIRE
HB1608**

Requires the Commissioner of Insurance to create a universal PA form to be accepted and used by insurers when requiring PA for medications or use of the NCPDP SCRIPT Standard for ePA.

Electronic prior authorization is not required if a pharmacist or prescriber lacks broadband Internet; or has low patient volume; or has opted-out for a certain medical condition or for a patient request; or lacks an EMR system; or the ePA interface does not provide for the prepopulating of prescriber and patient information; or the ePA interface requires an additional cost to the prescriber. Does not apply to Medicaid.

Rule INS 2705, passed March 8, 2017, Department of Insurance adopted PA universal form as required by HB1608.

**NEW MEXICO
SB296**

Requires a uniform PA form to be used by all plans. A health insurer must exchange PA requests with providers who have E-Prescribing capability.

NEW YORK
SB4721A

Requires the Department of Health and Financial Services to develop standards for PA, taking into consideration the NCPDP SCRIPT Standard.

OHIO
SB129

Effective Jan. 1, 2018, insurers must permit health care providers to access the PA form through applicable electronic software. Insurers and PBMs must also accept PA requests through a secure electronic transmission using the NCPDP SCRIPT Standard.

Faxes are not considered secure electronic transmissions and proprietary payer portals are not considered secure transactions unless they use the NCPDP SCRIPT standard. Prescribers and insurers can enter into contractual agreements foregoing this process if it's an undue hardship.

OKLAHOMA
SB1128;
HB2190

SB1128 PROPOSED – Requires the Commissioner of Health and State Board of Pharmacy to create an electronic transmission process for drug PA requests by February 15, 2019 that aligns with national standards. This electronic transmission process must be accessible and submitted by health care providers and accepted by group purchasers (i.e. health plan, reviewing entity) no later than January 1, 2021.

Fax shall not be considered electronic transmission. Also requires no later than January 1, 2020, a uniform formulary exception form be accessible and submitted by health care providers, and accepted and processed by group purchasers.

HB2190 – A health benefit plan must utilize PA forms for obtaining any PA for prescription drug benefits. A form shall not exceed three pages. The form may be customizable to a specific drug. A health benefit plan may make the form accessible through multiple computer operating systems.

**PENN.
HB1293**

PROPOSED – Prior authorization requests shall be accessible to health care practitioners and accepted by insurers, pharmacy benefits managers and utilization review organizations electronically through a secure electronic transmission using the NCPDP SCRIPT Standard electronic prior authorization transactions.

Fax, proprietary payer portals and electronic forms shall not be considered electronic transmissions. Act would take effect 60 days after passage of the law.

**TEXAS
SB1216**

Standard state adopted PA form required for PA requests. Mandate requires acceptance of NCPDP SCRIPT Standard of ePA.

**VERMONT
HB559**

When requiring PA for prescription drugs, a health plan must accept for each PA request either the national standard transaction information or a uniform PA form. A health plan must have the capability to accept both the national standard transaction information and the uniform PA form.

**VIRGINIA
HB1942**

Requires carriers to accept phone, fax or electronic submission of PA requests that are delivered from E-Prescribing systems, EHRs and health information exchange platforms that utilize the NCPDP SCRIPT Standard.

Requires all PA forms accepted by the carrier be made available through one central location on the carrier's website and that information be updated by the carrier within seven days of approved changes.

ePA (NO STANDARD)[12]

**ARIZONA
SB1001**

The health insurer or its utilization review agent must allow providers to access the PA request form, but no universal form named or adopted; Beginning January 1, 2020, the health insurer or its utilization review agent must accept PA requests electronically, but no standard named; and the health insurer or its utilization review agent must provide at least two forms of access to request PA.

**ARKANSAS
SB318**

A health care insurer must utilize only a single standardized PA and non-medical review form for obtaining approval in written or electronic form for prescription drug benefits. The form must be accessible through multiple computer systems.

The required form must not exceed two pages and be designed to be submitted electronically from a prescribing provider to a health care insurer.

**COLORADO
SB277; 3CCR
702-4, 4-2-49**

All carriers must utilize the uniform PA process established by the regulation. A PA process for a drug benefit must allow for electronic submission but is not required. The carrier must make available on their website the standard form for PA for a drug benefit.

**FLORIDA
HB221**

A health insurer or a PBM on behalf of the insurer, which does not have an ePA process for its contracted providers must use only the PA form approved by the Financial Services Commission.

MASS. TITLE XXII, CHAPTER 1760, SECTION 25

Nothing should prohibit a payer or any entity acting for a payer under contract from using a PA methodology that utilizes an internet webpage, internet web portal or similar electronic, internet and web-based system in lieu of a paper form, provided that it is consistent with the paper form.

A payer or any entity acting for a payer under contract, when requiring PA, must use and accept only the PA forms designated for the specific type of services and benefits.

MICHIGAN SB178

If an insurer uses a PA methodology that utilizes an internet webpage, internet web portal or similar electronic, internet and web-based system, they will not be required to utilize the standard form adopted by the Department of Financial Services, Community Health or Insurance.

The form approved by the Department of Insurance and Financial Services must be used in requesting PA for prescription drugs.

MISSISSIPPI HB301

A health insurance issuer must use only a single, standardized PA form for obtaining any PA for prescription drug benefits. The form must also be made available electronically and the prescribing provider may submit the completed form electronically to the health benefit plan.

NORTH DAKOTA HB1274

Effective August 1, 2015, a drug PA request must be accessible to a health care provider with the provider's E-Prescribing software system and must be accepted electronically, through a secure electronic transmission, by the payer, by the insurance company, or by the PBM responsible for implementing or adjudicating the authorization or denial of the PA request. For purposes of this section, a fax is not an electronic transmission.

OREGON SB382 AND OAR 836-053-1205

Plans must accept the requested universal PA form through any reasonable means of transmission, including but not limited to paper, electronic or another mutually agreeable accessible method of transmission or using an internet or web-based system.
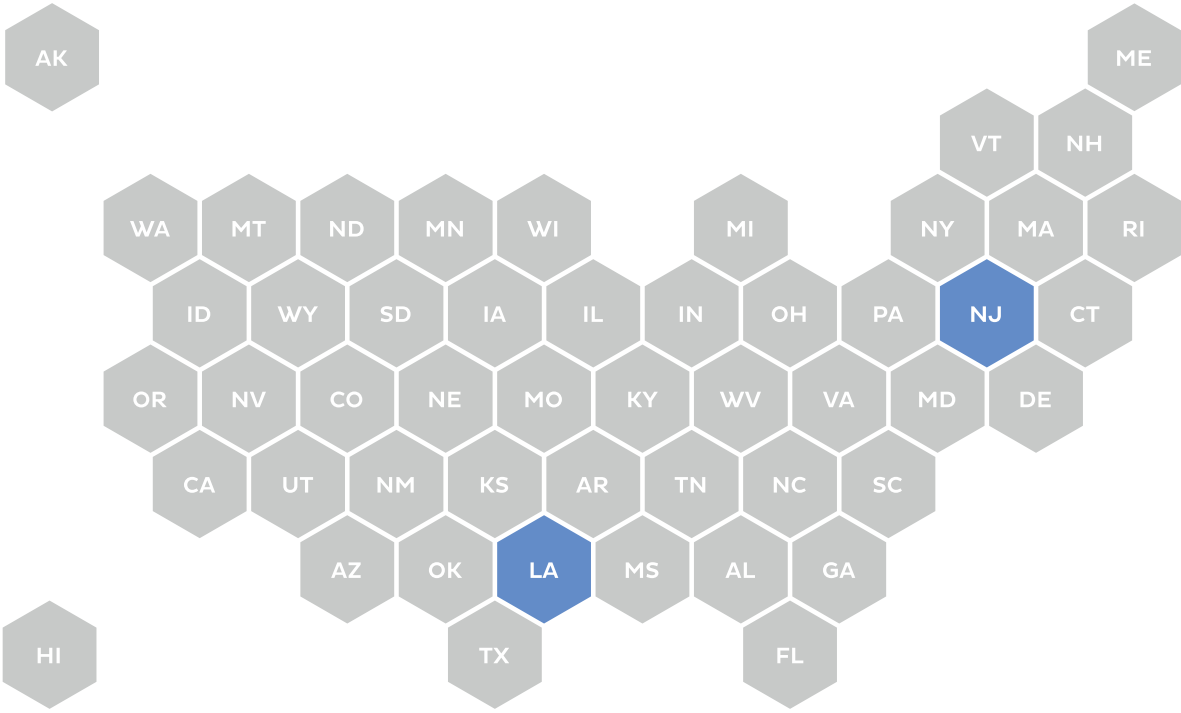
WASHINGTON WAC CHAPTER 284-43-2020 (II)

Whenever there is an adverse determination resulting in a denial the issuer must notify the requesting provider by one or more of the following methods; phone, fax and/or secure electronic notification, and the covered person in writing or via secure electronic notification.

Status information will be communicated to the billing pharmacy, via electronic transaction, upon the issuer's receipt of a claim after the request has been denied.

WEST VIRGINIA HB4239

PROPOSED – Public Employees Insurance Agency, managed care organizations and commercial insurers shall accept ePA requests and respond to the request through electronic means by July 1, 2019.
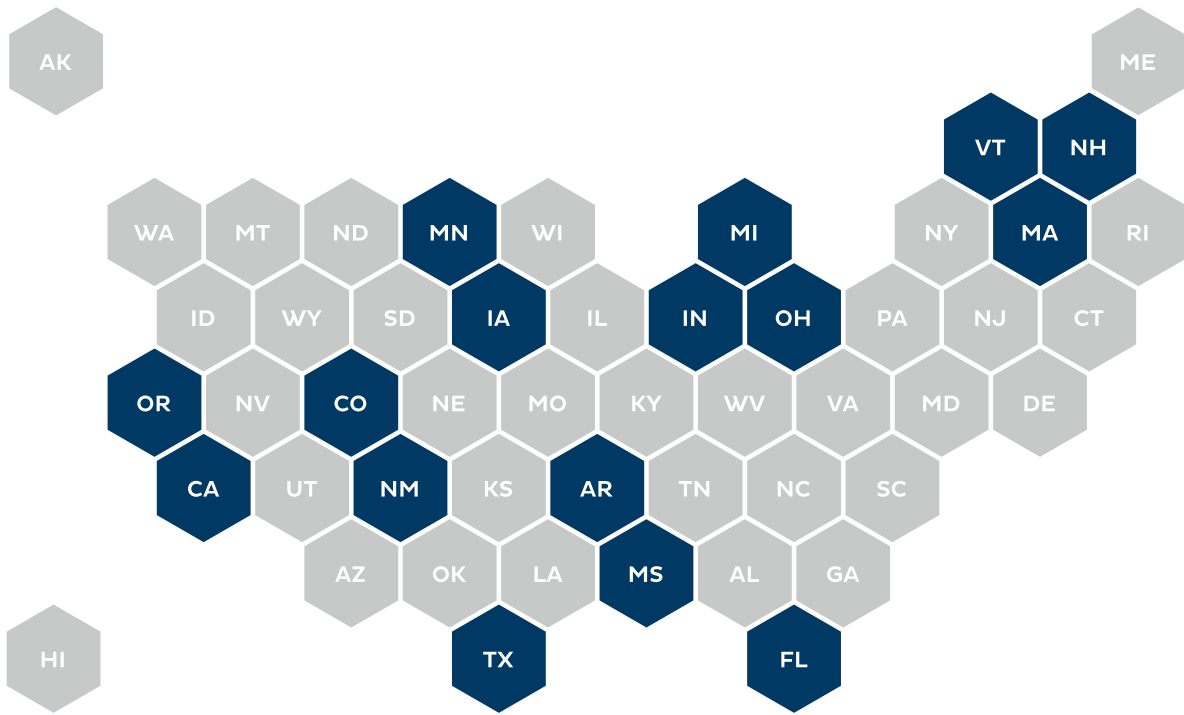
STANDARD FORM[12]

**LOUISIANA
SB231**

Insurers were required to create their own standard PA form, no more than two pages in length and made it accessible through multiple computer operating systems. The forms must be filed with the Department of Insurance.

**NEW JERSEY
A.B. 2589**

PROPOSED – Requires the Commissioner of Banking and Insurance to develop a standard PA form for use by network providers to determine coverage of prescription drug benefits. No effective date as of yet.

STANDARD FORM & ePA[12]

**ARKANSAS
SB318**

A health care insurer must utilize only a single standardized PA and non–medical review form for obtaining approval in written or electronic form for prescription drug benefits. The form must be accessible through multiple computer systems.

The required form must not exceed two pages and be designed to be submitted electronically from a prescribing provider to a health care insurer.

**CALIFORNIA
SB282**

The Department of Managed Health Care and the Department of Insurance jointly created a standard PA form, publishing rules effective July 1, 2017. The rule requires the use of the adopted standard form on or before January 1, 2018.

Every prescribing provider must use the adopted standard PA form, or an ePA process utilizing the NCPDP SCRIPT Standard ePA transactions to request PA. Every health insurer should accept that form or NCPDP SCRIPT Standard ePA transactions as sufficient to request PA for prescription drugs.

**COLORADO
SB277; 3CCR
702-4, 4-2-49**

All carriers must utilize the uniform PA process established by the regulation. A PA process for a drug benefit must allow for electronic submission but is not required. The carrier must make available on their website the standard form for PA for a drug benefit.

**FLORIDA
HB221**

A health insurer or a PBM on behalf of the insurer, which does not have an ePA process for its contracted providers must use only the PA form approved by the Financial Services Commission.

**INDIANA
SB73**

Effective Jan. 1, 2018, the bill requires a health plan to accept and respond to a PA from a prescriber or a pharmacist through an electronic transmission using the NCPDP SCRIPT Standard. Encourages all entities to use a common form for PA but no standard form created or mandated.

**IOWA
ARC 2348C**

The regulation requires each insurer to create a PA form unique to that insurer, not to exceed two pages and to be approved by the Commissioner of Insurance. The form must be made available electronically by the carrier or PBM. The form to be submitted by the health carrier must take into consideration forms developed by CMS or U.S. Department of Health and Human Services and any national standards to include the NCPDP SCRIPT Standard.

The division recognized the importance of technology to the industry and modified the proposed rule to emphasize that the statutory language requiring a form does not preclude the use of or compliance with NCPDP SCRIPT Standards.

**MASS.
TITLE XXII,
CHAPTER
1760,
SECTION 25**

Nothing should prohibit a payer or any entity acting for a payer under contract from using a PA methodology that utilizes an internet webpage, internet web portal or similar electronic, internet and web-based system in lieu of a paper form, provided that it is consistent with the paper form.

A payer or any entity acting for a payer under contract, when requiring PA, must use and accept only the PA forms designated for the specific type of services and benefits.

**MICHIGAN
SB178**

If an insurer uses a PA methodology that utilizes an internet webpage, internet web portal or similar electronic, internet and web-based system, they will not be required to utilize the standard form adopted by the Department of Financial Services, Community Health or Insurance.

The form approved by the Department of Insurance and Financial services must be used in requesting PA for prescription drugs.

**MINNESOTA
62J.497**

Drug PA requests must be accessible and submitted by health care providers, and accepted by group purchasers, electronically through secure electronic transmissions. Fax should not be considered an electronic transmission.

The Minnesota Prescription Drug Companion Guide v1.1, names the NCPDP SCRIPT Standard for ePA transactions as the methodology for secure electronic transmissions. All health care providers must submit requests for formulary exceptions using the uniform form, and all payers must accept this form from health care providers.

**MISSISSIPPI
HB301**

A health insurance issuer must use only a single, standardized PA form for obtaining any PA for prescription drug benefits. The form must also be made available electronically and the prescribing provider may submit the completed form electronically to the health benefit plan.

NEW HAMPSHIRE HB1608

Requires the Commissioner of Insurance to create a universal PA form to be accepted and used by insurers when requiring PA for medications or use of the NCPDP SCRIPT Standard for ePA.

Electronic prior authorization is not required if a pharmacist or prescriber lacks broadband Internet; or has low patient volume; or has opted-out for a certain medical condition or for a patient request; or lacks an EMR system; or the ePA interface does not provide for the prepopulating of prescriber and patient information; or the ePA interface requires an additional cost to the prescriber. Does not apply to Medicaid.

Rule INS 2705, passed March 8, 2017, Department of Insurance adopted PA universal form as required by HB1608.

NEW MEXICO SB296

Requires a uniform PA form to be used by all plans. A health insurer must exchange PA requests with providers who have E-Prescribing capability.

OHIO SB129

Effective Jan. 1, 2018, insurers must permit health care providers to access the PA form through applicable electronic software. Insurers and PBMs must also accept PA requests through a secure electronic transmission using the NCPDP SCRIPT Standard.

Faxes are not considered secure electronic transmissions and proprietary payer portals are not considered secure transactions unless they use the NCPDP SCRIPT standard. Prescribers and insurers can enter into contractual agreements foregoing this process if it's an undue hardship.

**OREGON
SB382 AND
OAR 836-
053-1205**

Plans must accept the requested universal PA form through any reasonable means of transmission, including but not limited to paper, electronic or another mutually agreeable accessible method of transmission or using an internet or web-based system.

**TEXAS
SB1216**

Standard state adopted PA form required for PA requests. Mandate requires acceptance of NCPDP SCRIPT Standard of ePA.

**VERMONT
HB559**

When requiring PA for prescription drugs, a health plan must accept for each PA request either the national standard transaction information or a uniform PA form. A health plan must have the capability to accept both the national standard transaction information and the uniform PA form.

Medicaid and ePA

A recent study indicated specialty medications account for nearly 33 percent of the total Medicaid drug spend, despite only 0.9 percent of the nearly 75 million Medicaid patients utilizing specialty medications.[13,14]

———

Because non-adherence is a common problem among the Medicaid population, and an increasing number of patients are prescribed specialty medications[5], it's vital that states latch on to an ePA solution.

A patient with limited resources and extenuating circumstances, such as lack of transportation, is more likely to be non-adherent. Non-adherence could lead to hospitalization, especially for patients on expensive specialty medications, which can ultimately create a costlier burden for states.

An integrated ePA solution could lessen these issues for Medicaid patients and assist with medication readiness and adherence.

Specialty medications account for 33% of total Medicaid drug spend, despite only 0.9% of Medicaid patients utilizing specialty medications.[13,14]

Non-adherence to specialty medications can create an even costlier burden.

KEY TAKEAWAY

Currently, government at both the state and federal levels are taking note of the importance of legislation around an electronic solution for PA. With the recent announcement of H.R. 4841, the country is one step closer to aligning on a solution that works for all stakeholders, which will help patients get the medications they need more quickly.
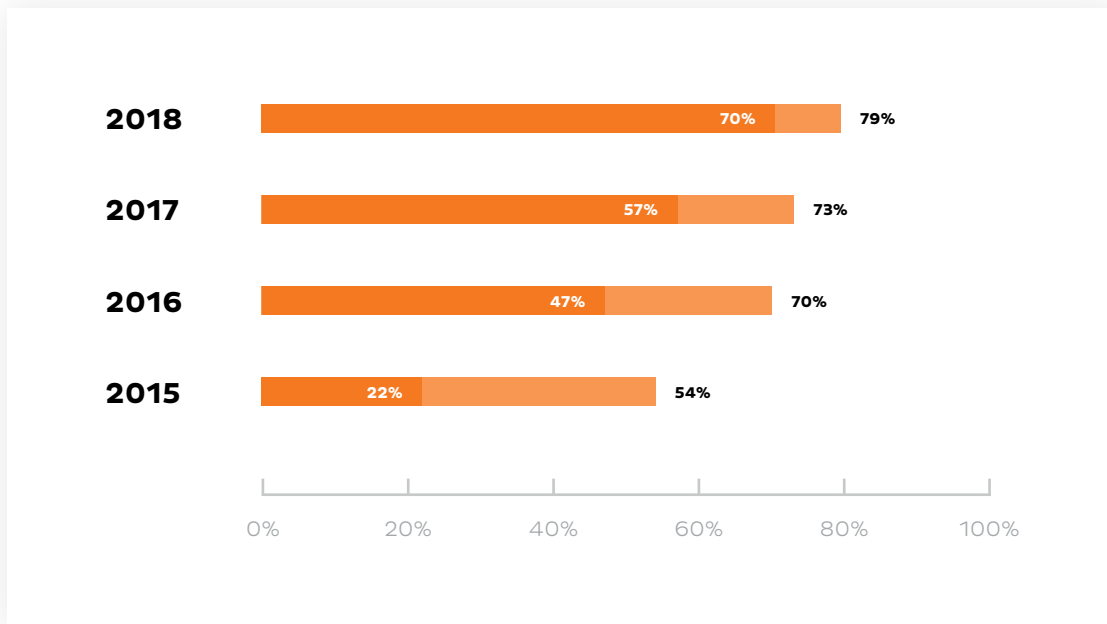
06

AVAILABILITY

EHR Availability

The integration of ePA within EHR systems is potentially transformative to providers and their staff by providing decision support at the point of prescribing and a method for completing PA in workflow.

⎯

Realizing this potential is largely dependent on vendors supporting retrospective, prospective and all-payer capabilities.

Electronic prior authorization integrations that incorporate these capabilities essentially eliminate the need for paper PA forms. Integrations that are missing one or more of these capabilities will still require providers and their staff to use multiple methods for completing PA requests.

Percentage of the EHR market, representing the majority of market share, committed to an ePA solution.[15]

Year	Committed	Available
2018	70%	79%
2017	57%	73%
2016	47%	70%
2015	22%	54%

AVAILABLE

The company publicly announced they are committed to implementing an ePA solution.

COMMITTED

The company and the ePA vendor completed the integration work and it is available to the market.

EHR	COMMITTED	AVAILABLE	CAPABILITIES
Allscripts	●	●	⬅ ➡ 🛡
AmazingCharts	○	○	⬅ ➡ 🛡
athenahealth	●	●	⬅ ➡ 🛡
Cerner	●	●	⬅ ➡ 🛡
DrFirst	●	●	⬅ ➡ 🛡
eClinicalWorks	●	○	⬅ ➡ 🛡
e-MDs	○	○	⬅ ➡ 🛡
Epic Systems	●	●	⬅ ➡ 🛡
GE Healthcare	●	●	⬅ ➡ 🛡
Greenway Health	○	○	⬅ ➡ 🛡
MEDENT	●	●	⬅ ➡ 🛡
Meditech	○	○	⬅ ➡ 🛡
NewCrop	●	●	⬅ ➡ 🛡
NextGen Healthcare	●	●	⬅ ➡ 🛡
Practice Fusion	●	●	⬅ ➡ 🛡

⬅ .... Retrospective Functionality

➡ .... Prospective Functionality

🛡 .... All Payer Submission Functionality

Vendor Assessment

It is important to understand how an ePA vendor will accomplish key goals needed to successfully complete PA requests.

While it's important to clarify pricing and ease of implementation, these are not the only factors to consider when selecting who to work with.

The wrong solution could create administrative waste, cause confusion between stakeholders (payer; pharmacy; provider) and hinder a patient getting the medication they need to be healthy.

01. Does the ePA vendor allow for both prospective and retrospective requests? How does the solution support retrospective pharmacy-initiated requests?

A prospective ePA occurs when a provider initiates the request before a rejection occurs at the pharmacy. With the right vendor, it is possible to proactively begin a request at the point of prescribing, directly within the EHR system.

Retrospective ePA occurs when a pharmacy is alerted that PA is needed when they bill insurance for the medication. The pharmacist can initiate the PA directly in their pharmacy system, which triggers a notification to the provider. Retrospective PA accounts for the majority of PA volume today.

A preferred vendor provides both capabilities. Good questions to ask are: How many pharmacies currently leverage your ePA functionality? How many pharmacy-initiated requests are generated through your system?

02. How much does the ePA solution cost?

> While it is important to find out how much it will cost to integrate a solution into an EHR, it is also important there be full disclosure in subscription fees and any other costs that may be accrued or assessed. Health systems often cite cost as a barrier for not implementing an electronic solution, so it's important to get this information in advance.
>
> Electronic prior authorization delivers the greatest benefits when it is free to use for providers, pharmacists and their staff.

03. Does the ePA vendor provide a financial model that benefits the entire health care network?

> The market stands to save billions of dollars when all stakeholders, especially providers, adopt ePA solutions at scale. Financial models that are free for providers and pharmacists encourage ubiquity and are therefore in the best interest of all stakeholders.

04. Does the ePA vendor technology support APIs?

> The technology for ePA solutions will grow and change with the industry; therefore, API support makes it easier for technology teams at EHR, payer and pharmacy systems to quickly implement new and optimized ePA solutions.
>
> Documented, standards-based ePA APIs will be a key to driving adoption in the market.

05. Is there a dedicated team of PA experts focused solely on assisting with PA?

> Providers will have questions as they adopt an ePA solution, so it's important that your vendor provides direct, user support. The support staff should be easily reachable by phone, email and chat and be subject matter experts on the ePA solution.
>
> Electronic prior authorization, as with any new IT solution, does require a change in workflow; therefore, it's important to support providers and their staff.

KEY TAKEAWAY

EHRs representing 79% of market share are committed to implementing ePA. With the right ePA partner, an electronic solution can be a significant revenue opportunity for EHRs and time-saver for health systems, while benefiting the provider and their patient. Additionally, ePA in EHRs is an effective way to add ePA legislative compliance to the E-Prescribing experience.

Payer Availability

Payer integration of ePA functionality helps to ensure all PA requests may be reviewed and determined electronically. Currently, 96% of payers are committed to an ePA solution.
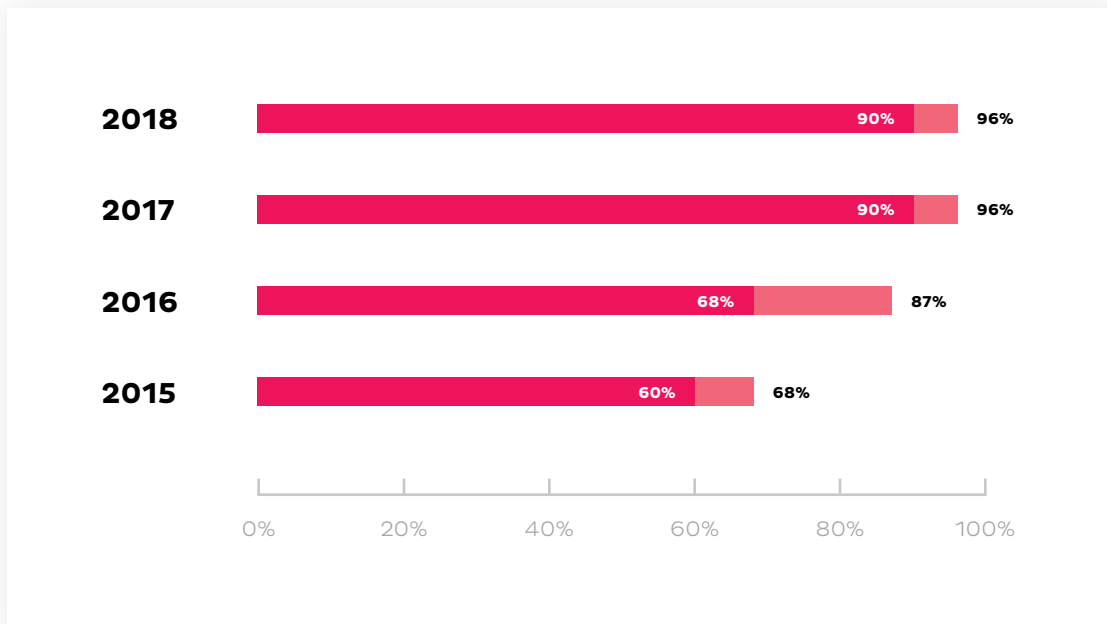
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For payers, ePA eliminates manual entry of faxed or phoned PA requests, enables payers to receive complete information on initial submission and can facilitate real-time determinations based on payer-specific criteria.

Auto-determination functionality helps payers auto-review requests and provide real-time determinations based on preset criteria.

In many cases, providers receive the outcome within moments of submission.

Indicating a payer is live with ePA does not mean all medications or plans— in the case of a PBM—use ePA functionality. The majority of payers initially activate ePA for a select number of medications or plans that they service while they work toward electronic incorporation of all criteria, which differs by plan and medication.

Percentage of the payer market, representing the majority of market share, committed to an ePA solution.[15]

2018 ████████████████████ 90% 96%

2017 ████████████████████ 90% 96%

2016 ████████████████ 68% 87%

2015 ██████████████ 60% 68%

| 0% | 20% | 40% | 60% | 80% | 100% |

AVAILABLE

The company publicly announced they are committed to implementing an ePA solution.

COMMITTED

The company and the ePA vendor completed the integration work and it is available to the market.

PAYER	COMMITTED	AVAILABLE
Aetna	●	●
Anthem	●	●
Argus Health Systems	●	●
Cigna	●	●
Conduent	●	○
CVS Health	●	●
EnvisionRx	●	●
Envolve Pharmacy Solutions	●	●
Express Scripts	●	●
HealthSpring	●	●
HealthPartners	●	●
Highmark	●	●
Humana	●	●
Magellan Rx	●	●
Mayo Clinic Health Solutions	●	●
MedImpact	●	●
Moda Health Plan	●	○
OptumRx	●	●
Prime Therapeutics	●	●

Vendor Assessment

It is important to understand how an ePA vendor will accomplish key goals needed to successfully complete PA requests.

While it's important to clarify pricing and ease of implementation, these are not the only factors to consider when selecting who to work with.

The wrong solution could create administrative waste, cause confusion between stakeholders (payer; pharmacy; provider) and hinder a patient getting the medication they need to be healthy.

01. How many live integrations does the solution have with payers? Is there an option for submitting forms for health plans that do not offer an electronic solution?

It is important that PA requests can be submitted to any plan in the same ePA solution and workflow.

Ideally, the ePA vendor will have a direct, electronic connection with payers representing the vast majority of prescription volume, and the ability to facilitate auto-determinations.

It is equally important to facilitate an electronic workflow for providers that connects with health plans who are not ePA enabled. While the majority of the payer market is working toward ePA availability, there remain lines of business, regional plans and Medicaid and Medicare Part D plans that are not yet live with ePA functionality.

02. Is auto-determination functionality available through the ePA vendor?

Auto-determination functionality enables payers to set criteria for PA determinations to eliminate manual review. The result is a more efficient process for payers and faster determinations for providers.

Electronic prior authorization vendors who offer this functionality should allow full customization of the criteria used to make an auto-determination.

03. Does the ePA vendor technology support APIs?

The technology for ePA solutions will grow and change with the industry; therefore, API support makes it easier for technology teams at EHR, payer and pharmacy systems to quickly implement new and optimized ePA solutions.

Documented, standards-based ePA APIs will be a key to driving adoption in the market.

"

"We have had tremendous success
with electronic prior authorization.
The physicians have really had a great
experience and it's also really helping
improve things for the patients
because the turnaround time on
the responses is so much faster."

—

-DR. LYNNE NOWAK, VP PROVIDER SOLUTIONS,
EXPRESS SCRIPTS

KEY TAKEAWAY

Nearly the entire payer industry with leading market share is committed to ePA and are bringing additional lines of business onto their electronic solution. By doing so payers are creating greater access for providers and decreasing turn-around time; however, there is still work to be done for each payer to get every line of business on ePA and increase usage of auto-determination functionality.
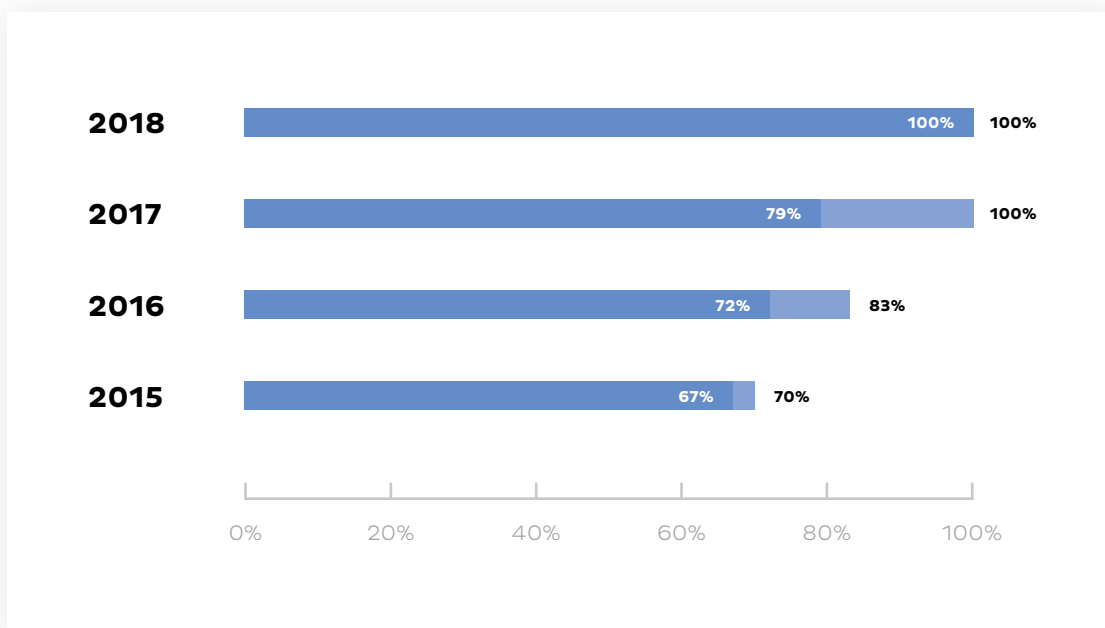
Pharmacy Availability

The majority of PA requests are still initiated at the pharmacy, causing an administrative burden for pharmacists trying to fill prescriptions for their patients and often causing the patients to have to leave the pharmacy without their prescription in hand.

Integrating ePA functionality into pharmacy systems gives pharmacists the ability to create a PA, auto-fill patient and medication information and electronically send it to the provider in one or two keystrokes.

There exists a wide range of functionality available from ePA vendors. A comprehensive solution meets the needs of all stakeholders while creating an efficient, in-workflow solution for providers and pharmacists. The wrong solution could create administrative waste, varying workflows based on the health plan associated with a PA request, cause confusion between stakeholders and hinder a patient getting the medication they need to be healthy.

Percentage of the pharmacy market, representing the majority of market share, committed to an ePA solution.[15]

AVAILABLE

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COMMITTED

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PHARMACY CHAINS	COMMITTED	AVAILABLE
Ahold	●	●
Albertsons/ Safeway	●	●
Costco	●	●
CVS Specialty	●	●
CVS/pharmacy (Retail)	●	●
fred's Pharmacy	●	●
Good Neighbor Pharmacy	●	●
Health Mart (McKesson)	●	●
Kmart	●	●
Medicine Shoppe International/ LeaderNet	●	●
Publix	●	●
RiteAid	●	●
Southeastern Grocers	●	●
Walgreens	●	●
Walmart (includes Sam's Club locations)	●	●

PHARMACY SYSTEM VENDOR	COMMITTED	AVAILABLE
AbacusRx	●	●
AdvanceNet Health Solutions	●	●
Best Computer Systems	●	●
BMI	○	○
CarePoint	●	●
Cerner	●	○
ComputerRx	●	●
Cost Effective	●	●
CPR+	●	○
Creehan	●	●
DAA	●	●
DATASCAN	●	●
DigitalRx	●	●
FSI	●	●
HBS, Inc. (RxGENESYS & RxAXIS)	●	●
Kalos	●	●
Key Centrix	●	●
Lagniappe Pharmacy Systems	●	●

PHARMACY SYSTEM VENDOR	COMMITTED	AVAILABLE
Liberty Computer Service	●	●
McKesson (Pharmaserv)	●	●
McKesson (Pharmacy Rx)	●	●
McKesson (Enterprise)	●	●
Micro Merchant Systems	●	●
PDX (Classic & EPS)	●	●
Pioneer Rx	●	●
PK Software	●	●
Prodigy Data Systems, Inc.	●	●
QS/1	●	●
RNA	●	●
Rx30	●	●
ScriptPro	●	●
Speed Script	●	●
SRS Pharmacy Systems	●	●
SuiteRx	●	●
SWI Softwriters, Inc.	●	●
VIP Computer Systems	●	●

Vendor Assessment

It is important to understand how an ePA vendor will accomplish key goals needed to successfully complete PA requests.

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While it's important to clarify pricing and ease of implementation, these are not the only factors to consider when selecting who to work with.

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> The technology for ePA solutions will grow and change with the industry; therefore, API support makes it easier for technology teams at EHR, payer and pharmacy systems to quickly implement new and optimized ePA solutions.
>
> Documented, standards-based ePA APIs will be a key to driving adoption in the market.

KEY
TAKEAWAY

One hundred percent of pharmacies in the U.S. are committed to implementing ePA. Pharmacies across the country are seeing consolidations, which temporarily could inhibit the use of ePA, and if not handled well could have a negative impact on the pharmacist's workflow. Many independent pharmacies have access to ePA functionality through pharmacy systems, most of which have live, integrated ePA capabilities.

Sources

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4 – CMS data: CY Specialty Tier Methodology

5 – Future Vision: The Top 10 Drugs of 2020

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7 – CoverMyMeds denial data for specialty drugs, 2016

8 – Specialty Follow Up Survey, 2017

9 – CoverMyMeds Analytics, 2016

10 – AIS Health "Despite Widespread Adoption, Electronic Prescribing Still Has User Limitations". Nov 2013

11 – CoverMyMeds Provider In-Depth Interviews, 2017

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14 – Individuals Enrolled – November 2017 Medicaid and CHIP Enrollment Data Highlights

15 – CoverMyMeds In-Depth Research, 2016

View the full ePA Scorecard with real-time adoption statistics at
epascorecard.covermymeds.com.