SIMPLIFY PRIOR AUTHORIZATION

WE ALL BENEFIT

Report on Private Payer Prior Authorization in Canada:

Simplify Prior Authorization

connex

pangaeagroup

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Executive Summary

The goal of this white paper is to examine the private payer prior authorization (PA) policies and processes in Canada. We have documented how private payers, insurers and pharmacy benefit managers (PBMs), are managing PA based on their own accounts. We have also identified specific challenges in the PA process as they have been told to us and documented opportunities to create efficiencies in the process to ensure patients receive timelier access to appropriate medications prescribed by their physician according to current clinical guidelines. Specifically, this white paper addresses the following:

- Identification of stakeholders in the PA process
- Development and application of PA criteria
- The claims and appeals processes
- The proprietary nature of the PA process and obstacles to change
- The challenges in the current PA process and the opportunities for improvement
- The imperatives to enable change
- The answer to the question of 'Is it possible to create change at an industry level?'

The findings of this white paper were developed based on a comprehensive landscape survey of private payer PA processes and practices which was conducted in Spring 2020 by Denise Balch, principal consultant and president, Connex Health and Beverley Herczegh, pharmacist, director and consultant at The Pangaea Group. The paper was supported by a grant from AMGEN Canada and Gilead Sciences Inc.

Six private payers and 11 other industry stakeholders subject to the PA process were interviewed via teleconference. With insurer and PBM input the private payer industry is well represented in this report. It is acknowledged that there may be information gaps in some areas of the results because not all insurers chose to participate.

We have Included a breakdown of results of the landscape survey conducted with both private payers and other stakeholders subject to the process, including challenges, and potential opportunities for solutions based on the following:

- Private payers (insurers and PBMs) - the role and characteristics of PA, how a drug is identified for PA listing, PA adjudicators and claims submission, the proprietary nature of PA, claims review and adjudication, appeals, evaluation and reporting, as well as the future of PA, including electronic PA (ePA).
- Other stakeholders (including patient groups/navigators, pharmacists, physicians, plan advisors and plan sponsors) – the physician-patient relationship, prescribing and the administrative burden, payer to stakeholder communications and access to information, transparency, cost/benefit metrics, and evaluations.

Prior Authorization in Canada Today

Prior authorization is a process by which private payers (insurers or PBMs) reimburse a prescribed medication on the condition of satisfactory medical evidence from a patient and their physician according to criteria established by payers. 'Now it [PA] is really focused on higher-cost drugs' according Shawn O'Brien, Principal, with TELUS Health[1] . While PA may appear at first sight to be relatively straightforward, it is not without its challenges, including:

- The financial burden of PA management and administration on insurers
- The administrative burden on patients, medical practitioners, and patient navigators
- The variability in criteria and how criteria is used to evaluate PA medications
- The assessment of patient eligibility
- The impact on patients of the time it takes to adjudicate claims
- The inconsistent grandfathering provisions on change of carrier
- The physical and mental health impact of PA on patients, particularly those who experience extended wait times to access sometimes life-changing therapies.

[1] 2020 TELUS Health Drug Data Trends & National Benchmarks, https://plus.telushealth.co/blogs/health-benefits/wp-content/uploads/AST2986-Drug-Trends-Report-July-2020-EN-V6.pdf

Improving PA for Tomorrow

The opportunities and recommendations for improving PA proposed in this white paper have been developed based on the results of the landscape survey and on the authors' background and education in the private payer sector and pharmacy/pharmaceutical industry. Proposed changes address many of the challenges identified in the landscape survey through a multi stakeholder collaboration with the following objectives:

1. **Creating a patient-centric PA process**

2. **Creating consensus on some standardization between private payers to create**

    a. administrative efficiencies
    b. expedited claims processing
    c. reduced administrative burden on all stakeholders

3. **Developing standards for**

    a. annual reporting
    b. accreditation and recognition for private payers who achieve and maintain best practices
    c. cost/benefit metrics
    d. stakeholder evaluations

4. **Identifying industry best practice benchmarks for PA**

5. **Providing a central web portal managed by an independent agency dedicated to simplifying PA while serving the interests of patients**

We recognize that developing a solution will be challenging, but believe that the timing is right for creating efficiencies in PA. Since at least 2007 there has been a growing percentage of total drug spend on specialty drugs, and this category is expected to continue to grow[2]. According to Express Scripts Canada's President, Dr. Dorian Lo, 'We will continue to see breakthrough treatments with high prices on the horizon.' [3] As the number of drugs, including specialty drugs, that are subject to PA grows, so will the associated financial burden of PA management and administration on payers and other stakeholders. Addressing PA now to simplify the process and create efficiencies will reduce administration costs and improve the experience for all stakeholders, most particularly patients.

This paper proposes that change in PA be made through a multi-stakeholder collaboration using four guiding principles developed with input obtained during stakeholder interviews, and five areas of fundamental change in PA to satisfy the guiding principles.

Guiding principles

Based on the interview discussions, we offer these four guiding principles for change:

1. **The objective of PA is to ensure the right drug, at the right time, for the right patient**

2. **The process should be patient-centric**

3. **All stakeholders should be involved in any change process**

4. **Maintaining payer autonomy is critical**, including which drugs are identified for PA and the internal criteria used to adjudicate PA claims.

[2] 2020 Prescription Drug Trends Report, Express Scripts Canada, https://www.express-scripts.ca/sites/default/files/ESC%20DTR%202020%20EN%20(final).pdf

[3] Ibid

Fundamental changes needed to support PA improvement

To support the guiding principles above and create a more efficient and effective PA process we recommend that improvements in the following five fundamental change categories be implemented:

1. **Establish a patient-centric claims process** based on clear and common clinical practice guidelines, common reimbursement principles and practices, clear and consistent claims adjudication processes and improvement in claims adjudication timelines.

2. **Simplify the PA claims process and make it more transparent and traceable** by implementing administrative efficiencies, including a web portal managed by an independent agency to provide a centralized online source for accessing lists of PA drugs by payer, standardized claim forms, implementation of electronic claims submission for PA (ePA), 'fast tracking' claims for designated 'qualifying physicians', agreement on adjudication parameters to the extent possible, minimum training standards for adjudication personnel, and improved adjudication turnaround time.

3. **Establish common cost/benefit metrics for PA administrative processes** and implement new processes to maximize efficiencies and manage PA administration costs.

4. **Implement evaluations and reporting of key process satisfaction indicators for** stakeholders, particularly for patients and physicians, that are reported annually.

5. **Create an opportunity for voluntary participation in an independent ombudsman/industry standards council** that would serve several roles including to monitor best PA practice standards and grandfathering provisions, and act as a moderator for payers and patients. The same council would receive, monitor, and report on stakeholder satisfaction surveys as well as claims and administration metrics from payers annually, and including recognize payers who meet or exceed best practice standards.

Next steps

We believe that the findings in this paper will garner interest and support from multiple stakeholders, including payers, to engage in discussions on making changes to improve PA. An awareness campaign to communicate the results will be socialized in Fall/Winter 2020 and early 2021, during which time Connex Health and The Pangaea Group will be speaking with original interviewees and other stakeholders to gather momentum for the next phase.

Connex Health and the Pangaea Group would like to thank those who participated in the interview process for this white paper and provided their input. We look forward to working with these and other private payer stakeholders as we proceed.

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Introduction

Project rationale

Prior authorization has become an integral part of the private payer landscape in Canada, where each payer manages patient access for a unique list of usually specialty medications[4] based on criteria they develop, using claim forms and processes that are unique to them. While at an individual payer level this system may appear to be effective, at a patient and clinical level, simplifying the current process into one that is more consistent across payers and more streamlined would best deliver timely access to patients of the right drug at the right price and create system wide efficiencies that would also benefit payers.

Creating efficiencies is particularly timely and relevant now. Payers continue to report growth trends in the percentage of specialty drugs versus their total drug spend and this growth pattern is expected to continue. According to Express Scripts Canada's President, Dr. Dorian Lo, 'We will continue to see breakthrough treatments with high prices on the horizon.'[5] The number of drugs that require PA will therefore also continue to grow as will the associated administrative burden for payers and other stakeholders in the PA process.

[4] Specialty drugs are typically defined as those that cost $10,000 or more per patient annually.

[5] 2020 Prescription Drug Trends Report, Express Scripts Canada

Objectives

In Spring 2020 Connex Health Consulting and The Pangaea Group conducted a landscape survey of PA processes in the Canadian private payer industry with the financial support of Amgen Canada. The goal was to identify any opportunities for improvement in current processes and practices that would lead to greater efficiencies, including easing the administrative burden on stakeholders and optimizing the patient experience.

This white paper is an examination of prior authorization policies and processes by private payers in Canada and provides recommendations on improving the process at an industry level. It also identifies challenges in the system, provides recommendations for change, a list of action items and next steps to improve the current system.

Process

During the landscape survey private payer stakeholders responsible for PA were interviewed in a series of one on one interviews. This included insurers and pharmacy benefits managers with oversight and insights into the development and administration of PA. With insurers and PBM input the private payer industry is well represented in this report, however the authors acknowledge there are some limitations to our analysis of current policies and practices based on corporate decisions by some payers not to participate.

While private payers were the primary target for this landscape survey, additional stakeholders who are impacted by the PA process were invited to participate to develop a broader perspective on the current landscape. Also included was a sample from the medical specialist community, as well as patient access navigators, pharmacists, patient advocates, plan advisors and plan sponsors.

The recommendations for change in this white paper have been developed based on the results of the landscape survey and the authors' background and education in the private payer sector and pharmacy/pharmaceutical industry, along with insights from several key opinion leaders. These changes, if implemented over time, will address many of the challenges identified through the landscape survey.

Background

Prior authorization

Prior authorization is a process used by private payers (insurers or PBMs) to evaluate weather a prescription for a medication and meets the payer criteria for reimbursement.

Patients are required to apply for pre-approval of coverage to be eligible for reimbursement for a PA drug, which includes medical documentation from their physician. Each payer uses PA to manage patient access for a list of medications they select and adjudicate based on criteria which is then assessed in a manner that is proprietary.

This process is perceived by some to provide oversight of and direction on physician prescribing. This is because there is typically a strong element of cost management in the process, so that patients receive the most cost-effective treatment for their condition, but not necessarily the one that their physician prescribes.

Prior authorization began on a limited basis over twenty years ago to manage access and plan liability for prescription drugs that had the potential for high utilization or inappropriate use and could negatively impact the claims experience of group benefit plans. Some early examples included anti-obesity and smoking cessation medications. Since then, as an increasing number of specialty drugs have been released in the marketplace, the list of drugs which require PA has grown. As a result, PA has become an integral part of the private payer landscape in Canada.

Challenges

While PA may appear to be relatively straightforward, it is not without its challenges. The authors were aware of some of the challenges of PA anecdotally before embarking on this research and these were confirmed during the interview process. This includes

- The financial burden of PA management and administration on insurers
- The administrative burden on patients, medical practitioners, and patient navigators
- The variability in criteria and how criteria is used to evaluate PA medications
- The assessment of patient eligibility
- The impact on patients of the time it takes to adjudicate claims
- The inconsistent grandfathering provisions on change of carrier
- The physical and mental health impact of PA on patients, particularly those who experience extended wait times to access sometimes life-changing therapies
- The financial burden of administration on plan sponsors expenses.

Developing successful solutions to some of the challenges of the current PA system will be easier than others. Success will largely depend on the extent to which payers and other stakeholders are willing to work together to create change that will improve the process. An attempt was made several years ago to harmonize the PA process for rheumatoid arthritis PA medications with the assistance of the Canadian Life and Health Insurance Association (CLHIA) and the Canadian Rheumatology Association. The resulting program was voluntary to CLHIA members but few, if any payers, are following the program guidelines.

In the research for this paper, we heard that private payer stakeholders themselves are ready for change and they have an opportunity to ensure that changes in the PA process create new efficiencies. Some are already looking to new solutions outside the current PA model, but they may not result in a process that is easier to navigate. In 2015, FACET was launched by Cubic Health who has been working directly with plan sponsors to manage their drug benefits. FACET is a PA program "developed to ensure medication experts assess every complex case to ensure safe and responsible use of drugs"[6]. FACET appears to operate outside of the insurer/PBM PA process. This type of program is suitable for plan sponsors with an administration services only (ASO), self-insured plan and could mean an additional or an alternate step in the reimbursement process for patients and additional administration for physicians. This paper recommends a different approach.

[6] CUBIC Complex Claims Management https://cubichealth.ca/facet-claims-management/

Prior Authorization in Canada Today

The Process: The Landscape Survey

Denise Balch an expert in private healthcare and benefits and President of Connex Health Consulting, and Beverley Herczegh, a pharmacist and consultant at The Pangaea Group, developed and administered a comprehensive landscape survey of the private payer PA landscape in Spring/Summer 2020 to meet the objectives of this project.

The primary target of the landscape survey was insurers and pharmacy benefit managers (PBMs) with oversight and an administrative role in the development and administration of PA. Other stakeholders who either participate in the PA process or are affected by it were also invited to participate. The goal of engaging these groups was to evaluate their experiences with PA and identify related challenges to reveal opportunities to improve the process.

The private payer survey was 30 questions and customized for other stakeholders based on their role within the PA process. The number of survey questions for stakeholders not in a payer role ranged between 15 and 25. The majority of questions in each survey were open ended.

A total of 17 survey interviews were conducted between May 22, 2020 and July 13, 2020 through phone interview by Denise Balch and Beverley Herczegh with representatives of the following categories of stakeholders[7]:

Decision maker representatives

- Six interviews were conducted with insurers and PBMs, each of whom have a role in the PA process in the private payer marketplace
- Interviews were primarily conducted with clinical personnel or nonclinical personnel at the manager or director level with direct responsibilities for managing PA.

[7] Stakeholders who were interviewed participated on the condition that their identity would not be released.

Other stakeholders

Interviews were conducted with individuals from the stakeholder groups listed below with clinical and non-clinical personnel at the manager, director, or vice president level:

- Medical practitioners and pharmacists - 4
- Patient groups/navigators - 3
- Plan advisors – 2
- Plan sponsors - 2

The scope of the questions and the results of these interviews are summarized in this section of the white paper and form the basis of this landscape review, the opportunities for PA in the future and the recommendations in this white paper.

Survey Responses

Decision Makers – those who create and administer PA

Both insurers and PBMs participated in the survey (n=6). These stakeholder groups play a fundamental role in the development and administration of PA. Their role in the PA landscape and the results of the landscape survey are summarized below.

- **PBMs** – traditionally PBMs, including ClaimSecure, Express Scripts Canada, HPM+ and TELUS work with their partners, usually insurers, to electronically adjudicate prescription drug claims and in recent years, claims for dental and allied health professionals. According to survey results, PBMs are significantly influential even at the insurer level. PBMs conduct reviews of medications and make recommendations to their insurer clients on whether they should be flagged as PA medications and provide criteria recommendations to all insurers, even when the PBM does not administer the insurer PA program.

  Perhaps not surprisingly, PBMs also develop, manage, and administer PA programs for many of their insurer clients with some notable exceptions. The expertise and infrastructure for claims adjudication within a PBM outweighs most if not all within insurers, although PBMs typically operate at arms length from plan sponsors and plan members (patients). This may add an additional layer of administration and turnaround time for some PA claims that are referred by the PBM to the insurer for further consideration.

- **Insurers** – the 'big three', Canada Life, Manulife and Sun Life typically do not use their PBM for PA adjudication. They have their own PA team, as do hybrid insurer/PBMs like Medavie Blue Cross and Green Shield Canada. Other group insurers rely on a PBM not only for adjudication but also to manage their PA program, although each insurers' program may look somewhat different in terms of final criteria and its application. These insurers will also become involved in complex PA claims or claims for drugs for rare diseases (DRD).

1. Prior authorization objectives

Overwhelmingly the primary objectives of PA are cost containment and ensuring appropriate use, although there was no definitive dollar threshold above which a drug is automatically driven to PA. One payer told us that the purpose of PA is "not to decline" therapy.

- Most insurers, PBMs and plan advisors report that their fundamental objective for PA approvals is "the right drug at the right time for the right patient". For others, objectives are that "patients get the drugs they need" or that they find the "balance between savings and clinical"
- Some consider their role as one of influencing prescribing practices so that both clinical outcome and cost of therapy are considered
- For others PA is in place to manage potential abuse or to optimize opportunities to coordinate with public programs provincially
- PA is used to meet plan sponsor objectives of the "wise use of funds" in employee benefits.

2. Drivers and characteristics leading to application of PA

A drug that falls into one or more of the categories below may be listed as a PA medication (in alphabetical order):

- Drugs for rare disease
- Drugs included in step therapy program
- High cost drugs
- Infused medications
- Lower cost alternatives available as options i.e. biosimilars and biologics
- Off-label use or medications with a high risk for off-label use/prescribed outside clinical guideline.

For some insurers, where a high cost and/or infused treatment was the only appropriate therapeutic option, PA may not apply at all or may be applied only to confirm diagnosis.

Challenge:

- Every payer sets their own list of PA medications which results in inconsistencies in the lists of medications subject to PA between payers and increases the time it takes for physicians, patients and other stakeholders to identify which drugs prescribed are subject to a PA process

Opportunity:

- Agreement by all payers to make their list of PA medications easily available online; this would remove one of the administrative burdens for physicians, patients, and other stakeholders.

3. **Who assigns PA status?**

PA Team - Primary oversight of the PA criteria is the responsibility of an internal team which meets regularly, often monthly, during which new medications and reimbursement criteria are considered and recommendations are developed (see below). The team can include the following internal personnel (ranked by the frequency these professionals are used on the PA team):

- Pharmacists
- Physician (either on the team or more frequently an external resource as required)
- Health economist
- Registered Nurse
- Actuary

Challenge:

- Every payer has their own internal team which adds cost and time to the process of evaluating a drug.

Opportunity:

- Pool some professional resources between payers to streamline the process, reduce costs associated with drug review administrative/time.

4. Criteria considerations

Common considerations to evaluate product for PA include (in alphabetical order):

- **Cost (the #1 consideration)** – this can move a medication to PA or can exclude it from coverage all together
- **Clinical criteria, including product monographs**
  - Most drugs are used for their approved indication, others are used off-label, or are restricted because of step therapy or high price. New drugs that fall into these categories will be the subject of PA and may or may not be eligible depending on the payer.
  - Oncology drugs have historically been administered in hospital and covered by provincial plans, but more oncology drugs, infused and oral, are now being submitted to private plans for reimbursement during the period before provincial reviews and negotiations are completed (see below under public review and reimbursement negotiations). As a result, infused therapies and oral cancer therapies are usually subject to PA and there is resistance from private payers to reimburse infused therapies.
  - Drugs for rare diseases – cost, patient demographic, extension of life, whether the treatment will halt or slow the progression of the disease, are all considerations under PA programs.

- **Clinical trials** – used to evaluate emerging trends in outcomes and likelihood of application for new indications for PA medications and off label use (for some payers).
- **Health technology assessments (HTAs)** – are used to some extent by payers but there is a move to more reliance on HTAs to determine whether a drug is subject to the PA process and even whether or not it is included in an existing formulary.
- **Industry submissions** – from pharmaceutical companies are considered in developing criteria and the decision to designate a medication for PA.
- **Lowest cost alternative** - ensuring reimbursement is according to step therapy guidelines to support the best use of claim dollars.
- **New medications** – likely to enter the Canadian market that may become the treatment of choice for physicians. Access may be limited through step therapy depending on existence of other effective therapies and initial assessment of cost/benefit impact.
- **Peer reviewed journals** – used by payers to reference latest scientific research to determine eligibility of PA claims that are prescribed off-label.
- **Public coverage criteria** – while some physicians will not prescribe PA medications unless their use meets public payer criteria, restrictions in access to public coverage will push some patients into making claims through the private insurance PA process.
- **Public plan coverage and criteria** – can vary between provinces – some alignment of criteria with some payers actively coordinating coverage with provincial plans, particularly in British Columbia, Saskatchewan, and Manitoba where the public payer is the first payer. Others may mimic coverage provided under public plans.

- **Public review and reimbursement negotiations** – it can take 18-24 months or more for provincial approval under public plans because of the complexity in the current environment. Medications must navigate public agencies before market entry including:

  - CADTH[8] , CDR[9] /pCODR[10] /INESSS[11] – public drug plan review agencies evaluate clinical and economic evidence, making listing recommendation to public drug plans only.

  - pan Canadian Pharmaceutical Alliance (pCPA) – provinces negotiate product listing agreements (PLAs) for preferred pricing on medications.

    Until public coverage, private payers have an opportunity to provide interim funding through group benefit plans.

- **Volume of use** – will be taken into consideration when evaluating a medication for PA. For example, high volume - high cost will likely be subject to PA despite clinical guidelines and HTA assessments.

Challenge:

- Various independent information sources driving decisions contributing to inconsistent PA criteria between payers

- Cost and time for payers who review and evaluate a lengthy list of resource material before designating a medication for PA.

Opportunity:

- A single, independent review panel of qualified medical experts could develop an online resource library for payers of credible current medical evidence, research, and peer reviewed literature.

- Payers could then make their own independent assessment and review for PA and develop their internal criteria, saving time and resulting in greater consistency in PA criteria between payers.

[8] Canadian Agency for Drugs and Technologies in Health (CADTH)

[9] Common Drug Review (CDR)

[10] Pan-Canadian Oncology Drug Review (pCODR)

[11] Institut National d'Excellence en Sante et en Services Sociaux (INESSS)

5. Proprietary nature of PA

- Payers consider their internal claims adjudication process proprietary i.e. how their criteria are applied once a claim is submitted. PA is also highly valued as a market differentiator and insurers believe PA plays an important role in finalist presentations. This belief helps explain why the process is considered proprietary. Any discussion of changes to the PA process must make an allowance for the proprietary nature of some aspects of PA.

Challenge:

- Inconsistencies between how payers internally assess a claim can result in one payer considering a claim to be eligible for reimbursement and another declining the claim despite those claims being based on the same medical and patient information.

Opportunity:

- A common framework/guideline for application of criteria would address some of these inconsistencies, while recognizing the proprietary nature of the internal claims adjudication process based on contractual eligibility requirements and formularies.

6. Access to list of PA medications and claim forms

Each payer controls how and when physicians, patients and other stakeholders in the process have access to their list of PA medications and accompanying claim forms. Currently, payers take one of three approaches:

- **Open access** - some publish a list of drugs that require PA and/or the appropriate claim form(s) online without restricting access
- **Limited access** - some restrict access to their list of PA medications and/or claim form(s) to plan members only, through an online portal
- **Other access** – at least one payer uses one standard form across all PA medications as an initial entry point to the PA process which offers no guidance to prescribers and creates another step in the PA process.

Challenge:

- Because each payer manages access to their own list of PA medications and claim forms, physicians, patients and other authorized stakeholders do not have an easy and consistent method to know which drugs require PA and what claim forms are required to help guide them through the PA process in a timely and efficient manner.

Opportunity:

- Creation of a single, online repository for physicians, patients and other authorized stakeholders to access lists of PA medications and claim forms by payer would facilitate prescribing and the timeliness of the claims process.

7. Claim formats, design, and submission

Claim form formats and designs for PA vary between payers and are typically required to be submitted manually versus electronically although there are some exceptions. Claim forms are designed in any one or combination of the following:

- **One general, open PA claim form on initial claim** - after which the payer initiates the claim file and requests detailed claims information based on the product or therapeutic diagnosis as required
- **A claim form with a checklist** by medication or diagnosis - which is the basis for either approval, request for further information, or decline.
- **An open-ended claim form that is medication or diagnosis specific** - this type of claim form can require extensive written information from the patient and their physician, including medical and medication history. Reportedly, some open forms are as long as 11 pages.

8. Submission formats – paper and electronic prior authorization (ePA)

The majority, but not all, payers use a manual paper-based versus electronic claims submission and review process. Systems limitations, privacy concerns and payer requirements for original signatures from prescribing physicians and in some cases the patient, contribute to the reluctance to move to electronic submission. The restrictions that resulted from the COVID-19 pandemic have challenged payers to create new solutions for the collection of claims information electronically. Payer interviewees are either already looking at the potential of ePA or agreed that there is a strong case to be made for moving in that direction. Only one payer who uses a relatively new PBM system accepts electronic PA claim submissions (pre COVID-19).

Manual, paper-driven processes cause unnecessary burdens on time and money while creating an access challenge for those suffering from a debilitating condition. There is a better way. The adoption of digital strategies across the ecosystem is a viable option to improving the PA experience for all stakeholders. Payers maintain an important check in the access to certain medicines; providers enjoy a more streamlined and efficient process; and patients get on treatment faster and have a higher probability of staying on therapy.

Shabbir Ahmed, Chief Commercial Officer, CareMetx, Rethinking the Prior Authorization Process, Pharmacy Times, 2020-02-24 12:00,

https://www.pharmacytimes.com/publications/specialty-pharmacy-times/2020/February2020/rethinking-the-prior-authorization-process

Challenge:

- Paper based claims submission is time consuming and expensive for payers and inconvenient for physicians and patients, resulting in additional administration costs for payers and delays in access to prescribed drugs for patients.

Opportunity:

- Adoption of an industry wide, single source, electronic PA (ePA) network that can ensure transfer of confidential medical information and signatures to improve the flow of information and turnaround time for claims adjudication.

9. Claims adjudicators, approvals, and declines

Pharmacy technicians, nurses or those trained on the job as 'clinical services associates', overseen by pharmacists, are the primary adjudicators of PA requests, with processes to escalate claims to the pharmacist, physician (external) or higher within the organization. Claims escalation is the common route for extremely high cost claims for DRDs or some oncology medications. Some non-payer interviewees expressed concern that under-qualified personnel were responsible for what they perceived as medical decision-making while other opined that such decisions are simple when guided by clear criteria.

Overall PA claim approval rates are high and target turnaround times for uncomplicated PA claims are typically processed within one week once all information is received, however these were estimates and most payers did not have a common measurement process for their PA claims turnaround time. Several payers told us PA claim approvals were in a range of 80% to 95%. One payer told us that their tracked approval rate was 73% in 2019, however this was deflated by mandatory generic substitution which was included in this number. With approval rates so high, it may be viable to automate the PA process for claims with common markers that would allow for a 'fast track' approval for some PA claims. This would reduce the administrative burden for all stakeholders saving time and money and reduce wait time to therapy for patients.

"Either the exam question is too easy, or everyone knows the answer, that's why the approval rate is so high" plan advisor commenting on high PA approval rates.

For those PA claims that are declined, particularly for specialty medications, the impact can be devastating for patients from a financial and health perspective. Limitations and differences in PA criteria between payers result in some claims being declined by one payer and not another. The most common reasons for declines provided to us by payers are as follows:

- **Reason for declines (alphabetically)**
  - Any circumstance requiring additional case-specific information to enable consideration
  - Change in carrier, existing PA claim not grandfathered
  - Drug not covered
  - Insufficient information on claim form (10-20% according to one payer)
  - Medication subject to step therapy
  - Off label or ineligible indication

Challenge:

- There are inconsistencies between payers that affect the outcomes of claims, including non-clinical personnel responsible for adjudication and appeals review, no industry standards for grandfathering provisions, lack of 'fast track' claims process for uncomplicated claims.

Opportunity:

- PA best practice guidelines could address many of the inconsistencies that affect claims outcomes. Those payers that follow the guidelines could present their compliance as a competitive edge, knowing that their clients can rest assured that as a payer they hold high standards for adjudication practices.

10. Appeal and review

When a PA request is declined payers confirm there is an appeals process although this also varies between payers. One PBM estimated the appeal rate for their PA process at 3-5%. Exceptions and appeals are typically redirected by claims adjudicators to a pharmacist within their organization, but the claim may escalate beyond this and may include managers or senior nonclinical personnel. Here is a summary of the types of medication typically affected and the appeals process within some payers:

- **Medications**
  - Drugs that are not for rare diseases or do not have an extremely high cost point - can be appealed but there is no consistent process for appeals between payers. As an example, off label use of a medication, whether validated through scientific papers or not, is sometimes automatically denied while in other cases an additional review process may secure coverage (i.e. oncology).
  - Drugs for rare diseases or those with an extremely high cost point – these are frequently escalated to payer senior management or on occasion to plan sponsors, particularly those with ASO plans without appeal. However, because of privacy restrictions, the information made available to them is limited.

- **Appeals process**
  - Initially claims are escalated to a pharmacist or management that oversees the PA process.
  - In the case of DRDs or high cost drugs an appeal process may include senior individuals within payers, while for others it is a formal review panel. At least one payer told us that a patient can meet with or submit to this panel to appeal their decision.

Challenge:

- There is an inconsistent appeals and review process between payers which can result in delays and disparities in reimbursement decisions that impact patient access to medications. Some PA drugs may be pushed to appeal because they are for rare diseases or extremely high cost drugs (i.e. >$100,000 p.a.), and reimbursement decisions may be made based solely on the significant financial impact to the payer's block of business or the plan sponsors budget (in the case of ASO). In both scenarios, patient outcomes can be compromised.

Opportunity:

- Development of industry standards for claims appeal and review will ensure claims are reviewed based on medical criteria within specified timelines. To do this will require new ways to expedite collection of appropriate medical information and improve turnaround time on decisions. DRDs and extremely high cost claims should have their own industry standards and consideration should be given to include provincial public plan negotiations to create an agreement to cost share claims in these categories, including engaging patient advocacy groups such as CORD until such time as a Federal program for rare disease is created.

11. Evaluation and measurement

Overall, payers were confident their PA program was meeting objectives but only some were willing to discuss the basis on which they evaluate their PA program. For those that did discuss, there was no common frame of reference, benchmark, or quality process for evaluating the impact of the program. This makes it difficult for payers to clearly understand whether their PA program is achieving objectives or meeting quality process criteria internally and externally. It also makes it difficult for new and existing clients to evaluate the performance of PA programs.

The need for common and transparent metrics is growing. While releasing no specifics, one payer told us that while PA is achieving goals, it is also requiring more resources to do so as medications, and therefore their PA criteria, are becoming increasingly complex.

Some elements of evaluation criteria used by payers include one or more of the following metrics:

- **Savings on drugs** - One payer tracks savings resulting from the PA process, but the rest indicated that the information was not readily available.

- **Changes in physician prescribing habits** – are monitored to assess appropriateness of prescribing of PA drugs.

- **Claim approval rates** – interviewees provided an approximate approval rate between 73 and 85 percent for insurers, 85 and 90 percent for PBMs.

- **Off-label use metrics** – not all payers consider reimbursement for claims made for off label use. Of those who did, one payer told us that about 25 percent of requests are for off-label use and roughly 85 percent of those are approved.

Challenges:

- Overall, we found a paucity of metrics and data to inform decision-making, at least those that payers were willing to share. The metrics that were shared were inconsistent and not necessarily of any real value.

- Changes in physician prescribing habits away from PA medications is not necessarily good medicine or a good metric to evaluate savings, which may occur at the expense of patient outcomes leading to higher costs in other areas of the benefit plan or the health system.

Opportunities:

- Plan sponsors would be in a better position to make an accurate evaluation of PA programs and the savings they may deliver with improved metrics and reporting.

- By developing voluntary best practice industry standards for annual evaluation and measurement of PA, including savings from the PA process that payers report annually, PA could be a tangible competitive advantage to some payers.

- Payers should consider monitoring changes in physician prescribing habits over time to determine the impact PA listings and pursuant medical information requirements on approval/decline rates as well as treatment failures, absence, and disability.

12. Grandfathering

Grandfathering is the process by which coverage for individual plan members or their dependents continues, and may not decrease, solely because of a change in insurance carrier thereby preventing a loss in coverage. This has historically been commonly applied to group life and disability insurance but has become more common for prescription drug plans in recent years as differences in drug plan formularies and the number of PA medications have grown.

When coverage for a PA medication is in place on change of carrier, the plan advisor coordinates the process, including negotiation of the duration of grandfathering, and facilitates a list of individuals and their approved drugs. This information is provided by the terminating carrier to the new carrier.

Challenges:

- While a one-year grandfather period is common for non-specialty medications, the duration of grandfathering for PA approvals varies between payers. Some carriers extend PA coverage for six months and at least one payer extends grandfathering indefinitely for PA medications, which is 'contingent on monitoring by the pharmacy which requires the enrolled (patient) use a specified pharmacy'.

- To grandfather PA coverage the new insurer will require a list of existing PA approvals, which the advisor coordinates. One advisor reported that in one case proof of coverage was withheld by the terminating insurer, creating a challenge to the successful transfer of coverage.

Opportunity:

- Develop an industry standard that require minimum time periods for grandfathering of PA approvals and requires insurers to exchange lists of PA patients and approved drugs on change of carrier.

13. Feedback and evaluation

We asked payers whether they have a formal PA evaluation for those who used the PA process, particularly patients and physicians. Some payers told us they receive anecdotal feedback on their PA process, but none reported a formal evaluation.

The anecdotal feedback payers reported receiving on their PA process include:

- **Patients** – complain of loss of coverage on change of carrier (see grandfathering above), and the length of time that they wait for reimbursement decisions
- **Physicians** - do not like the PA process because of the additional administration and wait time for access to medication as well as the return rate for missing information (one payer reports 10 to 20 percent return rate).

Challenge:

- Without evaluations and the opportunities to improve the PA experience, payers risk reputational damage and those subject to PA have no formal way to communicate their concerns. This is reiterated by stakeholders we spoke to who observed that payers are unaware of gaps in customer service and the administration efficiencies/inefficiencies in their process.

Opportunity:

- By using common industry PA evaluations for those who are impacted by PA or involved in the process, and reporting on results, payers can make improvements where needed and demonstrate their competitive advantage.

Representatives from stakeholder groups subject to the PA process participated in a modified version of the landscape survey and the results are summarized in the next section of this paper.

Other Stakeholders - those subject to the PA process

There are several stakeholders, including physicians and patients, who are subject to and impacted by PA programs, but have little influence, if any, over the PA process. Many of these stakeholders are keenly aware of shortfalls in the current PA system and are anxious for their voices to be heard. As part of this landscape survey we spoke to many of these stakeholders. A summary of our results is found below:

Physicians (1) – understands the need and purpose of PA but are frustrated with complexities in the process and the perceived disservice to patients who require prompt treatment with the medications prescribed. This physician expressed several opinions about the current process:

- It is payer focused
- It is enough of a burden on his time that he wants to find ways to reduce his administrative burden and improve the transparency of PA
- He told us his prescribing habits have changed because of the challenges of complying with complex payer criteria, but not necessarily because a different drug was in the best interest of the patient.

Approval delays can result in the need for him to re-educate or re-engage the patient with respect to their required therapy.

Challenges:

- Process is not patient centric.
- The biggest challenge is the administrative burden – including the reporting of historical medical information going back years that may not always be available to specialist (often the same information is requested at renewal – more headaches).
- Inconsistencies between payers can mean different forms and different criteria by provider.
- There appears to be a lack of trust in the prescribing decisions physicians make.

Opportunities:

- Streamline administration for physicians to reduce their workload and their frustration with PA. This could include common claim forms between carriers that would satisfy both payer PA and PSP programs, electronic claims submission, including the use of electronic signatures.
- Create 'trusted prescriber' status for some physicians resulting in PA fast track status for their patients' claims.
- Review mandatory step therapy requirements where a patient cannot tolerate a class of drugs in step therapy process.
- Stop the requirement for extensive medication use histories, some of which the specialist prescriber does not have and cannot procure, and other unnecessary information.

Pharmacists (3) – other than in specialized settings, pharmacy involvement in PA and the relevant clinical criteria is low, limited primarily to advising the patient that there is a PA requirement and referring them back to the prescribing physician. However, patients will frequently contact their community pharmacist to ask whether their PA drug has been approved, for changes in therapy (PA or not), or to explain why the PA process initially requires that the patient be prescribed and fail to respond to a more cost-effective agent. The current pharmacy system does not provide satisfactory information for pharmacists to assist patients in these circumstances.

Specialty pharmacies routinely work on behalf of patients and their physicians to gather the necessary requirements forsuccessful submission of PA claims. However, some payers require that patients procure PA medications from a preferred pharmacy network (PPN), even though the specialty pharmacy may have gone to great lengths to gather appropriate information for successful reimbursement. Specialty pharmacies should be informed when they will not be eligible to dispense the prescription once the PA drug is approved.

Pharmacists we spoke to want improved messaging through PBM pharmacy system and engagement in PA communications to redirect and inform the status of a PA claim to their patient and physicians.

Challenge:

- The current pharmacy communication network does not deliver sufficient messaging to community and specialty pharmacies on PA drugs, submission requirements, approval status and the existence of PPN arrangements.

Opportunities:

- Patients would be better served by enhancing communications to pharmacists on PA so they can inform the patient on the status of their claim, including any outstanding requirements, and assist or redirect patients to online information on the claims process, criteria and forms with a single online access point.

- Those interviewed feel they could accommodate ePA technically and that it would improve PBM-pharmacy communications.

Patient groups/navigators (3) – while patient groups may hear from patients about their PA experiences, they infrequently become involved in advocating on an individual patient level for coverage – public or private. One role (or a key role) of patient support programs and oncology **drug access navigators**[12] is to aid patients and their physicians in navigating public and private access to medications. This can often be a frustrating process.

Patient groups report that only 5% of rare diseases have the benefit of a medication therapy. All patients who require drugs for rare diseases (DRD) will require PA for their medications either because of cost or because they are being used off-label. Developing a public plan for DRD is a priority for patient groups, but in the meantime, patients with rare diseases must navigate the public-private system.

According to these groups, patients undergo a lengthy process to reimbursement because criteria is not always clear, resulting in delays to effective therapy. Oncology navigators also report being shut out of the information loop by payers even when they have patient permission to act on their behalf. These patient groups want an improved process that will reduce the time for access to appropriate medication and oncology navigators need to be included in the information loop between physicians, patients, and payers so that they are enabled to assist with securing oncology drug coverage.

[12] Oncology Drug Access Navigators are represented by the Oncology Drug Access Navigators of Ontario (ODANO), which is a provincial organization founded to provide support, advocate for members, share resources and educate existing and new navigators in order to maximize the appropriate funding for all cancer patients

Challenges:

- Some patient advocates, such as those for DRDs, are working to facilitate access for their patients with insufficient information because payers will not include them in the process.
- Access to appropriate medications for patients in need can be slow, sometimes because of step therapy, where patients are required to use the lowest cost option first. Regional differences can also play a part, with Atlantic and BC being more challenging for private access.
- Criteria are not always clear and this results in considerable back and forth with physician (either because the disease is rare and we are still learning or in the case of oncology, the product is new and does not have public coverage while undergoing HTA review)
- There are multiple reasons for rejections including carrier change, drug is off formulary, off label, or for a rare disease where annual costs are often more than $100,000. Disease and medication options may also be evolving.
- Denial can sometimes make no sense to the patient and those in the circle of care and can be devastating for a patient; maybe a death sentence or result in disease progression in either DRD or cancer or immunological disorders.
- The appeals process is inconsistent.

Opportunities:

- Explore opportunities for a simplified claims process that is more open, transparent, and collaborative where drug access navigators (DANs), who are acting on behalf of patients to secure access to often lifesaving medications, are part of the information loop.
- Identify and negotiate solutions to the issues that are slowing claims adjudication through a collaboration between payers and other stakeholders
- More clearly define the right criteria and requirements for appropriate prescribing through consultations with physicians and patients using a clinical and scientific process.
- Require Transparency regarding any changes in criteria.
- A consistent appeals process so that patients are equitably covered for medications based on clinical criteria.

Advisors (2) – when PA first started the intent was to apply it to new high cost drugs to ensure appropriate use (right drug, right person, right time). Over time, right price, and right source (as in network pharmacy), were added as considerations for PA medications. As part of the plan advisory role to plan sponsors, their clients, advisors have certain responsibilities regarding PA claims:

1. **Coordinate continuation of coverage for PA claimants on transfer of insurer – grandfather (see previous section)**

2. **PA claims assistance when claim is under review (usually because of denial)**

    a. When the PA claims process does not go smoothly i.e. the PA claim is declined, the advisor may have discussions with the plan sponsor or with the patient, the insurer or the PBM. Plan sponsors play almost no role in managing the claims process unless the patient/plan member approaches them. Patients and their employer are often reluctant to share or receive confidential health information; patients because of repercussions for revealing their health and claim status to their employer and plan sponsors for privacy reasons.

3. **Reporting of claims trends in preparation for plan renewal**

    a. Advisors make the connection for plan sponsors between protecting their plan against high claims and providing access to plan members for the drugs they need. Unfortunately, the data reported by insurers at renewal is limited even for larger ASO clients primarily because of patient confidentiality. Therefore, advisors and their clients have few resources to evaluate the PA program managed by their insurance carrier. This also poses challenges at change in carrier.

Some insurers allow their clients to opt out of the PA process, but this is limited to those plans with an AS0 arrangement where there is no insurance. According to our discussions with advisors, plan sponsors do not typically opt out, perhaps <1% do. The groups that do opt out are inclined to believe that the physician/pharmacist/patient relationship with respect to treatment should be honored. In opting out, the plan sponsor is at risk for large and unpredictable claims levels for specialty drugs or drugs for rare diseases.

While insurance carriers who participate in the study see PA as a competitive advantage, one advisor reported that he rarely sees presentations to plan sponsors that position PA in this way although it may be part of some finalist presentations. Based on our discussions with carriers, most were not able or not willing to discuss metrics for their PA program. It appears that at least some carriers are not gathering sufficient metrics to provide evidence of savings generated, and therefore value of their PA program.

While insurers are confident about the value of PA, not all advisors are. 'With approval rates of 85 to 90 percent, why are we doing it?"

Challenges:

- Advisors question the value of the administrative costs of PA for the perceived benefit of controlling access; one advisor suggesting that if approval rates are so high (85-90%) then "why are we doing it"?

- A lack of transparency related to the PA process and PA drugs makes the advisor role in PA challenging, including their ability to assess pricing differences, process, industry norms, adjudicator qualifications, and cooperation between carriers.

- Ensuring grandfathering is in place for PA claimants falls to advisors to coordinate. Since grandfathering varies between carriers', patients can suffer a loss of coverage for their PA medication on transfer of carriers if advisors fail to do this or insurers fail to cooperate.

- Limited information is provided to advisors at renewal, and usually only about claims that are denied during the policy year. This means plan advisors have limited information to provide to their clients on the impact of the PA process.

Opportunities:

- Create industry level norms/standards to address advisors' concerns including:
  - Grandfathering provisions
  - Harmonization of claim forms and initial medical information requirements between payers
- Introduction of metrics and reporting to assess the cost/value of PA at the payer and client level, either on the carriers block of fully insured business or by client for large groups.
- Improve transparency by addressing advisor concerns through an industry PA portal. This would require investment in the following:
  - Electronic claims process technology for PA (ePA)
  - Online access to list of PA medications, PA claim forms, and medical information requirements
  - Identify the qualifications, experience requirements of those within the organization that are authorized to review and approve or decline claims, including the level of authority within roles e.g. claims <$10,000 requires review by a PA adjudicator, claims >$50,000 and off-label prescribing requires review by a senior adjudicator/adjudication manager and/or expert input where requried/ indicated, appeals require adjudication manager/director approval. The rational is that 'An educated human must assess and make a discerning decision of someone's treatment options.' In some cases such review may require a medical specialist opinion.

Plan sponsors (primarily employers) (2) – based on comments from advisors and plan sponsors, plan sponsors do not typically become involved in PA for one or more of the following reasons: either they are not knowledgeable about PA, they do not consider themselves qualified to interfere with prescribing and reimbursement decisions, or to protect plan member confidentiality.

While some plan sponsors understand the principles behind PA, most have not been educated about or exposed to PA, the process that surround it and the potential impact on employees. Therefore, plan sponsors rely on their plan advisor's expertise and their insurer to guide them through reimbursement issues, including PA. As one plan sponsor told us, 'The buyer (employer) is very naive and relies heavily on their advisor'.

As a result of these limitations, as well as other limitations in transparency of PA already noted, the information plan sponsors receive is limited. Typically sponsors will receive the number of claims paid with no other metrics for PA. With these limitations, neither plan sponsors or their advisors, can evaluate the impact of reimbursement decisions made by payers on employee health and morale, work performance, presenteeism, absenteeism, disability, loyalty, and their administration costs.

Challenges:

- Plan sponsors are removed from the PA process because of concerns over confidentiality. This means sponsors receive limited information on PA claims and reimbursement decisions with the following impact:
  - Sponsors are not able to develop a good understanding of whether PA is effective and efficient
  - Sponsors have no way to check that eligible plan members received drugs to which they are entitled under the benefits contract or vise a versa for those drugs they are not entitled to under the contract
  - Sponsors have no method to evaluate the value PA delivers to their employees and their benefit plan in terms of cost/benefit, presenteeism, absenteeism and disability or whose PA claim takes an extended period of time to approve or is denied.

Opportunities:

- Create industry benchmarks and promote reporting of claims cost/ benefit based on
  - Experience within their own plan (or compared to groups of similar size and/or industry sector)
  - Payer's block of business including PA claims submitted, paid, declined, average administration cost, claim turnaround time, as well as patient and physician satisfaction metrics
- Develop plan sponsor education on PA and the process based on best practices and identify industry benchmarks.

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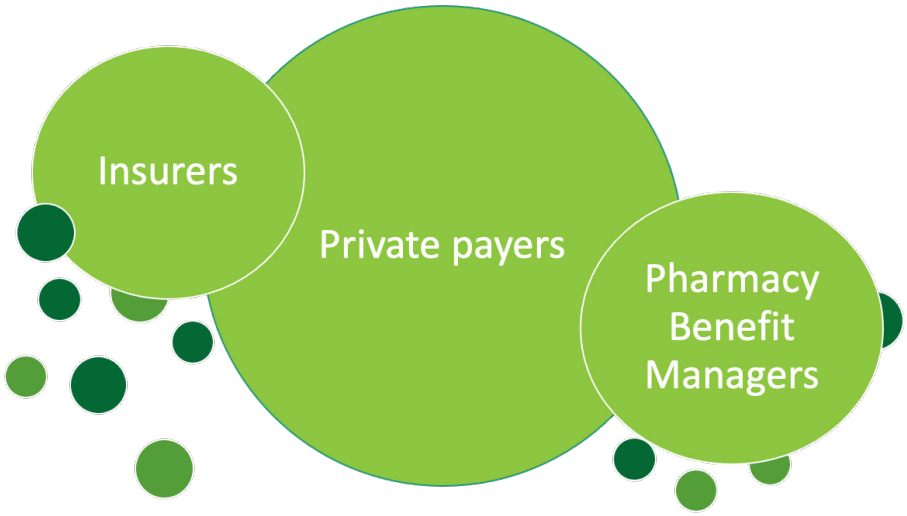
Current Prior Authorization Landscape

Supplementary to the survey deliverables, the following landscape maps illustrate the relationships between stakeholders within the current PA environment, including decision makers, influencers and those impacted by PA.

Private payers are decision makers in the PA process (insurers and pharmacy benefit managers). They are jointly responsible for the development and management of PA programs - figure 1.

Figure 1 – PA Decision makers



While patients, along with the drugs they are prescribed, are the joint focus of PA decision makers, there are many other stakeholders involved in the PA process who are subject to PA requirements to varying degrees - figure 2.

Figure 2 – Other Stakeholders in the PA Process

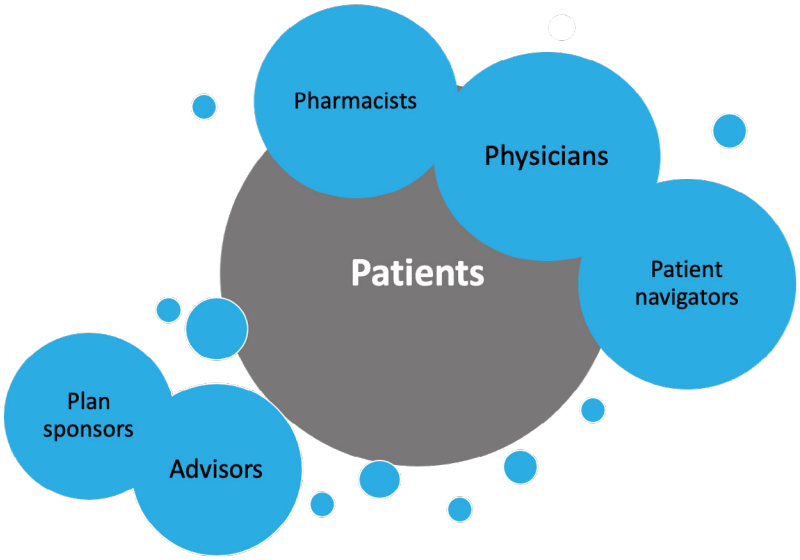
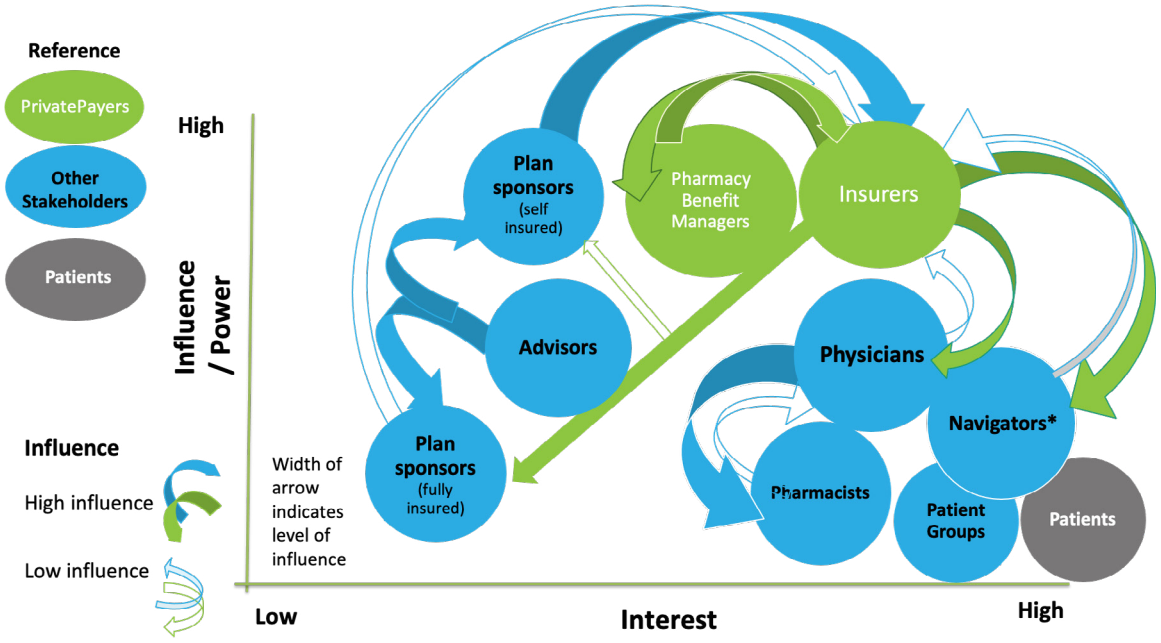


Figure 3 is an influence map of the interconnectivity between payers, the decision makers for PA, and other stakeholders in the PA process. The PA process is a complicated one which would benefit from re engineering to create efficiencies that would benefit patients as well as other stakeholders and decrease administrative costs for payers, while maintaining payer autonomy of their list of PA drugs and their internal criteria for approval.

Figure 3 - Influence Map of PA Decision Makers and Other Stakeholders



*Navigators in this case includes drug access navigators, patient support programs and private payer network case managers.

Improving Prior Authorization for Tomorrow

Positioning for Change

Based on the landscape survey findings there are clear opportunities to improve the PA process with benefits to all stakeholders. Our key observation is that patients, plan sponsors and other stakeholders would be best served if the PA process were simplified and accessible, so that it becomes more focused on the needs of the patient; more patient centric. To do this will require streamlining of the PA claims process, creating a more consistent and collaborative system for PA, with the following critical benefits to each stakeholder (in alphabetical order):

- **Advisors** – facilitate improved communications between payer and plan sponsor, and coordinate grandfathering based on clear minimum industry standards.
- **Patients** – more transparent and collaborative process, with a quicker claim adjudication time frame, particularly for uncomplicated PA claims and renewals.
- **Payers** – reduced administration costs for PA claims, particularly for uncomplicated PA claims and information requests; superior offering.
- **Patient groups/navigators** – improved access to information that will assist patients and physicians in accessing list of PA drugs, PA requirements, PA forms, outstanding requirements, and claims status.
- **Pharmacists** – improved messaging through PBM-pharmacy systems so that pharmacists can help patients understand the PA process, requirements, and the status of their PA claim.
- **Physicians** – reduced administration and easier access to list of PA drugs, PA requirements, and standard PA claim forms.
- **Plan sponsors** – better member experience, improved health outcomes with a resulting positive impact on presenteeism, absenteeism, organizational culture, and retention. Plus, the potential for lower administration costs for PA claims.

Private payers who participated in the landscape survey expressed an interest in changes to PA on the condition they retain sufficient autonomy to maintain a competitive advantage based on their unique criteria, which is applied internally. Some payers are currently considering changes to their process including exploring electronic PA options and all were, in principle, open to at least some collaboration between payers.

There are many opportunities to improve the PA process in Canada, but it will be challenging. Successful change will require a multi stakeholder collaboration and an approach that engages private payers as well as other stakeholders in the process, while respecting payer autonomy.

Based on feedback from the landscape survey we have developed the following list of guiding principles and fundamental changes that we believe will be critical to achieve the stakeholder benefits outlined above.

Guiding Principles

Payers told us that the overriding, number one, value proposition of PA is a process that delivers "the right drug at the right time for the right patient", and several made a reference to access, savings and according to TELUS Health's Shawn O'Brien, '...to balance that sustainability in the drug plan,"[13]. Based on the interview discussions, the authors therefore offer these four guiding principles for change:

1. **The objective of PA is to ensure the right drug, at the right time, for the right patient**
2. **The process should be patient-centric**
3. **All stakeholders should be involved in any change process**
4. **Maintaining payer autonomy is critica**l, including which drugs are identified for PA and the internal criteria used to adjudicated PA claims.

[13] 2020 TELUS Health Drug Data Trends & National Benchmark

Fundamental Changes

Guiding principles are not enough to drive change. We have identified five specific and fundamental changes that will enable a more efficient and effective PA process, and meet the four guiding principles listed above:

1. **Establish a patient-centric claims process based on**

- Clear and common clinical practice guidelines.
- Common reimbursement principles and practices.
- Clear and consistent claims adjudication processes.
- Improvement in claims adjudication timelines, including expediting uncomplicated claims and lifesaving therapies through a fast track process.

2. **Simplify the PA claims process making it more transparent and traceable**

- **Implement administrative efficiencies in the claims process by**

    - Developing standardized claim forms between payers, after which - payers can then apply their own criteria.
    - Consistently providing easy access to lists of PA drugs by payer.
    - Developing a process for eclaims submission, submission of additional information and for claim status inquiries.
    - Improving communications and transparency with all stakeholders through a web portal, and upgrading pharmacy systems to improve messaging.

- Designating some physicians with 'preferred physician' status and expediting the claims process for their patients. Preferred physicians would qualify to have claims for their patients 'fast tracked' by demonstrating consistent prescribing in accordance with a payer PA criterion.
- Developing a clear and consistent appeals process between payers and a process for a nonbinding second opinion from an independent ombudsman/industry standards council.

- **Create a central web portal that provides stakeholders with access to**

  - Clinical resources and reference material for payers
  - eclaims submission
  - Lists of PA drugs by payer
  - Online claim status inquiries
  - PA guides for claimants and other stakeholders
  - Payer claim forms
  - Payer contact information

- **Establish recommended minimum qualifications for adjudication personnel** based on the price and category of drugs they are adjudicating including

  - complex therapies
  - drug cost
  - oncology drugs
  - rare disease drugs

- **Improve adjudication turn-around**
  - Create a fast track adjudication process for uncomplicated claims and claims for critical use drugs including oncology and DRDs where a delay can cause loss of life or irreversible harm.

3. **Establish common cost/benefit metrics of administration process**

- Identify inefficiencies in current PA processes through process mapping i.e. duplication, unnecessary/duplicate information collected
- Create baseline cost/benefit metrics for the new PA administration process to maximize efficiencies and manage cost of PA administration.

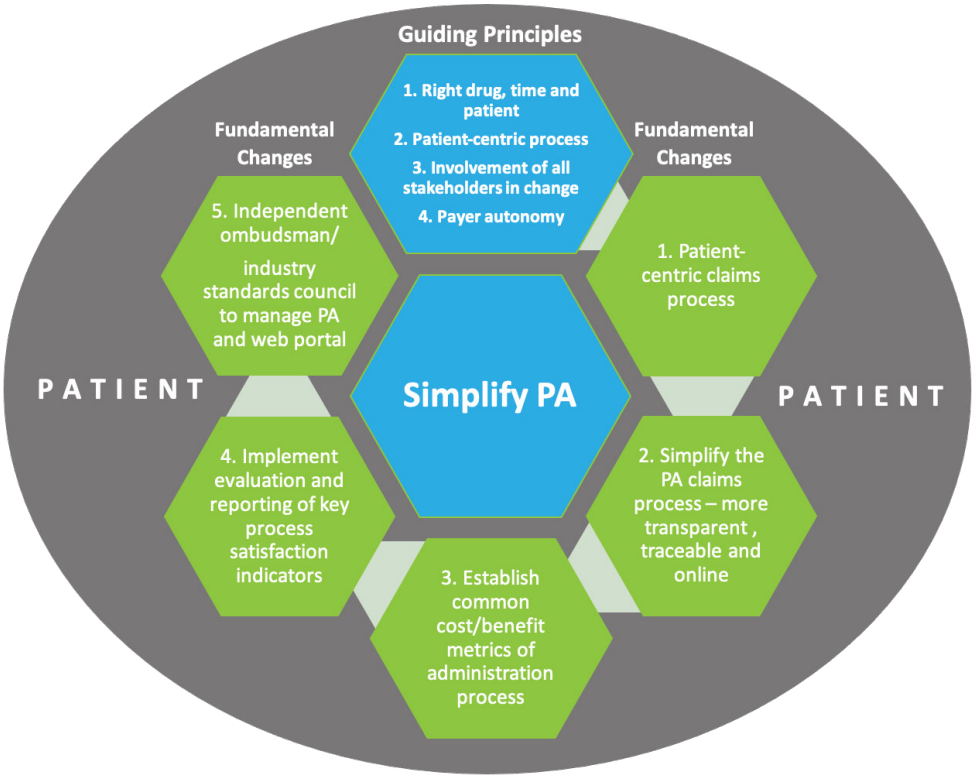
4. **Implement evaluations and reporting of key process satisfaction indicators for** stakeholders, particularly for patients and physicians that are reported annually.

5. **Create an opportunity for voluntary participation in an independent ombudsman/industry standards council that would**

- Monitor established best practice standards
- Monitor recommended minimum standards for grandfathering provisions
- Act as claims moderator for payers and patients
- Receive stakeholder satisfaction surveys to contribute to evaluation of private payer performance metrics and for consideration towards continuous improvement of PA process
- Gather claims and administration metrics from private payers
- Annually report aggregate results from private payers and stakeholder evaluations
- Annually recognize those payers who meet or exceed best practice standards.

The figure below represents a summary of the guiding principles and fundamental changes proposed based on a patient-centric model.

Figure 4
Guiding Principles and Fundamental Changes for Simplifying PA



Creating change to simplify PA and engaging payers in the process will not be easy but it is clearly a necessity. The expanding list of PA drugs on payer formularies, the increasingly complex claim process that is frustrating to stakeholders, and the extensive list of stakeholders involved in the process, all support the need for taking a fresh look at PA and working together to simplify the process. Prior authorization is unique among drug plan management strategies, most of which are much less burdensome to administer and less costly than PA e.g. drug plan maximums, restrictive or managed formularies, and PLAs.

The Future Prior Authorization Landscape

The following graphics illustrate our recommendations for simplifying the PA process and how stakeholders would be impacted. They are based on a patient-centric model using the guiding principles and fundamental changes that have been outlined above.

Figure 5 illustrates the relationship of the industry council to payers using a PA web portal to support a PA process that is more transparent and easier to navigate. The agency would be responsible for updating best practice standards, recognizing payers who meet or exceed best practices for PA, and working with the PA web portal developer to manage the portal on behalf of payers. Payer participation in the industry council and web portal would be voluntary.

Figure 5
PA Decision Makers Within A Simplified PA Process

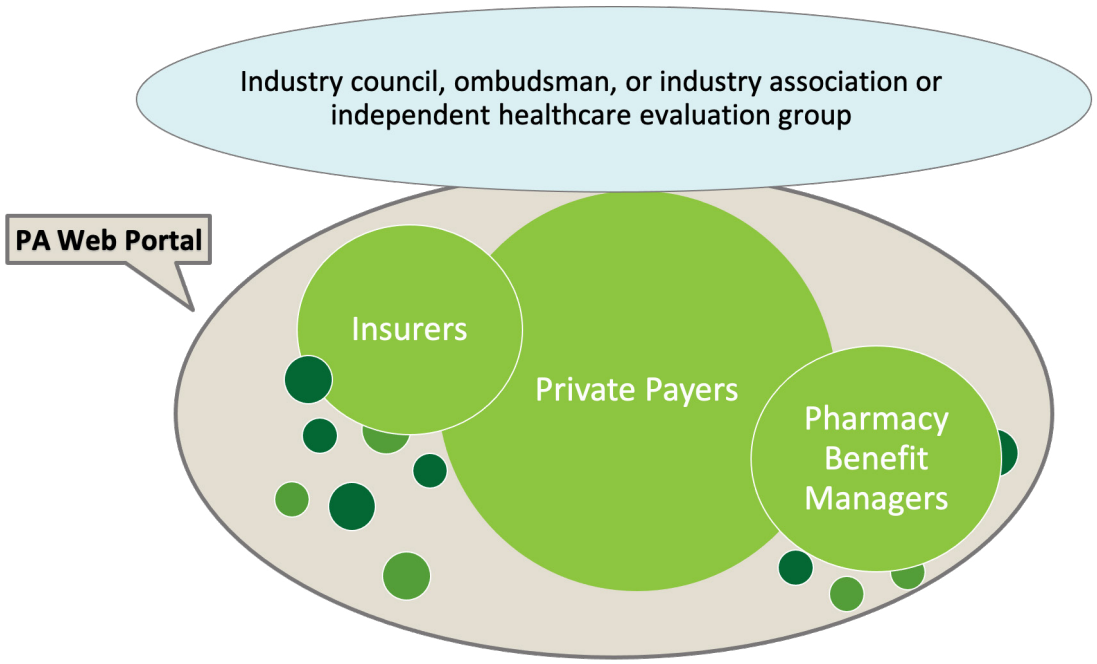
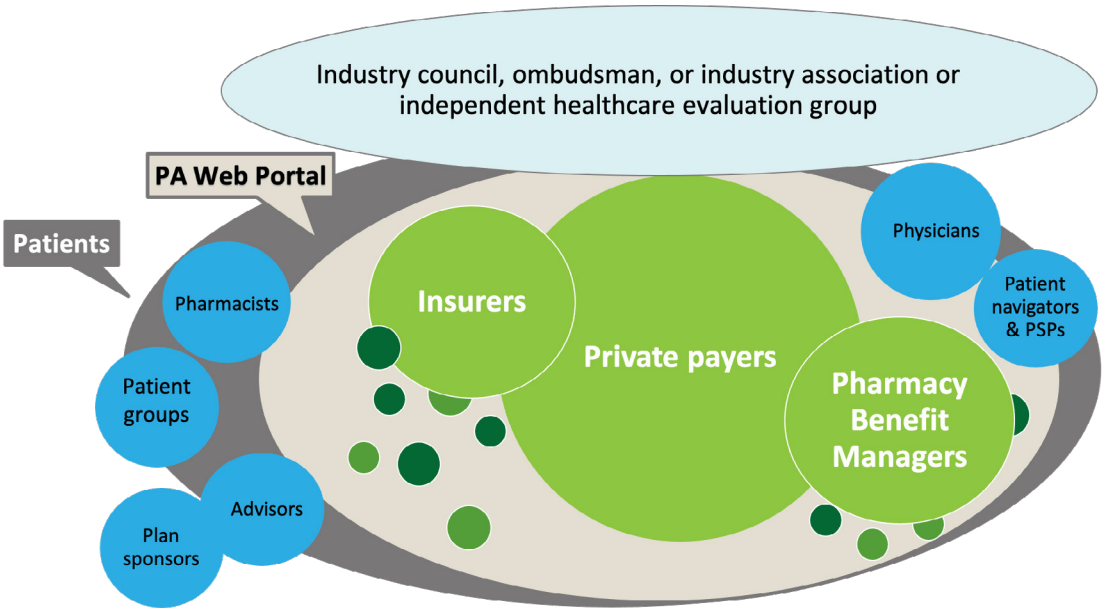


Figure 6 illustrates the simplified relationship between stakeholders and the PA process through a PA web portal that will act as a central source for access to information, claim forms and claims submission for those payers that participate. Under this model, stakeholders can be confident that the industry council will monitor the PA web portal and work with payers to maintain best practices.

Figure 6
Influence Map of PA Decision Makers and Other Stakeholders Within A Simplified PA Process



*Navigators in this case includes drug access navigators, patient support programs and private payer network case managers.

Next Steps

The results of the examination and review of private payer PA policies and processes in Canada have been documented in this white paper along with the opportunities and our recommendations for change. Through Fall and Winter 2020 – early 2021 we will be socializing the results in the group benefits community, with payers, with plan sponsors, with industry associations, and with stakeholders impacted by PA. The goal is to generate discussion and feedback on the challenges and opportunities identified in the research, and on the recommendations set forth in this document, as well as to gather support for the next phase.

In addition to this white paper, a microsite is currently under development that will allow stakeholders to access this report and follow articles, webinars and podcasts associated with PA. When the site is live, in late November 2020, postings will be found at simplifypriorauth.ca.

The critical recommendation in this white paper is that an implementation strategy be developed and implemented to create industry level change to simplify prior authorization. To be successful, it is recommended that change be created through a multi stakeholder collaboration that respects payer autonomy of internal criteria and claims adjudication practices. While all stakeholders should benefit from changes to PA, including administrative and financial relief for payers and other stakeholders, patients are considered the primary beneficiary. Connex Health and The Pangaea Group look forward to leading this collaborative effort.

Shortly before finalizing this white paper we spoke with key opinion leaders who provided additional insights and support for our findings and recommendations. Here is a summary of their recommendations that will be incorporated into our future strategy.

1. **A not for profit 'industry' solution will appeal to stakeholders.**
2. **Develop a multi stakeholder collaboration of funding and expertise will need to be developed.**
3. **Engagement the right IT partner with the skills to move PA to an electronic platform is necessary.**
4. **Focus should on simplifying the process – not interfering with each payer's criteria.**
5. **Payer engagement will require that we, identify how they will benefit from changes to PA.**

We expect and invite unsolicited feedback on this white paper from stakeholders involved in the PA process or impacted by PA. This input will be taken into consideration during phase 2, which will begin in November 2020 and consist of several elements that will move stakeholders closer to an industry solution for simplifying PA.

During phase 2 Connex Health and Pangaea, as project managers, will form a steering committee with expertise from multiple stakeholders. The steering committee will oversee the development of a business plan for simplifying PA, work with Connex and The Pangaea Group to identify potential vendors, partners, and payer partners interested in becoming early adopters in the first pilots, and secure the necessary additional financial resources from a number of sources to fund the change process through its entire development and implementation cycle.

Those interested in finding out more or receiving regular updates please contact one of the authors below.

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"It always seems impossible until it is done."
- Nelson Mandela