The Office of the National Coordinator for Health Information Technology

Meeting Notes

INTERSECTION OF CLINICAL AND ADMINISTRATIVE DATA TASK FORCE (ICAD TF)

April 28, 2020, 3:00 p.m. – 4:30 p.m. ET

VIRTUAL

EXECUTIVE SUMMARY

Co-chairs **Alix Goss** and **Sheryl Turney** welcomed members to the Intersection of Clinical and Administrative Data Task Force (ICAD TF) meeting. **Alix Goss** and **Josh Harvey** summarized recent work on the tabs of a shared Google workbook that has been used to determine how to improve the PA workflow process. **Sheryl Turney** summarized new work she completed on the workbook to better reflect work done over the past year on the topic of prior authorization (PA) by the Health Information Technology Advisory Committee (HITAC).

Luke Forster-Broten from Surescripts presented an update on the automation of ePA. **Kim Diehl-Boyd**, **Miranda Gill**, **Anna Klatt**, and **Liz Otley**, all from CoverMyMeds, gave a presentation that detailed the state of the current ePA workflow process, how their ideal ePA process should look, and their recommendations the future state of ePA. ICAD TF members submitted questions and discussed the presentations.

There were no public comments submitted by phone, but there were several comments from ICAD TF members and members of the public submitted via chat in Adobe Connect.

AGENDA

03:00 p.m.	Call to Order/Roll Call and Welcome
03:05 p.m.	Summary and Action Plan
03:10 p.m.	Review Workbook Progress
03:20 p.m.	Surescripts Demonstration
03:50 p.m.	CoverMyMeds Demonstration
04:20 p.m.	Public Comment
04:30 p.m.	Next Steps and Adjourn

CALL TO ORDER/ ROLL CALL AND WELCOME

Lauren Richie, Designated Federal Officer, Office of the National Coordinator for Health IT (ONC), called the April 28, 2020, meeting of the ICAD to order at 3:00 p.m.

ROLL CALL

Alix Goss, Imprado/NCVHS, Co-Chair
Sheryl Turney, Anthem, Inc., Co-Chair
Anil K. Jain, IBM Watson Health
Jim Jirjis, Clinical Services Group of Hospital Corporation of America (HCA)
Gaspere C. Geraci, Individual
Jocelyn Keegan, Point-of-Care Partners
Rich Landen, Individual/NCVHS
Arien Malec, Change Healthcare
Thomas Mason, Office of the National Coordinator
Jacki Monson, Sutter Health/NCVHS
Alexis Snyder, Individual/Patient Rep
Ram Sriram, National Institute of Standards and Technology
Debra Strickland, Conduent/NCVHS
Sasha TerMaat, Epic
Denise Webb, Individual

MEMBERS NOT IN ATTENDANCE

Steven Brown, United States Department of Veterans Affairs
Mary Greene, Centers for Medicare & Medicaid Services

Leslie Lenert, Medical University of South Carolina
Aaron Miri, The University of Texas at Austin, Dell Medical School and UT Health Austin
Jacki Monson, Sutter Health/NCVHS
Abby Sears, OCHIN
Andrew Truscott, Accenture

SUMMARY AND ACTION PLAN

Alix Goss, co-chair of the ICAD TF, reviewed the agenda for the current meeting and explained that Surescripts and CoverMyMeds would present pharmacy-oriented perspectives on prior authorization (PA).

At the previous meeting of the ICAD TF, they examined the work done on the shared Google document workbook (the workbook). The Guiding Principles and Ideal State/ "Happy Path" subgroup presented their work, and members discussed guiding principles and ideal state entries, particularly the concepts and considerations of "minimum information necessary" and the need to understand workflows for data creation and usage. The ICAD TF worked on the data categories table, and they described Interoperability Standards Advisory-based (ISA) categorizations, data classes, and maturity of standards in the current marketplace. Also, the ICAD TF discussed the need to begin abstracting up from PA to the broader intersection of clinical and administrative data.

She explained that their approach for the current meeting would include updates about progress on the workbook since the last meeting, including the incorporation of the discussion points from the last meeting. They decided to deduplicate, consolidate, and reframe the higher-level context for the ideal state points. These items will be cleaned up and reframed to focus their work at future meetings. Also, the ICAD TF will review items **Sheryl Turney** added to the "Recommendations" tab in the workbook; she consolidated items that the Health Information Technology Advisory Committee (HITAC) discussed and recommended at their meetings during the past year. She included sources for all HITAC items added to the workbook.

REVIEW WORKBOOK PROGRESS

Josh Harvey summarized work members completed, which was related to cleaning up the workbook rather than making major changes. **Sheryl Turney** summarized her recent additions to the workbook, and she asked ICAD TF members to focus on the "Other Considerations" and "Recommendations" tabs of the workbook as homework.

Alix Goss noted that the ICAD TF would focus on presentations for their next two meetings. Surescripts will give a presentation on their electronic PA (ePA) work, and then presenters from CoverMyMeds will give a demonstration on their ePA work.

Surescripts DEMONSTRATION

Luke Forster-Broten, Director of the Product Innovation team at Surescripts, presented an update on the automation of ePA.

He began by discussing the background of Surescripts' work on solving PA challenges through an electronic process. He noted that two-thirds of physicians surveyed reported that they are anxious and are suffering from burnout. Of these physicians, family doctors report the highest burnout rate at 47%. He explained that the last thing they want to do is spend their time on what they consider unnecessary administrative red tape. PA is one of the elements they spend the most time on when interacting with a patient's health plan, and the majority of their interactions with that plan revolve around PA, as 80% of PA requests require follow up from benefit plans. More than 66% of pharmacies must call the health plans to get drug formulary coverage information. He explained that the burdens in this process are shared by

physicians, patients, pharmacies, and health plans.

He described the evolving process of PA and shared a depiction of a manual PA workflow from the perspective of a prescriber up to the advent of ePA. He emphasized several burdens, including:

- Prescriber chooses a medication without access to patient-specific benefit information.
- No chance to compare pharmacy channel options.
- No chance to compare costs with therapeutic alternatives.
- Pharmacist, prescriber, and pharmacy benefit manager (PBM) exchange phone calls and faxes to get prescription authorized or find an alternative.
- Member discovers PA is required or cost is too high.
- Pharmacist, prescriber and PBM exchange phone calls and faxes to get prescription authorized or find an alternative.

He explained that this process has been frustrating for the physician and the pharmacy, and also from a patient standpoint. He referenced a study that showed that 40% of the time when a patient arrived at a pharmacy and was turned away because PA was needed, the patient never returned or went on any medication at all.

Surescripts wanted to address the negative health impacts of this process and frustration across the spectrum of care. He elaborated on the model that they use, called enhanced prescribing (e-prescribing), to avoid the pitfalls of a manual process, and referred to a depiction of this improved workflow. Steps included:

- The electronic health record (EHR) checks group-level benefit plan information via American National Standards Institute (ANSI) X12 eligibility & National Council for Prescription Drug Programs, (NCPDP) formulary.
- The prescriber uses e-prescribing to enter medication and the member's choice of pharmacy.
- The real-time prescription benefit shows the member's out-of-pocket cost at three pharmacy options, as well as a less expensive, equally viable therapeutic alternative. A coverage alert that PA is required is given.
- ePA finds the correct prior authorization form, automatically populates the member's information, and displays required questions. The request is submitted to the payer. As a result, PA is approved in under a minute.
- If the prescriber needs to start the member on a specialty medication, Surescripts' specialty patient enrollment pulls the form into the prescriber's workflow and connects it to the specialty hub.
- Both medications are waiting when the member arrives at the pharmacy, and the member knows how much they will cost.

He gave an overview of what ePA provides. It proactively notifies providers of medication PA requirements, and it highlights PA questions specific to the patient, the plan, and the medication prescribed. Also, it prepopulates the required patient information. This reduces office complexity and frustration with real-time PA responses from health plans. He explained the sections depicted in a mock-up of an EHR and what the physician would view in their workflow.

He presented the method Surescripts has used to drive adoption during the transition to ePA from the older, manual process. He noted that they've identified four key lessons as they support industries moving to ePA, which center around supporting provider experience, collaboration by standards bodies, and data quality. These key lessons are:

- Focus on the holistic process
- Include all patient groups
- Emphasize speed and accuracy
- Drive change in workflow

He highlighted the rapid growth rate of the use of ePA and noted that 94% of prescribers have EHRs signed on for ePA. Additionally, 97% of patients are covered by PBMs using ePA. The top five specialties using ePA are family practice, internal medicine, psychiatry, pediatrics, and neurology. He described a case study in which an advocate of Aurora Health Care conducted a study of what the process looked like before and after ePA. In it, they went from only 30% of PAs being started a day after the prescription was written to 75% of their PAs being completed. The average time to complete the request was reduced from an average of 22 minutes to an average of 12 minutes. They saw a 6% increase in first fill adherence for all drugs, and the wait time was reduced by nearly two days.

Discussion:

- **Alexis Snyder** inquired how the automated electronic process works for patients with dual insurance and more than one payer, especially when one payer requires PA while the other does not.
  - **Luke Forster-Broten** responded that the challenge is that the standards in the traditional eligibility process allows payers to indicate in the eligibility response if they are the primary or secondary payer, but because this section is often left blank, payers have to check with physicians to see which coverage should be used. Surescripts is working on the pain point of benefits coordination, and he described some workarounds being used currently in these situations.
- **Gus Geraci** inquired about the amount of pushback Surescripts received from providers and prescribers during their trial run with Aurora Health Care and other early adopters. He also asked how the workflow has been received.
  - **Luke Forster-Broten** responded that since different physician's systems, vendors, and health systems handled it differently, Surescripts recommended that health systems use a centralized process to implement ePA, which is what Aurora did. In these systems, physicians were able to rely on a team in the background to take care of coordinating the PA process because the EHR system automatically routes the PA task to designate staff and not the prescribing physician.
- **Alix Goss** requested more specific information on how the timing and communication of prescription costs work in the ePA process, from a patient's point of view.
  - **Luke Forster-Broten** responded that the cost and real-time prescription benefits information could be added to the EHR, and that usually, the cost information is already in the system. The prescriber can retrieve it quickly and discuss this information with the patient during the initial office visit. Some systems also route the patient to speak with an individual about costs following an office visit.
  - **Alix Goss** clarified that this is nearly immediate and interactive information that enables the doctor/prescriber to share information with the patient right away (even if there are additional activities that would be handled by someone else on the care team for the necessary PA follow-up requirements).
- **Rich Landen** inquired about how much of the described ePA process has already been deployed and is operational in EHRs and health plans, and how much will be implemented in the future.
  - **Luke Forster-Broten** responded that there are differences between the PBM and payer sides. A PBM's relationship with the member health plans determines how ePA works; though a majority of health plans in the United States are

enabled to use ePA, many do not designate PA to their PBM. Also, he noted that many state Medicaid plans have had challenges using ePA because they lack the infrastructure, but Part B for the Medicare Drug Transcription Program patients either have or will have access to PA soon, if they do not already. On the physician side, there has been a rapid uptick in use. Because some EHR partners have enabled all of their users, Surescripts has a dedicated team that has been working with them to make sure their end-users are all trained and are engaging with the software.

Alix Goss thanked **Luke Forster-Broten** for his presentation, and she asked **Sheryl Turney** to facilitate the next demonstration.

CoverMyMeds DEMONSTRATION

Sheryl Turney introduced the presenters from CoverMyMeds. **Kim Diehl-Boyd**, VP of Industry Relations and Government Affairs at CoverMyMeds, introduced herself and gave an overview of her career as it relates to PA, and she provided background information on CoverMyMeds. She explained that, since its inception in 2008, CoverMyMeds has helped people access medication more than 180,000,000 times through their collaborative network and innovative solutions. She then introduced the other presenters from CoverMyMeds:, including **Miranda Gill** (an Advanced Practice Nurse and Senior Director of the Provider Team), **Anna Klatt** (Senior Manager of the Product Team, reporting to and supporting the Provider Team), and **Liz Otley** (Senior Product Manager). She explained that they would detail the state of the current ePA workflow process, how their ideal ePA process should look, and their recommendations for the future state of ePA.

Liz Otley provided a high-level overview of end-to-end ePA transactions. She explained that there are four ways to submit a PA to CoverMyMeds, and all are facilitated via the NCPDP SCRIPT standard. Methods that retrospectively start at the pharmacy are:

- Via CoverMyMeds web portal
- Via CoverMyMeds pharmacy integrations (96% of pharmacies)

Submissions that are prospectively started by the provider are:

- Via CoverMyMeds web portal
- Via CoverMyMeds EHR integrations

She presented and described the various steps in the workflows for the retrospective pharmacy path and the prospective provider path, which were illustrated in the presentation slides. These steps included actions taken by both the provider and the payer. She summarized the parts of the process that are working well, including:

- Retrospective PA workflow (retail ambulatory settings, medication space)
- One-stop shop for pharmacy, providers, and payers, with dynamic question logic
- Real-time responses
- Formulary alternatives

She described areas in the process that still need improvement, including:

- Prospective initiation
- Expand to Medical Drug PA
- EMR ePA usability
- Accuracy of formulary data
- Bi-directional data exchange

Miranda Gill presented the ideal state of an ePA workflow, and she noted that elements of it are built out and are being used in the EHR and provider networks today. It is an in-workflow PA process that is prospectively created during e-prescribing. She explained that auto-populated data reduces keystrokes and administrative burden on the provider, staff, and other care team members, who complete the remaining fields. Then, she presented a mock EHR landing page that appeared as it would to a provider who is logged into their account. Elements shown on the mock landing page included a schedule, list of patients, detailed information about various patients, and more. She noted that everything was generated and not real data. She demonstrated to the ICAD TF how a provider would add a new medication for a patient in the e-prescribing workflow, including information about the cost of the new medication. The physician would then be provided with the information necessary to discuss the costs and efficacy of various medications with their patient. By sharing generated screenshots, she presented a simulation of the various steps in the ePA workflow within the EHR.

Anna Klatt presented the two key areas the industry is working on to make the ideal ePA experience a reality for providers. Necessities within the first area, eligibility and benefits included:

- Plan-driven information that is updated in real-time
- Accurately maintained
- Real-Time Benefit Tool (RTBT) solutions

Resources that would be leveraged within the second key area, automation of clinical data exchange, to minimize provider burden included:

- National Council for Prescription Drug Programs (NCPDP) SCRIPT Standard
- HL7 Fast Healthcare Interoperability Resources (FHIR)
- OAUTH2 (Open Authorization 2.0, an open standard authorization framework for token-based authorization)

She noted that they have taken significant steps toward the goal of the ideal state in the past year. However, she shared recommendations for ways to improve the process to drive the industry toward a fully automated PA workflow, which included:

- Reduce false positives with accurate PA prediction
- Update F&B file by completing PA flag section of file
- Drug-specific utilization logic to increase automation
- Patient-specific info available in real-time
- Auto pulling & population of data
- Leverage industry standards (SCRIPT & HL7 FHIR)

Discussion:

- **Alexis Snyder** inquired how the automated electronic process works for patients with dual insurance and more than one payer, especially when one requires PA, and the other does not. How can the patient make shared decisions?
  - **Liz Otley** clarified that there are two scenarios related to this question. In one, the health plan itself reviews the PA, and, in the other, the PBN reviews the PA. CoverMyMeds has tried to automate this process as much as possible to avoid confusion around which PBM provides the benefits. However, they have not solved the problem yet.

- **Kim Diehl-Boyd** added that coordination of benefits is still a challenge, especially given the growth of specialty. They have tried to alleviate this pain point by surfacing as much information as possible in the EHR and at the point of prescribing, but they are still working on addressing this issue across the industry.

Due to time constraints, **Sheryl Turney** requested that ICAD TF members pause their discussion, and she asked **Lauren Richie** to open the meeting for public comments.

PUBLIC COMMENT

There were no public comments.

Questions and Comments Received via Adobe Connect

Jocelyn Keegan: here.

Jocelyn Keegan: sorry for tardiness :)

Lauren Richie: thanks Jocelyn, no worries

Arien Malec: Arien is here as well.

Lauren Richie: hi Arien

Jorge Ferrer: What role do PBM's serve in this process?

Jocelyn Keegan: The are often the outsourced party that owns administration of pharmacy benefits for membership. They act on behalf of the payer/health plan to manage patients benefits.

Jorge Ferrer: What is the administrative cost of having PBM's as intermediaries?

Jocelyn Keegan: This queuing task list management we do on pharmacy vendor side is incredibly important foundation of how to match real world.

Gus Geraci, MD: PBM's add a cost, theoretically offset by their ability to negotiate better discounts, get better rebates, which offset their costs. Like bulk purchasing agreements, they get better deals.

Gus Geraci, MD: If they didn't no one would use them.

Jocelyn Keegan: I think also important to understand where the data can be surfaced and having it be actually populated. NCPDP is writing a white paper on this topic. I can share link.

The public comment period closed, and ICAD TF members continued their discussion of CoverMyMeds presentation:

Continued Discussion:

- **Jim Jirjis** noted that he has been an ambulatory primary care physician, so he is familiar with the burden of managing all of the aspects of PA. He submitted several questions:
  - He noted that if the process works well, he has seen about 30% of PA requests automatically adjudicated. He inquired if they have seen a similar percentage.

        - **Kim Diehl-Boyd** responded that they have seen some plans at an 85% rate of using ePA.
    - For those that cannot be automatically adjudicated, he requested more information about what can be done at the front-end of the PA process to help providers. He cited the example of step therapy.
        - **Kim Diehl-Boyd** noted that the adoption of electronic processes is determined by the plan's lift and willingness to programmatically adopt the electronic process and provide more transparency and automation to the process. She described how the clinical question sets, which are facilitated at the point of prescribing, can address variables between plans. Also, she described the retrospective process for the PA workflow, which is made possible through the NCPCP SCRIPT and FHIR-based technologies in the system.
        - **Liz Otley** clarified that CoverMyMeds does not use the term "auto-adjudication," but, rather, they call the process "auto-determination," which means that the PDM or payer that receives the submitted criteria has the option to either automatically approve or automatically deny the PA. She explained that they do not see many automatic denials, because these are often flagged and added to a queue for review, instead. She noted that their number for ePA submissions that have some auto-determination is about 34%, which leaves room for growth. She referenced the previously stated recommendation made by CoverMyMeds to improve formulary data and drug-specific criteria and criteria management systems.
- **Gus Geraci** inquired if software is integrated into existing EHR, or if it requires opening another program.
    - **Miranda Gill** responded that it is integrated into many of the largest EHRs in the industry, but they also do integrations for smaller practices and groups. Functionality also exists through their web portal.

NEXT STEPS AND ADJOURN

Sheryl Turney thanked the presenters and the ICAD TF members for their participation in the meeting. She requested that any further questions be submitted in writing, and they will be forwarded to the presenters.

She asked members and subgroups to continue submitting feedback on the workbook as homework.

Lauren Richie noted that the next meeting would be held on Tuesday, May 5, 2020.

The meeting was adjourned at 4:26 p.m. ET.