The Office of the National Coordinator for Health Information Technology

Transcript

HEALTH INFORMATION TECHNOLOGY ADVISORY COMMITTEE (HITAC) INTERSECTION OF CLINICAL AND ADMINISTRATIVE DATA TASK FORCE MEETING

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

VIRTUAL

Speakers

Name	Organization	Role
Alix Goss	Imprado Consulting, a division of DynaVet Solutions	Co-Chair
Sheryl Turney	Anthem, Inc.	Co-Chair
Steven Brown	United States Department of Veterans Affairs	Member
Gaspere C. Geraci	Individual	Member
Mary Greene	Centers for Medicare & Medicaid Services	Member
Jim Jirjis	Clinical Services Group of Hospital Corporation of America (HCA)	Member
Anil K. Jain	IBM Watson Health	Member
Jocelyn Keegan	Point-of-Care Partners	Member
Rich Landen	Individual/NCVHS	Member
Leslie Lenert	Medical University of South Carolina	Member
Arien Malec	Change Healthcare	Member
Thomas Mason	Office of the National Coordinator	Member
Aaron Miri	The University of Texas at Austin, Dell Medical School and UT Health Austin	Member
Jacki Monson	Sutter Health/NCVHS	Member
Abby Sears	OCHIN	Member
Alexis Snyder	Individual	Member
Ram Sriram	National Institute of Standards and Technology	Member
Debra Strickland	Conduent/NCVHS	Member
Sasha TerMaat	Epic	Member
Andrew Truscott	Accenture	Member
Denise Webb	Individual	Member
Lauren Richie	Office of the National Coordinator	Designated Federal Officer
Michael Wittie	Office of the National Coordinator	Staff Lead
Luke Forster-Broten	Surescripts	Presenter
Kim Diehl-Boyd	CoverMyMeds	Presenter
Liz Otley	CoverMyMeds	Presenter
Anna Klatt	CoverMyMeds	Presenter
Miranda Gill	CoverMyMeds	Presenter

Operator
All lines are now bridged.

Lauren Richie
Good afternoon, everyone. Welcome again to another meeting of our Intersection of Clinical and Administrative Data Task Force. This is Lauren Richie with ONC. Quick roll call – the task force members that I see on the phone and in Adobe – we have Alix Goss, Alexis Snyder, Anil Jain, Deb Strickland, Denise Webb, Gus Geraci, Jim Jirjis, Ram Sriram, Rich Landen, and Sasha TerMaat. Are there any others I did not announce that are on the phone? Okay. Just a quick audio check – do we have Sheryl Turney on the line yet? Alix, in the meantime, I will hand it over to you to get us started, and we'll circle back to confirm when we have Sheryl on the line.

Alix Goss
Thank you for –

Sheryl Turney
I'm back.

Alix Goss
Oh, awesome. Good to have you. I know I had a little bit of a challenge getting in as well today. We've completed roll call, so let's go ahead and advance to the next slide. I'm sorry, you can stay here, actually. I apologize. Go back one slide. So, on today's agenda, we're going to provide a brief recap from our last meeting, talk about the progress that has been occurring in the last week since we last met, and then we're going to pivot over to have two sets of demonstrations today from Surescripts and CoverMyMeds. This is the pharmacy part of our demonstration opportunity. We'll have those demonstrations before we go to public comment, and then wrap up. Next slide, please.

So, let's go to the next slide and get a little bit of perspective about the last meeting and what we accomplished in that very productive dialogue. We took two paths. The first path was to describe the work of the ideal state and guiding principles small subgroup, also known as the "happy path" group. We had a good discussion last week that helped give us some perspective related to the preliminary set of principles and ideal state requirements that we had identified. It really provided us with an opportunity to consolidate some of our thinking around ceiling and floor facets as well as transparency aspects related to the information that would need to be exchanged in prior authorization. We also took a deep dive into some of the minimum necessary considerations and how we might want to phrase those up.

Josh and the team walked us through the data categories table. They really advanced the framework of the data classes consideration and really synced up the work with the ISA, the ONC's interoperability advisory, to sync categorizations, data classes, and maturities standards, coming up with a nice visual way to categorize the classes and the standards that are in the marketplace today on a low/medium/high framework. We also took some time to consider the need of extracting our work from a prior authorization level up to a higher level of intersection of clinical and administrative concepts. We're going to need to get back to that level of discussion, but thought that we really wanted to take a deeper dive into some demonstrations, first with pharmacy and then with medical prior authorization, and that will be a main focus of our conversation this week and next. Can we go to the next slide, please?

So, today, Sheryl and I thought we'd give you a brief update on the workbook progress that's been made between meetings before turning it over for our demonstrations. So, I'll cover a bit on the happy path group to talk about that we met at the end of last week. The team got together and walked through the feedback from the last call. We did some consolidation, as anyone who's been out there looking at the workbook might see. We incorporated the discussion points from the last call, we enhanced – added a new guiding principle, and then started to de-duplicate, consolidate and reframe as appropriate to the higher-level context that we're trying to take with the ideal states.

And so, we've provided detailed notes in the workbook on the changes that we've made. We're going to continue to evolve that work this week, and then also take – start to look at the "recommendations" tab that Sheryl discussed last week and that she was – she had gone back through HITAC recommendations. The full HITAC body had had some discussions and recommendations over this past year, so she captured those recommendations as a starting point for us. Once the guiding principles and ideal state happy path team finishes up the initial work on our tab, we will take a review of those recommendations before we then reframe and try to put into a much cleaner format our guiding principles and ideal state work, and that'll give us the focus for the next couple of calls that we'll have – at least, that's our current game plan for the happy path. That consists of Anil, Arien, Alexis, Tom Mason, and myself. So, that's my update on that workbook effort this week. Sheryl, would you or Josh like to talk about the data classes effort?

Sheryl Turney
I'm going to have to let Josh talk about it because I wasn't able to meet with the team this week. I do think they met at least one time. Josh, are you on the call?

Josh Harvey
Hey, Sheryl. Yeah, I'm on. So, I think the email that went out last week requested any additions or augmentation to what we had discussed last week by Friday of last week, so I'm not aware of any feedback we got on any potential changes to what we discussed last week, so we did a little bit of cleanup of the table to make it a little more presentable, but outside of that, it seemed like the feedback from the group was supportive overall. There weren't any significant changes necessary. If there's anything we've missed, please feel free to reach out to us, and we'd be happy to incorporate those changes, but there are no significant updates over the past week.

Sheryl Turney
Okay, great. I have looked at the data classes. They look really great right now in terms of – you guys have filled out most of the information, and regarding the work that I did – Alix covered most of that – I did also add considerations under "other considerations" that came from any of the presentations where groups came to HITAC as well, and they didn't really fit as recommendations, but there were things that groups had asked me to consider when we were doing this work, so one of the future activities we need to all be going through is to review all of the things we've pulled out of other documents and added to the "other considerations" tab. So, again, part of the homework we're going to ask you guys to do over the next week is to take a look at that "other considerations" tab and the recommendations. The recommendations are not meant to be – they're meant to seed for us to review so we can say, "Does this recommendation make sense?"

So that you know or for other considerations, I did include in the recommendations what the source document was that these came from and when it was shared with HITAC, and all of those documents are available to everyone in this group out on the website, so you simply look at the HITAC calendar, and you can find that date, and then you can find the presentation with the individual's name and the group that they represented. I included that there. So, please take the time to go out, review these, ask questions, and make comments so that when we do review them, we'll have good, meaningful conversations about these topics. Back to you, Alix.

Alix Goss
Thank you, Sheryl. So, at this point, I think the key message is that we're looking for all task members to take a look at the workbook. You can focus on any or all of the tabs. What we're really looking for is broader input or, at least, familiarity with the content to aid our discussions. We will be resuming some of our detailed discussion in about two weeks, and we're going to focus this week and next on some demonstrations. So, I think at this point, Sheryl, we're about ready to pivot to that point. Would you agree?

Sheryl Turney
I agree. Thank you, Alix.

Lauren Richie
Okay, great. I just want to make sure everyone's seeing the slides.

Alix Goss
Yes.

Sheryl Turney
From Luke?

Lauren Richie
Yes.

Sheryl Turney
Yes, we are.

Lauren Richie
Okay, great. At this time, I'd like to introduce and welcome Luke Forster-Broten to our task force call. Luke, I'll hand it over to you.

Luke Forster-Broten
Okay, thank you so much. Hello, everybody. This is Luke Forster-Broten. I'm a director on the product innovation team at Surescripts, and I've been working on electronic prior authorization for the last eight years, and working closely with NCPDP when they initially developed the standard way back in 2012 and 2013, so I'm excited to talk about all the progress that we've made in the meantime.

If we go to the next slide, just to set up the challenge a little bit, as I'm sure you're all well aware, prior authorization is a huge challenge for physicians, both from the administrative standpoint and from the burnout standpoint, so we've done a few studies on physician burnout, and it's really family-practice doctors that are being hit the hardest in terms of burnout, and if you think about all the other things they have to do in their roles, the last thing they want to do is spend a lot of time on what they consider unnecessary administrative red tape, and prior authorization is certainly one of the things that they spend the most time on. When we're thinking about how often they're interacting with a patient's health plan, the largest chunk of their interactions with that plan revolves around prior authorization.

From a pharmacy's perspective too, once a prescription actually makes it to the pharmacy, pharmacists are reaching out a lot to get in touch with the health plans to figure out if that's even the best medication for the patient to be on, or if there's a medication that could be dispensed that wouldn't require prior authorization, so it's a problem not only for physicians and patients, but also for pharmacies and plans, too. The plans spend an awful lot of time on the phone with prescribers trying to walk them through the process and figure out how to get the medication that's needed.

So, if we go two more slides, it's certainly an evolving process. This slide outlines what the traditional prior authorization workflow looks like from a prescriber perspective, and up until the advent of electronic prior authorization through the NCPDP standard, the prior authorization process was very manual and phone- and fax-based. So, you can see that if we think about this in terms of the e-prescribing experience, the member would arrive at the clinic, the physician would use her EHR to try and identify the best medication for the patient, and a lot of times, she would not be looking at patient-specific data, but at traditional formulary data at a group or plan level, and that is directionally accurate and directionally helpful, but it's not really helpful in assisting the provider and making the most efficacious choice when it comes to what medication to prescribe for the patient, so there are no opportunities to look at costs across different channels.

It's difficult to compare therapeutic alternatives when you're looking at group- and plan-level data, so a lot of times, the physician is practicing and prescribing in the dark without knowing if prior authorization is going to be required for the patient. So, the end result is that the prescription leaves the EMR system, arrives at the pharmacy, and then when the pharmacy adjudicates the claim, it gets rejected because prior authorization is needed, and then the pharmacist is reaching out using phone, fax, or some other method back to the physician office to try to get that prescription authorized or find the alternatives.

What we see is not only is that frustrating for the physician and the pharmacy, but from a patient standpoint, there was a study several years ago that showed that 40% of the time, when a patient arrived at a pharmacy and was turned away because prior authorization was needed, the patient never actually went on any medication at all, so it's not just that they arrive at the pharmacy and then can't get the medication that their doctor prescribed them, it's that they're not getting on medication, period. So, this has negative health impacts for the patient and causes a lot of unnecessary delay and frustration across the spectrum of care that we wanted to try and tackle in a better way.

So, if we go to the next slide, what we try to do as an organization is rather than have the prior authorization be only identified once the prescription has already arrived at the pharmacy, we wanted to make the identification of the need for prior authorization part of the e-prescribing process and make sure

that all the different tools and standards that our EMR partners are using are working in conjunction with each other to provide that actionable data at the point of care so the physician can make the best possible choice for the patient. And so, the electronic prior authorization process is really an additional layer onto the traditional e-prescribing process and isn't something that happens after the fact or outside of the physician workflow.

So, in an ideal scenario, the member is arriving at the clinic, the EMR system is using the X12 eligibility standard to determine where that patient has pharmacy benefit coverages, and then they're cross-referencing that with the NCPDP formulary data that the EMR is downloading on a weekly basis. And so, that's really the fundamental basis on which prior authorization has been based until we started getting into the technology that allowed real-time prescription benefits, which is now the best way to identify for a patient-specific prescribing event what the best medication would be for that patient.

So, using that data, the physician is able to see not only alternatives that are patient-specific for the medication that they try to prescribe, but they can also see cost at those different channels, whether it's a 30-day retail, 90-day retail, or mail-order, and are able to see at a patient-specific level if prior authorization is required. So, at that point, if the physician wants to switch to a medication that doesn't require prior authorization, she can do that, or if she wants to pursue the original medication that she wanted to prescribe, she can kick off that electronic prior authorization process prospectively so they can get that prior authorization out of the way before the patient even gets to the pharmacy.

And then, I'm not going to spend a lot of time on this, but as an organization, we're also focusing on trying to help with that specialty patient enrollment form, so if there's a specialty medication that's been prescribed, that form can be filled out electronically as part of that prescriber's workflow, and then make its way to the specialty hub or the specialty pharmacy that's dispensing the medication. So, they have the medication and the enrollment form there electronically when they can start the process. So, the end goal with all of this is to have prior authorization be done electronically when truly necessary, but to avoid PA if possible through the use of real-time prescription benefit transactions, and if it is one of the specialty medications, to try to get that work done as far up front in the workflow as possible so everything can be done and get the patient on the medication quickly.

If we go to the next slide… Really, an overview of what that prospective ePA provides is it allows that proactive notification of PA requirements for physicians within their workflow. Because we're pinging the pharmacy benefit manager in real time for all of our ePA transactions, it's no longer a matter of wondering as a physician or a nurse if you're actually even filling out the right prior authorization form because we're getting that criteria back in real time from the payer directly, so all of the information that a physician or end user is filling out to do the prior authorization is always the most up-to-date criteria that the payer needs to know in order to quickly adjudicate that prior authorization.

And, because the messages are coming straight from the EHR, a lot of that prior authorization information is already pre-populated, so you don't have to spend time filling out the patient name, the prescriber information, and the medication information. All of that is getting pulled automatically, so the only answers that a physician or an end user has to complete are related to the clinical data around that prior authorization. And, what we've seen is that really cuts down on the amount of time that prescriber and their staff are spending on PAs. It essentially cuts that time in half, and we'll show that in a couple slides.

So, if we go to the next slide, this is just a mock-up of an EHR and what the physician would see within her workflow. You can see that for the patient she was trying to prescribe Prometrium for, using that real-time benefit data on the bottom of the screen, you can see what that medication would cost at a range of pharmacy channels – 90-day retail, mail-order, and 30-day retail – so that allows the physician to make an informed choice and have the conservation with the patient on if the cost is manageable or she should pursue a different alternative, and it also gives her that patient-specific prior authorization information so she can choose to switch to a different medication information that doesn't require prior authorization if that's available.

And so, it just outlines the type of information that is now available at the point of care, and the EMR partners all across the country are working hard to make sure that they're presenting the right level of detail, where they can have the physician be engaged with that display and be ready to have that conversation with the patient in a way that just hasn't been possible before, and that's really important because when you talk to physicians and look at different studies, a cost of as little as $10.00 can be the difference of whether or not the patient will actually pick up that medication or not, so it is really important to have that conversation, and we're finally able to provide the physician with that level of detail, where she can have that cost discussion and make sure that the patient knows exactly what he or she will have to pay when they arrive at the pharmacy. If we go to the next slide –

Alix Goss
Hey, Luke, this is Alix. I just wanted to ask if you wanted to take questions at the end or as you go.

Luke Forster-Broten
I'll just get through these, and then I can take any at the end, if that works.

Alix Goss
Sure, thank you.

Luke Forster-Broten
Thanks. So, the next slide outlines the growth of electronic prior auth – sorry, some of the keys that we focus with our partners on as they're transitioning from a manual prior authorization to an electronic one, and that really is to focus on the holistic process. So, it's not just reimagining how you can ask questions now that you can ask them electronically and have complicated logic built in to make sure that the physician is only answering the minimal amount of question necessary, but it also involves things like making sure that your eligibility and formulary data is up to date and accurately reflecting all the medications that actually require prior authorization, and then making sure that the real-time prescription benefit solution – from a payer perspective – is actually reflecting what medications require PA and what the cost is.

It's also important to make sure that you're enabling that across all patient groups, so there's a regulation in flight to require it for Medicare Part D plans, but it really is important in order to encourage as wide adoption on the physician side as possible. You want to make sure that payers are making electronic prior authorization and real-time prescription benefit information across their entire book of business because that will help the uptick and the adoption outside of just focusing on it for Part D.

And then, the other important thing is just making sure that on the EMR side, if they're implementing these standards, they can really be thinking about how to improve the physician's workflow overall by not making things so obtrusive that the physician gets overwhelmed with information, but to try to do as many things automatically as possible, and we really focus with them on getting the workflow right to drive additional adoption and utilization as well.

If we go to the next slide, we can see that across the country, 94% of prescribers are represented by an EHR that's contracted for prior authorizations, and I'm sure CoverMyMeds has some great stats on this in their presentation too, but we really have seen a wide uptick and adoption across the physician space and across our payer space. Ninety-seven percent of patients are represented by a PBM that has electronic prior authorization available, so it has been having outstanding growth. Not all of the health plans underneath each of those PBMs are enabled. That's something that we are working with our PBM partners on to make sure that they have as many health plans as possible participating in electronic prior authorization, and it'll take some time before we get full saturation there, but it really has been encouraging to see the amount of adoption and utilization across the country, even with the lack of federal regulation forcing them to move.

If we go to the next slide, I'll just wrap up by – why don't we go to the next slide, just to make sure we'll have time for questions? The one thing I wanted to highlight is our partner advocate Aurora Healthcare did a study to look at what their prior authorization process looked like before and after electronic prior authorization, and they went from only 30% of prior authorizations being started a day after the prescription was written to 75% of their PAs being completed the day after a prescription was written, and they cut the time almost in half of the number of active minutes their users were spending filling out prior authorization questions, and they also saw that by having this be a prospective part of the e-prescribing process rather than a retrospective process that only happened once the prescription got to the pharmacy, they saw a six percent increase in the first six months they were live with ePA – a six percent increase in the first-fill adherence for all medications.

So, they were just making sure that all the things they were doing to improve the prior authorization process for their users impacted not only medications that required PA, but medications that didn't require PA, so it's just an important part of increasing member satisfaction and making sure that patients are getting the medications that they need. It decreased the wait time patients had in waiting for their medications by over two days. So, I just wanted to highlight that as a case study that brings to life some of the workflow improvements I was speaking to earlier in the slides. So, I will pause here and answer any questions anybody has.

Alix Goss
Thank you, Luke. It looks like we already have two in the queue: Alexis, and then Gus.

Alexis Snyder
Hi, it's Alexis Snyder. I had a question in reference to those with dual insurance – more than one payer – and the automated process that is able to show cost, whether or not a PA is required, and the automated process for the questions to be able to submit that PA and get it done in such a timely fashion, which is terrific. However, a lot of the adherence, and the non-picking-up of medications, and the problems

patients are having when they are complex – or, sometimes particularly complex, but have the secondary insurance is that it's all well and good to see the first payer up front, but without being able to see what the second payer is going to do, sometimes there's not even a PA required for the first insurance, but there is for the second insurance, and that sometimes falls through, and as far as expense, knowing what the second one is going to pick up or not, et cetera. So, I'm wondering if Surescripts has contemplated that and if there's any way you're going to be able to bring it into your electronic process to account for a secondary payer.

Luke Forster-Broten
Yes, that is a really good question. So, one thing I'll say is that part of the challenge that we have today with the traditional eligibility process is that a lot of times, using the 270/271 eligibility X12 standard – it does have the ability for payers to indicate in the eligibility response if they are the primary or secondary payer, but a lot of times, the payers don't do that, and they leave that blank. So, as a prescriber, if I run an eligibility for a patient that has dual coverage, it will come back and – say it's Express Scripts and Caremark.

Both of those coverages will come back, and I'll be able to alternate between the two, but since the payer is not identifying whether they are primary or secondary – and, sometimes they just don't know – that remains a challenge, so it would fall to the physician to check with the patient and see what coverage they want to use, essentially, and hope they're doing it in the right order, but that's definitely a pain point where we're trying to figure out how, as a network, we can work with our payer partners to help get a better understanding of the dual coverage and benefits coordination at the point of care so we can present that in a meaningful way. Right now, it's definitely a challenge where even though the standard allows it, our partners oftentimes do not populate that, so it does leave it to the physician and patient to try and figure that out on their own, which may not be ideal.

Alexis Snyder
Right, I think you mentioned the second piece I was thinking as you were talking about coordination of benefit really being the piece. Even though both are there and both are entered by the physician and the patient, the coordination isn't there, so the first payer is sometimes allowing payment, and the second payer does not, and the second payer will cover a different medication that the first payer doesn't, so I think it's that coordination piece that also makes it really difficult for the patient.

Luke Forster-Broten
Agreed, and one of the things that's important, too, is that in the eligibility response, you also have the ability to indicate what type of coverage it is, which would allow EHRs, us as a network, or anybody else to help with that benefit coordination a little more, where even if you had two coverages come back in the eligibility response and the PBMs didn't know if they were primary or secondary, if you could see that one was commercial and one was Medicare, you could do some of that benefits coordination on your own. We could indicate that when we sent that to the physician system so they would be able to display those in the proper way. So, I think there are some workarounds that we're trying to work with our payers on to see if they can populate as much information as they know about what type of coverage it is, so even if they can't say if they're primary or secondary, you might be able to determine that on their behalf when you send that to the physician system.

Alix Goss
It's certainly been an interesting consideration related to coordination of benefits and dual eligibles. It really reveals an increased complexity related to transparency for patients and their caregivers as well as the providers. Alexis, are you good? Do you have a follow-up question?

Alexis Snyder
No, I'm good, thanks.

Alix Goss
You're welcome. Gus?

Gaspere Geraci
Thanks, Alix, and thank you for that presentation. Of course, I haven't worked with lots of providers and prescribers. The question comes to me that in your trial run with Aurora or other experiences, how much pushback did you get from providers and prescribers, and how is the workflow worked out? So, in other words, in the middle of a busy day, you're seeing patients. You write a script for somebody, and then it's saying you need additional clinical information for prior auth. I can just see a prescriber throwing the monitor through the wall. How did that work?

Luke Forster-Broten
Yeah, that's a great question, Gus. I think we see different physician system vendors handle it differently and some health systems handle it differently. The way that we recommend that a health system implement ePA is to use a centralized process, and that is what Aurora did, where they'd go to their organization and say, "Rather than have every physician's nurse or set of nurses handle prior authorizations individually, why don't we create a centralized team of people that know PA really well and can handle PAs on behalf of the entire organization?"

So, that's what Aurora did, and from a physician standpoint, that's really great because then they can focus on prescribing, and if they see that a medication requires PA, they know that when they submit that prescription, they've got a team is going to get routed that prior authorization task in the background so they can take care of it, and the physician doesn't have to. So, the physician can still make a decision on whether or not pursue a medication that requires PA, or she can switch to one that doesn't, but a lot of times, there's a team behind her where she knows that if it requires PA, that team is going to handle it, and they'll do the coordination of making sure that patient gets to the pharmacy and gets dispensed the medication.

Even in cases where we don't see a centralized workflow, I think the physician still – it's better for her to have the information up front and then switch to a medication that doesn't require PA. Then, at least, the staff is set up and can start that prior authorization process immediately rather than send the patient to the pharmacy, and then the patient gets there and gets turned away, and then they're frustrated with the physician because they're wondering, "Why didn't my doctor know this required PA? They prescribed me this, and now I can't get the medication. I don't know why that is." But, you're right, Gus. It's hardly ever the physician herself that's filling out the criteria. Oftentimes, she's writing the prescription, but then the EHR system is routing the actual prior authorization task to the nurse, the medical secretary, or whoever in that organization is doing the prior authorization on the physician's behalf.

Gaspere Geraci
Okay, so there is a way to move on to the next patient without necessarily having to dot every i and cross every t, and defer i-dotting and t-crossing to someone else on the team.

Luke Forster-Broten
Yeah, absolutely, and that's one of the nicest parts about the electronic workflow, is that because everything is happening within the physician's EHR, you can designate certain responsible individuals. So, the physician hits "submit" on the prescription, we're sending that request to the pharmacy benefit manager, but then when they return the question set for the PA, they're not returning it to the physician's queue, they're returning it to either a queue that all of the nurses review or a specific user's queue that is responsible for PA, so the physician doesn't have to worry about that.

Gaspere Geraci
Okay, thank you.

Alix Goss
So, this is Alix, and I just raised my hand. I'm going to jump in the queue here, building on what Gus has just talked about, because it seems to me that one of the things we've been looking at is this transparency aspect, not just about the caregivers and the patient throughout the entire process, but ideally, there might be some opportunity for some price knowledge, and Luke, I remember you noting that there was this opportunity – you said that $10.00 could even be a difference in price that influenced a patient's choice on whether or not to pick up a prescription or not, and so, if I'm hearing the dialogue between you and Gus correctly, at that point of care with the patient, the doctor says, "Okay, Suzy Q, I'm going to recommend this prescription."

That gets put into the system, the request goes out to the PBM, then comes back into the queue of the applicable person on the team for that provider, and so, at that point, Suzy Q has left the front-facing experience with the doctor or the prescriber, and then has left that room. The PBM would reply, and the patient may or may not still be in the building, so to speak. Am I following correctly?

Luke Forster-Broten
That's a really good question, and I should have been clear. The PA information is often not handled by the prescriber. The cost piece and the real-time prescription benefit – the EHR can design it so they have somebody who's designated to talk about cost with the patient, which they sometimes do. They could route that information to that person, but oftentimes, what we see is that because the cost information comes back so quickly – it's coming back in under a second with all the alternatives, so it's coming back to the prescriber. She can see as she's typing it in that if she wants to prescribe Prometrium, here is the price and here are the alternatives. She can actually make the decision there if she wants to, or she can have that made somewhere else, but it comes back quickly enough for her to make the decision and have the conversation with the patient that she wants to while she's still sitting there with the patient.

Alix Goss
Thank you, Luke, for clarifying that because it is really on-the-fly, interactive information that enables that doctor/prescriber to still have the patient there with them, even if there's some additional activity that would be handled by someone else on the care team for the prior authorization follow-up remarks.

Luke Forster-Broten
That's exactly right.

Alix Goss
Okay, awesome. Thank you. We have another question for you. This one is from Rich Landen.

Rich Landen
Hi. Thanks for a really good presentation. It's interesting stuff, and it looks like it took a whole lot of time and effort to put it together, so we appreciate that. You made several references in your presentation about EHRs and health plans building toward this. Can you give us some sense of how much of this is really deployed and operational and how much is looking forward to some sort of implementation in the future? Thanks.

Luke Forster-Broten
Great question, Rich. I would say from a PBM side, it's a little different on the payer side because a lot of times, depending on the PBM's relationship with their member health plans, sometimes they have to sell through to individual health plans before they would turn them on for prior authorization electronically. Some of them just have it as part of their main service, so they automatically turn on all of their health plans.

So, underneath the contracted number, I would say the majority of health plans in the country are enabled for ePA, but because there are so many health plans, it's hard to get a totally accurate sense of what that is, and also, a lot of health plans don't designate prior authorization to their PBM; they do it on their own, so I'd say in general, a lot of state Medicaid plans are having challenges getting up and running with electronic prior authorization just because they don't have the infrastructure set up and they don't have the bandwidth at the moment to be able to implement an electronic process, so we do see a lag on the Medicaid side of things, but for Part D patients, I would say the vast majority will either have or will have access to electronic prior authorizations for their patients by the first of the year if they don't have it already.

On the physician side, we do see a pretty rapid uptick. Some of the EHR partners have enabled all of their users, and now we're working with them to make sure that their users are using it, so the software might be available to an end user, but the physician might not actually be engaging with it a lot, so that is something that we've got a dedicated team that works with all of our EHR partners to go onsite, sit with users, do education, and train the EMR trainers so they can activate all of their users that want to do electronic prior authorization. So, on the EHR side, because of all their priorities, they're not quite as far along as I'd like in terms of use of electronic prior authorization because there hasn't been that regulatory mandate, but hopefully the one that is will have a final rule on anything, and will help spur them along and make sure all of their users have access to ePA and are actively using it for Part D patients.

Rich Landen
Thanks.

Alix Goss

And Luke, thank you for this. This is Alix. I just wanted to clarify when you were talking about Part D, you were saying "Part D" for the Medicare prescription drug program – that insurance program, correct?

Luke Forster-Broten
Correct.

Alix Goss
Okay, awesome. Thank you so very much for your presentation and answering our questions. I believe we're now going to pivot to CoverMyMeds, and Sheryl will be facilitating this portion of our call today.

Sheryl Turney
Thank you so much, Alix, and let's transition to the CoverMyMeds speaker. I think the first one is going to be Kim Diehl-Boyd.

Kim Diehl-Boyd
Yes, hello. Can you hear me?

Sheryl Turney
Yes. Go ahead, Kim.

Kim Diehl-Boyd
Thank you, Sheryl, and thank you for the opportunity to present to the task force today. We really appreciate it. As you referenced, my name is Kim Boyd. I am the VP of industry relations and government affairs at CoverMyMeds. I've worked in the healthcare technology space for over 17 years, operationalizing claims, prior authorization transactions, and more. I am also the task group lead for the NCPDP prior authorization workflow task group.

Just by way of background, really quickly, I wanted to give you some information about CoverMyMeds. We are one of the fastest-growing healthcare technology companies in the U.S. We have technological solutions that help patients get the medications they need to live healthy lives by seamlessly connecting the healthcare network to improve medication access, and thereby increasing speed to therapy and reducing prescription abandonment, but we also do this by facilitating appropriate access to medications through those solutions that help our customers avoid billions of dollars a year in administrative waste and avoidable medical spend caused by that prescription abandonment, and also help to reduce the administrative burden for providers and their clinical and support staff.

Next, please. Since our inception in 2008, we have helped patients access their needed medications more than 160 million times – actually, 180 million; I need to update my talking points. My apologies. We've actually done that 180 million times, and we've done this by leveraging that healthcare technology platform and using functionality such as electronic prior authorization and real-time benefit tools. Next, please. Joining me today are Miranda Gill, who is an advanced practice nurse and also our senior director on our provider team, as well as Anna Klatt, who is a senior manager on our product team, reporting to and supporting our provider team, and then Liz Otley, our senior manager of product, on the payer/PBM team.

Next, please. During our time together, we would like to detail for you what the current electronic prior authorization process looks like today and, given our years of experience, what the ideal electronic PA process and workflow should look like, and last but not least, our recommendations for the task force consideration as you prepare your recommendations for the HITAC committee. I'm going to now turn this over to Liz Otley, our senior product manager.

Liz Otley
Thanks, Kim. Can you guys hear me okay?

Alix Goss
Yes, we can hear you.

Liz Otley
Thanks. I just wanted to confirm before I started talking. So, to kick things off here, we just wanted to provide as high level of an overview – and, this is a little bit in the weeds, but a high-level overview of the end-to-end ePA transactions. So, there are really four ways to submit a prior authorization via CoverMyMeds, and all of these are facilitated via either our portal or our pharmacy and EHR integration, and then submitted to the plan or the PBM via the NCPDP's script standards. So, that can be done retrospectively, which is started by a pharmacy, and prospectively, which is started by a provider.

So, at the top on the left, you can see there are two initiation points for an ePA. Retrospectively, when the patient goes to pick up a medication and the claim is rejected, the pharmacy system will automatically initiate a prior authorization request, or prospectively, the provider's office – and, that's usually a medical assistant or other PA specialist – can also initiate a prior authorization. And so, under that subdomain of "prospective," there are two ways that provider can initiate a request. No. 1: If the pharmacy notifies the provider that a PA is required via fax or phone call, the provider can initiate the request in the CMM portal, or if the EHR indicates that a PA is required, which is usually done via the formulary and benefit file… In both cases, the provider is usually not proactively initiating a prior auth unless they are notified in some way, shape, or form that the patient will need one.

So, once the EPA request has been created, the user can then enter the demographic details. This can usually include information about patients, health plan information, coverage, provider details, and any prescription information. Depending on how the request is actually created, the PA can have that information auto-populated via the pharmacy system or the EHR, or the user has to enter it in manually. This information can dramatically vary by payer, by drug, and in fact, we're seeing more payers ask for more information as part of the PA initiation request as well.

So, once it's completed, the provider will actually submit that PA initiation request, as the standard dictates that part of the transaction. When the PA initiation request is sent to the plan, a few things can happen. So, we will generate an XML file that is sent over to the payer. This information includes all the demographic information, as well as member information. Once it's received, the payer can check the member's eligibility, and if the patient isn't found or is not eligible, the payer will return a "closed" code, and the PA can either be closed out or retried. If the patient's eligibility is confirmed, the payer will then return any drug-specific question sets with questions via the PA initiation response.

Once the PA initiation response is received, the provider can complete the requested information by sharing relevant clinical information, so these questions are dynamic in nature, meaning if a provider answers it in a certain way, only certain questions will appear, as determined in the payer's clinical criteria management system. Once that is completed by the user, the XML is then generated and sent to the payer via a PA request.

So, after the PA request is received in their PA review workflow system, a few things can happen. No. 1: If the payer has logic, the system can read the answers provided and send back a determination almost immediately. We do see this happen about 34% of the time in our system. So, some PBMs and health plans do have that auto logic setup, but we definitely need to see more adoption and more automation there. If the payer cannot provide an auto determination, the review likely needs to have someone review that actual request, so a human being has to look through the details of the PA and issue a determination. So, once that determination is actually made, the payer will send that determination back to the provider, and then sometimes, they'll provide a reasoning for the determination, but this is not necessarily consistent from PBM to PBM.

If the PA is approved, the claim can be paid and the prescription can be dispensed, and if the PA is denied, the payer can indicate that they will – I'm sorry, if a payer indicates that they will allow it, in certain cases, an e-appeal can be initiated. So, this is when the payer sends us a flag that says if determination was denied and is eligible for an appeal, we present a few more questions, and then the user can answer those questions and submit an appeal electronically. Again, this is something that's not widely adopted, but we anticipate we'll see more traction with this given the Med D mandate specifically calls out requiring appeals. So, that's the PA workflow end to end. I'll say we should keep questions to the end so we can get through the meat of our content. Please go to the next slide.

Overall, the medication ePA workflow is really effective, and it's working really well today. We have really built our business and the user experience around the retrospective workflow, and it works well because ultimately, from a retrospective perspective, the pharmacy is removing the burden of knowing when a PA is needed from the provider workflow given today's current state of affairs and how that eligibility and benefit information is available. So, CoverMyMeds – because of that, the other reason our users and network work really effectively is because we provide one place – a one-stop shop – for everyone in our network – that's pharmacies, providers, and payers – who provide that drug-specific dynamic question logic. It's responsive, and it's providing that information in real time, and a common problem that you see with drugs that may be a mixed benefit or PAs that may be reviewed by a health plan directly and not a PBM – you have to go out to separate portals or many different places, and it's hard to know where to go, so this is a place where we provide that one-stop-shop access.

We also provide fast determination and real-time responses. So, what was once a three- to five-day process can now be turned around in the same day, and in some cases, in as little as a few minutes. That's really the magic that electronic prior authorization can provide, especially when you're talking about a patient who's at the pharmacy, waiting for that medication. In addition, we see that when we present options to the users of alternative paths, if the PA is denied or if the patient can't get the medication – for example, formulary alternatives are the primary one. We definitely see a positive reaction from our users because they no longer have a dead end, and they know how to take action and move forward.

So, while we've seen it be really effective and impactful to the network and the users in our network, there are still some significant challenges preventing the industry from realizing the true potential that automation and electronic prior authorization can promise. So, truly prospective initiation is problematic, and this is due to a few different reasons. The EMR user experience can vary, but it's also a native integration, and sometimes those implementations can be a difficult user experience, and one of the things that we'll talk about a little bit more is the accuracy of the formulary and benefit information, as well as the data exchange. So, you have duplication of data entry, which can be ultimately resolved by bidirectional data exchange.

In addition, we are also working on expanding our offering into the medical drug PA space because if you zoom out and think about if a drug – especially mixed-benefit drugs and, more commonly, specialty medications can be covered under either the pharmacy or the medical benefit – it's incredibly difficult, as I mentioned before, for a provider to understand how the drug is going to ultimately be covered based on a number of different parameters that vary health plan to health plan and PBM to PBM, and how it ultimately needs to be dispensed.

So, can it go through a specialty pharmacy? Does it have to – will they allow a reimburse for buy-and-bill? The buy-and-bill one is really tricky because providers are storing those medications, so there's a really big risk for them if they administer a drug that's ultimately not going to be covered. So, the remainder of our presentation is going to be highlighting more of the details around how to resolve some of these challenges, so I'm going to hand it over to Miranda, the director of our provider business unit, to talk through that ideal workflow.

Miranda Gill
Great. Thank you, Liz. Please move on to the next slide. Some of the things that we're going to talk about are really along the lines of an ideal state, and we are fortunate to have these elements built out and alive in the network today with EHRs and provider users. So, some of the things that I'll point out here are that this is an in-workflow process. What I will show you in just a couple minutes is truly a prospective prior authorization workflow that is created during that e-prescribing workflow. You will have an opportunity to see that auto-population of data, reducing keystrokes and, ultimately, administrative burden on the provider their staff, as well as the opportunity for other care team members that support that provider to become involved and help in this process.

And, as Kim mentioned, if you'll go ahead and switch to the next slide for me, I do have a pretty significant clinical background, and so, for me, when I think about these things, it's really helpful for me to see what it actually would look like if I were working in an academic medical center or my own primary care clinic. So, here on this screen, what you'll see is a mock EHR. All of the information is safe. These are generated screenshots of an EHR notice that was real, so for disclosure on that. This is a mock EHR landing page, so when I'm logged in as a provider, here are some things that I might see. I might see my schedule, I might see my list of patients, and I might see my recent activity.

Please click, and then click again to move to the next slide. You will see that I have a full list of patients that I will be working with today on my primary care clinic day, and what you'll see is that we are going to spend some time talking about Cherise. Cherise is planned for a 1:00 visit, and she's a patient that I know

very well. She's a 64-year-old female, and she happens to just be coming in for her annual well visit. If you could click again, that'll take us to the next screen in our EHR. Here, you can review a couple of important things as a provider. So, you can see her current medication list, you can see her most recent office visit, you can see her vaccination status, and you can see the reason for her visit today.

So, here's where I would take a step away from the computer and spend some time talking to Cherise about what's going on with her health and wellness since the last time that I saw her. I would eventually return to my screen after making a decision based on her assessment to add a new medication to her treatment plan, and to do that, we'll need to click, and then, what we'll see is the opportunity to add a new medication – so, here in my e-prescribing workflow, I'll go ahead and put the prescription details in, and once complete, I'll click "confirm," and then I will have some additional information.

So, we'll spend a little bit of time talking through this particular view of my EHR. At this point for me, Cherise is still in the office. I will talk to her about this new medication. First, I'll describe what the medication is and how it should be taken, and in this case, it's once daily for 30 days. Here, I'll also have visibility into some of the key pieces that have been mentioned earlier in this presentation, as well as in the previous presentation, and we'll see that because we do have that real-time benefit transaction happening, I can see some things that are very specific to my patient, Cherise. Based on her medication, her insurance, and that transaction running in the background, I can see that a prior authorization is, in fact, required for the medication that I would like to prescribe for Cherise.

I can also see a few other things, including the patient pay amount at her preferred pharmacy. I can see recommended alternatives, and I can talk to her about whether those alternatives might be a good choice for her condition or not. And then, I can see the available cash discount price, and so, this is a price that I would want to talk to Cherise about and talk about her ability to afford her medication or the urgency in receiving the medication, knowing that there's a prior authorization required. And, I can talk to Cherise about that cash price, and it might make sense for her to forego her prescription benefit and pay that out-of-pocket cash price, but ultimately, what I'm going to do at the bedside with Cherise is use all of these data elements to drive that conversation around cost and convenience, and allow that shared decision-making to happen.

You can go ahead and click to the next slide. Ultimately, what Cherise and I decide after having a discussion is that it is best to stick with the originally prescribed medication, which means that we will have to go down that prior authorization pathway. And so, the pathway includes automatically starting that prior authorization, and then, I will click to complete that PA, so we can go ahead and move to the next. You'll see the process outline that others have described for the steps that need to be taken to complete the prior authorization, and so, I'll go ahead and fill those out under "medical details," and we'll move to the next slide.

After completing those elements, I will go ahead and send it to the plan, then we'll click to the next slide. On this particular PA, there are some additional questions that come back from the insurance plan. Now, as a provider, I would have moved on to see another patient, so this would populate in my EHR into a queue managed by my centralized prior authorization team, who's extremely proficient at completing prior authorization. They would go ahead and fill out the remaining questions that were sent by the plan, so you can go ahead and click.

After my centralized prior authorization team finishes that PA, they would go ahead and make that final submission to the plan. So, we can click one more time, and you'll see that for Cherise, we did submit this prior authorization electronically, and we did get that quick auto-determination, and for Cherise in this particular scenario, she did get an approval, so now we can send her to the pharmacy without any fear or anxiety around that medication being covered. So, we'll talk more about the future state of what we expect to see and what our recommendations are to you all, and for that, I will hand it over to Anna Klatt, who leads our provider products team.

Anna Klatt

Thanks, Miranda. So, there are two key areas that we wanted to touch upon that both we and the industry at large are investing in to help make this ideal ePA experience a reality for providers. So, first, we need better eligibility and benefits data to help drive a more accurate end-to-end ePA process. So, today, the PA flags in the F&B file are not consistently completed by plans, and as a result of this, we receive provider feedback that indicates that providers have a severe lack of trust in the F&B file as it stands today.

So, to make progress in this area, we need plan-driven information that is updated in real time. Additionally, RTBT solutions take us a step forward by leveraging several different data sources to provide greater accuracy, mitigating false positives and offering clinical decision support in real time, and really farther up in the process. Second, the continued automation of clinical data exchange will further minimize provider burden by leveraging information that is already present within the EHR. We should continue to leverage the NCPDP script standard and enable coexistence with the new emerging FHIR standard.

FHIR is great because it offers a standardized way to reach into an EHR system and get data that we need to process a PA. This is a huge step forward in interoperability because we can pull in addition to receiving a push of data, which creates this bidirectional data exchange between the two systems. Additionally, OAuth 2 is a standardized way to authenticate so that we can access EHR resources faster and more efficiently, and because this is a standard, it is, of course, vetted in a secure option for our partners.

We can go ahead to the next slide, please. So, we've taken significant steps toward decision within the past 12 months, so there are just a couple of things to highlight here. We currently have a production implementation that uses these concepts, and we focus on meeting the provider where they are by using FHIR-like technology to enable a preferred user experience while also leveraging the information that is already present within the EHR. The team is also actively working on enabling the automation of clinical data to keep the clinician from having to key in repeated information that already exists in their system. So, this is really getting to that clinical data pre-population.

Next slide, please. So, we've made great progress, and we're really proud of our team, but there's certainly ample opportunity to improve. As a summary, we've put together the following recommendations to help drive the industry closer toward a fully automated PA workflow. As we talked a lot about today, one of the greatest pain points for providers in the PA space is that false positive. We can alleviate this burden with more accurate PA prediction, and we have a couple of strategies to achieve this. In the short

term, this can be improved by encouraging plans to complete the PA flag section of the F&B file, and this will create some efficiency, but it won't completely alleviate the issue of false positives, as the F&B file is not patient-specific, nor is it updated in real time.

More robust drug-specific criteria and auto-determination logic would also increase the automation of the ePA process. Furthermore, plans should really strive to make patient-specific information available in real time to help inform the PA routing for retail and specialty medications. Lastly, we should be using and expanding upon industry standards, such as NCPDP script and HL7 FHIR, to expediate the patient, provider, clinical, and administrative data exchange. So, Kim, Miranda, and Liz, is there anything you guys want to add here before we open it up for questions?

Kim Diehl-Boyd
Thanks, Anna. Nothing from my end. Are there any questions from the task force? We're happy to answer them.

Sheryl Turney
Okay, great. I do see a question. Alexis, this is Sheryl. Would you like to go forward?

Alexis Snyder
Thanks, Sheryl. I'm going to ask the same question that I asked at the end of Luke's presentation, and that would be the availability of being able to see more than one payer, and additionally, the coordination between the two payers. As you talk about the case presentation of Cherise being able to make a shared decision, if she had multiple insurers in the process, she wouldn't be able to completely make a shared decision, and end up having difficulty, perhaps, at the pharmacy, as well as the end-to-end piece of it for everybody involved, so there's no more work in the end. So, I'm wondering where that can fit into your automation, if at all.

Sheryl Turney
Great. Kim, who can answer that question for CoverMyMeds?

Kim Diehl-Boyd
Hi, this is Kim. Liz, are you going to grab that?

Liz Otley
Yes, I've got it. I had to get myself off mute. So, I want to make sure I'm understanding your question. So, when you talk about knowing the health-plan-to-health-plan, do you mean a health plan that is reviewing the prior authorization itself, or do you mean the PBM that's reviewing the prior authorization? Because there's a bit of a difference there in that the user typically doesn't know who – if it's a PBM and they've got their member information, they enter that into the prior authorization, and that's if they have it. Sometimes they don't have it. And so, we try to automate that part of the process as much as possible so that they're not having to pick and choose and essentially figure out which payer or PBM provides that coverage. So, that's why I wanted to clarify to make sure I'm understanding.

Alexis Snyder

I guess I mean it in terms of automating the PBM ahead of time to account for more than one payer source for the patient. So, in the presentation, where you have Cherise, and you pull up the EHR, and it says you want to order a new medication, and it shows you the new medication and pops up, "Oh, well, this insurer requires the PA," and it starts the process for you, can you have more than one payer pop up there in that process, and furthermore coordinate the benefit between the two, where one might require a PA and one may not? More so that the first may not, but the second might.

Liz Otley
Yeah, it is definitely still a problem, and Luke mentioned this as well. It's something we're working on. We haven't quite figured it out yet. Kim, do you have anything you want to add in?

Kim Diehl-Boyd
Yeah, I'm happy to. Alexis, that's a great question. Coordination of benefits is a difficult challenge, and it's becoming even more challenging given the growth in specialty, and really understanding where the patient is in their benefit and who all is covering them for that benefit. Having information surface more readily at the point of prescribing is definitely there, versus staff getting on the phone, figuring out eligibility for a patient, and even then, understanding whether or not to ask if they have dual coverage and forcing that information to the healthcare system. I did have an NCPDP work coordination-of-benefit detail, but to the extent that that information is readily placed at the front of the prescribing – upstream with the prescriber, it's still a difficult challenge at this time.

Sheryl Turney
Thank you for that answer. That's great. I think for the team, this is something we're going to have to keep into our recommendations and other considerations because it does seem to be a challenge to the industry to deal with at this point. We're going to take a pause and do public comment right now, and then, Jim, you're going to be next up after public comment. Lauren, can you open the public line?

Lauren Richie
Sure. Operator, can we open the line?

Operator
Yes. If you would like to make a public comment, please press *1 on your telephone keypad. A confirmation tone will indicate your line is in the queue. You may press *2 if you would like to remove your comment from the queue, and for participants using speaker equipment, it may be necessary to pick up your handset before pressing *..

Lauren Richie
Do we have any comments in the queue?

Operator
There are no comments in the queue.

Lauren Richie
Okay. Sheryl, we'll let you know if any other comments come through.

Sheryl Turney
Thank you very much. All right, Jim. Why don't we move to you? You had a question.

Jim Jirjis
Yeah, thank you very much for the work and the presentation. Having been an ambulatory PCP, I know the burden of managing all this on staff and physicians and patients are pharmacists are great. I had a couple of quick questions you maybe can answer. One is if the process works well, there are different concepts, like there's a percentage of these that can be automatically adjudicated, and I think the prior speakers had 30% or so. Is that the same kind of percentage you're seeing? The second question is for those that can't just be automatically adjudicated yet still need prior auth, is that something at the front at the process that the providers need? For example, step therapy: If someone's trying to prescribe a medication that really requires step therapy, is that something provided as the PA is being filled out, or is that returning to the provider group after a denial or request for more information? Could you go into a little bit more detail about how that works?

Kim Diehl-Boyd
Hi, this is Kim, and Liz and folks, you can connect on the auto-adjudicate. So, to answer the first question around automation, we have seen some plans who are at an 85% rate of using electronic prior authorization via the standard process. Really, adoption of electronic processes in determinations is really about the plan lift and the plans' or PBMs' willingness to programmatically make these things happen. Over the course of the last 12 years or so, we have seen significant changes there where plans are doing more to adopt the electronic process and provide more transparency and automation to that process. Step therapy is still something that is done today – it can be done prospectively through that clinical question set, so as a prescriber is going through the process, let's say they put in X medication. Through that clinical determination process, a plan can ask if they have tried a different medication – maybe a lower-cost one. The variables are different from plan to plan based on their formulary coverage, but it can be facilitated prospectively at the point of prescribing.

But, what we do sometimes see – as was mentioned in the presentation – is we also have a retrospective process. So, for whatever reason, if the prescriber determines not to do the PA – wasn't aware that a PA was needed because there were false positives or negatives at the point of prescribing due to inaccurate data in the system, such as formulary and benefit not being complete, PA flag not being indicated – and it rejects the pharmacy for step therapy, we can still facilitate via the standard and electronic means to get that detail back to the prescriber versus having to get on the phone or fax, and we can do that instantaneously to get back to the prescriber for the prescriber to make an alternative decision to move forward or provide additional clinical documentation to support the need for the originally prescribed medication. So, that is capable today through the NCPDP script and FHIR-based technologies that are in the system today, and hopefully that answers your question, Jim.

Liz Otley
Can I tack on real quick there? Just to clarify, when we say "auto-adjudication," I'm not sure – I don't know that I'm familiar with that term, but how we tend to refer to it is an auto-determination. So, what that really means is that the PBM or payer that's reviewing the criteria and the information that has been submitted can either auto-approve or auto-close – we actually don't see a lot of them auto-denied because typically, they like to review if something throws up a flag and it can't be auto-approved, so that

will go into a queue where they will approve. So, end to end, we see about 34% of our total ePA submissions actually have some sort of auto-determination today. That number has plenty of room to grow, especially if you think about – and, that's part of the reason of why we made the recommendation that the more the PBMs and plans adopt drug-specific criteria and criteria management systems to be able to manage that criteria, the more accurate the questions are and the better ability for them to actually automate that determination.

Sheryl Turney
Yeah, that's a good point. All right, we have one more question we'll take, and then we have to wrap it up. Josh?

Josh Harvey
That's very interesting software. Is any of the software already integrated into existing EHRs, or does it basically require opening up another program on the computer?

Miranda Gill
I'll speak to that real quickly. This is Miranda. So, it's integrated into many of the largest EHRs that you're familiar with in the industry. For those smaller practices and physician groups that don't use one of the larger Epic/Cerner/Allscripts type of names, we do have all sizes of integrations, but then, the functionality also exists via our web portal, which anybody can access from their computer.

Josh Harvey
Thank you.

Sheryl Turney
Fabulous. All right, so, I think we had a great meeting today. Fabulous demonstrations by both Surescripts and CoverMyMeds. If folks have any additional questions that we didn't have time for today, I'm just going to ask you if you could write them separately, and we will get them off to the speakers to see if they can get answered, but I think we drove some great points with both of these presentations today that we'll be able to carry through for our considerations and recommendations. So, the homework for this team for this week: Please review the workbook; please make questions or comments on the materials in all of the tabs. Again, if you can't get into the workbook, let the folks from Excel know, and they will make that happen for you. Again, if you have any questions, please let us know and we'll forward them on to the speakers. We'd like to thank the speakers for coming today. We really appreciate it. The information you shared was very important, and it's going to be important for us to keep in mind as we go through our work. Alix, did you want to add anything?

Alix Goss
I think you did a great job. Thank you.

Sheryl Turney
All right. So, with that, it's a wrap. Thanks, everybody, for your time today. We hope you have a wonderful week.

Lauren Richie

Thanks, everyone.

Josh Harvey
Thank you. Bye-bye.