Medication Therapy Management: The State Of The Art For Standards and Interoperable Data Exchange

Jennifer Brock:

Hello everyone. My name is Jennifer Brock. We're going to get started for today. First, I'd like to thank everyone for joining us, and I would like to welcome everyone to today's learning event, titled "Medication Therapy Management: The State of the Art for Standards and Interoperable Data Exchange." Before we get started, I would like to point out a few tips so we can have a successful webinar. First, we are recording this learning event, and will make it available on the CMMI Part D Enhanced Medication Therapy Management model webpage shortly following this event. Second, while there will be no question and answer period during this learning event, you are welcome to submit any questions you might have into the chat box on the right of your screen. You may also email your questions following this event to enhancedmtm@cms.hhs.gov. All questions will be compiled into a frequently asked questions document that will be submitted to attendees. To ask a question using the chat, you will select chat at the top of your screen. Select the recipient in the drop down menu, and type your question and click enter. Please mute your lines during this call. If you have any technical issues, please submit a chat to Charles Gluck who is our producer for today's event. So let's get started. I would now like to welcome our first presenter. Starting the discussion today will be Gregory Woods, who is the director for Health Plan Innovation at CMMI. Gregory?

Gregory Woods:

Thank you, Jennifer. I'd like to thank everyone for taking the time and joining us this afternoon for a productive discussion on the current state of Medicare Part D systems and technology for data exchange and interoperability. Before we launch into that discussion, I'd like to briefly orient attendees on the Center for Medicare and Medicaid Innovation (or the Innovation Center), the Health Plan Innovation Division, and the Enhanced Medication Therapy Management model. The Innovation Center was created by the Affordable Care Act in 2010. It's a new office. It's part of the broader CMS agency and is intended to serve as the R&D or research and development arm for CMS. The Innovation Center's mission is to test models or demonstration projects aimed at improving quality or reducing expenditures under Medicare or Medicaid. To date since our launch in 2010, the Innovation Center has launched 30 — over 30 payment and delivery models or demonstration or pilot programs. The majority of those models to date have focused on the Medicare fee-for-service, parts A and B spaces. However, we have in the past year begun testing models within the Medicare Advantage and Medicare Part D spaces, and my — the work of my division, the Division of Health Plan Innovation, is focused on that work. Specifically the Division of Health Plan Innovation has announced two models to date — the Medicare Advantage Value-Based Insurance Design model, the MAVBID model, and the Part D Enhanced Medication Therapy Management model. Both of those were announced in September and the Enhanced MTM model is the focus of today's webinar. I should also say the Health Plan Innovation team is continually working on additional model ideas, and I would like to take this opportunity to encourage all stakeholders who may have model ideas to email them to us as we're always open to have a conversation about those.

I'd like to give a very quick overview of the Enhanced MTM model. Going through the details of the model is not the focus of today's webinar, but it is the reason that we've convened people. Just to give some context, I'll give a very high level overview. Additional information is available on our website, and I would encourage everyone to go there to review that. So the Enhanced MTM model is a test of new approaches to provide medication therapy management services for enrollees in the Part D program. The model has a five year model performance period. It begins in January of 2017 and runs through 2021. Eligible prescription drug plans that participate in the model are standalone basic plans with a minimum enrollment of 2,000 beneficiaries in five select regions — region 7, region 11, region 21, region 25, and region 28. To translate that into English, that's Virginia, Florida, Louisiana, Arizona, and the upper Midwest Plains region. The key elements of this model include increased flexibility for plans, specifically a waiver of existing regulatory requirements around MTM to allow plans to vary the intensity and types of MTM items and services that can be provided to beneficiaries through the MTM program.

Secondly, the model includes new, different, and we hope better aligned payment incentives for plans. This includes a prospective payment to fund planned interventions and then incentive payment operationalized as a potential increase in the beneficiary premium subsidy for plans that are successful in reducing Medicare medical expenditures through their Enhanced MTM interventions. In addition, I'd like to point out that the model will support interested and selected applicants with the opportunity for learning and diffusion events. This is the first of said learning of diffusion events where model participants and in some cases other stakeholders will have the opportunity to share information of mutual interest and to — that can support the goals of the model.

Before I turn over to our next presenter, I'd just like to mention that there will be a brief two minute evaluation survey, an opportunity for feedback, immediately following today's webinar. We appreciate all feedback and look forward to hearing from you, and as such, I'd like to request that everyone take a minute (I think it's a seven question instrument and should only take a minute or two for you to complete) at the end of the event today to complete the survey. I'd also just like to say that your success in this model test is our success, and we consider your input and feedback very carefully and want to encourage all stakeholders and all participants to continue to provide feedback to us going forward. With that, I am going to hand it over to Tracey McCutcheon who is the Team Lead for the Enhanced MTM model and who will lay out the topics for discussion in today's webinar.

Tracey McCutcheon:

Thank you Greg. Next slide please. I'm going to make a few remarks about the function and purpose of these learning events in general. Today's learning event, as you can see on this slide, is to provide some basic understandings of the current state of the art of MTM-related technology standards with the goal of providing a better understanding of existing solutions to potential implementation options. This event will be followed by a companion event next month which will look at projects where these potential solutions are actually engaged. However, as stated in our request for applications (RFA), the purpose of learning events in general is to support the potential applicants and the participants in our models in accelerating progress in the model test. It does this first by sharing information on potential opportunities for achieving

performance improvements, and secondly we can provide a space to identify topics of mutual interest to model participants for more collaborative learning events. So today's webinar is the first learning event to help ensure that potential participants have a shared understanding of certain topics, and can start the process of identifying opportunities for collaboration. Next slide please.

Now I'm going to talk about what these learning events are intended for and what they're not intended for. Today's topics have been selected to share information on the current state of electronic exchange of MTM-related information. Our goal in presenting this information is to help spur creative thinking about how adopting existing standards might support Enhanced MTM program designs, you know, particularly in opening new channels for targeting and engagement of at-risk beneficiaries. Our goal is not to signal that applications should or must include these features. Our goal is to provide a shared baseline level of information on current opportunities for better linkages with pharmacies and prescribers. We then expect to just observe how the private market adapts to these opportunities given the new incentives presented by the Enhanced MTM model. To avoid any possible misunderstanding, I will add that we are not intending to fund substantial HIT infrastructure projects through the model prospective payment. Rather, we're hoping that participating PDP sponsors will start by testing strategies such as, but not limited to, those presented today in targeted and selected circumstances, that they will test innovative approaches and then adapt to lessons learned. CMS views this model as a test of innovation, and therefore does not aim to penalize plans for trying new, inventive strategies. So therefore, similar to our approach towards developing performance measures, we will not make any determination that a given strategy or measure is one that should be pursued by participants unless we have determined over time that such a strategy or measure is very well correlated with improved overall outcomes.

We intend to be very transparent about what we are tracking, but we do not intend by doing so to signal our preference for certain strategies or interventions. For instance, if we were to propose to track the proportion of targeted beneficiaries for whom a plan sponsor provided medication history to an electronic health record (EHR) we would simply be tracking this metric to observe how often it occurs, and whether it turns out to be correlated with improved outcomes in any significant way. We would not be signaling an expectation that participants should include that feature, let alone achieve some threshold of performance. We do not know what a robust and effective MTM program looks like, and therefore we cannot yet establish meaningful indicators or requirements. That said, we do hope that this model will yield valuable information to inform the development of potential future outcomes focused quality measures. I will now turn the presentation over to Tricia Lee Wilkins from the Office of the National Coordinator or ONC.

Tricia Lee Wilkins:

Thank you Tracy and good afternoon to our participants. I'm going to briefly introduce the Office of the National Coordinator for Health Information Technology, and some of what we do and how we view health IT as essential to healthcare efforts such as the MTM Enhanced model. I'll first start with our history. ONC is the principle federal entity charged with promoting the adoption and use of health information technology, as well as the exchange of health information. We were created in 2004 by Executive Order of President Bush, and in 2009 we received expanded regulatory authority over the certification of health IT products and modules

and systems. We're best recognized for our work with CMS on the Meaningful Use Program, also known as the EHR Incentive Program, and I'll say more on our certification work shortly, but first on the next slide I'll talk a little bit how ONC's work supports delivery system reform.

When we think about the goals of health system reform and the key components needed to transform delivery of care, the ability to connect providers, to engage caregivers and patients in managing their health, to have data to track and inform clinical care, all these things are possible with standards based use of health IT. Health IT is what provides the necessary backbone to support improved safety, quality, and efficiency, and all of these are necessary for managing the health of individuals as well as populations. It's the data that gives us insight. Technology provides us efficiency, but it's the standards that are what make data and technology useable across settings of care.

On the next slide, I'll briefly highlight three specific ways that ONC's promoting delivery system reform and the triple aim through the use of health IT. This slide talks about our certification program, and it's really the first and primary way that ONC is promoting standards based use of health IT. You'll see a progression from our regulatory authority, and how we move to actually put forward criteria for certifying products, how developers then take those certification requirements and actually build products that meet those specifications. We have a system of test labs that then test health IT products to ensure they meet the functionality that's required within our certification regulations, and then we certify health IT products and make those available to the public on a place called the CHPL, our Certified Health IT Product list. This is where a provider can go to view products and modules and systems that meet those certification criteria. These certified products may then be used in different programs, and I'll just briefly mention for example the Meaningful Use Program. It's a policy program that's in place by CMS. It outlines the requirements to receive incentives around using health IT, but that program points to ONC's certification requirements saying that to receive those incentives certain objectives must be met using a certified health IT product. So our certification program in essence is basically voluntary, but it has teeth when another policy program points to that as a requirement. And so now you have providers and hospitals that will use these certified health IT products in accordance with a HHS program such as Meaningful Use Program to meet those particular requirements. The certification program, outlines specific health IT functionality and the standards that should be used and in place by health IT vendors when they're building and developing these health IT products, modules, and systems. So the ONC certification program is focused on mostly external stakeholders and industry at large like the vendors and developers who make these. However, we also work closely with federal partners to coordinate other federal health IT efforts.

On the next slide, I'll talk a bit more about some ways ONC is working with the public and private sectors to develop and implement specific health IT strategies. First, we have our Federal Health IT Strategic Plan. We also have our patient safety action and surveillance plan, and then we also have reports to Congress, and all of these are ways that ONC coordinates a broad health IT agenda with a variety of stakeholders. And so we don't just want to move adoption among industry participants. We also want to think strategically about how we can better position the work that we do at the federal level to promote this broadly for today and also for where we think we see the healthcare system going for tomorrow. So for example, our Federal Health IT Strategic Plan in 2020, it focuses on things such as how health IT can be used to support delivery

reforms and population health management, how research and innovation can also be supported through health IT, and ways that we can keep patient centered care at the focus of what we do through the use of health IT.

The third example on the next slide I highlight will be our shared nationwide interoperability roadmap. Interoperability really creates an ecosystem that no longer centers on siloed institutions or organizations. Interoperability really means that all individuals, their families, and healthcare providers are able to send, receive, find, and use electronic health information in a manner that is appropriate, secure, timely, and reliable. All this is supporting health and wellness of individuals. It allows informed shared decision making. It also makes the right information available at the right time so that everyone can really be active partners and participants in their healthcare. And it's our vision of interoperability, a system that allows this exchange of information through standards, that makes ONC so excited about the Enhanced MTM model. We really view what CMMI has put forward as important steps towards creating a supportive payment and regulatory environment that encourages better communication and connectivity between plans, physicians, and pharmacists. We know we're really looking forward to see what the innovative proposals and solutions are, and we really encourage plans to think of ways to incorporate health IT and standards based interoperable solutions in the way they manage their patient populations. I'm not going to steal our next speaker's thunder, but I will say that, you know, ONC is absolutely committed to assisting CMMI and model participants as they explore how health IT can be used to meet the goals of better care coordination and better patient outcomes through the Enhanced MTM model. And so with that, I will turn the presentation over to Shelly Spiro.

Shelly Spiro:

Good afternoon everyone, and thank you for joining us in today's webinar. I just want to thank Tricia Lee Wilkins, Dr. Wilkins, for all of her help, and we're going to talk now about interoperability. So as we talk about interoperability, as Tricia Lee had outlined in the roadmap that ONC has worked on so diligently, interoperability is a major function of where we need to go forward. And the best analogy I can give you is all of us use email, and lo and behold, I might have one email system and you might have another email system, yet we can still exchange that information using our email which goes over the internet. In the email itself, I can open it up the email you have sent me. I can file it. I can copy some of the information out of that email, and that's exactly the type of aspect or process that we're looking to get with health information and the data that's actually collected within that health information. So if you can go to the next slide.

In this picture using our same analogy, if you look at the two funnels in this particular picture, you can see the funnel on the left is just slightly different from the funnel on the right because we don't use the same email systems. I might use a different one than you do, and so as it turns out information, as you're typing into your electronic health record, that information is in the text based aspect, but it actually gets codified into terminology that actually comes out of the system and goes through a health information exchange using electronic structured documents, ends up in your system, and then it is readable or useable to the user who's using that electronic health record. Now this information can also come out of your system and be collected into a quality or registry through a similar type of process. Remembering that all this information through the standards that we use stays very secure and private, very similar to some organizations that might

use a certain portal or VPN type of technology to keep that information secure from one business partner to the other. You can go to the next slide.

So what are standards? In the United States, standards are governed by the American National Standards Institute or what we call ANSI, and they go through ANSI accreditation and they have to follow certain governance in order to make sure that the standards are actually good to be used in the United States. There are standards that are available for travel, for finance, banking, and even for electricity. Go to the next slide, there are three standards that are used for healthcare in the United States, and these are what we call X12 or the Accredited Standards Committee, which mainly deals with billing standards for medical bills, National Council for Prescription Drug Programs, which is NCPDP, and also Health Level Seven or HL7, which is an international organization that deals with mostly the electronic health record and some of these electronic structure documents and interfaces from one electronic health record to another. If you can go to the next slide.

So there are different types of standards that we use in pharmacy. We have standards for billing claims, which uses an electronic data interchange, or EDI, and these are for pharmacy would be the NCPDP D.0, and on the medical side would be the X12 837 professional. For hospitals, they might use the 837 institutional, or 837I. There are other types of messaging standards that are out there that also use electronic data exchange and that would be something similar to the HL7 ADT or admission, discharge, and transfer type of interfaces. There's also other types of standards such as conformance criteria standards for functional models such as the functional models and defining the conformance criteria for electronic health records. Within pharmacy, we actually have a pharmacist EHR functional profile that was accredited both through NCPDP and HL7. We also use other technologies such as extendable markup language or XML. This is a newer type of standard that's being used instead of the electronic data interchange or the EDI type of standard. Very similar to what we see in web-based type of programming, HTML which I assume most of you are used to who are using computers or websites or even web portals where you're using a programming called HTML. In healthcare for this type of standard, we use XML. Examples of these would be the continuity of care document or the CCD that uses something called consolidated clinical document architecture or C-CDA. And we also use other types of XML types of standards, such as electronic prescribing following the SCRIPT standard within NCPDP, and those are both examples of XML. If you can go to the next slide.

There are other types of standards specific for medication therapy management, or MTM services. Through the standards development work at NCPDP, we actually have an MTM specialized transaction. This uses the extendable markup language or XML very similar to the SCRIPT standard that we use for e-prescribing, and it has ability to actually take referral information and can request for a service. We also can use the X12 N278 which is a referral transaction that can be used for MTM services. So the specialized transaction for MTM is very robust. Unfortunately, we haven't had a lot of adoptions for this particular standard. There hasn't been a driving force or a need, but it is available for those who are going to be part of the Enhanced MTM model to actually use this particular specialized transaction. If they are interested, it is a balloted standard and accredited within NCPDP. If you can go to the next slide.

In terms of the actual documentation, one of the areas that is important is clinical terminology. One of the terms that you're hearing about, especially in the Enhanced MTM model, is the use of

SNOMED CT. SNOMED CT is a nomenclature or terminology that is being used by others in health IT, especially those who are receiving incentives through the CMS Meaningful Use Incentive Program, mostly physicians' offices and hospitals who are adopting meaningful use of the electronic health record programs. SNOMED CT is a language. It's a terminology that's specifically used for clinical documentation, and it is defined through situations, procedures, and findings. You can go to the next slide please.

SNOMED CT is downloadable through the National Library of Medicine, through their SNOMED CT web browser. The National Library of Medicine is the overseer of SNOMED CT in what we call the U.S. realm. It is actually an international database that's governed by IHTSDO out of Copenhagen, but as I said the National Library of Medicine has the ability to add and create codes. Here in the United States, we would go through the National Library of Medicine to submit any new terminology. One thing about SNOMED CT, it is free through the National Library of Medicine, but you have to receive a UMLS license. There's no charge for the license, but that's to ensure that you're going to follow the governance structure within SNOMED. SNOMED CT and IHTSDO and even National Library of Medicine through the U.S. realm states that SNOMED CT is to be used specifically for clinical documentation, not necessarily for billing.

Now it can be used as an attachment to billing. So as an example, if a radiologist was to send a claim in for an MRI and that payer wanted to receive additional information, an attachment to that claim, they might embed in that attachment some of the SNOMED CT codes. So the attachments themselves can be, such as a discharge summary or a patient care summary, could contain SNOMED CT codes. It just can't be added into the actual claim. Now it is updated twice a year. The other thing with SNOMED CT that's important to remember, it is a very specific terminology with hierarchy. That means that if you submit a code, they're not going to just assign the next number that's on the list. It actually has to go through a vetting process to make sure it meets certain hierarchy standards within the standard itself, and that's what makes SNOMED CT very unique.

So as an example you deal with parents and children. So if we were looking at a SNOMED code which does exist, a recommendation to discontinue a medication that would be the parent code. A child of that would be recommendation to discontinue prescription medication and another child would be a recommendation to discontinue over the counter medication. So as you can see SNOMED codes are actually used in a way to help document clinical information in a way that can be quantified, especially if we want to go ahead and do quality measurement reporting off of SNOMED or any type of reporting in terms of having an even playing field nationally on what some of the terms are actually being used. If you can go to the next slide please.

So some of the areas of — that are categorizations of SNOMED CT, realizing there are 330,000 terms in the IHTSDO or international database for SNOMED CT. These are things like vital signs, height, weight, blood pressure, smoking status, adverse drug event reporting, allergies, encounter diagnoses and problems. What we do with older terminology is that — older standards that are out there or older proprietary processes where we already have identified codes or those codes that are actually being used that have been developed by one organization or another, or even a quality measurement group, is a term that we use called mapping. It's very easy to take a term that you're currently using. If we use our example of recommendation to discontinue

medication, your system might have said discontinued medication recommendation. It means the same thing, and you can identify one code to the same type of terminology that you're trying to identify. If you could go to the next slide please.

So from a SNOMED CT standpoint for MTM, the Pharmacy HIT Collaborative which was actually formed by the nine pharmacy professional associations of which I am the Executive Director and very honored to be, we did a project. We did a gap analysis of the 330,000 SNOMED codes and found that there were several terms that were missing from medication therapy management. So we added about 270 terms into the international database that will help us as pharmacists begin to clinically document MTM services. Now there are other types of terminology that we would use and the pharmacy HIT collaborative is categorizing the SNOMED codes that we originally put in into categories or classifications or what we call value sets. Now value sets are important because value sets are the things that we can clump together such as drug therapy problems can be added in as a value set. The National Library of Medicine has a Value Set Authority Center where we can register those and record those value sets. And this will make it easier for the system vendors to take a consistent set of terms so that when they're actually being used within your electronic health record behind the scenes then those terms become consistent and we move towards standardization, realizing that the terms themselves are not something that a user would put in their system themselves. As an example, if a pharmacist is filling a prescription for dispensing, and they're picking a drug from a list of medications, they're not picking that drug from — or the medication from an NDC number or national drug code number. They're actually picking the name of the medication, and behind the scenes the actual code gets codified. Well it's the same thing with SNOMED CT. The clinical documentation, especially our payers in this new Enhanced MTM program, might already be collecting terminology or key points even through maybe an MTM subcontractor that they're using, but that subcontractor would then have those terms mapped to a SNOMED CT code. You can go to the next slide.

So to help educate the industry in relationship to SNOMED CT, the Pharmacy HIT Collaborative through our workgroups, and we have over 70 volunteers from all different aspects of pharmacy who volunteer their time to work on guidance documents. We have two guidance documents on our website. One is just an overview on SNOMED CT, and it's a really good background document. It's free for anyone who wants to just go to our website and I put the links on this particular slide, but you can go to pharmacyhit.org and find them on there. Another document we tried to do proof of concept of our MTM SNOMED CT codes and ran the codes through a Comprehensive Medication Management Team-Based model. We used the Patient-Centered Medical Home model to test MTM SNOMED CT codes. If you can go to the next slide.

There are types of standardized terminology that's out there, such as RxNorm for medication, LOINC, which is used for laboratory test results. There's also CVX for immunizations, ICD10 for diagnosis, and CPT codes for procedures or current procedure terminology. If you go to the next slide. There's really great value in using interoperability for data exchange. It's not just a matter of the exchange. So in as our example of an email, it's not that you're just sending an email. It's also how that email is codified. In our example, if we're going to send an email and if I'm going to receive an email from, let's say, somebody in Japan and it's written in Japanese, if my system or myself can't read Japanese, I'm not going to be able to do anything with that information. So it's very similar of why we're driving within the United States health IT

initiatives to push to standard terminology such as the use of SNOMED CT, RxNorm, and LOINC for laboratory findings. Now when we also work towards interfaces, having proprietary interfaces makes it more difficult, and this is where, if we can come to some type of standardization it'll be helpful. Also if we can capture some of this data such as SNOMED CT, then we would be able to do clinical quality measures more consistently in a standard way. If you can go to the next slide.

So there are ways that we take these actual terminologies and we embed it into forms. We use forms such as what I talked about before, Clinical Document Architecture. And these are forms like a patient care summary or a discharge summary or progress notes or care plans. All of these are templates that are part of the Health Level Seven or HL7 standard, and they use extendable markup language. It's very similar to what we do when we send an electronic prescription. Electronic prescription is just a standard form of a prescription. When the prescriber fills that prescription out, that prescriber is doing it in a standard way. It is transmitted through a health information exchange or some type of exchange network, and then it shows up in the pharmacy in another viewable form that the information can be broken out and integrated with that pharmacy management system. Well it's the same thing for clinical documentation such as discharge summaries or progress notes or care plans. We have moved to this type of standard documentation of forms so that we can exchange information in an interoperable way. If you can go to the next slide please.

So there are other ways to exchange information in the standard way following very strict protocols, and especially with healthcare, these protocols are set up to secure privacy and security of health information. So there's Direct Edge Protocol which is the Secure Trusted Agents that use something called HISPs or Health Information Service Providers that make the connections for our different organizations. As an example, electronic health record to electronic health record. Also there's DirectTrust. So there's a collaboration of several groups and in this case, 150 health IT and healthcare providers came together to make those direct connections so that we can exchange information in a secure way. There are also Simple Object Access Protocols that help when your developers are programming the information that stays secure and private to meet all of the HIPAA security and privacy standards. If you can go to the next slide.

Also we have FHIR which is what we call Fast Healthcare Interoperability Resources and this is to help our programmers create programs to some of the things like CCD or the using Clinical Document Architecture just more quickly. And we also have Open APIs, which are Application Program Interfaces. This is a way of standardizing the interfaces to decrease proprietary interfaces so many of the entities who have to program to exchange this particular information don't have to go through that exact interface programming that's specific or proprietary to just those two entities. A good example of an Open API that we would use every day is most of you might have a smart phone and you have applications on your smart phone. Most of those are API interfaces and are Open API interfaces. Another good example and I don't mean to name a particular organization, but most people can relate to Netflix as an Open API. Now you might go ahead and sign up with that particular vendor, but you can do that automatically. Then when it comes time for payment of using that particular application that comes in later through business to business integration. And if you can go to the next slide please.

We have other types of programming such as JSON, which is a data-interchange format that's easy to read and write to that makes the programming much simpler, and also REST, which is more of a web-based service again to make it very simple for your programmers. I shouldn't say simple. You have to have some programming capability, but as you as an organization are moving into more of the health IT arena, these are standards that have been put in place and that most of the national health IT organizations, including those that Dr. Wilkins mentioned earlier, in terms of the interoperability roadmap, are supported by these types of exchanges. If you can go to the next slide, please.

So in summary, where we are currently today, we have transactional based standards that are followed through NCPDP and X12, most of our claims-based types of standards, our transactional base NCDCP SCRIPT standard. We have other types of structured documents that come out of Health Level Seven. Those are things like the Clinical Document Architecture that uses XML. We have coding standards such as SNOMED CT, RxNorm, and LOINC, and then we also have in this national health IT initiatives that are taking place nationally that Dr. Wilkins mentioned. We also have exchange standards and these exchange standards that will help us with meeting our interoperability requirements of exchange of information are things like Direct Edge protocols, Direct Trust, SOAP, Open APIs, FHIR, JSON, and REST. And with that, I am going to turn the presentation back over to our moderator, Jennifer Brock, and thank you very much.

Jennifer Brock:

Thank you so much, Shelly. We are very fortunate today to be joined by an esteemed panel of stakeholders in the field of MTM. Thank you so much to each of you for taking time to join us for today's learning event. As part of this panel, each of these five panelists will respond to two questions in order to provide their perspective of the field of MTM. There will be no external questions for the panelists. However, participants are encouraged to submit questions into the chat to be answered as part of the frequently asked questions document submitted on the webpage. The two questions the panelist will respond to are as follows — what standards are your industry sector currently using, or proposing to use, and how does the portion of the industry you represent propose to support this type of technology? Now to begin the panel I would like to turn the presentation over to Jessica Frank representing the subcontractor perspective on MTM. Jessica?

Jessica Frank:

Great, thank you Jennifer, and good afternoon everyone. As Jennifer said, my name is Jessica Frank, and I'm a vice president of Quality with "OutcomesMTM." For those of you who don't know, "OutcomesMTM" is an MTM subcontractor for Part D plan sponsors, and we definitely appreciate the opportunity to share with the audience today the subcontractor perspective on the state of MTM standards and interoperable data exchange. Next slide please.

So in response to question one, "OutcomesMTM" currently utilizes several HIT standards in our MTM program. We utilize NCPDP and X12 file standards in our data intake process. Each Part D plan sponsor may implement these a little bit differently. So we have built flexibility into that data intake process to accommodate that. We also use XML to organize data in a tag based representation for simplified data transfer and processing. JSON is the standard format we use to

pass information to and from our Open API and user interface, and we utilize REST in the web services that we have in place with pharmacies and Part D sponsors. We couple this with our Open API library of proprietary code base for use by pharmacy and Part D plan sponsor custom user interfaces. I'll talk a little bit more in detail about this in a few minutes.

The MTM services in our program are documented and billed using a proprietary coding system that uses a Reason-Action-Result format, and I do have an example of what those codes look like in a following slide as well. We are proposing to map the proprietary codes utilized in our program to SNOMED CT codes for the Enhanced MTM model for standardized clinical data collection. The OutcomesMTM model has been founded on a pharmacy network based approach to the delivery of services, and as such, we have coordinated closely with pharmacies to integrate MTM opportunities seamlessly into workflow through a single sign on process that allows pharmacies to access and complete MTM opportunities via their pharmacy management system. So you can see here on this slide, there is a diagram that demonstrates that process whereby we provide the pharmacies with a secure MTM opportunity file feed that the pharmacy then uses to display indicators within their dispensing application screen regarding MTM opportunities. The pharmacists then access those opportunities during the dispensing process and completes that documentation for the clinical documentation and billing process within the Connect platform. This allows seamless integration within the dispensing workflow. Next slide please.

All of the MTM services are documented in the Connect platform which is a web-based platform that's designed for MTM service clinical documentation and billing. As I noted earlier, we do have proprietary coding that we've utilized for that clinical documentation. Next slide please. On this slide here you can see that proprietary coding that I mentioned that we use to capture clinical documentation today. On the left is the reason codes that are utilized, in the middle is the action that the pharmacist has taken, and on the right is the result, or the outcome of service.

On the next slide, in response to question two, OutcomesMTM plans to actually map these proprietary codes to SNOMED CT codes for the Enhanced MTM model, and our implementation of that mapping will occur behind the scenes so that we are able to maintain a consistent user experience for the pharmacies that are using the Connect platform for their documentation and billing today. As an example of this mapping, on the following slide, we've actually included an example of what these codes would map to for SNOMED. Next slide please. So you can see here on the left, are the OutcomesMTM proprietary codes, and then on the right are the SNOMED CT codes that these codes would map to. So we've already started this code mapping process. For example, an MTM claim with a code combination of dose too high, prescriber consultation decrease dose in that last example would map to a SNOMED CT code for medication dose too high and recommendation to change medication dose.

OutcomesMTM is a member of the Pharmacy HIT Collaborative that Shelly had mentioned earlier, and we've been very active in participating in the development of the MTM SNOMED CT code set that's in place today. Another effort that's ongoing within the industry is within the PQA Measure Development Team that's been charged with developing a drug therapy problem framework to use for quality measurement, and it is envisioned that this framework will utilize SNOMED CT codes to standardize data collection and reporting. So we do plan to continue to support these efforts and be involved with both organizations to develop a comprehensive code

set for the MTM industry to use for the Enhanced MTM model. And with that, I will turn the presentation over to Patty Kumbera.

Patty Kumbera:

Thanks Jessica. Next slide please. Yes, thanks for the introduction. My name is Patty Kumbera, and great job Jessica from the vendor perspective. The perspective we want to share now is the planned or payer perspective as it relates to medication therapy management and the interoperability. And if you could go to the next slide please. Plans or payers are really delivering medication therapy management services through about four different venues if you will. The first is through outsourcing it to vendors for that delivery of the MTM services, and that might be a single vendor like a Mirixa, SinfoniaRx, a Cardinal Health, the OutcomesMTM, or other vendors that are out there, or some are using multiple vendors. Some vendors are more network approach, some are more phone based approach, and some are a combination thereof. So an outsource vendor can sometimes do some or all of those services for the payer. Another option in the payer world is using their own in-house medication therapy management providers, and those payers might be using one of the exterior vendors for tracking that intervention or managing those services delivered to their eligible beneficiaries. Another option might be where they're using their own in-house personnel, but they've used their own system or software or platforms. So perhaps they've done some customization with their case management software, or simply created something from scratch as well. And there are also payers who are using multiple combinations of these type of MTM providers. So taking the approach of there really is not one silver bullet that may work and be the most effective for the process of delivering medication therapy management, that's where some of the payers are using lots of different strategies to hopefully increase that effectiveness. Next slide please. Next slide, thank you.

As Shelly mentioned, there are lots of different transactional standards that are being used, and when looking at the majority of the payers out there, I think of these listed on this particular slide that Shelly shared, probably the majority are using the NCPDP and X12 standards. So those around that of prescription claims and also the medical claims. How are they using that? Well in some cases they're using it for patient identification. So they're using the prescription claims process to identify perhaps by proxy then of what conditions the patient may have in order to bump up against the inclusion criteria they used in order to identify what patients should get medication therapy management services. In some cases, they're using that X12 data that helps give clarity to, was the identification done accurately, or does it give another layer of clarity that the right patients have been identified based on the clinical protocols that they're using. So another way they're using this data would be for the identification of the appropriate medication therapy management services to be delivered. So by looking at that prescription claims data through that NCPDP standard, they might be able to tell according to treatment guidelines what medications might be missing due to protocol that might have drug-drug interactions and if they can see in the claims feed whether there are duplications and unnecessary meds, or all the other types of drug therapy problems. Jessica provided a few examples of that as well. It also allows for the measurement of the impact of what the MTM providers are doing with the patients, and are changes being made and are we seeing better outcomes. So some of the payers you might see them using some of the other codes that Shelly mentioned like the LOINC codes, or that laboratory data. Now they might have the laboratory data. They might not have it in that specific standard, but they might be interfacing that into their decision support as well. Next slide, please.

So what standards are the industry using? I mentioned that those are — I think there are probably examples of several of the standards that might be used in pieces, but not across the vast majority of payers to the level of detail of which standards are out there and ready to be used. Many organizations when you talk to them and their IT departments, they talk about that they could do things. So from a technical perspective, they understand that the ability to do it is there and they understand how it would work and what would need to be done. But the difference between where they could do something and where they actually do it, and thus the functionality of interoperability, is a very wide chasm. And so that's part of the challenge I think we're dealing with today as we are moving very quickly down this road and this huge opportunity with the CMMI Enhanced MTM model presents. It's very exciting, but the readiness may not be there for the payers. So the vast majority are using the NCPDP and X12 standards that I mentioned, but all that other very useful information for true communication is not standardly used. Next slide please.

How does the portion of the industry of the payer side propose to support this technology? Again, it is not a case of wanting to support it or not. I think all would — all would agree that they want to do this, that they want to be able to communicate in a way that helps improve patient care, but the demand of technically getting that done is very different from where we are today and where we need to go. And it may take the penalties or the stick side for the carrots, the bonus side of different payment programs and performance-based programs that help shift the prioritization of getting that work done technically. Now there are cases within the payer industry where there are stakeholders who are risk-bearing agencies, risk-bearing partners that need to increase the effectiveness of a program as in improve the quality and decrease the cost. Those may be — those entities such as accountable care organizations or patient-centered medical homes because the incentives and business cases are different for them. You might see those entities be quicker to the market by following the standards because they understand the business case for it, and that intuitively it is a good idea for improved information, for better measurement, for more clarity of how to help those patients more specifically. So again, as I serve as the AMCP MTM consultant for their advisory group too, and that voice of payers has said as a group we commend CMS and CMMI for this opportunity in the Enhanced MTM model. The challenge will be how quickly it can occur. So you have the announcement that came out in September, and the application due in January, and then the implementation to be ready in 2017. It's a wonderful chance. The challenge is, that when folks think about 2107 that really, in a world of time, it feels like it is tomorrow. Again, thank you for this opportunity to provide the payer perspective and we look forward to solving the issues of — and we can go to the next speaker.

Kristina Crockett:

Thank you. This is Kristina Crockett and I'm glad to be on the call today to provide a pharmacy switch perspective and discuss how NCPDP transactions can be leveraged today. So I wanted to start with, if we can go to the next slide, a quick overview of RelayHealth. RelayHealth provides connectivity and solutions that enable constituents across healthcare to exchange information securely and conveniently. For over 30 years we've been the technology between the pharmacy and the PBMs, and we provide real time in work flow solutions to streamline interactions and ensure accuracy, safety, and compliance. With a network of over 50,000 retail pharmacies, we've processed more than 17 billion NCPDP pharmacy transactions annually. We've been behind the

scenes a long time. We are now leveraging our pharmacy access and in work flow technology to provide a channel for health plans. We are specifically enabling pharmacies on your behalf to engage in face-to-face interactions with your targeted members. Pharmacists are consistently ranked one of the most trusted professionals, and more and more studies and research show the impact that they can have on overall quality of patient care. Patients trust their pharmacists, and pharmacies trust RelayHealth. To enable pharmacies to have enhanced face-to-face discussions with their customers, we've leveraged our ability to interact with standard NCPDP pharmacy billing claims, the one that we see 17 billion annually, to deliver targeted customized messages direct from the health plan to the pharmacist in real time when they are processing a prescription for a patient. This allows the pharmacist to know about an opportunity for a specific patient and have that discussion when they come in to pick up one of their prescriptions. Next slide please.

So RelayHealth currently has three innovative solutions that open up a new channel of member engagement directly through pharmacy. These solutions are designed to work as a standalone or as a compliment to existing solutions that may already be in place. Our current solutions include Medication Refill Adherence, and for this program a pharmacist is alerted when a patient comes in for any prescription of a patient not adherent to one specific medication so they can have a consultation with the patient with the goal of processing the needed refill. The second program, Cash Prescription Monitoring, enables the health plan to get visibility into claims initially processed under cash. IMS estimates that nearly eight percent of prescriptions are filled utilizing cash despite having existing insurance coverage and this appear to be a gap in the patient's medication regime. Thirdly, Flu and Immunization, which provides targeted messaging when patients are eligible to receive immunizations. The pharmacist can ask the patient if they'd like to receive one and then administer it on the spot. So each solution addresses a unique challenge, but operates in the same manner within the claims processing workflow. Next slide please.

We believe this is a powerful platform technology that can be used for multiple intervention opportunities to alert the pharmacist to take action for your member. We have the experience and scale to provide positive effects on your quality scores, considering some of the statistics. Approximately 50 percent of adults have one or more chronic conditions. On average only 25 percent of members 40 and up are fully adherent, and often these members need to have a conversation to better understand the issue. And a simple dialogue can change everything and help the member focus on good health, take needed action, and return to the medication. Lastly, 94 percent of all Americans live within five miles of a pharmacy.

Let's review a little bit more how to engage the pharmacy as a channel in more detail on the next slide. So step one starts with the health plan providing an eligibility file to RelayHealth. It identifies the eligible member and the intervention opportunity. RelayHealth then intersects that with our pharmacy billing claims network, and when a participating pharmacy submits an NCPDP billing claim for prescriptions, we check to see if the patient on the claim corresponds to the patient on the eligibility file. If there's a match, we reject the claim pre-adjudication with a message letting the pharmacist know the patient is eligible for intervention such as adherence counseling. The pharmacist then resubmits the claim to bypass the message and adjudicate the original billing claim. When the patient picks up the prescription, the pharmacist is able to have a face-to-face discussion on the clinical intervention. The pharmacist then submits a subsequent billing claim activity such as processing a refill for the chronic medication or processing a billing claim for the immunization administered. Or in the case of cash prescription, they change the

prescription BIN to be sent to the health plan. RelayHealth provides program reports and detailed results back to the health plans.

So in conclusion, health plans can leverage the pharmacy channel and have direct impacts on members and quality scores by alerting the pharmacist to have face-to-face interventions with your members when they're in the store to pick up one of their many prescriptions. And now I'll turn it over to Kevin Larsen.

Kevin Larsen:

Great, thank you. So sorry about the trouble with mute. I'm Dr. Kevin Larsen, the Medical Director of Meaningful Use of the Office of the National Coordinator of Health IT. I'm here to speak on the physician and provider's perspective, and like Patty, I would describe the provider's perspective as being — having a number of different ways in which MTM is being implemented across the country. As you know there are many providers of many different types and many different business models under which they work. So providers in large integrated delivery systems, especially those that are in value-based contracts or risk based contracts like ACOs, will now often have a clinical pharmacist as part of a medical team actually employed by the health system as a team member. And those health system pharmacists will often do MTM at the site of care connected with the rest of the care team. So when those MTM pharmacists work, they usually use the electronic health record and the pharmacy system that the health system owns in order to do their communication and MTM back and forth with providers on that same care team. The standards they use there are the same standards that are used for electronic health records and retail pharmacy systems. So it's the SCRIPT standard, the NCPDP claims standard, the X12 standard. Also health systems and providers in general, in part two to the Meaningful Use program, use a medication terminology standard called RxNorm that is becoming more and more prevalent. And the RxNorm standard is a way to encode medications that allows for SNOMED like flexibility. So rather than encoding them as NDC codes, the RxNorm standard allows you to encode them by drug class and allows you to group and build rules around medications in a more sophisticated way.

Another set of providers again will —- that work in advanced payment models often are all separate individual providers that have banded together for example to form an ACO. And those providers will potentially contract with an MTM group in order to provide MTM on behalf of their ACO. There they may or may not be using a single EHR, so they're more likely to use exchange standards. When they're exchanging information with those MTM pharmacists, they will use tools like a Direct Messaging standard which is the secure messaging approach to send emails which may or may not contain clinical information back and forth between members of the team. Often those direct messages will contain things like discharge summaries, referral notes, et cetera, and so that is a standard that could be used in a tightly integrated system of people using multiple kinds of technology that want to share communication back and forth around the MTM or other kinds of care plan information. Most providers that are doing MTM are in more fee-for-service model and typically the MTM is provided on their behalf by the retail pharmacy chain, by the payer, or by some other system that is separate from the provider. What we hear from providers is that they would really like to get good messaging about what has happened for the MTM and that they would — there is a strong desire from those providers to be able to communicate and share back and forth the kinds of consultation questions and the kinds

of inputs from the pharmacists that have done the MTM. Why have the suggested a change and what is that change?

We are really excited about the new updated SCRIPT standard in the Meaningful Use Program for e-prescribing that requires a number of additional data information types that can be part of a prescription. The prescription information actually can start to be part of that exchange where things like cancelled requests and discreet structured sig information is passed back and forth. And I think we shouldn't overlook that as a really terrific way to enhance communication between providers and pharmacists, and that can include things like indication for a prescription. And so a combination of that SCRIPT standard and NCPDP 10.6, along with some direct secure messaging is likely a way that many, many providers and retail pharmacists with the kind of infrastructure they already have can enhance their ability to communicate and do shared care around patients with MTM needs.

What does the industry plan to do to support MTM? I think the providers are, you know, again a very diverse heterogeneous group, and so I would imagine that those in more value-based payment models, ACOs, large integrated systems, will continue to bring more and more MTM services into the care team in a direct way with either employed pharmacists or direct contracting that will then have specific interfaces and specific interconnections between two tools. What we have done at ONC as part of the 2015 certification addition rule, which is the rule that describes the standards for the Meaningful Use Program, is to encourage the use of the PDP template standard by including it in the stage three rule. We also have included the continuity of care document that was mentioned by Shelly as a way to send and receive information about referrals, and that's a fairly generic referral and transfer note in this XML documentation. So we are hoping and anticipating that that kind of information is shared back and forth between pharmacists and providers as they collaborate on patient care. Because that's now a routine requirement under Meaningful Use, we are — we are expecting and we know that those are sent very commonly between providers and others in hospitals, and are looking to have that sent more routinely between providers and pharmacies.

I think there is also a lot of potential for care plans and the care plan document that was briefly mentioned by Shelly as well, that a new standard that is based on this thing, our new care document standard that has a couple of additional components that describe a care plan. And it's really in that care plan around patient's goals and the interventions that would be appropriate for that patient that we see the future of multidisciplinary care coordination occurring and the way the standards by which we think we'll be able to do that. So with that I will hand it on to the next speaker.

Anne Burns:

Thank you. This is Ann Burns. Can you hear me all right?

Jennifer Brock:

We can hear you perfectly.

Anne Burns:

Great. I work at the American Pharmacists Association, and appreciate the opportunity to present the pharmacist/pharmacy profession perspective today. We can go to the next slide. The previous speakers did a great job of covering many of the standards in use today that pharmacists in different practice settings are encountering, and Kevin I really appreciated your comments about coordination of care. Pharmacists, as alluded to earlier, have extensive medication-related training and expertise, and as primary providers of MTM services, are very excited about the promise that robust technology infrastructure can bring to their practices and the patients that they serve. As with other healthcare practitioners, pharmacists have a need for technology that supports efficient and effective delivery of care services, including their MTM services.

There are three key areas of focus among the pharmacy organizations right now as it relates to MTM and the technology that can support it. The first is the need for user-friendly documentation and billing, and very important in the MTM realm is that pharmacists are able to document in their own documentation system that interfaces with other systems to share information. It's not efficient for pharmacists to have to document in a variety of proprietary systems, and the standardization that's going on in the marketplace is viewed as a mechanism to help address the variability. What pharmacists really want is technology that supports their care, not having their care driven by technology.

The second key area for pharmacists is the need for seamless electronic information exchange. Pharmacists need access to information like diagnoses and goals of therapy for patients, and likewise pharmacists need to be able to share the data from their patient care services with other providers including prescribers. So how do we make seamless electronic information exchange happen between providers? That's a big undertaking right now, but one that the pharmacy profession feels is critically important.

And finally, pharmacists need technology that supports quality measurement, documentation, and reporting. We've talked on this webinar about all of the different standards. The pharmacy profession does support X12, NCPDP, and HL7 standards. The important thing again is that there are interfaces built so that information can be communicated effectively between systems. Shelly talked at length about the SNOMED CT codes and their use in clinical documentation and quality reporting, and the pharmacy profession's work to develop MTM SNOMED CT codes is a testament to the importance that pharmacy sees for these types of coding standards. Next slide.

This slide shows the pharmacist's patient care process, and I really wanted to use it to demonstrate that the care process is the foundation for how pharmacists deliver care including MTM services. Having the technology infrastructure to be able to communicate information from the various steps in the patient care process is going to be very important for pharmacists to be able to coordinate care with other providers. You can see some of the structured documents that either have been developed or are under development right now to support pharmacists in the effective documentation and communication of their MTM services. Next slide.

This work overall, and Shelly mentioned it earlier, has been conducted under the auspices of the Pharmacy Health Information Technology Collaborative, the result of the national pharmacy organizations coming together with other interested parties to make sure that pharmacy is

playing an important role in what's happening within the HIT realm. Within the HIT collaborative, there are three overarching goals for how the profession is trying to help support technology standards. The three goals are to ensure that HIT supports pharmacists in patient care delivery, to achieve pharmacist integration within health information exchange, and to support national quality initiatives enabled by HIT. Some of the activities are detailed underneath each goal. There's active engagement with national and state HIT stakeholders including the Office of the National Coordinator to make sure that pharmacists are integrated into HIT initiatives, and the Collaborative works very closely with various standards development organizations. And the Collaborative has also focused on developing structured documents and working within AMA/CPT's coding infrastructure to evolve some pharmacy service billing codes.

To achieve pharmacist integration within health information exchange, we are actively encouraging pharmacists to participate in activities at the local, state, and national levels. There's a lot of outreach and education to pharmacists to make sure that they're advocating and understanding the role that technology can play in their practice, that they're working with their system vendors to make sure that their systems will help to facilitate their care, and that they are trying to address any workflow needs that might occur as the result of technology implementation. And then finally there is a lot of effort underway to support national quality initiatives. The development of the MTM SNOMED CT codes and the value sets associated with them is just one example of those activities. So in closing, pharmacists are very supportive of a technology enabled integrated healthcare system, and we look forward to continuing to work with ONC, CMS, CMMI, and other stakeholders to advance the use of technology to improve healthcare delivery. At this point, I'll turn the presentation over to Tracey McCutcheon from CMMI for closing remarks.

Tracey McCutcheon:

Thank you very much for today's presenters and to everyone who participated in today's learning event. We hope this helps to spur creative thinking about how Enhanced MTM programs in our model can leverage existing standards and transactions to improve care coordination, as well as to improve beneficiary outcomes and satisfaction with their prescription drug therapies. To reiterate my opening remarks, our goal has not been to signal that applications must include the specific linkages described today. Our goal has been to provide a shared baseline level of information on current opportunities for better patient care through greater exchange of information and care coordination among plan sponsors, pharmacists, and prescribers. Our next learning event will build on today's presentation by providing information on several projects that are currently utilizing some of these strategies, and you will receive, anyone who registered for this event will receive a message on saving that date and the ability to register for that second event.

When you fill out your post event survey responses, and let you know that those will appear in real time so stay on the line, we are very interested in hearing whether more information on any of the topics covered today would be of particular interest. And we would also be interested in if there are any initial ideas out there on collaborative learning projects that CMS could help convene. Next slide, okay. The — here's just the housekeeping slide here. The recording, the audio recording, the transcript, and slides from today's event will be available on the model

website that's listed there as well as these slides. I'm not exactly sure whether those are available currently, where people have registered.

Tracey McCutcheon:

Not yet. They will be available on our website. For questions pertaining to today's event, the email box is there and we will be providing a document on our website that will be updated from time to time answering selected questions. It will be called Responses to Stakeholder Inquiries I think is the title. You know, we'll be focusing on questions that haven't been addressed elsewhere in the model announcement, RFA, and other documents, but we appreciate people sending in questions that they feel have not be addressed otherwise. And please visit our model webpage to get additional information if this is — if you haven't already had the opportunity. So we appreciate your feedback on this webinar and we hope you do take a moment to fill out the survey that will pop up as soon as the event closes. Next slide. And now I'm going to turn the presentation back to the moderator.

Jennifer Brock:

Thank you so much Tracey, and thank you so much to everyone for participating in our learning event today. Thank you extremely very much [laughs] to our speakers and panelists for being here to share their perspectives. Again, we would very much appreciate your feedback on today's learning event. A PDF copy of the slides is now available for download in the file transfer box that is popped up on your screens. Please click on the file, then the download button. This webinar is now considered closed. I hope everyone has a fantastic rest of their day. Thank you.

[end of transcript]