



Department of Vermont Health Access
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Agency of Human Services

Meeting Minutes
December 14, 2011, Stakeholder's Meeting
Topic: Single Prescription Drug Formulary & Electronic Prior Authorization
Location: Department of Vermont Health Access, 312 Hurricane Lane, Williston, Vermont
1:00 to 3:00 p.m.

The following stakeholders were in attendance. Conference call capabilities were available, and several individuals participated in the discussions in this manner. The power point handout and agenda for the meeting were posted to the DVHA website prior to the meeting. The agenda and presentation for this meeting can be found on DVHA's website at <http://dvha.vermont.gov/stakeholders-meeting-single-formulary-and-electronic-prior-authorization-1/?searchterm=None>.

Those attending in person and phone participants who checked in (not a complete list of attendees)

First Name	Last Name	Organization	First Name	Last Name	Organization
Paul	Amato	GSK	Diane	Neal	MedMetrics Health Partners
Stacey	Baker	DVHA	Nancy	Miner	MedMetrics Health Partners
Hunt	Blair	Deputy Commissioner, DVHA	Brian	Murphy	Blue Cross and Blue Shield of Vermont
Thomas	Brownlie	Pfizer	Diane	Neal	MedMetrics Health Partners
Jennifer	Egelhof	DVHA	Anthony	Otis	Otis & Kennedy, LLC
Lucie	Garand	Downs, Rachlin and Martin	Jai	Persico	ENDO
Susan	Gretkowski	MacLean, Meehan & Rice (MMR)	David	Reynolds	Department of Banking, Insurance, Securities and Health Care Administration (BISHCA)
Carrie	Hathaway	Department of Vermont Health Access	Heather	Shouldice	William Shouldice & Associates, LLC
Nancy	Hogue	DVHA	Michelle	Sirois	MedMetrics Health Partners
Jeanne	Kennedy	JB Kennedy & Associates	Bill	Smith	Miller & Smith for CVS/Caremark
Theo	Kennedy	Otis & Kennedy, LLC	Charles	Storrow	KSE Partners for ExpressScripts
Nolan	Lanweil	Joint Fiscal	Leigh	Tofferi	Blue Cross and Blue Shield of Vermont
Cheri	L'esperance	William Shouldice & Associates, LLC	Lindsay	Tucker	Deputy Commissioner, DVHA
Victoria	Loner	Deputy Commissioner, DVHA	Lynne	Vezina	Vermont Family Pharmacy / DUR board
Robin	Lunge	Director of Health Care Reform, Office of the Governor	Julie	Wasserman	State of Vermont, Duals Project
Robert	Mann	GSK	Nicole	Wilson	State of Vermont, Agency on Aging
James	Marmar	Vermont Pharmacists Association			

The meeting minutes are as follows:

Introductions, Overview of Legislation and DVHA Presentation

At approximately 1:00 p.m., Nancy Hogue, Pharm.D. Director of Pharmacy Services for the Department of Vermont Health Access began the meeting by introducing herself and Robin Lunge, Director of Health Care Reform for Governor Peter Shumlin's office. Ms. Lunge provided an overview of the two pieces of legislation that are the subject of the meeting: Acts 48 and 51. Section 18 of Act 48, the state's health care form bill, requires the state to explore and propose recommendations for implementing a single prescription drug formulary for the state, a single mechanism for negotiating rebates and discounts across payers and a uniform set of drug management rules. Recommendations are due in a report to the legislature by 1/15/12. The second piece of legislation, Act 51, also requires a 1/15/2012 report to the legislature, proposing recommended standards for electronic prior authorizations. Since both legislations affect similar stakeholders, the stakeholder meetings for the two reports have been combined.

Areas discussed and clarified in regard to the presentation:

During Dr. Hogue's presentation, she clarified the importance of understanding what drives formulary development: Formularies are developed using evidence-based clinical literature and analysis of net cost. Formularies generally prefer generics 80% of the time. The future single formulary will have a structure that will have copayments / tiers based on the product's status on the formulary. What drives the positioning of the drug on a formulary often relates back to rebates and discounts, and for commercial plans, what percentage of those rebates and discounts are shared.

Advantages: Having unified rules, one preferred drug list (rather than dozens) and a single point of contact for members and providers.

Disadvantages: Having a single formulary with multiple PBMs is problematic. PBMs are large national companies whose formularies are based on national rebate contracts affecting their entire book of business as well as clinical considerations. If Vermont were to mandate a single drug list in a multiple-PBM environment, some of those pricing advantages delivered by those contracts could go away and ultimately raise costs to insurers and their members. In addition, coordinating the administration of a single formulary among multiple payers and PBM's would present difficult challenges. However, a single formulary in a single payer/single PBM model makes a lot more sense and most of the disadvantages would disappear.

Dr. Hogue provided detail to page 7 of the presentation, which describes the "Roadmap to Single Formulary," which has three steps:

- Facilitate administrative simplification in multi-payer environment (Short term beginning in January 2012)
- Begin to implement single formulary with early adopters of single payer (Intermediate beginning January 2013)
- Implement single PBM and single formulary for expansion to single payer groups (Longer term beginning January 2017).

Additional points/comments were made:

- How can we improve physician access to information about what drugs are on multiple formularies and what rules govern their use

- How can we improve physician access to this information using the technology delivered by electronic health records (EHR) and e-prescribing capabilities?
- It makes sense to align our initiatives with those of others and national trends.
- There are provider incentives for adoption of electronic health records.
- It makes sense for EHRs to have a consistent display of information for a more seamless provider interface.
- Medicaid is looking into whether some transactional costs can be reimbursed by CMS.
- As a group of stakeholders, we should explore common rules and best practices that we all can adopt.
- We should evaluate the feasibility of developing a web-based multiple payer portal
- The use of clinical pharmacists on community health team through the Blue Print for Health was discussed. They will have a structured role in the prescriber's office and may assist the prescriber in choosing the correct drug and managing the PA process.
- Expand academic detailing to encourage generics. If we can promote generics across all formularies, those are the generally speaking the most cost effective and best choices when they exist.
- DVHA will look to the group for a lot of other suggestions

Hunt Blair, State of Vermont HIT coordinator, spoke about emerging EHR standards:

- CMS and the Office of National Coordinator jointly administer and operate incentives to prescribers for setting up EHRs in their offices.
- The future of prescribing is e-prescribing with its inherent safety benefits.
- As we move to greater EHR adoption, e-prescribing is going to happen fairly naturally.
- One strategy being employed is through another federal program for medical practices that are reluctant to adopt EHRs in their entirety.
- Through the state Medicaid HIT plan (SMHP) and the SMHP IAPD, the state is obtaining funding to support the transaction costs of e-prescribing for prescriptions by Medicaid providers to Medicaid beneficiaries. Funds are available on a limited-time basis as HI TECH funds are really being made available to "prime the pump" for the electronic health information technology future.
- One of the open questions we face as a community is exactly how those costs get sorted out. We may be able to clearly demonstrate gains in terms of lives saved, but we need to understand how to connect the chain of dollars back to writing prescriptions.
- In October DVHA launched the Medicaid EHR incentive program in Vermont. CMS recently gave its approval to send the money out for the providers who have signed up. Providers receive the funding over a period of five years (they do not have to be contiguous years). In the first year the provider has to adopt, implement or upgrade an EHR.
- Meaningful Use: It is an expectation that systems providers can meet certain minimum standards including the ability to e-prescribe. It is anticipated that standards will be phased over time. It is expected that requirements will be much more intense by Phase 3. Providers need to comply with the meaningful use requirements that are in effect in the year that the prescriber begins implementing EHRs. Prescribers who wait will have a higher bar to meet.

Dr. Hogue provided the following information:

- Clarified that "Meaningful Use" does not include the requirement of an electronic PA, only the requirement to e-prescribe.
- Currently there are no widely adopted industry transaction standards that support electronic prior authorization (e-PA). There is no universal format, so in the current environment it becomes difficult to implement e-PA within the EHR system.

- NCPDP is in the process of developing a standard for e-PA that would allow us to have this capability within EHRs.
- There are draft standards and pilots not yet underway. Some pilots, with two or three of the major PBMs, should be underway sometime in 2012. We will be monitoring.
- A portal should be looked at as an intermediate step.

Robin Lunge provided the following information:

Ms. Lunge discussed the planning grant for which the state is applying, and which would enable the state to manage the dual eligible (Medicare and Medicaid) population, potentially acting like a Medicare C or Medicare Advantage plan that includes drug coverage. This would give the state an opportunity to align Part D, and Medicaid formularies along with Part B drugs in this population. It is a good opportunity to make a big step in the area of administrative simplification.

Comments Period:

Tom Bradley, Pfizer

Mr. Bradley introduced himself and stated that he performs alliance development in the northeast, mostly working with health care providers and trying to identify pressure points and develop solutions. Points addressed by Mr. Bradley:

Mr. Bradley states that his group's interest is mostly in the area of electronic prior authorizations, with the theme being simplification, one point of contact, and efficiency.

- Per Mr. Bradley, an EHR standard did come out in 2009 after CMS-funded pilots in 2006, but their results and recommendations have not been fully vetted and approved by CMS.
- NCPCP is supposed to come out with its next iteration of the XML standard, so he thinks it premature for the state to develop its own standards. He proposed that the state put a "placeholder" down the road for 2013 – 2014.
- Mr. Bradley noted that the presentation did not describe or show the "portal."
- Mr. Bradley asked about moving toward a standardized paper PA form. He stated that 72% of PA requests are still routed by traditional methods. Have we considered this? He noted that California had standardized PA forms.

Dr. Hogue followed up on Mr. Bradley's comments, noting that it could be a possibility, and that Minnesota had passed legislation in 2009 and reported in 2010 that uptake of the form had not been great. She further clarified that a standard PA form should not require that the clinical criteria around drug use be identical among insurers, as most insurers would probably not be willing to compromise their own clinical rigor.

Tom Bradley - Pfizer

Mr. Bradley pointed out that the difference between Minnesota's and California's PA uniformity law is that CA requires all providers and payers to use the standardized form. Mr. Bradley will provide California's law. He also pointed out that a fully electronic system will be much easier to adopt than the idea of a portal.

Susan Gretkowski, McLean, Meehan & Rice (MMR)

Re: Contract Standards

Ms. Gretkowski introduced herself and stated her affiliation with MVP Health Care. She explained that MVP was asked in statute to chair a workgroup of providers, insurers and other interested parties to study the edit standards used by insurers with the idea of seeing if any standardization can be achieved.. The group looked at Medicare and Medicaid. The group's work is ongoing.

Brian Murphy, R.Ph., Blue Cross and Blue Shield of Vermont

- Mr. Murphy suggested that the group consider prior authorization portability so that when an individual switches health care plans, the PA follows the patient. He agreed that electronic PA is the gold standard.
- Mr. Murphy clarified that a high percentage of drugs (approximately 2/3) on formularies are the same. If a common list can be developed, prescribers can prescribe off the common list. Tom Bradley (Pfizer) suggested that there should also be a list of the drugs not included on the preferred list, so it is easy to identify if the drugs that need prior authorizations.

Lynne Vezina, R.Ph., Vermont Family Pharmacy, DUR Board, Vermont Pharmacists Association:

Ms. Vezina asked how many people won't be involved in Single Formulary. Ms. Lunge responded by explaining that while ERISA plans are exempt, the plan is to offer incentives to participate. If we are successful with the duals project, we may have very good chance of bringing in Part D plans.

Hunt Blair:

One of the strategies in administrative simplification in the exchange as it transitions to single payer and simplification is to create an infrastructure in which some employers may choose to have portions of their ERISA plans included as the infrastructure, helping to support the exchange. Potential opportunities exist, from enrollment of members through claims management. There is quite a bit of work yet to do.

Michael Scovner, M.D., Chairman of the DUR Board to Hunt Blair:

Dr. Scovner explained that at the DUR Board, the members have discussed the inaccuracy and dangers of e-prescribing. He's seen examples where it can hurt people and has heard levels of inaccuracy in e-prescriptions (reported by pharmacists) to be in the area of 50%. He expressed his concern to assure that the system developed works accurately. Ms. Vezina concurred that e-prescriptions are not working accurately at this time.

Mr. Blair responded that this is clearly an opportunity for improvement, and the state is not interested in a system that does not work. As the state HIT coordinator, he informed the audience and Dr. Scovner that the office of the national HIT coordinator, and other parts of HHS, has been putting a lot of time of effort into these issues and are interested in feedback. Mr. Blair and Dr. Scovner agreed to set up a time to meet and discuss further. Mr. Blair is expecting that an effective system would see extremely high levels of accuracy (99% or higher).

Leigh Toffrei, Blue Cross and Blue Shield of Vermont:

Mr. Toffrei asked if it was anticipated that statutory language or a bill would accompany recommendations. Ms. Lunge responded that if there are recommendations they will come with statutory language, but that we are not at a point to develop legislative language that would map out the entire process, and that more work needs to be done in duals project. Ms. Lunge further noted that guidance on health benefit exchange is still not available.

Additional comments/suggestions:

- Nancy Hogue suggested that smaller work groups of stakeholders convene through 2012.
- Robin Lunge regarding formulary development: In general, 2/3 of drugs are the same on formularies. For the remaining 1/3 or less, the group would work with CMS to work out the differentiated drug lists.
- Dr. Scovner asked if there were plans to have workgroups of BCBS, Medicaid and MVP to develop the single formulary. Nancy Hogue clarified that we are implementing the process in stages so that we are not mandating a single formulary in the current multi-payer environment. Robin thinks we have plenty of time as the waiver would take effect in 2017.

Theo Kennedy, Esq., Vermont Pharmacists Association and Vermont Retail Druggists Association

Mr. Kennedy asked for a description of the community health team pharmacists. Vicki Loner, Deputy Director at DVHA, stated that DVHA is working with UVM to perform an evaluation to assess the correct right mixture of pharmacists on a community team and what their scope of work should include. There are currently 4-5 pharmacists spread across the state performing certain functions for the community health team. They will perform an assessment to see what the best practices are and how we can apply them uniformly, if we can. There is a significant amount of work still needing to be done on this project. Albany College of Pharmacy is involved.

Nicole Wilson, Director of the State Employees Health Plan.

Ms. Wilson clarified that the state workers' collective bargaining agreement doesn't allow for state employees to be involved in the current timeframe. However, she is in discussions with Ms. Lunge and Dr. Hogue to determine what needs to be changed in the collective bargaining agreement – and if it is possible.

Madeleine Mongon, Vice President of Policy, Vermont Medical Society

Ms. Mongon asked for clarification on how to provide input and comments. Dr. Hogue replied that comments will be accepted at least through December 28th. There may be extra time as the state is requesting an extension to the 1/15/12 report due date. If an extension is granted, then stakeholders will be notified about the extended time period. At this time, December 28, 2011, is the comment due date.

Ms. Mongon then asked for more information on the provider portal. Ms. Lunge responded that the portal should be thought about in relation to the exchange portal, and that we need to make sure that whatever provider portal we have is the same as the exchange portal. Ms. Mongon will send information to Ms. Lunge on the State of Washington's health portal.

The meeting was adjourned at approximately 2:30 p.m.