January 11, 2018

The Honorable Seema Verma

Administrator

Centers for Medicare & Medicaid Services

Department of Health and Human Services

Attention: CMS-4182-P

P.O. Box 8013

Baltimore, MD 21244-8013

**Re: CMS-4182-P Medicare Program: Contract Year 2019 Policy and Technical Changes to the Medicare Advantage, Medicare Cost Plan, Medicare Fee-for-Service, the Medicare Prescription Drug Benefit Programs, and the PACE Program**

Dear Administrator Verma:

On behalf of CoverMyMeds, I am pleased to submit comments and recommendations on the proposed rule, “Medicare Program; Contract Year 2019 Policy and Technical Changes to the Medicare Advantage, Medicare Cost Plan, Medicare Fee-for-Service, the Medicare Prescription Drug Benefit Programs, and the PACE Program (CMS-4182-P).”

CoverMyMeds is pleased to see the progress made by CMS in the proposed rules on several important issues that can have a significant, positive impact on Medicare patients, providers and other system stakeholders. We are also pleased to share our industry experience and provide input to CMS on this important rule making.

CoverMyMeds is the nation’s leading ePA technology partner. CoverMyMeds streamlines the medication PA process, electronically connecting providers, pharmacists and plan/PBMs to improve time to therapy and decrease prescription abandonment with electronic prior authorization (ePA).

Since our inception in 2008, we have helped over 80 million patients get their needed medications via our automated processes. Nationwide, we bring our solutions to more than 700,000 providers, 62,000 pharmacies, 500+ EHRs and payers representing 80% of U.S. prescription volume.

As it relates to the proposed adoption of the NCPDP SCRIPT Standard v2017071, we concur that CMS should move forward with adopting this updated version but do not concur with the omission of the electronic prior authorization (“ePA”) transactions from the rule adoption. CoverMyMeds ask that CMS reconsider this position and in the final rule adopt the ePA transactions.

The industry began work on the ePA process over a decade ago because the current standardized frameworks (X12 278, 275, and PA attachments) were incomplete in providing a truly standardized end to end process for prior authorizations for prescription drugs.  In the same sense, NCPDP’s Telecommunications standard permits payers to notify the pharmacist of a claim requiring prior authorization, or when a prior authorization was used to pay a claim; but does not account for the process by which an approved entity is able to request and obtain a prior authorization.

Additionally, the National Committee on Vital and Health Statistics (NCVHS) in a letter from May of 2014, stated the following:

“In 2004, the National Council for Prescription Drug Programs (NCPDP) organized a multi-industry, multi-Standards Development Organization task group to evaluate a prior authorization (PA) standard, particularly the medication prior authorization, that would support the needs for e-prescribing transactions and to develop a solution. Investigators found that the HIPAA-named PA standard (the X12N 278 v4010 or v5010), was not adequate to support medication PA because it was designed for procedures/services or durable medical equipment (DME) prior authorization and did not accommodate the information necessary to facilitate prior authorization. It also did not have a mechanism for providers to provide relevant information for e-prescribing. Consequently, the NCPDP developed and through its vetting process, received industry approval for e-Prescribing Prior Authorization transactions (included in the NCPDP SCRIPT Standard), which enables the healthcare industry to exchange prescriber-initiated prior-authorization requests for prescribed medications as part of the provider-patient encounter.”

In a May 2014 letter, NCVHS recommended to the Secretary of Health and Human Services that the prior authorization transactions found in NCPDP SCRIPT Version 2013101 be adopted for the exchange of prior authorization information between prescribers and processors for pharmacy benefits. They also recommend the standard be named in the most appropriate regulation and at the earliest possible time.

CoverMyMeds aligns with NCPDP, and the industry’s understanding that prior authorization transactions are named under HIPAA and not the MMA. However, we also feel strongly that ePA also be included in this Rule. We offer the following to support our request of CMS:

* + ePA via the NCPDP SCRIPT Standard is widely used in the commercial market today. Presently, in our network, ePA adoption by plans is at 60% globally and rising. Some plan utilization of ePA is as high as 80%. Med D plans and stakeholders would reap great benefit from the adoption and utilization.
  + In the commercial market today, not just through CoverMyMeds network, following are the percentage of stakeholders committed to ePA utilization:
    - EHR/Providers – 70%
    - Payers – 96%
    - Pharmacies – 100%
  + The inclusion of the NCPDP SCRIPT Standard ePA transactions helps CMS achieve the intent of supporting innovative approaches to improving program quality, accessibility and improvement in the CMS customer experience.
    - Through the innovation and interoperability provided through the ePA transactions, prescriber burden is reduced; therefore, they can spend more time on patient quality and outcome efforts;
    - Via ePA, patients obtain their needed medications in a more timely manner, improving not only their experience with the system at large but also with speed to therapy.
    - Quicker access to needed medications, can lead to greater patient therapy adherence, reducing overall health care spend for the Medicare system.
* Part D Star Performance Measures for Plans (See Table 2B of the proposed regulations), includes a measure – Getting Needed Prescription Drugs and more specifically access to Diabetes, Hypertension and Cholesterol medications and improvement in outcomes. ePA supports the proposed measures for the 2021 Star Ratings in which the plans will be scored on how easy it is for members to get the prescriptions they need.  ePA expedites the ability of beneficiaries to get the prescriptions they need, thereby allowing for improved star ratings for plans. Via ePA most determinations happen within minutes/hours vs. days. CoverMyMeds analyzed integrated dispensing system data from January 1, 2017 to September 30, 2017 to compare speed-to-therapy rates between traditional PA methods (paper-fax) and CoverMyMeds ePA. The following are specific details of the analysis:

  35% overall improvement in speed-to-therapy

  31% improvement in speed-to-therapy for medications associated with diabetes

  33% improvement in speed-to-therapy for medications associated with hypertension

  22% improvement in speed-to-therapy for medications associated with COPD

This analysis bears out the fact that ePA vs. traditional paper PA speeds time to therapy and supports the improvement in outcomes measures in the Part D Star Performance Measures for Plans.

* + ePA transactions would also support CMS’s intent of establishing a framework and addressing the opioid epidemic, under Part D, in which plan sponsors may establish a drug management program for beneficiaries at risk for prescription drug abuse or misuse.
    - The ePA process is the clinical backbone as it can help answer clinical and utilization questions before an opioid is prescribed or dispensed.
    - ePA saves significant time and resources, allowing physicians to spot problems and halt prescriptions for patients who may be at risk for abuse, or abusing.
    - Handling the authorization process via paper makes little sense, as paper:
      * Slows the process;
      * Inhibits good information sharing on potential abuse;
      * Is not within the prescriber’s workflow and therefore leads to a gap in interoperability.
  + CMS has identified an intent to reduce the burden related to printing and mailing, reduce the number of paper documents that plans have to provide.
    - By adopting the ePA process, additional paper burden could be reduced for the plan(s) and the prescribers in that the PA determination process would be electronic, eliminating the need for the plan to send the prescriber a paper version of the determination.
    - The continued use of the paper-fax process exposes stakeholders to the risk of a potential privacy/HIPAA related error.
  + ePA aligns with enhancement efforts to utilize measures developed by consensus-based organizations.
    - NCPDP is one of the most recognized consensus-based organizations and the SCRIPT ePA Transactions are such measures.
  + There is an unbalanced process right now at the state level, adopting NCPDP SCRIPT ePA in Med D could help stabilize adoption in the states.
  + Because this would be a new process for Med D plans, the timing of the proposal and eventual passage of the new Med D regulations and standard IT implementation timeframes, we recommend a 24-month implementation of the NCPDP transactions from the date the final rule is published and additionally recommend that the effective date not occur on a national holiday.

CoverMyMeds appreciates the opportunity to comment on this proposed rule and supports the efforts of CMS in improving the Medicare program. If you have questions or need further information, please contact me, Kim Boyd, Director of Industry Relations and Government Affairs at (615) 663-5579 or [kdiehlboyd@covermymeds.com](mailto:kdiehlboyd@covermymeds.com)

Respectfully,

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Attachments: <https://www.ncvhs.hhs.gov/wp-content/uploads/2014/05/140515lt2.pdf> referenced NCVHS Letter