BACKGROUND ON THE CARIN ALLIANCE

The CARIN Alliance is a bi-partisan, multi-sector alliance convened by David Brailer, David Blumenthal, Aneesh Chopra, and Mike Leavitt, to unite industry leaders in advancing the adoption of consumer-directed health care information exchange across the U.S. In collaboration with government leaders, the group seeks to rapidly advance the ability for consumers and their authorized caregivers to easily obtain, use, and share their digital health information in order to achieve more efficient use of health care services and improve overall health.

The CARIN Alliance is uniquely positioned at the intersection of public and private organizations seeking to advance the enablement of patient-centered, value-driven health care through the adoption of consumer directed health information exchange.

THE REAL-TIME PHARMACY BENEFIT CHECK WORK GROUP

The **Real-Time Pharmacy Benefit Check Work Group (RTPBC WG)** within the CARIN Alliance is a convening of existing CARIN members, such as payers, patient groups, and provider groups and additional health sector representatives who have not traditionally participated in the CARIN work, such as manufacturers, PBMs, and pharmacies. The RTPBC WG seeks to centralize existing, disparate efforts to accomplish RTPBC, to vet and develop best-in-class policies to accomplish RTPBC, and to collaboratively implement RTPBC with a broad set of stakeholders, including Congress, CMS, and the White House who have expressed strong support for RTPBC solutions.

RTPBC POSSIBILITIES

Granting patients and their physicians access to the coverage, formulary tiering, and patient out-of-pocket costs for a particular drug on a patient's insurance at the point of service will permit physicians to choose/prescribe a drug that is both clinically appropriate for the patient and in line with the patient's ability to pay for the drug.

These cost and access conversations between the physician and the patient can serve to increase communication on drug choice, frame the clinical benefits of particular drugs against their cost under the patient's insurance and underscore the importance of drug adherence. It will also eliminate the burdensome work that is currently required to approve a substitution when a pharmacist discovers the prescribed drug is not covered or has an unmanageable copay.

A physician's ability to pair clinical judgment with drug cost also gives the physician more information for prescribing. While drug cost may not ultimately impact a provider's drug choice, it may also provide a platform for the prescriber to evaluate clinically equivalent drugs in a more proactive way. Pharmacists already have access to drug coverage, tiering and out-of-pocket costs for the prescribed

drug at the point of sale, and this additional ability for physicians may better align communication between the two.

In addition, by increasing patient participation in their health care through greater access to data, other initiatives, such as HSA reform may have more meaningful effects.

PUSH FOR TRANSPARENCY

The Center for Medicare and Medicaid Services (CMS) has issued a call to action on bringing RTPBC to the Medicare Part D program, and in conjunction with the Administration's increased focus on transparency in the drug supply chain, the White House has expressed strong support for the creation of a RTPBC pathway as a means of increasing transparency for consumers and perhaps reducing drug costs through smart therapeutic substitutions, greater patient adherence, and more overall patient engagement in their health care choices.

In addition to the above articulated benefits of granting patients and their providers access to drug coverage, tiering and co-pay information, access to this information may also offer the following benefits:

- Enhance and/or integrate use of state-based PDMPs.
- Increase ability for physicians to contribute to coverage with evidence development determinations.

IDENTIFIABLE OBJECTIVE

Today, there is no single framework for how we enable a consumer to better understand and become empowered with respect to their health care and to facilitate evolutionary advancements in consumer-directed health care outcomes. Data from payers is not currently available to a consumer through an open API framework and therefore is not accessible by third party applications authorized by the consumer. The CARIN Alliance has already achieved success across the spectrum of stakeholders in establishing a framework for clinical data exchange to third party applications through the use of FHIR and the RTPBC WG is now seeking to advance the adoption of consumer-directed health insurance data exchange.

The objective of the RTPBC WG is to identify, discuss, and reach consensus on the data elements to be made available, the standards for digital health information exchange, and the scope of application for information to be shared. Specifically, the WG's primary goal will be to develop an agreed upon set of FHIR resources to release to consumers via open APIs that is consistent with the goals of the My HealthEData initiative and the Medicare Blue Button 2.0 project.

MUTLI-SECTOR INTEREST

The Alliance is comprised of stakeholders representing all areas of the health care delivery system including government, providers, payers, health systems, consumers, patient advocates, EHR providers and third party consumer solutions.

CMS is the first payer to standardize around the FHIR specifications and is already in testing with more than 75 solution providers leveraging access to CMS claim data on behalf of consumers.

GET INVOLVED

The RTPBC WG is looking for forward-thinking payers, manufacturers, PBMs, pharmacies, and patient and provider groups aligned with the mission of releasing data to consumers to join us to advance and implement RTPBC. Please bring your ideas, current initiatives, and concerns!

If you would like to get involved, please contact Ryan Howells, Principal at Leavitt Partners at ryan.howells@leavittpartners.com or Anne Marie Polak, Senior Director at Annemarie.polak@leavittpartners.com

APPENDIX

INTRO TO FHIR/ARGONAUT STANDARD

The Argonaut Project is a private sector initiative to advance industry adoption of modern, open interoperability standards. The purpose of the Argonaut Project is to rapidly develop a first-generation RESTful-based API and Core Data Services specification to enable expanded information sharing for electronic health records and other health information technology based on internet standards and architectural patterns and styles. This effort follows on recommendations from the Joint HIT Standards and Policy Committee's *JASON Task Force Report*, the HIT Standards Committee's *NwHIN Power Team*, the MITRE JASON Reports of *2013* and *2014*, and the *2010 PCAST Report*.

The result of the Argonaut Project has been the creation of FHIR (http://hl7.org/fhir/). FHIR has become the de-facto successor to HL7 and is currently being pushed as the new standard for digital health information exchange. EMR vendors such as Epic, Cerner, Allscripts, and more have settled on this standard to transition their external integrations to supporting.

One of the biggest advancements of FHIR over HL7 is the standardization of data formats beyond the traditional medical record. The standard has been expanded to reflect data objects that would be used by insurance payers and providers such as financials, work flows, clinical reasoning, and more. By having

all parties in the medical ecosystem agree on a unified data model, we can rapidly accelerate the advancement of digital technology in health care to improve outcomes and reduce costs.

A big advantage of the FHIR standard is that its information scope is almost universally set for an individual. All access and security protocols outlined at http://hl7.org/fhir/security.html require the end user to provide approval before any application can make benefits on its behalf through the consent model included in FHIR (http://hl7.org/fhir/consent.html). This approach ensures that data is not shared for populations as a whole and that data cannot be used by third parties to reverse engineer important details such as provider contracts, fee schedules, and other proprietary payer intel.