COMMONWEALTH of VIRGINIA

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TO: The Honorable Robert D. Orrock
Chairman, House Committee on Health, Welfare, and Institutions

The Honorable Louise L. Lucas
Chairman, Senate Committee on Education and Health

The Honorable George L. Barker
Chairman, Joint Commission on Healthcare

FROM: Arne W. Owens *Arne W. Owens*
Director, Virginia Department of Health Professions

DATE: October 5, 2023

RE: Report on All Prescription Monitoring Options pursuant to Ch. 628 of the 2023 General Assembly

This report is submitted by the Department of Health Professions and the Department of Health in compliance with Chapter 628 of the 2023 Acts of Assembly, which states:

> The State Health Commissioner (the Commissioner) and the Director of the Department of Health Professions (the Director) shall convene a work group to study and establish a plan to develop and implement a system to share information regarding a patient's prescription history and medication reconciliation. The work group shall include the Department of Medical Assistance Services and relevant stakeholders, including representatives of the Virginia Hospital and Healthcare Association, the Medical Society of Virginia, the Virginia Association of Health Plans, the Virginia Pharmacists Association, Virginia Health Information, and a private sector technology expert with experience in prescription data sharing and controlled substance monitoring. The Commissioner and the Director shall report their findings and

recommendations to the Chairmen of the Joint Commission on Health Care, Senate Committee on Education and Health, and House Committee on Health, Welfare and Institutions by October 1, 2023.

Should you have questions about this report, please feel free to contact me at (804) 367-4648 or arne.owens@dhp.virginia.gov.

AO/EB
Enclosure

CC: The Honorable John Littel, Secretary of Health and Human Resources

Preface

This report is submitted in compliance with the Virginia Acts of Assembly – Chapter 628:

> The State Health Commissioner (the Commissioner) and the Director of the Department of Health Professions (the Director) shall convene a work group to study and establish a plan to develop and implement a system to share information regarding a patient's prescription history and medication reconciliation. The work group shall include the Department of Medical Assistance Services and relevant stakeholders, including representatives of the Virginia Hospital and Healthcare Association, the Medical Society of Virginia, the Virginia Association of Health Plans, the Virginia Pharmacists Association, Virginia Health Information, and a private sector technology expert with experience in prescription data sharing and controlled substance monitoring. The Commissioner and the Director shall report their findings and recommendations to the Chairmen of the Joint Commission on Health Care, Senate Committee on Education and Health, and House Committee on Health, Welfare and Institutions by October 1, 2023.

Work Group

Staff

Department of Health: Kindall Bundy, co-lead
Department of Health Professions: Ashley Carter, co-lead

Membership

Department of Medical Assistance Services: MaryAnn McNeil
Medical Society of Virginia: Clark Barrineau, Scott Castro, Kelsey Wilkinson
Private Sector Technology Expert: Natalie Browning, Jacob Cooper
Virginia Association of Health Plans: Heidi Dix, Doug Gray
Virginia Health Information: Kyle Russell
Virginia Hospital and Health Care Association: Jake O'Shea, Ray Makhoul
Virginia Pharmacists Association: Karen Winslow
Health and Human Resources Secretariat: Lanette Walker

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Executive Summary

House Bill 2345 (HB2345) and Senate Bill 1255 (SB1255) directed the Departments Health and Health Professions to convene a work group to study and establish a plan to develop and implement a system to share information regarding a patient's prescription history for medication reconciliation. The stakeholders identified in the legislation convened three meetings on June 13, July 19, and August 1, 2023. The following report meets the legislative requirement set forth in Chapter 628 of the 2023 Acts of Assembly.

There are two primary components of such a system: 1) a mechanism to collect prescription data and 2) a means by which to deliver the data to eligible recipients to facilitate medication reconciliation. This report provides the work group's findings on these two primary components and important considerations for inclusion in any forthcoming legislative proposal.

Introduction

Virginia's Prescription Monitoring Program (PMP) was established in 2006 and is used to track schedules II-V controlled substances, naloxone, and medical cannabis dispensed (hereafter "covered substances") in the Commonwealth (*see* Va. Code § 54.1-2519 *et seq.*). Veterinarians dispensing a covered substance for course of treatment exceeding seven days must also report. On average, 1.2 million prescriptions are reported to the PMP monthly. There are approximately 72,000 providers and dispensers registered to use the PMP and over 57 million requests for a patient's prescription history in the last calendar year. The PMP may be accessed by law enforcement and regulatory personnel in limited circumstances.

Though PMP serves as a valuable resource for clinicians statewide, it is estimated that covered substances comprise only ten percent of total prescriptions dispensed. Currently many health care providers can view a patient's dispensed medication history data within their electronic health record (EHR) workflow via subscription to a commercially available service which aggregates data from pharmacy benefit managers and many pharmacies. However, this data source is incomplete and, as a subscription-based service, may be cost-prohibitive.

Though PMPs monitoring controlled substances have been adopted in every state, only one state is currently collecting all medications. Nebraska implemented data collection for all medications in 2018. Several states have passed legislation to collect all medications but are not yet operational. A neighboring state, Maryland, first passed legislation in 2018 to convene a work group to assess the benefits and feasibility of developing a repository for non-controlled substances. Legislation was enacted in 2022 to begin requiring dispensers to submit this data, but Maryland is still working through implementation and is not yet operational.

A legislative change requiring dispensers to report all dispensed medications, rather than only covered substances, would provide the most comprehensive prescription history for medication reconciliation. If Virginia wants to pursue tracking all prescriptions, it must be done thoughtfully so as not to negatively impact the critical functions of the PMP in detecting diversion, identifying doctor shopping, and screening and referring patients to behavioral health services.

Proposed Solutions

Though the PMP's primary focus is on federally scheduled controlled substances, it is operationally flexible adapting to collect additional medications over time. In both proposed solutions, existing PMP data collection infrastructure would be used to collect all prescriptions. In doing so, the burden on current data submitters would be minimized. There are currently 2,400 data submitters reporting to the PMP, and it is estimated that 720 additional submitters would become newly required to submit data on dispensed prescriptions. A requirement to report all prescriptions would extend to resident and non-resident pharmacies, physician selling drugs locations, and dispensing dentists. The Department of Health Professions (DHP) currently

contracts with a vendor to collect this data for the PMP. The estimated additional cost to expand from current covered substances to all medications is approximately $309,000 annually.

In addition to data collection, a cohesive plan for delivery of the prescription data is essential to maximizing use of collected prescription data. Experience with the PMP has demonstrated the tremendous impact of clinical workflow integration on overall utilization. Discussions of potential paths focused on integration with prescriber and pharmacy workflows, delivery of non-covered substances data to treatment, payment, and healthcare operations (TPO) entities, presentations of prescription data, access to interstate data, data governance, scalability, support needs, and patient matching. The work group reviewed two options: 1) expanding the PMP to include all medications or 2) maintaining the PMP for covered substances and expanding the health information exchange (HIE) to non-covered substances.

Option 1: Expanding PMP to All Medications

In addition to using existing data collection infrastructure, the PMP could also be expanded to share a patient's complete prescription history. This option leverages the existing workflow integrations for prescribers and pharmacies which Virginia has invested in since 2016. This advancement in ease of access has already resulted in an exponential increase in utilization of the PMP. In total, 5,200 facilities across the Commonwealth have access to the PMP integrated within their clinical workflow, representing 30,078 prescribers and 1,042 pharmacies. These clinical integrations conform to a high level of data security and complete audit records of all users and their patient prescription history requests are maintained. Complete audit records of individual user access are essential for access integrity and meeting federal Medicaid reporting requirements.

A benefit of using the existing PMP infrastructure to begin collecting all prescriptions is that it is proven to operate at scale. The PMP manages nearly 60 million requests from Virginia's users and is scalable to meet additional demand. Existing technology could be adapted to support additional use cases to deliver prescription data to entities with an authorized TPO patient relationship as statute permits. Additionally, the PMP is integrated with Virginia's HIE for authorized users.

To maintain the PMP's utility in managing controlled substances and begin displaying all prescriptions, funding would be necessary to modify the PMP report's user interface and visual display. The estimated cost of these enhancements is $250,000 in one-time development fees and $275,000 annually. The integration solution currently deployed would be used to deliver data for all prescriptions at no additional cost to the Commonwealth.

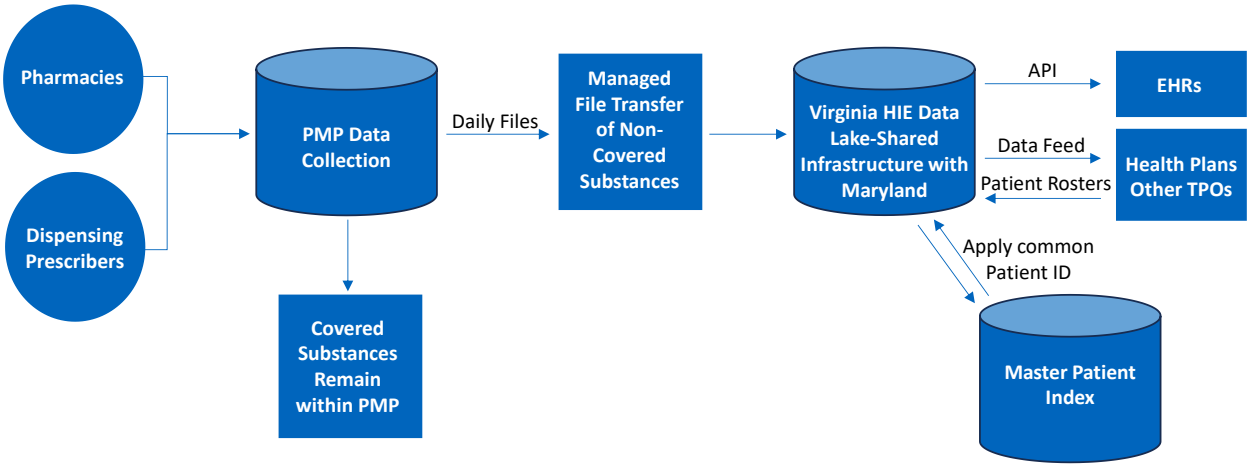
Option 2: Maintaining PMP and Expanding HIE

Another proposal would maintain current functionality of the PMP for covered substances and route non-covered substances to the HIE overseen by Virginia Health Information (VHI). Following VHI's review of the technical implementation options considered in the two other states which have previously constructed, or are in the process of constructing, all prescription

data exchange programs, VHI proposes a solution that would leverage both Virginia's PMP and HIE (Fig. 1).

In this option, data would be collected via the existing infrastructure established through the PMP. Data on covered substances would remain within PMP and non-covered substances would be directed to the HIE via file transfer on a daily cadence. The data lake housing non-covered substances would leverage common infrastructure with CRISP, Maryland's statewide HIE, which is in the process of working to implement a similar program. This shared infrastructure would maximize data security and delivery efficiency at a reduced cost. Patient data would be matched using VHI's Master Person Index (MPI) engine utilized by Maryland and other HIEs. The HIE would then oversee data governance and serve as an interoperability vehicle for any organizations wanting to access data on non-covered substances securely alongside other patient data types. Entities with an authorized TPO patient relationship could access non-covered substance prescription data via an application programming interface (API) through a direct EHR integration or through an HIE provided portal. Other organizations such as health plans and Accountable Care Organizations (ACOs) with defined patient roster files setup with the HIE could also receive daily data files specific to those patients along with their existing HIE data feeds. Beyond the costs associated with data collection, it is estimated that this functionality would cost approximately $1 million annually based on the scope of access discussed by the work group.

Figure 1. Proposed data flow between PMP and HIE



Comparison of Options 1 and 2

	Option 1: Expand PMP	**Option 2: Maintain PMP, Expand HIE**
Data collection	Uses existing PMP infrastructure	Uses existing PMP infrastructure
Integration with prescribers and pharmacies	Uses existing PMP integrations in EHRs, e-prescribing applications, and pharmacy dispensing systems	Uses existing HIE integrations in EHRs (no pharmacies)
Presentation of data	Builds upon existing PMP report format with interactive user interface Would allow side-by-side review of all prescriptions, covered and non-covered substances	Covered substances would be available in the PMP and non-covered substances in the HIE
Access to interstate data	Provides controlled substance prescription data for all bordering states (Virginia is interoperable with 41 other state/territory PMPs)	N/A
Data governance	Uses existing PMP role-based access, authorized users defined in statute Integrated with DHP's practitioner licensing database	User access to HIE managed by VHI, includes health plans, ACOs, TPOs with defined patient rosters; governed by Smartchart Network Advisory Council (formerly Emergency Department Care Coordination Advisory Council)
Scalability	Data collection and delivery currently utilized nationally	Regional shared HIE collaborative
Patient matching	Uses existing PMP patient matching methodology, includes MPI logic	Uses VHI's MPI, utilized by Maryland and other HIEs
Cost	Data collection through PMP for non-covered substances: $309,000/year Enhancements to PMP report user interface for displaying non-covered substances: $250,000 one-time development costs and $275,000/year	Data collection through PMP for non-covered substances: $309,000/year HIE functionality for non-covered substances: $1 million/year

Important Considerations

The work group recommended the following for any proposed legislation:

Patient opt-out

Any proposal should include an opt-opt allowing patients to opt-out of redisclosure of data on their non-covered substances. Developing and maintaining the opt-out provision will fall on the application developer rather than dispensers.

Date sold

At present, dispensers are required to report date filled; any legislation to require reporting of all medications should require dispensers to also report date sold as part of the data submission.

Interstate data sharing

Interstate data sharing should remain limited to controlled substances.

Veterinarian prescriptions

Requirements to report veterinary prescriptions should remain unchanged. The requirement to report all medications will not extend to non-human patients.

Law enforcement/regulatory personnel access

Access for law enforcement and regulatory personnel access should remain limited to controlled substances.

Duration of medication history

A 90-day lookback period for non-covered substances is sufficient for medication reconciliation and patient safety.