

Perspectives and Updates on Health Care Information Technology

HIT Perspectives Biopharma Insights

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Point-of-Care Partners helps Life Science and Biopharmaceutical companies develop EHR and Health IT strategies to increase product adoption, drive growth, and help their healthcare customers succeed in the world of value based care.

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Part 1: How Account Teams Can Help Ambulatory Physicians Succeed in the Era of Value-Based Care



By **Brian Bamberger**, *Life Sciences Practice Lead*

Ambulatory physicians are feeling overwhelmed these days. They must meet a variety of outcomes, quality, and other targets as health care transitions to value-based care arrangements. They are frustrated by the mismatch between their electronic health records' (EHRs) capabilities and the needs of their practice — especially as many practices are merging or being gobbled up by integrated delivery networks. They are also stymied by their lack of proficiency in using their EHRs to improve patient care, reduce costs and address the needs of payers. Pharmaceutical account teams can make a valuable contribution by providing support and materials to help providers succeed in this new environment.

Drivers for change. Several drivers contribute to physicians' needs for more effective use of their EHRs. These include:

- **Move toward value-based care.** In response to rising health care costs, stakeholders and the **Medicare Access and CHIP Reauthorization Act of 2015** are requiring new delivery models and payment structures. An increasing number of payers and practices are onboard with these value-based care arrangements, which reward improved quality, outcomes and reduced costs. EHRs play a big role in this transition as the main tool for gathering clinical and cost data, analyzing those data to show compliance and transmitting reports in order to get reimbursed — or not suffer penalties.
- **Complexity of the EHR market.** The practice of medicine today requires use of an EHR. Currently, there are more than 500 EHR companies with varying degrees of functionality and sophistication. For example, they use different nomenclatures and ways of capturing and sharing patient data. According to

a recent **Surescripts report**, the biggest data gap across EHRs involves medication adherence. Some 83% of physicians believe access to medication adherence information is a high priority yet only 17% can easily retrieve it electronically. Moreover, availability of advanced functionalities differs, such as clinical protocols, data analytics and clinical decision support. As a result, necessary data analysis and exchange are out of the reach of many providers.

- **Practice competency gaps.** Practices vary in their effective use of the tools that are available in their EHR, the sophistication of those tools and their integration within the practice. This results in competency gaps, which have implications for patient care and reimbursement. **A new survey shows** that 88% of small practices aren't optimizing advanced EHR tools.

How account teams can help. By providing clinical guidelines and educational materials for various conditions, uploading them into practice EHRs and training practice staff on their use, account teams can help fill these gaps. Assistance in framing possible EHR use for practice approval is key and provide a starting point for health system or practice discussions when establishing new EHR prompts or reporting on quality. This can be a new opportunity for account teams to systematically support physician efforts for meeting value-based care metrics.

This approach enables the account team to:

- Provide a curriculum of high-quality, comprehensive content that is engaging and actionable by physicians.
- Easily provide current content and information about treatment best practices.



- Help physicians achieve the measures on which their reimbursement is based.
- Create and/or deepen relationships with physicians and office staff.
- Help physicians maximize their time spent with patients during the office visit.
- Build loyalty and trust.
- Improve sales and patient retention.

Making it work. Translating this approach into action will require some work on the pharmaceutical company's part. First, buy-in will be needed for the practice to use and modify the company-provided materials for its own use. This should not be too challenging given that the materials can be used to meet requirements of both public and private payers. Practices do not want to leave money on the table.

Once buy-in occurs, the sales representative can work with the office's information technology (IT) staff to configure the EHR. In small practices, the IT contact may be the office manager or practice administrator. Larger practices may have consultants or dedicated staff handling IT matters.

For patient education on the EHR, a variety of educational formats are required. For example, some EHRs aren't optimized for outside PDFs. Inclusion of content in an HTML or RTF format allows inclusion with other patient instructions.

The company should make all materials easy to obtain and ideally have a method to update content as new guidelines and best practices are developed. To be sure, the materials need to be specialty specific and complement the needs and size of the practice.

Finally, the pharmaceutical company should make sure that providing educational content to

a practice augments its resources and is not an opportunity to develop relationships with patients without physician practice involvement. Too often, an account team's goals are centered on signing up and educating patients without physician and practice involvement. This makes practice staff wary when patients question physician choices based on what they've read in physician-provided but pharmaceutical company-directed content. With that in mind, note that physician practices are more likely to integrate materials when their practice's logo appears larger than the pharmaceutical company branding. •

How we can help. *Point-of-Care Partners can work with your account team to effectively implement clinical guidelines and patient education efforts. We provide sales force education, reference materials and content to use with practices. For example, we can develop easy-to-use instructions for EHR prompts or patient education that are EHR specific — a necessity now that EHR feature names and capabilities vary from one system to another. Speaking the practice's EHR 'language' is vital. Drop me an e-mail at brian.bamberger@pocp.com. Our knowledgeable and experienced staff are here to help.*

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Part 2: Improving Drug Price Transparency: The Case for Out-of-Pocket Drug Cost Information at the Point of Prescribing



By **Tony Schueth**, Editor-in-Chief

This is part 1 of a two-part series on price transparency. The second article will focus on the industry's response to the problem articulated in this piece.

Consumers are being asked to absorb an increasing share of their medication costs. Even with third-party help — such as coupons and patient assistance programs — patients' out-of-pocket (OOP) costs for medications can be steep, making therapy unaffordable. Now with advances in technology, patients and providers are beginning to ascertain what OOP costs will be for medications and alternatives at the point of prescribing. This understanding may help reduce costs as well as improve the quality and safety of patient care and enhance adherence to therapies.

The current lack of price transparency at the point of prescribing. Lack of clarity regarding a patient's prescription coverage for individual drugs at the point of prescribing is a significant challenge. Since **approximately two-thirds of Americans** have private — and 20% public (Medicare and Medicaid) — coverage, it all begins with how much an insurance company will cover. This can be a complex calculation, depending on whether the prescribed drug falls under the pharmacy or medical benefit.

Insurance companies will often contract with third-party companies -- called pharmacy benefit management companies (PBMs) -- to manage utilization and cost for drugs covered under the pharmacy benefit. If the drug is covered under medical -- e.g., cancer medications -- they will often administer this themselves.

It would benefit the patient, insurance company and prescriber to understand the cost at the point of care. Many different components are involved in making this determination.

Since the 1990s, health plans and PBMs have been providing formulary and benefit information on drugs covered under the pharmacy benefit to prescribers. Since the turn of the century, they have used the National Council for Prescription Drug Programs' (NCPDP) Formulary & Benefit (F&B) standard through the nation's largest electronic prescribing (ePrescribing) intermediary, Surescripts.

This information has shortcomings. Because health plans and PBMs don't have all of the data to provide F&B at the patient level, this information is often on a higher plan or group level and does not provide OOP costs. Further complicating the matter is the fact that formulary tiers constantly change, especially for higher priced medications. ePrescribing systems may lag behind, so prescribers may not have the latest or most accurate information. Flags noting the need for prior authorization (PA) are too often missing.

On the medical side the process remains primarily manual, relying on phone calls, faxes and portal calculators and submissions. There is no functional equivalent of formulary or even the powerful existing pharmacy "test claim" that allows a



prescriber or dispenser to understand the cost, PA or step-therapy requirements at a patient-specific level. This often results in a retrospective workflow with the patient, provider and dispensing location not clearly understanding the true cost of the product until claims are submitted and processed. Depending on the cost, complexity of the regimen and site of dispensing, a provider may order/prescribe the product for a patient and simply hit “send,” relying on one or more retail or specialty pharmacies to obtain accurate pricing information for the patient. If the prescriber is the site of dispense, it will use staff to collect data and review options with patient. Each of these options can take anywhere from days to weeks from the actual diagnosis.

The challenge is that today the information to make a fully informed decision isn’t available at the point of care. This issue is important as patients increasingly need high-cost medications and payers begin to transfer more OOP costs to the patient.

Since they don’t have all the facts at their fingertips — and don’t really trust what they do have — prescribers frequently order medications that are not on formulary, have higher

copayments or generally are unaffordable. This leads to prescription abandonment and medication noncompliance. Patients will not follow through with medications they cannot afford.

The industry is aware of these issues and their complexity, and is working to address them by providing more accurate and transparent drug information at the point of care. Although much progress has been made, more remains to be done. Challenges and opportunities will be discussed in the second article in this series. For the remainder of this piece, we will focus on the drivers for change.

Drivers for change. A number of factors are accelerating the need for drug price transparency at the point of prescribing. They include:

- **Reducing medication nonadherence.** Nonadherence to medication regimens is a serious problem that is expensive for the American health care system and has implications for the quality and safety of patient care. It’s caused, in part, by patients’ OOP costs. **The Kaiser Family Foundation**

Technology increasingly is available to provide some OOP information at the point of care.

found that one in four people taking prescription drugs report difficulty affording their medication. **An estimated 150 million prescriptions** go unfilled each year due to prescription costs. This has gotten the attention of payers and policymakers, which are beginning to link reimbursements to medication adherence.

- **Insurance coverage gaps.** The insurance industry is changing and, with it, the way medications are covered. Unfortunately, this change may lead to higher OOP prescription costs for consumers. High-deductible health plans are becoming the norm, which may put needed drugs out of reach until the deductible is met or because of minimal medications coverage. A growing number of health plans offer percentage-based copays and use of specialty tiers with coinsurance (percentage vs fixed copayment). This results in increasingly large OOP portions being paid by consumers.
- **Personal responsibility.** Consumers are increasingly being asked to bear the costs of medications. **The changes in insurance** discussed above have increased patients' OOP costs 10-fold. At the same time, consumers frequently lack a basic understanding of how their insurance works and what it covers, especially when it comes to medications.
- **Need for high-cost specialty medications.** Specialty pharmaceuticals are high-cost, complex drugs with special handling and administration requirements. Generic alternatives and lower cost biosimilars usually aren't yet available. Specialty medications are primarily used to treat rare or chronic conditions and half of American adults have one. On a practical level, the costs of specialty medications can lead to a huge financial burden for consumers.
- **Drug pricing policies.** Federal and state governments are concerned that drug manufacturers are launching products with

high prices and routinely raising the prices of existing drugs, often by amounts that hit the national news. In response, the administration is convening a group of drug manufacturers to discuss price transparency and reforms, as well as lower OOP costs for Medicare beneficiaries.

- **The move toward value-based care.** Many public and private insurers are moving toward value-based arrangements that reward lower costs and improve patient outcomes. Providers may be measured and reimbursed according to whether they meet certain quality and cost targets.
- **Availability of technology.** Technology increasingly is available to provide some OOP information at the point of care. Two complementary and needed transactions have been created: electronic prior authorization (ePA) and the real-time benefit check (RTBC). ePA helps providers know upfront whether the medication they want to prescribe requires PA, which could reduce speed to therapy. The RTBC provides real-time, patient-specific information to providers regarding a patient's prescription drug benefit coverage as well as OOP costs.

It is clear that drug transparency at the point of prescribing is becoming a front-and-center issue for prescribers, patients and ePrescribing vendors alike. While progress has been made to provide more information than we've had in the past, it is complicated and there are still missing pieces of the puzzle. •

Want to know how the ePrescribing industry is responding? Stay tuned to the next issue of HIT Perspectives, in which the second article in this series discusses challenges and opportunities. In the meantime, if you need to know more, please let me know. Reach out to me at tonys@pocp.com.

3 Part 3: Surescripts Issues National Progress Report for 2017



By **Tony Schueth**, Editor-in-Chief

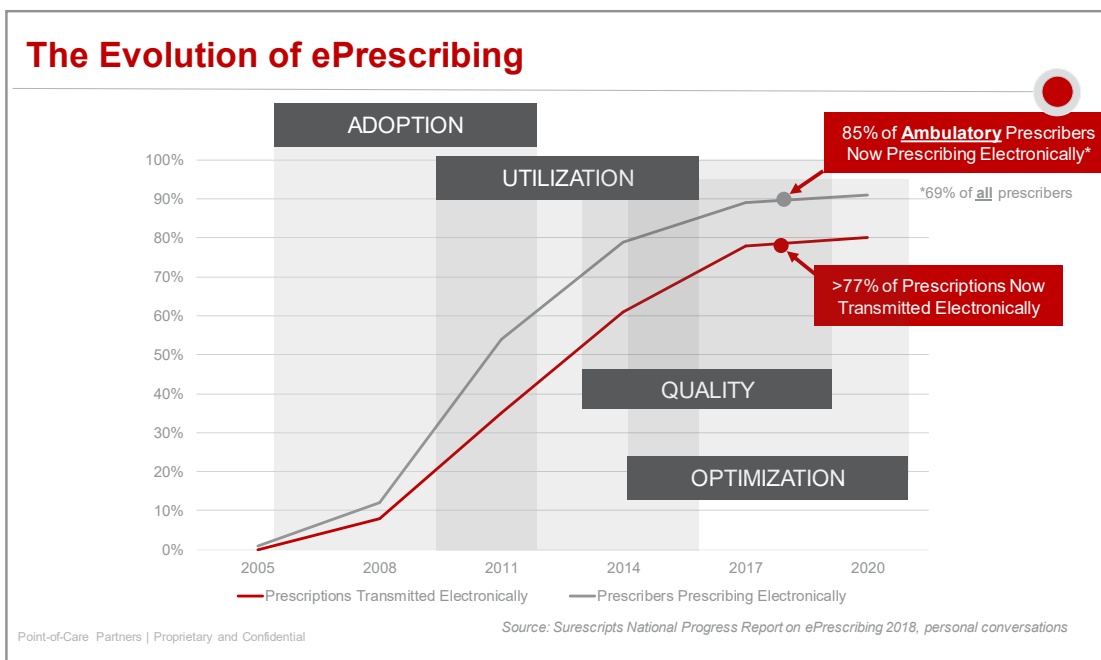
Since electronic prescribing (ePrescribing) was the first subject matter on which we focused, periodically we take a step back to ascertain where we are with this important function. Surescripts' recently issued **National Progress Report** for 2017 is helpful in making this assessment. As the unquestioned leader in ePrescribing and related transactions, Surescripts' annual report provides useful data showing much progress has been made and where there is work yet to do as it pertains to physicians transmitting a prescription electronically to a pharmacy and related transactions. This year's report contains more of the solid information we had been used to seeing in earlier years.

The Four Phases of ePrescribing. The overarching takeaway is that we're continuing to make progress but aren't there yet. We see the evolution of ePrescribing as being in four overlapping phases: adoption, utilization, quality and optimization.

• **Beyond Phases 1 and 2.** Beginning in 2005, the industry was focused on encouraging prescribers to adopt stand-alone ePrescribing solutions or electronic health records (EHRs) that have such capability, highly cognizant that the competition was a slip of paper. Sometime after that, it wasn't about just getting the technology, it was about using it. It's clear from the Surescripts' *National Progress Report* that we're past these phases. Overall ePrescribing transaction volume grew by 26%. This includes 1.74 billion ePrescriptions, representing 77% of all prescriptions.

One of the laggards in ePrescribing has been controlled substances because they require special certification and extra identification. Of prescriptions that are being transmitted electronically, 90% are for noncontrolled substances. Both adoption and utilization of ePrescribing of controlled substances are on the rise. (We provide more details later in this article.)

The other non-electronic prescriptions fall into a couple of categories. There are still providers who refuse to digitize their clinical practice, and the transaction needle won't move unless they either retire or merge their practices with larger, more modern organizations. Certain types of prescriptions don't lend themselves to ePrescribing because of unique data requirements. Compound medications, for example,



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are virtually impossible to ePrescribe using current EHRs. And for specialty medications that require documentation and additional forms, some providers don't think it makes sense to ePrescribe and then repeat the same information on a form. Standards continue to evolve to accommodate these unique prescriptions as progress continues to inch toward 100%.

- **Moving from Phase 3 into Phase 4.** We are now in the third phase (quality) and heading into the fourth (optimization). With regard to quality, for example, Surescripts provided for the first time information about such quality-related transactions as the Structured and Codified Sig. The Sig provides patient instructions in a machine-readable way, thus preventing the possibility of errors that can be made when such instructions are entered manually into the text field and must be interpreted by pharmacy staff.

At the same time, there was growth in two optimized ePrescribing transactions: electronic prior authorization (ePA) and real-time benefit checks (RTBCs). In addition, legislation is driving an uptick in electronic prescribing for controlled substances (EPCS). These developments are discussed below.

Quality-Related Transactions. The report clearly showed that we are firmly in the quality era, which is characterized by improvements in prescription quality. For example, growth in several quality-related transactions were noted:

- 26% growth rate was specifically cited for a combination of five quality-related transactions: **drug descriptions, Structured and Codified Sig, potency unit codes, representative national drug codes (NDCs) and RxNorm.** Despite the growth, using NDC and RxNorm codes is an EHR “best practice,” but not every ePrescription contains this information. Use of **Structured and Codified Sig** has not taken off, despite efforts by the federal government to move the adoption needle. Our experience is that prescribers still prefer to write free-form patient instructions in the text field despite the possibility of error and need for pharmacy callbacks. There are two reasons why. First, it takes longer for the prescriber to select each component of the Sig from a list of selections than to type the Sig in free text (not counting, of course, the callback from the pharmacy to clarify an unclear instruction). Despite efforts made by EHRs to improve the Sig selection process, prescribers still find it faster and easier to type in the Sig. The second reason is because most EHR “Sig

builders” don't easily accommodate liquids, injectables, inhalers, compounds and tapered doses. While the Surescripts report notes that use of Structured and Codified Sig doubled in 2017, the increase moves the total from 1% to 2%, leaving plenty of room for improvement.

- **CancelRx** is new to the *National Progress Report* this year and accounted for 3.8 million transactions in 2017. Not widely known, this transaction is primarily used to let pharmacists know that a prescription has been stopped by the prescriber. This leads to more accurate pharmacy records (a good thing) and eliminates unneeded prescriptions from being filled (which saves work for the pharmacy and prevents dispensed, unused medications from diversion). EHRs are required to support CancelRx as part of the EHR Certification Program of the Office of the National Coordinator for Health Information Technology, but providers are not required to use or report on it as part of meaningful use or attestation under requirements promulgated to implement the Merit-Based Incentive Payment System/Medicare Access and CHIP Reauthorization Act. Moreover, pharmacies are not required to support CancelRx. Although it is likely that a mandate ultimately will be put in place, transaction volume growth will continue to be strong even without it. From a public health perspective, it's a positive sign that utilization of CancelRx is increasing without regulatory requirement.
- **Medication history** long has been a core ePrescribing transaction. It has taken on increased importance as an enabler of medication reconciliation and compliance, which are directly related to improvements in quality of care. Some 1.46 billion medication history transactions were delivered in 2017, including approximately 1 million for long-term and post-acute care (LTPAC) facilities. In addition to illustrating growth generally, this also demonstrates improved connectivity of LTPAC. LTPAC has complex workflows, some of which have been challenging to automate. However, their evolution toward digitalization is evidence of the significant growth in this segment — with more to come. Stakeholder groups and vendors recognize this opportunity and are working to address the needs of these digitally underserved markets.
- **Direct clinical messaging** is another transaction that can help enhance care quality. It enables the exchange of patient data beyond the traditional ePrescription — putting clinical data

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directly in the hands of the patient's care team. For example, it can help physicians share patient information with other providers or assist a specialty pharmacy with receiving payer approval. Last year, clinical messages were sent 25.9 million times by nearly 52,000 clinicians via Surescripts. There are a number of clinical messaging exchanges, often competitors within the same geography. Consolidation of clinical messaging platforms and vendors should be expected as transaction volume increases due to the focus on quality and information exchange by Medicare and other payers.

Transaction Optimization. The optimization phase of ePrescribing is marked by several distinct trends. They include:

EPCS. EPCS mandates in four states (New York, Minnesota, Connecticut and Maine) continued to drive transaction volume. In 2017, 77.33 million electronic prescriptions were transmitted for controlled substances, increasing from 11% in 2016 to 21%. This mirrors the resulting growth in ePrescribing of noncontrolled substances when regulatory mandate overcame resistance to change — in the case of EPCS, to two-factor authentication — and workflow integration challenges.

EPCS volume will continue its rapid increase as more states pass EPCS legislation in response to the opioid crisis. Beyond the four states with mandates, seven have EPCS laws passed with future effective dates, an eighth state has an EPCS mandate law on the governor's desk for signature and six others have legislation pending. Significantly, transaction volume may get a huge boost if pending federal legislation is enacted to require EPCS for Medicare Part D prescriptions. If that's not enough, **Walmart just announced** it will require ePrescriptions for opioids by 2020. It's likely that other chains will follow suit, leading to major EPCS volume increases.

ePA and RTBC. Optimization also can be shown through the growth of these two previously cited transactions. Individually, they can help improve drug price transparency at the point of prescribing. Together, they help prescribers identify the lowest cost medications that are covered by a patient's insurance. Drug affordability and rising out-of-pocket (OOP) patient costs are hot topics in health care today. Studies have shown that patients do not follow through on prescriptions they cannot afford, leading to as much as \$300 billion annually in unnecessary hospitalizations, emergency department visits and premature deaths. (See the article

in this issue of HIT Perspectives for more detail about the need for price transparency at the point of prescribing.)

- **ePA** can help prescribers determine if prior approval is needed and apply for authorization at the point of prescribing. ePA utilization has begun to take off — with a 350% increase in transactions in 2017 — showing the need for and usefulness of the transaction. Despite this growth, widespread ePA adoption remains relatively low. Not all providers are aware this capability exists and not all EHRs have integrated ePA into their workflows, despite availability of connectivity from several vendors. The question remains whether providers are broadly concerned with price transparency to make wider use of ePA.
- **The real-time benefit check** is the bright, shiny new object in the world of ePrescribing. RTBC data are accessed in real time and directly from the payer, providing accurate and detailed benefit information at the patient level about medication coverage, copays and plan restrictions. There were 3.1 million RTBC transactions in 2017 through Surescripts, and several other vendors also offer RTBC connectivity.

The RTBC is needed because the eligibility-informed formulary has proven to be suboptimal in ePrescribing systems. For example, there is incomplete or inaccurate display of preferred status and tier level, a missing or incorrect prior authorization indicator, and benefit information at the plan level, not the patient level. While these issues are being fixed, there is debate over whether the formulary and benefit transaction is needed. Some argue that eligibility-informed formulary is still important because it helps determine whether an RTBC is needed.

Because RTBC focuses on price transparency, we expect interest (and transaction volume) to rise in response to federal and state efforts to reform drug pricing and reduce patients' OOP costs. •

Want to learn more? *To be sure, there is a lot happening in the world of ePrescribing. Have questions or need more information? Let our **Regulatory Resource Center** keep you on top of the dizzying world of federal and state laws and regulations. For more information, contact Keith Fisher (keith.fisher@pocp.com). As the nation's leading experts in ePrescribing, Point-of-Care Partners can help you understand the changing ePrescribing landscape, educate your internal and external audiences and position your firm for success in the market. Please reach out to me at tonys@pocp.com.*

