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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1 Part 1: Three Essential Trends to Include in Q4 Planning

By Brian Bamberger, Life Sciences Practice Lead

The dog days of summer are over and the kids are back in school. That means it's time to focus on fourth quarter (Q4) planning. For many companies, this is the most important quarter of the year: assessing how goals have been met, making final corrections and setting expectations for the following year.

Pharmaceutical companies should think outside the box and strengthen their planning efforts by including three essential trends:

1. **Real-time pharmacy benefit information.** Until recently, there was no method for prescribers to identify costs of drugs for patients — which drug is on formulary, how much insurance will cover and what, if anything, the patient might have to pay out of pocket. Now real-time pharmacy benefit information is appearing in practices via **real-time pharmacy benefit check** (RTPBC). RTPBC provides real-time copayment information at the point of prescribing along with prior authorization (PA) requirements and the payer's preferred alternative drugs. As the impact on pharmaceutical brands is significant, we're tracking RTPBC development and deployment closely. We will be updating our overview and collecting samples of electronic health record (EHR) deployment this fall.
2. **Electronic prior authorization (ePA).** Manual prior authorization (PA) for medications, devices and services is a pain point for providers, patients and plans. Now digital transformation is under way with the ability to make real-time authorization requests at the point of care. Automation reduces time to therapy and expensive overhead for pharmacies and physician practices while decreasing the need to use portals from payers and hubs. Efforts in this area are under way. (**Read our article on the evolution of ePA for the details**). We're happy to provide background on recent developments.
3. **Specialty pharmacy automation.** In contrast to retail pharmacy, which is highly automated, specialty pharmacy is mired in antiquated phone, fax and paper processes. Stakeholders are interested in automating specialty pharmacy because of the growing costs and use of expensive specialty medications to treat the rapidly growing number of people with chronic diseases. These efforts also dovetail with other efforts to computerize health care and reduce physician burden. Efforts to automate specialty pharmacy continue to accelerate, with progress already being made. For example, efforts are under way to computerize enrollment and identify which new data elements useful in the enrollment process can be incorporated in the SCRIPT standard from the National Council for Prescription Drug Programs (NCPDP). These include, for example, additional patient contact and demographic information, diagnosis, lab values, height and weight.

Why are these trends important? It's obvious that these trends are important to improve speed to therapy, reduce costs and improve quality of care. That said, there are other reasons why pharmaceutical companies should be paying attention.

- **Alignment with federal and state mandates.** In May, the Centers for Medicare and Medicaid Services (CMS) issued **a final rule** that requires plan sponsors to have real-time pharmacy benefit (RTPB) information capable of integrating with at least one prescriber's EHR system for drugs prescribed under Medicare Part D by **January 1, 2021**. Shortly after this rule was finalized, **CMS issued a proposed rule** that would require Part D plan sponsors to support version 2017071 of NCPDP SCRIPT for ePA transactions with prescribers regarding Part D covered drugs to Part D eligible individuals – **also by January 1, 2021**. Other public and private payers tend to follow Medicare's lead, which will make ePA for drugs covered under the patient's pharmacy benefit common across the industry. In addition, states are jumping on the ePA bandwagon. Nearly half now mandate use of ePA or allow its use, often in leveraging the NCPDP SCRIPT standard. However, state requirements vary. In addition, several bills have been introduced in the House of Representatives to expand use of the RTPB information beyond Part D. One of them may gain traction this fall. Planning for and complying with legislative and regulatory changes are business imperatives.
- **Intense stakeholder involvement.** Many trends involving health information technology (health IT) seem to run under the radar. Not so with RTPB information, ePA and specialty pharmacy automation. These trends are the focus of intense involvement by powerful stakeholder groups, whose collaborative efforts are rapidly driving changes. For example, the **CARIN Alliance** — a large, multistakeholder coalition — has formed a workgroup aimed at advancing the consumer-facing RTPB information. The American Medical Association (**AMA**) recently convened a group that led to the development of a consensus statement on improving the PA process. Participants included the AMA, American Hospital Association, America's Health Insurance Plans, American Pharmacists Association, BlueCross BlueShield Association and Medical Group Management Association. Since its creation, more than 100 other organizations have become involved in the project. Finally, the **eHealth Initiative** convened a collaborative ePA project. Participants include nearly three dozen organizations representing payers, providers, government agencies and vendors. Such collaborations and initiatives — with diverse and influential members — are high-visibility drivers for change.
- **Payer price transparency.** Price transparency at the point of care is a huge issue that is receiving national attention and considerable media coverage. It is **among the priorities** at the Department of Health and Human Services. Lack of stable prescription coverage, as well as unpredictable pricing and sticker shock at the pharmacy, are drivers for change. The real-time pharmacy benefit check (RTPBC) described above can help. It builds on progress to date concerning important prescription cost and coverage information available at the point of prescribing. A response to prescriber challenges with benefit information, RTPBC advances price transparency, especially when used in conjunction with ePA. This is far from a perfect solution because there isn't a way to convey any manufacturer programs

In addition, if patients and providers are equipped with partial coverage and cost information, prescription options can be distorted, leading to decisions that help payers but not necessarily patients

Response planning. There are many possible action steps for companies to consider. For example, pharmaceutical companies could:

- **Get involved with stakeholder collaborations.** Companies must understand the value and opportunity in participation and collaboration in the various stakeholder-led initiatives concerning RTBC, ePA and specialty pharmacy automation. They are particularly important opportunities for pharmaceutical companies—especially given the rapidly evolving niche markets for drugs and biologics to treat the growing number of patients with chronic diseases, which are expensive and require PA. Being involved is essential to having a voice at the table, understanding where opportunities lie and connecting with high-level, key decision makers.
- **Prepare for Deployment.** Companies should be reviewing and updating their internal training materials. For Q4, these should be revised — or created — to address the evolving requirements of public and private payers and the use of RTBC information and ePA, as well as how they are being integrating into EHR work flows. Sales teams and others also should be brought up to speed on accelerating efforts to automate specialty pharmacy prescribing and dispensing. •

Want to know more? *Point-of-Care Partners is here to help with analyses, details on federal and state requirements, use of EHRs, strategic planning and much more. Drop me a line at brian.bamberger@pocp.com.*

2 Part 2: Lack of Training Is Core Cause of Physician EHR Usability Complaints

By Michael Burger, Senior Consultant

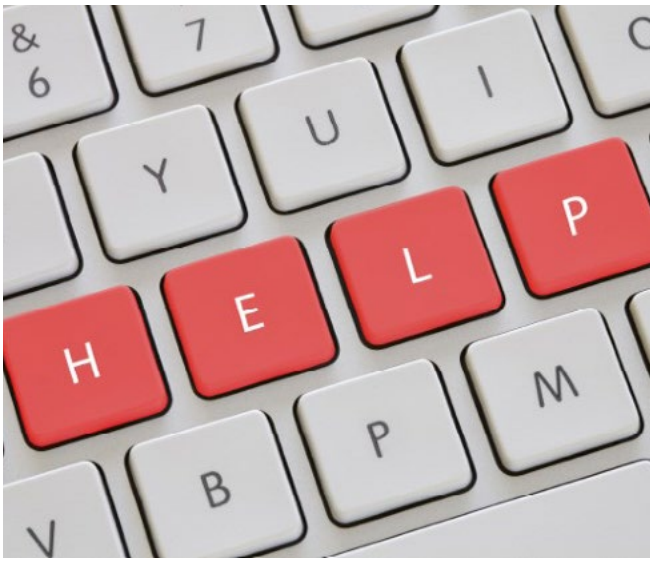
You hear it all the time: electronic health records (EHRs) are proliferating, yet doctors allegedly hate them because of usability issues. As a product manager, I've been the recipient of many a tirade from an unhappy physician client saying, "It's not intuitive," or "There are too many clicks," or "Why can't this be as simple as an iPhone?"

Physician disdain for EHRs has been expressed loudly and often enough that regulators have included usability testing as a certification criterion for EHR incentive programs. Consequently, everyone is searching for underlying causes. Some studies have already tied usability issues to physician burnout. Now **a new study** has determined that lack of training impacts physician usability perspectives.

EHR usability problems. EHRs are certainly not perfect. Software improvements can be made to tighten up the user interface (UI) to be more logical and reduce the number of clicks. Soliciting user feedback through usability testing is a valid and reasonable mechanism for prioritizing EHR enhancements, though I'd stop short of mandating it. A software vendor that doesn't pay attention to customer feedback about its product's usability is doomed to fail the old-fashioned way – customers simply won't buy it.

EHR vendors face a significant hurdle regarding usability. Because of its inherent function, an EHR simply can't be as easy to use as an iPhone. A UI that's perfect for Instagram and Twitter isn't practical for a task as complex as documenting the patient visit of a 72-year-old with comorbidities.

Equally challenging is finding the right balance between what information a clinician would like to see and how much is too much. In this regard, medicine is as much an art as a science, with each clinician having his or her own preferences. For this reason, EHRs are designed to be flexible in order to accommodate the unique style of the individual user. This has led to some of the resulting dissatisfaction because with flexibility comes lack of consistency. Time and again, clinicians have claimed that their practice is "differ-



ent." Yet what perpetuates the usability challenge is allowing insufficiently trained clinicians to use the EHR "their way" and ignoring the best practices (i.e., consistency) gleaned by trainers across thousands of implementations.

EHR training is a constant tug of war. Because EHRs are necessarily complex, education is essential. Unfortunately, it's often difficult for clinicians to set aside time for such in-depth training. Clinicians are among our best-trained professionals, having spent years of study in medical school. While clearly recognizing the value of proper training, they somehow fail to perceive learning about EHRs as an investment.

In my 12+ years' tenure as an EHR product manager, my experience with the correlation between training and satisfaction has been anecdotal. No real statistics exist to validate what I've learned from the college of hard knocks – that insufficiently trained clients are dissatisfied clients.

Shedding light on the problem. Now we have data to illuminate the problem. A recently published study (72,000 clinicians at 156 provider organizations) by **the Arch Collaborative** has examined EHR satisfaction. Its conclusion: "If health care organizations offered higher-quality educational opportunities for their care providers, and if providers were expected to develop greater mastery of EHR functionality — many of the current EHR challenges would be ameliorated."

Across this extensive dataset, the study notes that "the single greatest predictor of user experience is not which EHR a provider uses or what percent of an organization's operating budget is spent on information technology, but how users rate the quality of the EHR-specific training they received."

These are telling statements that highlight the challenges EHR vendors face regarding client satisfaction. With as many as 30% of practices looking to replace their EHRs, one wonders if their experience with a new EHR will be any better without a commitment to training. They also explain why EHR vendors that impose prescriptive training requirements are perceived as having a better product when compared with those that allow their clients to dictate the training curriculum and requirements.

These also help to explain why many of the advanced features that EHRs offer are underutilized. Population health comes to mind. Clinicians who are frustrated by clicking their way through poorly configured workflows that require bouncing from screen to screen aren't going to be receptive to messaging about evidence-based best practices. Instead, they'll succumb to alert fatigue and ignore every message as an interruption. Population health DOES work when well-trained clinicians breeze through optimized workflows that sequentially match the patient exam. Actionable population health information interspersed within such a workflow is unobtrusive and valuable. Instead of being an interruption, population health becomes a component of clinical decision making.

Opportunities. The conclusions of this study create some opportunities. Organizations, such as pharmaceutical, medical device and medical services companies, working with clinicians using an EHR should be prepared for workflows that differ from client to client, even those using the same EHR. They should be aware that client staff using the EHR may not have received (or paid attention to) the in-depth training offered by the EHR vendor or that workflows in place may not have been optimized. Coaching that incorporates those best EHR practices emphasizing fewer interruptions and actionable information will be welcomed by clinicians. •

Point-of-Care Partners are experts in EHR workflow. We can help your organization better prepare for discussions with clinicians about EHRs, including best practice workflows. Let me know how we can help. Please contact me at **michael.burger@pocp.com**.

3 Part 3: ePA 2.0: Taking Electronic Prior Authorization to the Next Level

By Jocelyn Keegan, Payer Practice Lead, and Ken Kleinberg, Innovative Technologies Practice Lead

Electronic prior authorization (ePA) is gaining traction and attention after a lull in progress and focus. The need for ePA is easy to understand. ePA is essential in reducing time to therapy, friction and costs by aligning payer and provider goals. The "how" is catching up in a big way. Now new technologies, evolving standards, government regulations and ePA's role as a critical tool for value-based care have created a perfect storm. The industry has brought ePA to an inflection point, and several leading payers, providers, vendors and standards groups are driving to advance ePA by making automated prior authorization (PA) the norm rather than the exception.

A way to conceptualize this progress is shown in the figure below. There are three phases in the evolution of ePA. The industry is rapidly transitioning from phase 1.0 and heading to phase 2.0.

ePA 1.0. This first phase is focused on ePA for medications covered under a patient's pharmacy benefit. Substantial progress has been made and is ongoing. Take, for example, the latest version of the SCRIPT standard by the National Council for Prescription Drug Programs (NCPDP). NCPDP SCRIPT version 20170701 contains ePA transactions that are more robust than those contained in the current ePA standard (ASC X12 278) and offer the ability for performing ePAs in real time.

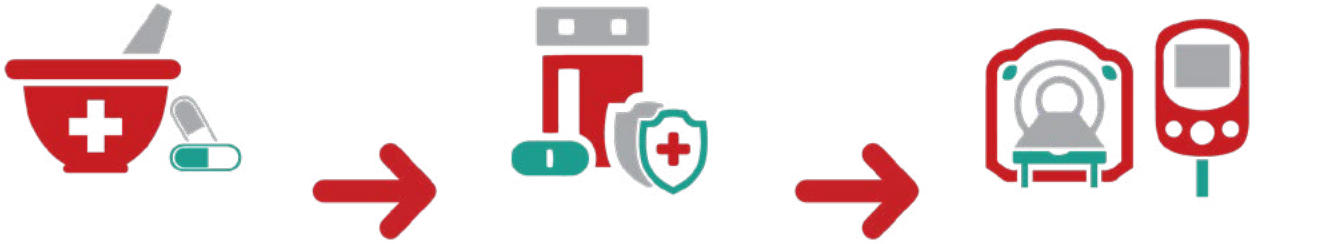
Adoption of the NDPDP standard will be reinforced with the **newly proposed rule** from the Centers for Medicare and Medicaid Services (CMS), which would require use of ePA transactions contained in NCPDP SCRIPT 20170701 for drugs prescribed under Medicare Part D instead of the ASC X12 278. The proposed implementation date is January 1, 2021.

Another CMS rule will support and accelerate use of the real-time pharmacy benefit check (RTPBC). The rule will require adoption of a "Real-Time Benefit Tool" by **Medicare Part D plans beginning January 1, 2021**. NCPDP has developed a draft standard for this transaction, which was approved to move forward at the August 2019 workgroup meeting.

With the RTPBC, both prescriber and patient can have up-to-date information on the out-of-pocket costs of a drug that is being prescribed as part of the electronic prescribing (ePrescribing) process at the point of care through the electronic health record (EHR). When used with ePA, the two transactions deliver more accurate information about coverage and costs of drugs at the point of prescribing and allow physicians to help their patients begin therapy faster. The newly proposed ePA transactions would enable the prescriber to submit the required information in real time and indicate in the RTPBC whether PA is needed. This will help the physician obtain faster approval and improve speed to therapy.

Improving the quality of the signal for PA through RTPBC will bolster the accuracy and utility of ePA as part of the prescribing process, such as support from industry groups such as the American Medical Association, which continues to support adoption of ePA as a way to reduce physician burden.

The evolution of electronic prior authorization



ePA 1.0
ePA for drugs covered under the pharmacy benefit

ePA 2.0
ePA for drugs covered under the medical benefit

ePA 3.0
ePA for devices, procedures and services covered under the medical benefit

Taking ePA to Level 2.0. ePA 2.0 involves automating PAs for drugs covered under a patient's medical benefit (mPA), such as drugs covered under Medicare Part B. Reducing provider burden is an increasing focus from the Department of Health and Human Services, including notices of proposed rulemaking that would increase the ability for payers to share coverage decisions as members change plans and make continued investments in emerging technologies that can expose coverage rules to providers in their work flow.

Currently, most PAs for those medications are processed manually through antiquated phone, fax and paper processes. There are several drivers propelling ePA to the next level. These are being addressed by various stakeholder initiatives. For example:

- **Specialty pharmacy.** A large driver for mPA is the rapid growth of expensive specialty medications. Specialty medications are the fastest growing segment of the nation's drug spend, primarily due to their high costs and use in addressing the large and expanding patient populations with chronic diseases. The **government estimates** that 60% of Americans have a chronic disease and 40% have two or more chronic conditions.

  At the same time, prescribing specialty medications generally is a manual process, leading to provider frustration and reduced speed to therapy. Automating and standardizing specialty pharmacy transactions will be the focus of a new workgroup that has been formed by NCPDP. The goal is to bring greater focus and coordination in how NCPDP standards are used for the electronic exchange of data in specialty pharmacy, including addressing gaps that exist in ePrescribing for specialty medications. This will complement and support ongoing NCPDP efforts to automate various aspects of specialty pharmacy, including the patient enrollment process. In addition, NCPDP and HL7 are working together to use Fast Health Interoperability Resources (FHIR) to extract the necessary clinical data required for enrollment from the native EHR.

Administrative burdens. Three-quarters of physicians (specialists and primary care) report the burden of PA is high. According to the **American Medical Association**, doctors and their staff spend the equivalent of nearly two business days navigating PA. Because this administrative burden is so great, about a third of physicians maintain staff members who exclusively deal with PAs. It usually takes days —even weeks — for an **insurance company** to decide whether it will approve a PA request. Needless to say, this leads to delays in therapy and frustration for both patients and providers. These factors are increasing the demand by provider associations for an mPA solution. Point-of-Care Partners (POCP) is tracking no fewer than a half-dozen separate, industry-led conversations to reduce the need for mPA and its associated provider burden.

Costs. Significant administrative costs are associated with PA. **Research by the Council for Affordable Quality Healthcare** reveals that each manual prior authorization for medical care costs $3.50 for plans and $6.61 for providers. Going electronic

Many challenges must be addressed to bring ePA to version 3.0.

brings that down to $2.80 per transaction for payers and $0.03 for providers. All in all, the study found that transitioning to electronic medical prior authorization could create $278 million in annual savings for providers and $139 million for health plans.

Da Vinci. Significant investment from CMS, payers, providers and vendors is under way to accelerate adoption of ePA leveraging application program interface (API)-based standards. HL7's FHIR is the basic building block for the **HL7 Da Vinci Project** — a private, multistakeholder initiative — with a number of use cases including PA. Da Vinci's open business model process enables payers, health systems and other industry participants to identify and enumerate use cases that involve managing and sharing clinical and administrative data among industry partners. Coverage Requirements Discovery, an early use case, leverages a FHIR-based API that enables care delivery organizations and providers to query payers in real time to find relevant guidance prior to care delivery to increase efficient delivery of care and corresponding payment. Building further, Documentation Templates & Rules enables providers to understand coverage requirements for a particular patient at the plan level, and work is under way to map the necessary clinical data required to automate the PA request itself with Prior Authorization Support. All of these use cases are in a single track at HL7's September Connectathon in Atlanta.

To be sure, this new tranche of work is early, but stakeholders are ramping up to enable their platforms for API access so ePA can move to the next level.

Moving to ePA 3.0. ePA 3.0 will automate PA for devices, procedures and services covered under the medical benefit. Electronic medical prior authorization is in its early phases, but real work is under way with significant interest and attendance at Da Vinci working sessions and Connectathon activities. Many challenges must be addressed to bring ePA to version 3.0. For example:

- The quality of provider data varies by vendor and payer capabilities. Payers will need to streamline and combine how pharmacy and medical claims are processed, as well as increase the **accuracy** and **availability** of PA requirements and benefit detail in workflow in **real time**.
- The increasing complexity of plan design, high-deductible plans, and members in at-risk contracts is **increasing pressure on plans to improve available provider tools**. Consensus will be needed on what those tools should be, the standards to support the underlying business design and how they will be handled in work flows.
- Refinements are needed in EHRs to support mPA. The **ability to seamlessly share or identify in real time existing data locked into EHRs** with APIs or data to create necessary attachments must be addressed. EHRs still provide little or no support for PA, except for enabling attachments using existing HIPAA-named standards. Creating a clear path for implementers from FHIR to other ePA standards is critical. •

Need more information? *POCP is here to help. Drop us a line (jocelyn.keegan@pocp.com and ken.kleinberg@pocp.com). Also, don't overlook the wealth of information in our new ePA report. This extensive document — with 40+ diagrams and tables and 90+ references — offers health care stakeholders an independent analysis of the market, realistic maturity models and a profile of what vendors and service companies are currently doing pertaining to ePA so they can arm themselves with the information needed to plan strategically and meet their goals. Set up a one-on-one meeting to discuss how this report may help your organization by calling us at 877-312-7627, option 4, or dropping us an email at info@pocp.com.*