Perspectives and Updates on
Health Care Information Technology

HIT Perspectives Biopharma Insights

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About the newsletter

HIT Perspectives Biopharma Insights is published by Point-of-Care Partners. Individuals at the leading management consulting firm assist healthcare organizations in the evaluation, development and implementation of winning health information management strategies in a rapidly evolving electronic world. The team of accomplished healthcare consultants, core services and methodologies are focused on positioning organizations for success in the integrated, data-driven world of value-based care.

Upcoming Speaking Engagements

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1 Part 1: New Proposed Regulation Rebrands and Retools Meaningful Use

By Tony Schueth, Editor-in-Chief

What's happening with meaningful use (MU), especially since the rumors of its demise were greatly exaggerated? Stakeholders have been eagerly awaiting the answer from the Centers for Medicare and Medicaid Services (CMS). Now we have a much better idea of its fate: CMS has rebranded and retooled the program, which is now called Advancing Care Information (ACI). Details are in a newly released Notice of Proposed Rulemaking (NPRM).

We got hints earlier this year about MU's future when it was announced that some MU elements would be rolled up into a new program created under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). MACRA provided CMS with the legislative vehicle to address physician payment reform, streamline quality-based programs payments and create an MU replacement.

But in typical government fashion, MU's replacement is not very straightforward. It is, in fact, quite complex. ACI is a program within a program within a program. It begins as part of a new Quality Payment Program "framework," which was created under MACRA.

The Quality Payment Program has two tracks providers can use to have their Medicare payments adjusted. The one of most interest to HIT Perspectives readers is called the Merit-Based Incentive Payment System (MIPS), which most Medicare clinicians are expected to use. The other is called Advanced Alternative Payment models. For more information, see the CMS fact sheet.

MIPS Overview. MIPS replaces Medicare's former payment adjustment system, which was based on the reviled Sustainable Growth Rate formula. MIPS is supposed to simplify Medicare's former patchwork of payment and quality programs by consolidating the Physician Quality Reporting System, the Value Modifier Program and MU. The health information technology (health IT) certification program by the Office of the National Coordinator for Health Information Technology (ONC) will continue as it did under MU. Certified electronic health records (EHRs) — or certified modules, such as application program interfaces — must be used to achieve MIPS objectives.

However, the heart of MIPS is another carrot-and-stick incentive program. As described below, physicians will respond to — and report on — the following weighted metrics:

- **Cost** (10% of the total score). It replaces the cost component of the Value Modifier Program, also known as Resource Use. The score will be based on Medicare claims, meaning there will be no reporting requirements for clinicians. This category would use more than 40 episode-specific measures to account for differences among specialties.

- **Quality** (50% of the total score). It replaces the Physician Quality Reporting System and the quality component of the Value Modifier Program. Clinicians would choose to report six measures versus the nine measures currently required under the Physician Quality Reporting System. This category offers clinicians reporting options to accommodate differences in specialty and practices.

- **Clinical Practice Improvement Activities** (15% of the total score). Clinicians would be rewarded for clinical practice improvement activities, such as those focused on care coordination, beneficiary engagement and patient safety. Clinicians may select activities that match their practices' goals from a list of more than 90 options. In addition, clinicians would receive credit in this category for participating in alternative payment models and in patient-centered medical homes.

- **Advancing Care Information** (25% of the total score). This renamed component is a repurposed version of MU. Clinicians would choose to report customizable measures that reflect how they use EHRs in their day-to-day practice, with a particular emphasis on interoperability and information exchange. Unlike the existing MU program, this category would not require all-or-nothing EHR measurement or quarterly reporting.

These four components will be added together to create a base score. The base score will be used by Medicare to increase or decrease a physician's overall Medicare payment by certain percentages. Doctors can earn bonuses (or receive penalties) of up to 4% starting in 2019, a number that grows to 9% by 2022 based on how well they perform.

CMS will begin measuring performance of doctors and other clinicians through MIPS in January 2017, with payments based on those measures beginning in 2019.

A closer look at Advancing Care Information. If MU wasn't complicated enough, ACI is very complex—even though its underlying logic is fairly easy to understand. CMS listened to physicians, who wanted flexibility in measures and reporting. However, the devil's in the details — especially in how the ACI is computed.

As mentioned previously, the ACI counts toward a quarter of the MIPS payment adjustment. The overall score of 100 points in this category is comprised of subscores in three categories.

1. **Base score**. The first is the base score, which accounts for up to 50 points of the ACI score. It is comprised of six objectives and measures, which will sound very familiar to those who've been embroiled in MU over the past seven years.

- Protect Patient Health Information Using a Risk Analysis (mandatory)

- Electronic Prescribing

- Public Health and Clinical Data Registry Reporting

- Immunization registry reporting is mandatory; other registry reporting is optional

- Health Information Exchange

- Coordination of Care Through Patient Engagement

- Patient Electronic Access

2. **Performance Score**. Next is the performance score, which accounts for up to 80 points toward the total ACI category score. Physicians and other clinicians select the measures that best fit their practice from three objectives: electronic patient access, coordination of care through patient engagement and health information exchange. These, again, harken back to MU's objectives and measures.

3. **Public Health Registry Bonus Point**. Immunization registry reporting is required. A bonus point can be earned for reporting to other public health registries.

Total Score. The base score, performance score and bonus point (if applicable) are added together to achieve the total ACI score. Note that they add up to a possible 131 points, while only 100 points are needed to receive the maximum points in the ACI category. There is no reward for exceeding the 100-point total. However, participants' overall score in MIPS declines proportionately if they do not meet the 100-point threshold. Scoring is not all-or-nothing.

What does it mean? The Point-of-Care Partners (POCP) team will be analyzing the new NPRM and what it means to various stakeholders. We do, however, have a few top-of-mind observations.

The first is that physicians who have participated in MU should be able to easily achieve the ACI measures due to the similarity of the objectives. By the same token, they should be able to use their certified EHRs to report on quality and clinical practice improvement measures. The laggards will continue to risk having their Medicare payments dinged unless they get with the digital age — except this time there won't be any money available to help defray the costs of getting wired.

Protecting patient health information using a risk analysis also should be easy to attain since this is a requirement under the regulations implementing the Health Insurance Portability and Accountability Act of 1996 (HIPAA). That is likely easier said than done. We would make a healthy bet that most providers have never heard of the HIPAA security rule, even though it has been in effect for more than a decade.

MIPS will continue to push adoption of electronic prescribing (ePrescribing) through regulation. This tried-and-true approach has resulted in 80% of office-based based physicians using this technology. However, there is still room for growth. Given that the remainder are hard-core laggards, it remains to be seen how much MIPS moves the adoption needle.

It is clear that the government will be moving MIPS beyond the measurement of EHR adoption and has created a renewed focus on patient-centered care using patient-centered health information technology. This was underscored in a blog post by CMS Acting Administrator Andy Slavitt and National Coordinator Karen DeSalvo, M.D. They said MIPS is "more patient-centric, practice-driven and focused on connectivity." We undoubtedly will continue to see this emphasis as MIPS rolls out in the future because it aligns with other ONC and CMS programs and initiatives. That said, patient-centered care hasn't gained much traction despite the government's best efforts to date. It's too soon to tell whether the piling on of MIPS' new regulatory requirements will help to create a tipping point.

Comment period. The NPRM provides for a 60-day comment period, which closes at 5 p.m. on June 27, 2016. This gives stakeholders an opportunity to make recommendations, which will be considered in the final regulation that will be issued in the fall. Because POCP will have a detailed understanding of the NPRM and its impacts, we can help you write and submit your comments. Please give us a call or send us an e-mail.

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2 Part 2: Cutting Through the Confusion Surrounding Electronic Formulary and Benefit Checks

By Tony Schueth, Editor-in-Chief

Research indicates that much of the value proposition for electronic prescribing (ePrescribing) lies in providing formulary information at the point of prescribing. Despite the value of point-of-care formulary validation, the current process is significantly underused due to a variety of issues. While slow progress has been made in addressing those issues, the industry has moved on a separate track toward developing a new technology being considered as a replacement for the current process – real-time benefit inquiry (RTBI). So, we now have a process with standards that are not providing sufficient value with disparate pilot projects and one-off, proprietary products based on interim standards that have not been finalized. The situation reminds me of the title of an old Temptations song: "Ball of Confusion (That's What the World Is Today)." Let's clear some things up.

The current process. There is confusion and consternation around the current formulary standard because of related implementation issues and how it is used. As a result, prescribers often ignore this valuable resource when ePrescribing or rely on the pharmacist to navigate the patient's formulary requirements after he or she attempts to get paid. This is unfortunate because it prevents providers from ordering the most appropriate and cost-effective medication options for patients at the point of care. There's a fairly long list of reasons why prescribers don't use existing formulary validation capabilities.

• **Granularity.** First, there are problems with data granularity. Presently, payers use the National Council for Prescription Drug Plans' (NCPDP) Formulary and Benefits (F&B) standard to provide formulary information generally at the "plan" level, sometimes at the "group" level, but never at a "patient-specific" level. (Examples: "plan level" would be General Motors, "group level" salaried employees in Detroit and "patient level" Jane Doe, plant manager.) The fact is there could be formulary variances depending on level. As a result, the formulary may just not be precise enough.

• **Data latency.** Formulary information in a prescriber's electronic health record (EHR) system may be stale. There are lags between the time when the formulary information is published to intermediaries, the largest of which is Surescripts, and the frequency by which EHR vendors incorporate formulary updates into their systems. Prescribers also may add to the data latency problem by not regularly installing the latest information into their system.

• **Data representation.** Formulary status data in an ePrescribing system may be difficult for prescribers to decipher because of the way they are presented. Formulary design is complex, and ePrescribing systems attempt to simplify formulary status using colors or tier designations that are open to interpretation. For example, many ePrescribing systems limit display of formulary benefits to three tiers; however, there are four-, five- and six-tier plans that need to fit into a three-tier display. Also, terms like "nonformulary," "not covered" and "nonpreferred" can mean one thing to the payer but may be interpreted as something else by the prescriber.

• **Prior authorization.** Then there's the issue of prior authorization (PA). Formulary files used in ePrescribing aren't always complete; for example, one common deficiency is they don't always have indicators that PA is required. Lacking such indicators, the ePrescribing system may show that PA is indicated (based upon the plan level) even though it is not required by the patient's group or individual coverage. These challenges may be magnified when providers manually try to match patients with a formulary if their ePrescribing systems do not conduct eligibility-driven formulary matches. So, doctors throw up their hands (who could blame them?) and patients end up with an alternative treatment that may not be optimal for them as providers try to avoid prescribing a drug listed as requiring PA.

• **Co-pay Information.** There also are cost implications for patients because copay information usually is not available in the formulary data, even though the current NCPDP F&B standard can accommodate it. Why? Most payers do not provide it because of the complexity in calculating copays, including days' supply and deductibles. Copays also are difficult to calculate precisely without knowing when and where the prescription will be dispensed.

A "shiny new thing" emerges: RTBI. Given the challenges with the existing formulary validation process, the industry is looking toward a new standard to address the issues. RTBI is the latest "shiny new thing" to grab people's attention. Its value lies in its ability to provide almost real-time, patient-specific formulary and benefits information at the point of care, including patient-specific utilization management programs (such as PA and step therapy), true out-of-pocket costs for a medication (specific copay/coinsurance amount and deductible information), and which pharmacy will be most cost effective in light of the patient's insurance coverage and available pharmacy benefit. On one hand, this should result in a cleaner prescription before it hits the pharmacy, which would increase efficiency. On the other, there are concerns that using it would add too much time to the ePrescribing work flow, which would serve as a barrier to adoption.

So, is RTBI really a better mousetrap? Eventually, perhaps. For one thing, RTBI was originally designed to be a secondary check of the current F&B transaction, not a substitute. It also is used in a different place in the ePrescribing process and work flow. While it adds value, it is not a replacement.

Pilots are under way. Several RTBI pilots are currently under way, each using different standards. Some pilots are using the NCPDP claims standard (NCPDP SCRIPT), which pharmacy benefit managers (PBMs) and payers have not yet integrated at the appropriate point in their claims adjudication process. Others are using the NCPDP telecommunications standard, which will require significant development and cost for integration into EHRs. Especially for the EHRs, it's not a question of standards so much as of prioritization of development, which is generally simplified to what the government is requiring or what business model is being used. Both PBMs and EHRs have expenses and a lot on their plates, so fitting in new ways of communicating formulary information must be prioritized and placed in the development queue. Frankly, it's not a priority for either PBMs or EHRs because there is no prescriber demand for it. Yet.

What about eBenefit verification? Adding to the confusion, people may think that electronic benefit (eBenefit) verification is the same as formulary verification. It's not. eBenefit verification is used in the rarified world of specialty pharmacy by "hubs," which were created to make it easier for patients to acquire biologics and other types of life-saving or enhancing, but sometimes expensive, specialty medications. Hubs use eBenefit verification to determine how much a payer will cover for a particular drug and then seek additional funding for the balance. It's an entirely different transaction in an entirely different world based on an entirely different set of standards.

Going forward. So, where do we go from here? Is there a real need for RTBI? Should we just make better use of the current F&B standard? Both? We have some thoughts.

• We think the answer is both. The current F&B standard can and should be improved. We hope the industry will continue work on both in 2016, but development of RTBI should proceed.

• While RTBI is attractive, we do not anticipate it being truly ready for prime time in the marketplace before 2020. More developmental work, pilots and testing are needed, and the driver – be it business model or regulation – needs to be identified and put into place.

• Pilots yield valuable information and feedback. We hope the pilot phase is not skipped or truncated to prematurely rush standards into the market.

• PBMs and EHR developers need to keep their eye on what's happening with RTBI. The push-pull of the marketplace could create demand for which they may be unprepared.

• Potential sponsors should be wary of vendors promoting one-off products based on their proprietary implementation of RTBI. Getting behind such products could end up for naught. Standards need to be finalized and diffused into the market. Embracing an early proprietary solution could be counterproductive and expensive. Remember Betamax?

We believe the confusion involving the mechanics and usage of RTBI will sort itself out. As a leader in eMedication management, Point-of-Care Partners is closely monitoring how all of this is developing and where it is going. Let us keep you updated.

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3 Part 3: Retail Medical Clinics: Untapped Resources for Patient Education

By Trey Riley

Retail medical clinics are on the rise, offering millions of Americans ambulatory and preventive care at their convenience and traditionally at a lower cost than regular doctor visits. Patients—primarily young adults and the elderly—are going to retail clinics more than 10 million times a year at 1,900-plus locations, including big box stores, pharmacy chains and grocery stores, according to a 2015 report. Moreover, more than half of these patients lack a primary care provider.

This offers pharmaceutical manufacturers an unprecedented opportunity to provide disease screening tools and educational materials to millions of patients, who are then likely to get their prescriptions filled at the same site. How can pharmaceutical manufacturers help develop relationships with these patients? Would they be more accepting of direct-to-consumer advertising in their requests for specific brands?

Retail medical clinics burst on the scene about a decade ago—and are still growing. By 2015 there were 1,900 retail clinics in the United States, which should reach 3,000 in 2016. They are attractive for several reasons:

- **Convenience.** The clinics are open nights and weekends, when physician offices are closed, and they have shorter wait times. The accessibility of retail clinics also plays into the rising impact of consumer demand on health care, including the so-called "convenience revolution" for treating simple, acute medical problems and some non-acute preventative treatments such as vaccinations.

- **Location.** Retail clinics are located where patients regularly shop and get their prescriptions filled. For the retailer, this tends to keep the prescription business in house for an episode of care.

- **Legitimacy.** The trend toward branding these clinics with a well-known health plan—such as collaborations with Michigan-based Henry Ford health system and Kaiser-Permanente--adds to their legitimacy as a treatment facility. One expert noted that such relationships are having a dramatic impact on the role of retail clinics, which are shifting away from episodic care and promoting chronic disease management and the sharing of electronic health records.

- **Insurance coverage.** Retail clinics typically take many kinds of insurance, including Medicare and Medicaid. Commercial payers also enjoy the lower cost these clinics provide for patient services.

- **Lower costs to patients.** Although there has not been much research on the topic, anecdotal evidence suggests that a routine retail medical clinic visit costs about $110 for commercially insured patients, compared with $166 at the physician's office. Many retail clinics additionally have competitive and transparent pricing. The cost factor is very important to the "young invincibles," who still lack insurance coverage despite the requirements of the Affordable Care Act and those senior citizens on a fixed budget and facing the Medicare "doughnut hole". Costs of visits also are critical to the millions of Americans with high deductible health plans, which are becoming the norm for workers with employer-based coverage and those who buy insurance through the federal and state exchanges.

- **Lower costs to retailers.** Retail clinics can leverage information technology and care guidelines, which makes it easier and more cost effective to provide ambulatory and preventive care with a nurse practitioner or physician assistant. In addition, their space in the store already is a sunk cost.

- **Filling a void.** Retail clinics are attempting to exploit a niche in affordable care delivery, since traditional health systems focus on the more lucrative conditions and forms of care delivery. In fact, RAND researchers found that the consumers who use retail walk-in clinics are less likely to go back to their family doctor. And the clinics are making it easy, offering tools—such as personal dashboards—to help patients manage their conditions, screenings and prescription refills.

That is why retail medical clinics are here to stay and why they are an untapped resource for brands to consider a platform for engaging this growing segment of potential patients. For example, RAND researchers point out that retail clinics could play an even bigger role in vaccination delivery if they reviewed patients' vaccination histories and counseled them about the benefits. A natural extension of this process is to provide related educational materials. The same goes for treating various ambulatory issues typically seen at retail clinics, such as rashes, bronchitis, ear infections and urinary tract infections. This path will be paved for chronic conditions as well, as patients migrate to retail clinics for their primary care needs.

Taking it a step further, the store's information technology system can be leveraged to find out about a patient's other conditions and co-morbidities. If an elderly patient comes in for a flu shot, a quick check of the store's medical record could reveal the presence of diabetes or chronic obstructive pulmonary disease or potentially the failure to refill a prescription. This opens the door for the patient to receive related educational materials and perhaps provide the impetus to fill another prescription.

Not only do the retail clinics reach millions of patients, manufacturers' materials already have been prepared. Providing them should be reasonably uncomplicated. It should be as simple as working with the stores' headquarters to get the materials entered into the computer system. Manufacturers also could provide retail clinics with information and resources to promote disease screening or targeted distribution of brochures to stores with a high volume of senior citizens, who prefer paper with big print.

All in all, the rising number of retail medical clinics will subsequently capture patient visits in EHRs and offer new outlets for pharmaceutical manufacturers to support prospective patients. Let Point-of-Care Partners help you tap into this opportunity.

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