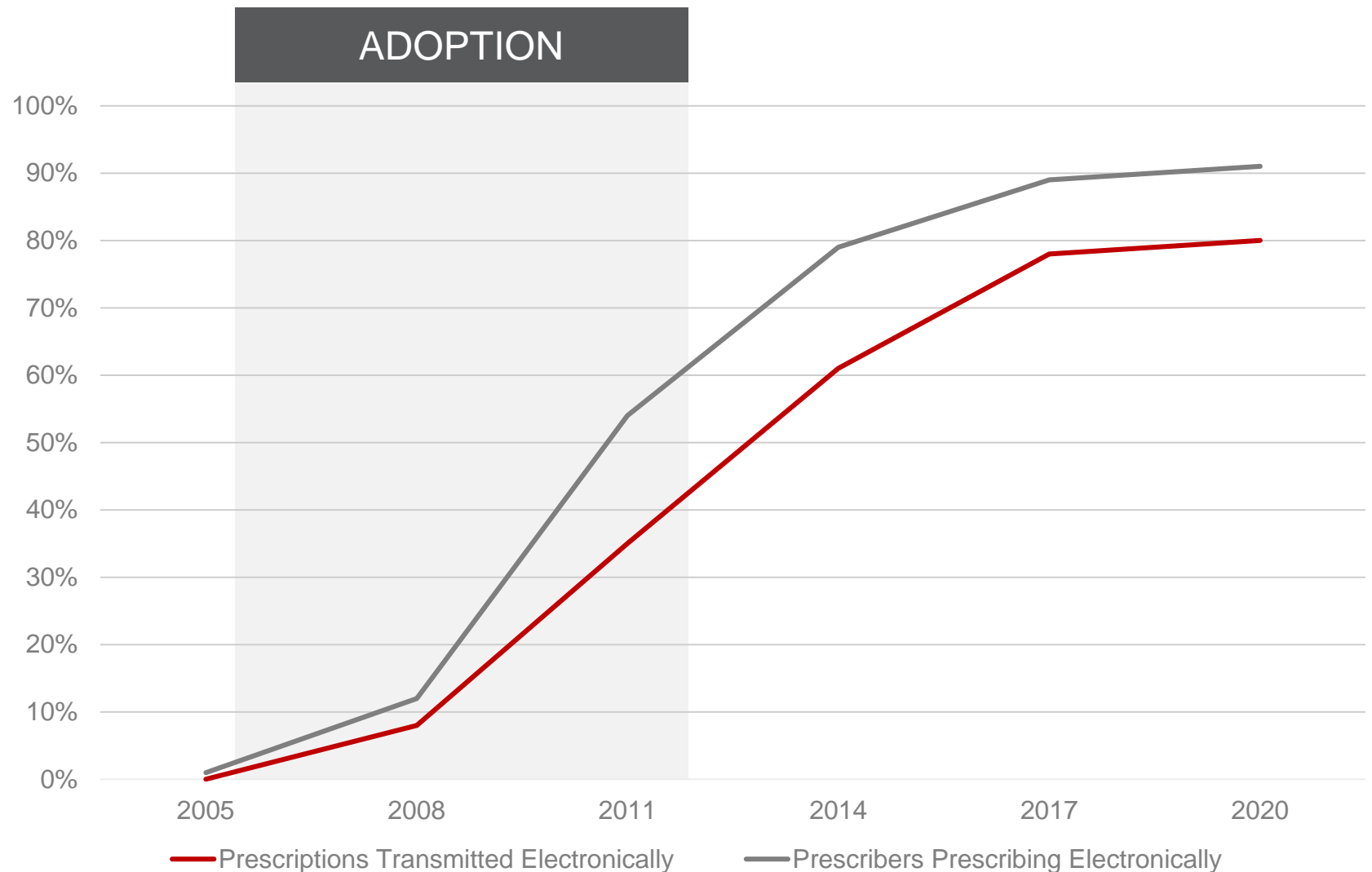# The Evolution of Electronic Prescribing: Closing the Gaps To Promote Quality of Care

Tony Schueth
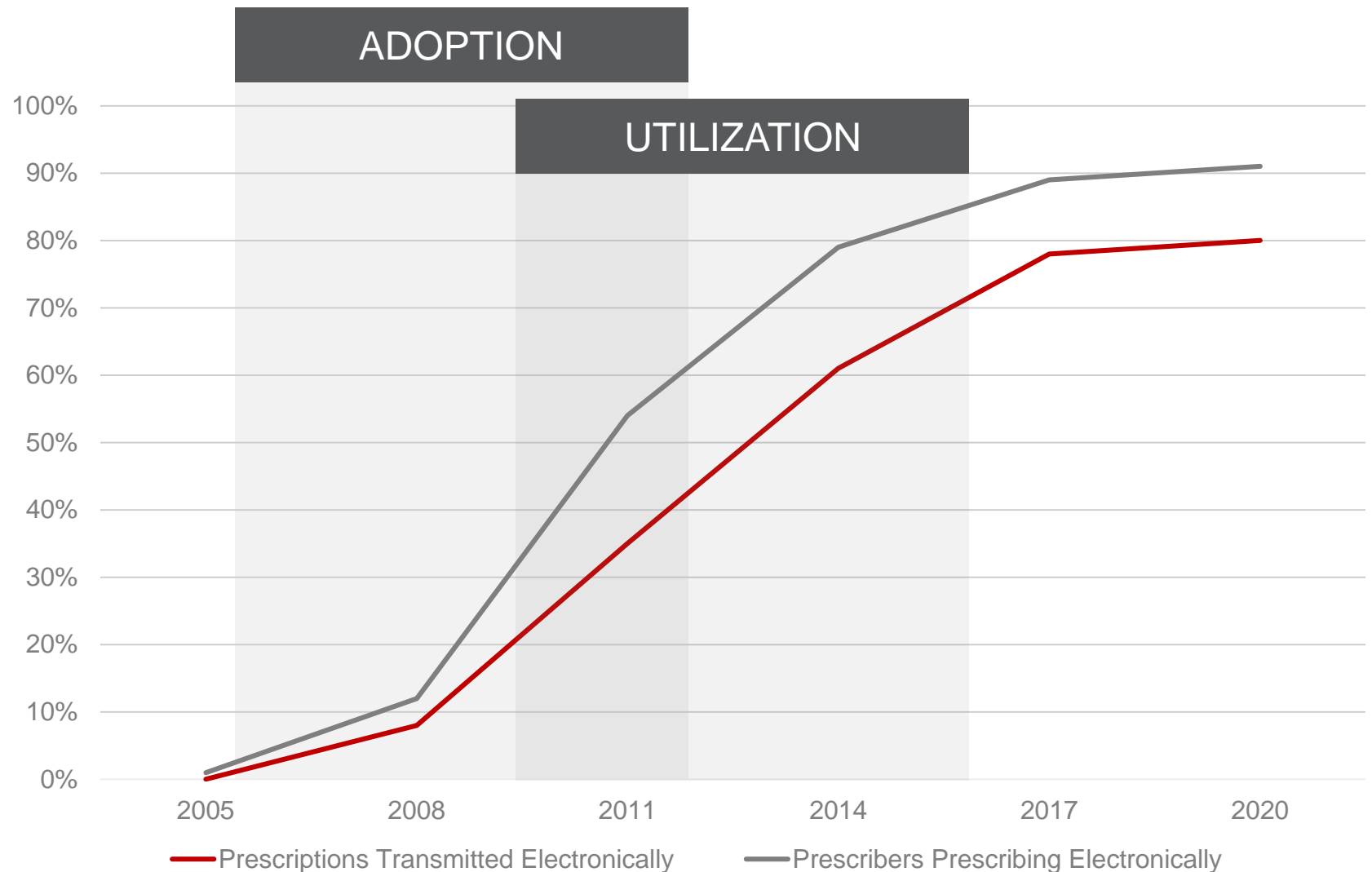*Chief Executive Officer & Managing Partner*

The Evolution of ePrescribing
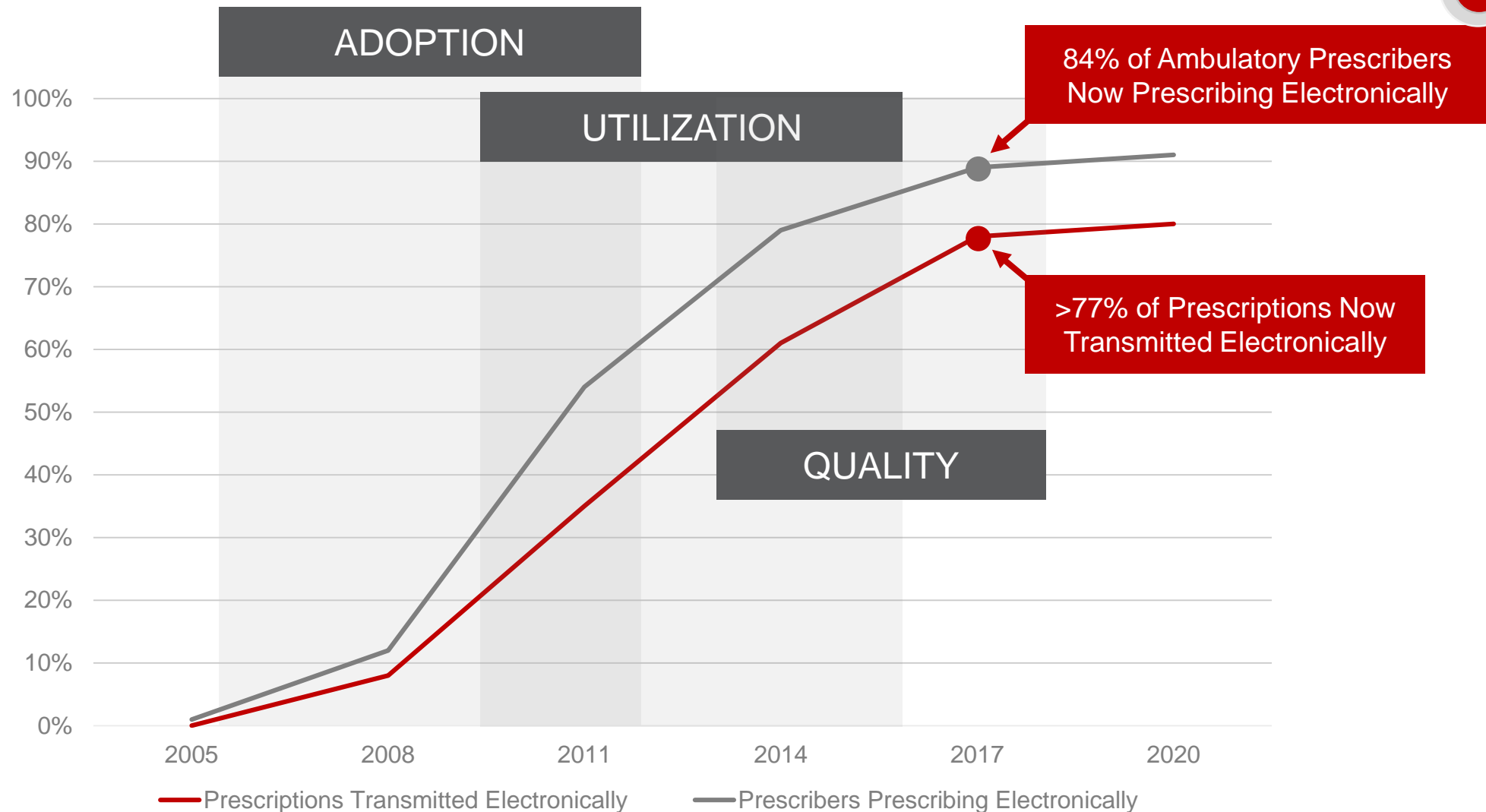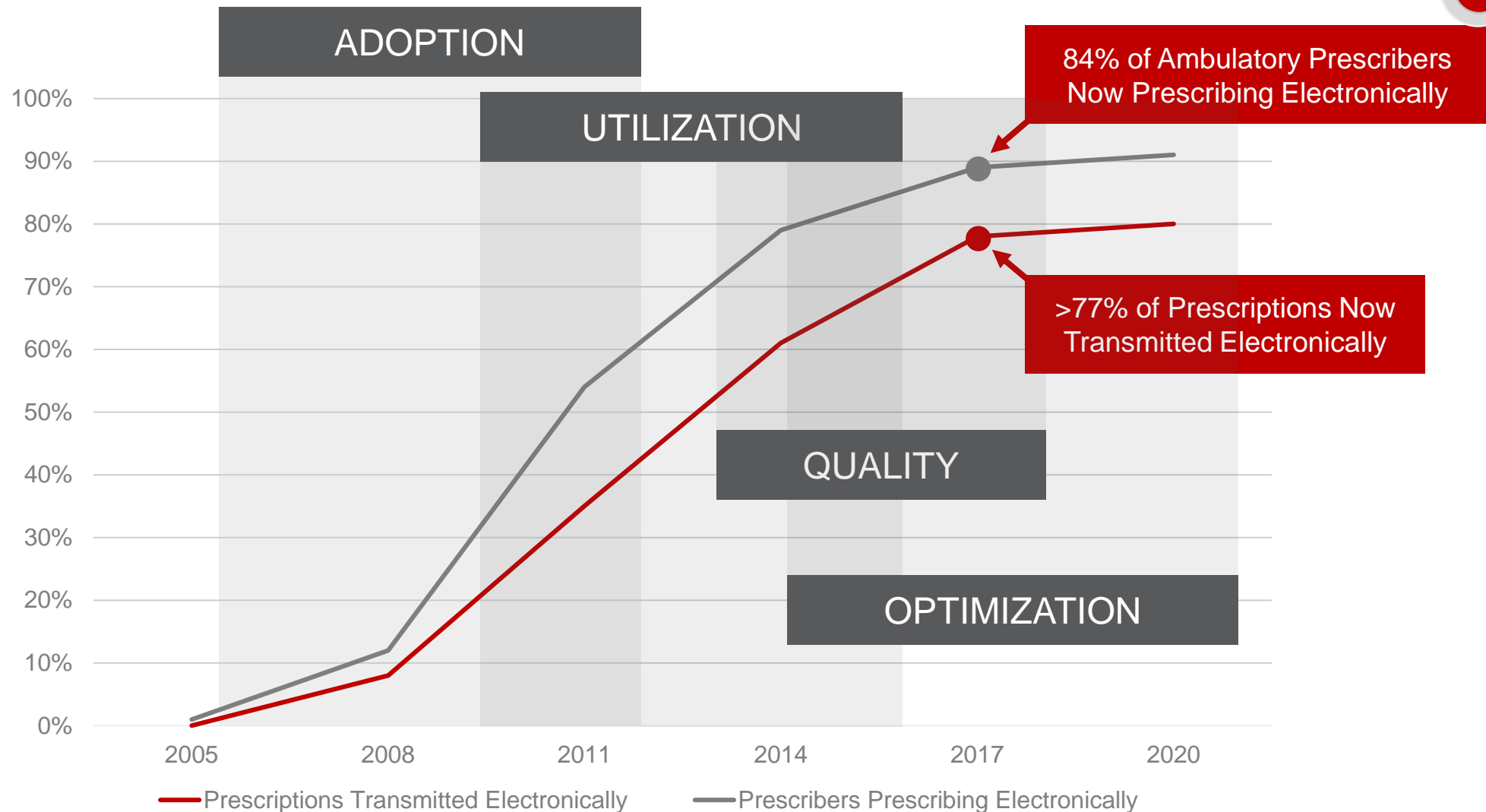

ADOPTION

Prescriptions Transmitted Electronically — Prescribers Prescribing Electronically

The Evolution of ePrescribing

ADOPTION

UTILIZATION

Legend: Prescriptions Transmitted Electronically · Prescribers Prescribing Electronically

The Evolution of ePrescribing

ADOPTION

UTILIZATION

QUALITY

84% of Ambulatory Prescribers Now Prescribing Electronically

>77% of Prescriptions Now Transmitted Electronically

100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%

2005   2008   2011   2014   2017   2020

— Prescriptions Transmitted Electronically   — Prescribers Prescribing Electronically

The Evolution of ePrescribing

ADOPTION

UTILIZATION

QUALITY

OPTIMIZATION

84% of Ambulatory Prescribers Now Prescribing Electronically

>77% of Prescriptions Now Transmitted Electronically

— Prescriptions Transmitted Electronically —— Prescribers Prescribing Electronically

The EHR Market Continues to Expand as Most Physicians Have Integrated the Technology into Their Practices

EHR systems are becoming the digital platforms where doctors practice: >85% of physicians are ePrescribing and >80% of office-based physicians are using EHRs

HCPs spend an average of 3.3 hours per day using EHR systems, twice as long as on all other digital resources combined
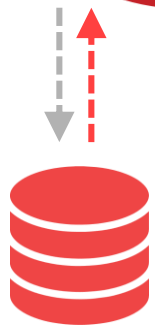
Opportunities exist to integrate utilization management tools within EHRs and ePrescribing workflow for both specialty and non-specialty medications
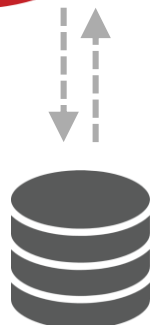
Current ePrescribing Flow

PHYSICIAN PRACTICE
EMR or e-Rx System

Request Eligibility,
Drug History

A1

PBM or PLAN
Claims Processing System Benefit
Plan Rules, Formulary, History

Intermediary

A2

Response

Drug Info
Database

Formulary
Database

Electronic
Transmission (EDI)

PHARMACY
Pharmacy Dispensing System

B

New Rx

Refill Request
Refill Auth/Denial
Change Request

C

ePrescribing Gaps
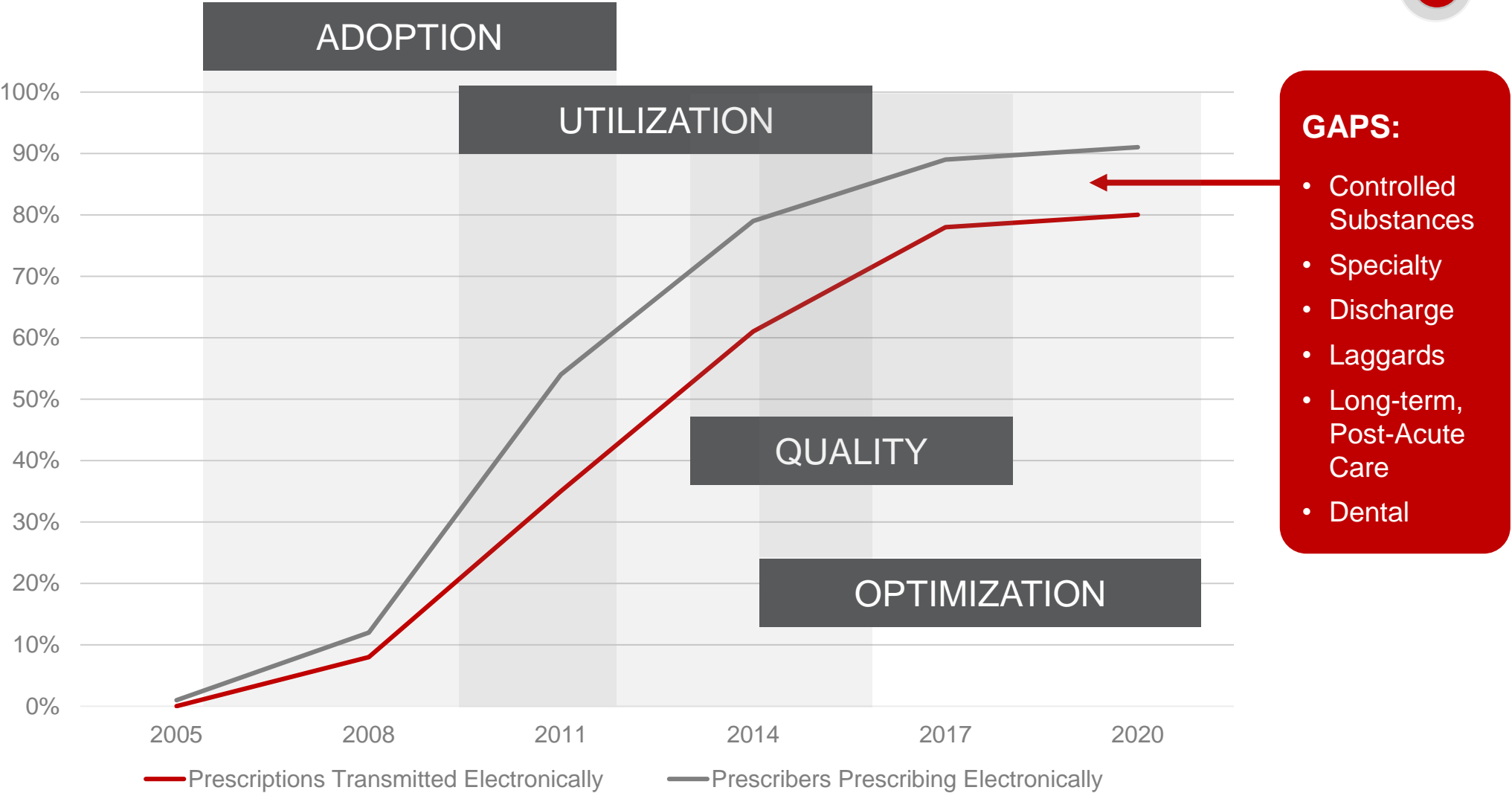
State Regulatory Drivers and Trends

- **Opiate Crisis**
  - States are ramping up on rules governing controlled substance prescribing
  - Includes new limits on prescribing, such as days supply maximums, or limits by prescriber type
  - PDMP programs are issuing new mandates for registration and utilization
  - The New York style mandates are gaining traction
    - Minnesota, New York and Maine
    - 5 other states have active bills in legislature
- **Biosimilars**
  - States are implementing new rules to govern biosimilar substitution

Prescriber PDMP Access Required
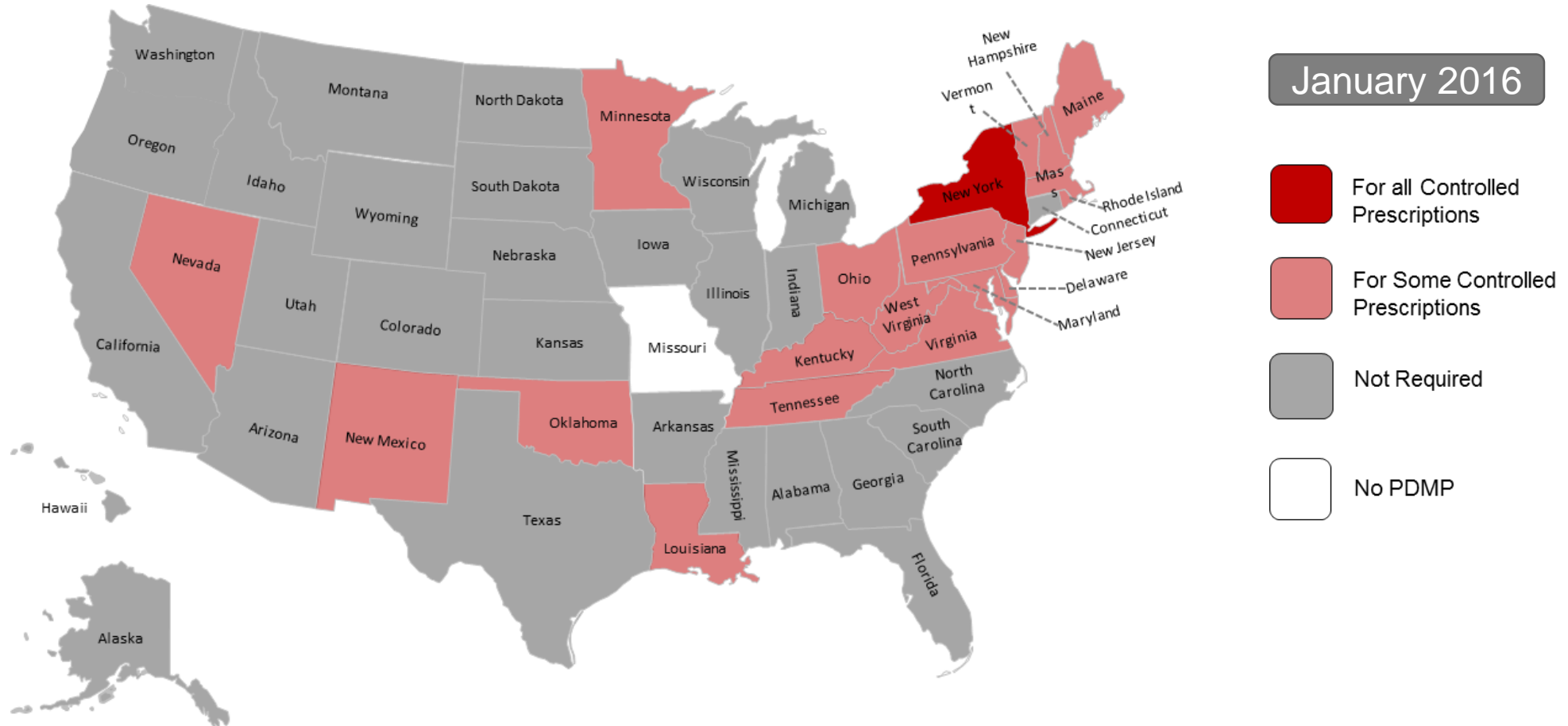

Kentucky is the first state to mandate prescribers to view PDMP before prescribing

Prescriber PDMP Access Required

January 2016

- For all Controlled Prescriptions
- For Some Controlled Prescriptions
- Not Required
- No PDMP

Prescriber PDMP Access Required

April 2017

For all Controlled Prescriptions

For Some Controlled Prescriptions

Not Required

No State PDMP; Local City and Country efforts

Proposed

Point-of-Care Partners | Copyright © 2017

Electronic Formulary Historical Timeline

MMIT offers data to ePrescribing vendors (not authorized by payers)

Medco distributes formulary data through MMIT on direct

3 major PBMS offer formulary dates

Standard format for formulary

Proved standard was acceptable

Data exchange needs to be in this format

Formulary on menu of objectives and available in all EHRs

Alternatives to batch update formulary info begin to appear

1998
First Formulary Data Appears

1999
Merck-Medco Formularies Available

2001
Rx Hub Begins

2005
NCPDP F&B Standard 1.0 Adopted

2006
NCPDP Standard Pilots

2008
RxHub and Surescripts Merge

2009
Federal Regulations Require Use of NCPDP F&B Format (MIPPA)

2010
ARRA Meaningful Use Requirements Include Drug Formulary Checks

2016
RTPBI pilots and standards discussions

Completeness of Information in F&B File

Despite industry focus on Prior Authorization, inclusion of PA indicator and other coverage restriction information in the Formulary and Benefit file dramatically lags behind expectations. A number of reasons exist, both at EHRs and at Payers/PBMs.

EHRs:

- Latency of update process
  - File size

- Lack of confidence in the data

- Flexibility in the standard leads to highly
variable data

Payers:

- Complexity in creating data
  - PA identifiers are not uniform across all patients using the formulary
  - Often lacks all coverage restriction information in the file

- Development priorities
  - NCPDP versions

Inclusion of PA flag is inconsistent across data. A missing flag causes a prescription to be sent to the pharmacy without the required PA

MACRA

The Medicare Access & CHIP Reauthorization Act of 2015 (MACRA) reforms Medicare reimbursement.

- Ends the Sustainable Growth Rate (SGR) formula for determining Medicare payments

- Creates framework for Value Based reimbursement – MACRA Quality Payment Program (QPP)

- Combines multiple quality reporting programs into one new system

- QPP has 2 parts

- Alternative Payment Model (APM)
  - Value Based Reimbursement
  - ACO

- Merit-Based Payment System (MIPS)

MIPS. It's Arrived.

**The Merit-Based Incentive Payment System (MIPS)
is a pay-for-performance incentive program that started in 2017.**

Practices will be graded in four performance areas:

- Quality

- Use of Resources

- Clinical Practice Improvement Areas

- Advancing Care Information

Scores in each area aggregated by CMS to determine a mean score

- Practice which score above the mean are eligible for incentives

- Practices which fall below the mean will face penalties

Incentives and Penalties

Performance Year	Payment Year	Maximum Incentive	Maximum Penalty
2017	2019	4% x Z Plus exceptional performance	- 4%
2018	2020	5% x Z Plus exceptional performance	- 5%
2019	2021	7% x Z Plus exceptional performance	- 7%
2020	2022	9% x Z Plus exceptional performance	- 9%

- Z = Medicare bonus pool, calculated annually to ensure budget neutrality. Capped at 3.

- Bonuses calculated based upon number of points in each performance area. (i.e. not all or nothing)

- For performance year 2020, up to 9% x 3 + 10% "exceptional performance bonus" = 37% bonus

Performance Areas

Quality
50% of Score

The Quality performance measures will be a combination of the existing MU, PQRS and Value Based Modifier, with additional measures addressing clinical care, care coordination Safety, population health and prevention, and patient and Caregiver experience.

Use of Resources
10% of Score

The Use of Resources measure includes some measures now used in the Value Based Modified program. This category will use more than 40 episode-specific measures to account for specialty differences.

Clinical Practice Improvement
15% of Score

Providers must show improvement in various CPI areas including Patient Safety, Population Management, Patient Engagement and Care Coordination

Performance Areas

Advancing Care Information
25% of Score

The 6 areas of focus/reporting include:
- Protection of Patient Health Information
- Patient Electronic Access
- Coordination of Care thru Patient Engagement
- Electronic Prescribing
- Health Information Exchange
- Public Health & Clinical Data Registry Reporting

So… Meaningful Use is dead. But not really.

The MIPS ePrescribing "Gotcha"

MIPS requires use of ePrescribing:

In 2017, providers must write at least one permissible prescription that is queried for a drug formulary and transmitted electronically using certified EHR technology in order to get credit for advancing care information.

Key Dates

2017 — **MIPS Will Begin Measuring Performance**

2019 — **First Year of MIPS Payments, Based on 2017 Performance**

2022 — **Maximum Penalty (-9%) Could Be Imposed**

MIPS Facts

Who is Effected?

Any Eligible Professional (EP) eligible to participate in Medicare Part B:

- Physicians
- Physicians' assistants
- Nurse practitioners

- Clinical nurse specialists
- Nurse anesthetists

Who is Exempt?

- Any provider who qualifies as an Alternative Payment Model (APM) participant, including partial
- Any provider who does not meet the 100 Medicare Patient or less than $10,000 per year Medicare charge threshold

- First year Medicare providers
- Part A Hospitals and Community Health Centers
- Part C Medicare Advantage

Alternative Payment Method (APM)

To quality for the APM exemptions in 2019 and 2020 payment years, providers must have had at least 20% of their Medicare reimbursement provided via an eligible APM entity, such as an ACO. Threshold increases to 50% for 2021 and 2022 payment years.

Exceptional Performance Bonus

Providers who obtain the highest composite scores will receive additional exceptional performance benefits

States Addressing PDMP EHR Workflow Integration

- Mandates are not effective if prescriber access is burdensome

- States are removing barriers to access
  - Allowing data sharing with EHRs
  - Encouraging integration into prescriber workflow

- Mandates are being implemented for PDMP registration as well as access.

29 states require prescribers to view the PDMP when prescribing specified controlled substances

Source: ePrescribing State Law
Review by Point-of-Care Partners

Opportunities for Therapy Driven Messaging and Programs

Therapy Driven Messaging

- Disease and brand awareness
- Formulary messaging
- RX support messaging
  - ☐ Financial
  - ☐ Treatment support
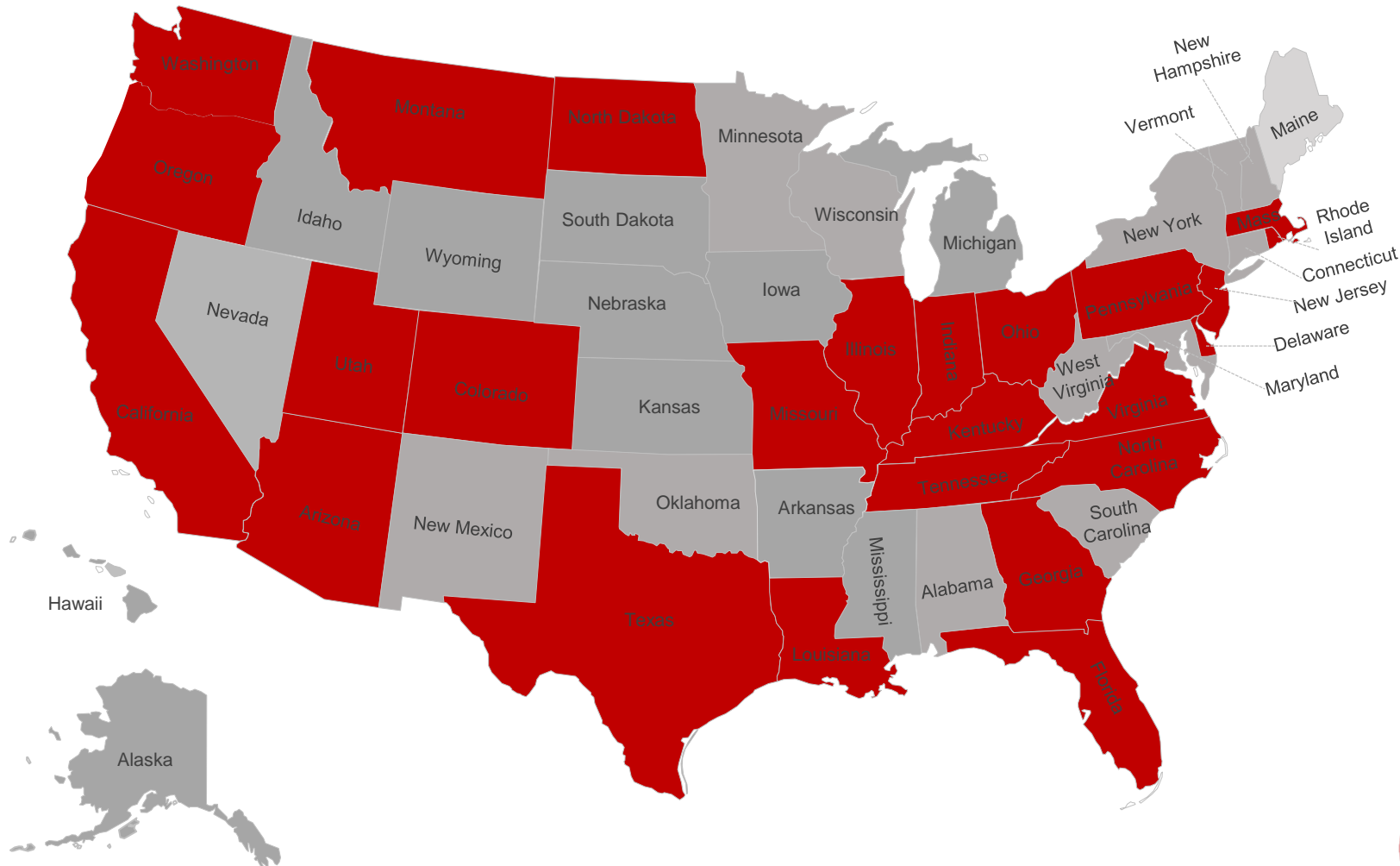
Point-of-Care Solutions

- Clinical decision support
- Disease identification
- Validated screeners and assessments

Real-World Insights

- Patient-level datasets
- Patient treatment journey
- Retrospective data analysis
- Prospective programs
- Integrated real-world evidence

Biosimilar Substitution

- 26 states have rules
- Amended substitution rules to address biosimilars
- Pharmacy must notify physician of product and manufacturer of dispensed drug

Has biosimilar rules

No biosimilar rules
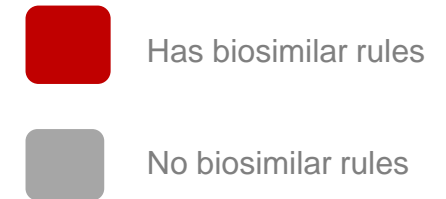
ePrescribing Feature Set Evolution in Emerging Markets

Goal: Improve communication from provider to dispenser

- Increase accuracy & safety

- Consumer or pharmacy driven

- Create method for delivery of medication order

Initial Effort: Build out ePrescribing infrastructure

- Delivery methodology to patient or pharmacy

  - Secure Messaging

  - Standards-based EDI

- Requires country-specific Drug List

Beyond – Value added and supporting workflows

- DUR (Drug Utilization Review)

  - Allergy, Drug Interaction, Generic Substitution

- Storage of prescription data in cloud for fill choice and availability

- Create repositories for audit, fraud, abuse patterns

Initial effort will vary for each country/market. Meet them where they are in the evolution.

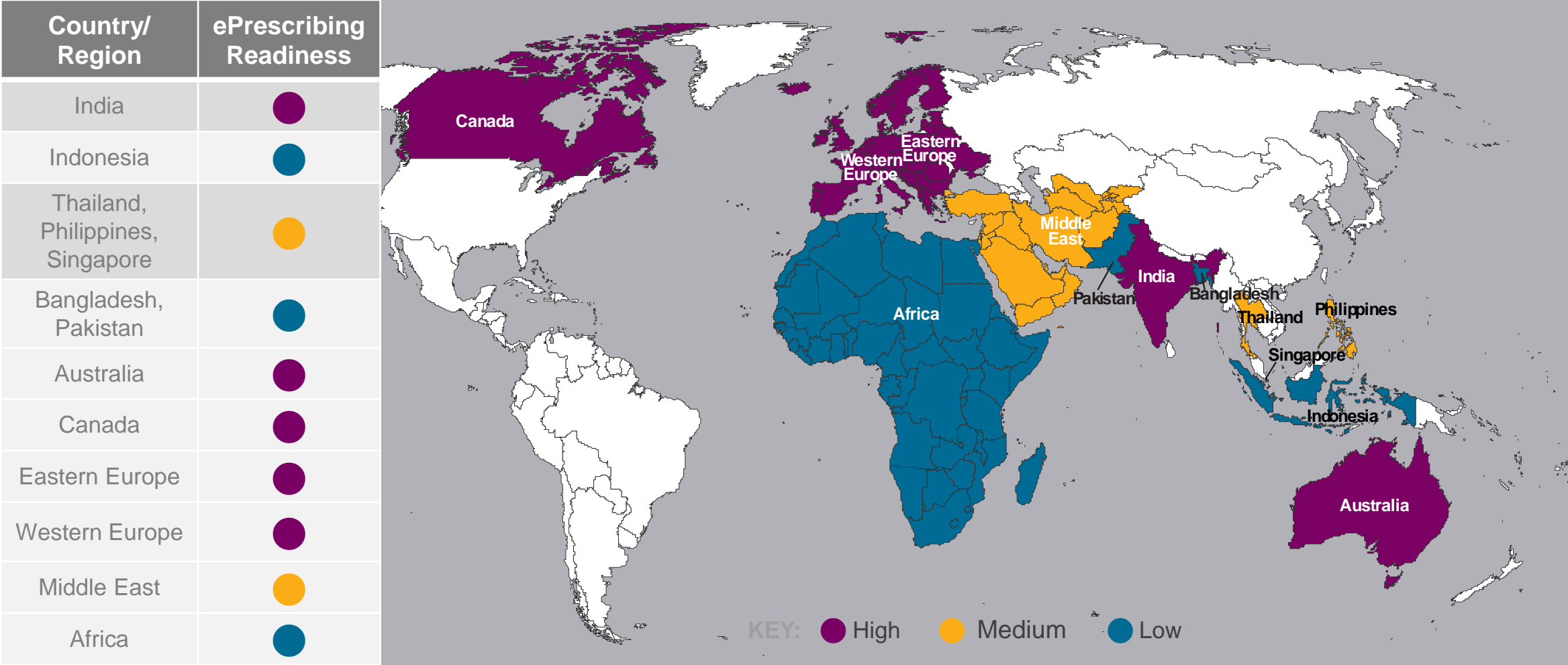# Contrasting of Two Mature Regulated Markets

United States

- Early market driven by national pharmacies and PBMs

- Pharma capital investment in eRX technology enabled low or no cost early adoption

- Federal incentives to spur EHR adoption

- Evolution over time created consolidators moving to central EDI hubs

- CMS mandates (Part D)

- Full industry collaboration with NCPDP
  - Pharmacy
  - Payer/PBM
  - Provider
  - Pharma

Canada

- Early adoption driven from Public/Private partnership

- No central mandate, each region write own regulations

- Low EHR adoption, volume constraints

- No central hub, many versions of "standard" in operation in regions

- Relaunch underway
  - Create federal (lighter-weight) standards
  - Canada Health Infoway to create and become hub and provide incentives and mandates

Maturity for Globe Picture

Country/ Region	ePrescribing Readiness
India	● (High)
Indonesia	● (Low)
Thailand, Philippines, Singapore	● (Medium)
Bangladesh, Pakistan	● (Low)
Australia	● (High)
Canada	● (High)
Eastern Europe	● (High)
Western Europe	● (High)
Middle East	● (Medium)
Africa	● (Low)

KEY: ● High ● Medium ● Low

World with Countries - Outline by FreeVectorMaps.com

Thank you

Tony Schueth

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