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: Why Population Health Management Should Matter to Pharmaceutical Manufacturers

By *Brian Bamberger, Life Sciences Practice Lead*

Population health management increasingly is being viewed as an essential strategy across the health care system. For many pharmaceutical manufacturers, it's a box they've already checked off. They currently interact with specific groups of patients through direct marketing and involvement in clinical trials. Sales are tracked across geographic regions and population groups. So, what else needs to be done? The answer is: plenty.

Why population health?

Population health is one of those "I'll know it when I see it" propositions. There is no standard definition. That said, the evolving health care system is more consumer facing and its success is predicated, in part, on improved management of the health of patient populations. Every stakeholder group is involved.

The federal government and private insurers are moving away from volume to value with new care models, such as accountable care organizations and patient-centered medical homes. These models are looking for ways to reduce costs and improve outcomes, as well as improve patient safety and satisfaction. The arrangements take various forms, such as agreements that include terms to reduce or eliminate therapy costs where patients do not achieve clinical outcomes promised. Addressing population health is a payment metric for Medicare and other payers. The shift toward outcomes-based payment requires significant investment in infrastructure and programs to manage the health of patient populations.

Population health also includes the health status and outcomes of the larger communities to which the physician and patient belong. Providers must consider a wide range of factors that influence their patients' health and outcomes, such as the social and physical environments in which their patients live and work. Addressing these factors affects how well physicians meet their savings and quality targets for reimbursement purposes. At the same time, patients are beginning to take charge of their health and wellness, as well as advocating for increased involvement in their own care and care decisions. Patient satisfaction and involvement also are metrics of many value-based care arrangements.

Technology vendors are playing a key role in population health. Electronic health records (EHRs) are being expanded and augmented to meet the new criteria involved with population health, including the ability to analyze patient populations and to capture and share necessary patient data. For physicians, the EHR is their hub for population health initiatives. EHR systems are adding capabilities to address the challenges population health places on practices. EHR efforts are competing with add-on population health software designed to be comprehensive population health systems.

Digital technologies — including wearables, mobiles and various applications — are a growing business, helping to connect payers, providers and patients to better manage health and wellness. They also are key to helping patients access and manage their health data.

How does this impact pharmaceutical manufacturers?

Pharmaceutical companies have taken note of these developments but few have taken them to heart. They should take a closer look for several reasons.

The first is that medications lie at the heart of most population health strategies. In fact, a recent survey found that three-quarters of health care organizations are targeting management of the health of a specific group of patients — those with chronic medical conditions. This is not surprising. Medications are the principal form of therapy to control the vast majority of chronic diseases. According to recent statistics, chronic diseases are responsible for 7 of 10 deaths each year, while treating people with chronic diseases accounts for 86% of our nation's health care costs.

Secondly, as a result of how new payment models work, fresh approaches will be needed to demonstrate clinical and economic values of a particular drug. As a result, pharmaceutical manufacturers must go beyond the traditional yardsticks of the cost and clinical efficacy of the drug itself. Increasingly, patient satisfaction, adherence and hospitalization rates are now part of the equation for physician payment and cost-sharing arrangements under the new value-based models. Pharmaceutical manufacturers must respond to these new metrics and accordingly prove the value of their products. They also must provide relevant data and analytics — efforts that will require more near-term attention and investment.

Third, payers and providers are well down the road to population health implementation. According to a recent KPMG survey, 44% of payers and providers surveyed said they have a population health platform that is being "utilized efficiently and effectively." Another 24% said they will have a population health program in place within the next three years. This means pharmaceutical manufacturers will have to hustle to provide the new kinds of information that payers need or risk losing market share. This is going to be challenging since data requirements can vary across payers and technology platforms.

Finally, pharmaceutical companies also will need to develop new ways to communicate with broader groups of patients and providers, as well as more effectively monitor outcomes. That may be easier said than done. A recent survey found that 88% of patients would be willing or somewhat willing to share personal health data with their doctors; in contrast, only 53% would do so with drug companies. In addition, there is a 30% dropout rate for clinical trials, which experts attribute largely to poor patient engagement and communications. Such barriers must be overcome so that pharmaceutical companies stay competitive while health care transitions to value-based arrangements.

What can pharmaceutical manufacturers do?

Obviously, they will need to reorient their processes and outlooks to be successful in addressing population health. Such efforts can start with identifying at-risk populations and creating intervention tools that improve outcomes. For example, pharmaceutical companies can work with practices to:

1. **Identify patients at risk who would likely benefit from a particular drug.** A fundamental goal of population health management is to bring patients into the system who are either (a) at risk of a chronic disease, (b) untreated for a diagnosed condition or (c) have lapses in care needed to control the disease. Proactive, early interventions help avoid high-cost health care events down the road. Pharmaceutical companies have a lot of data about patients who are more likely to benefit from and adhere to a particular drug. This can improve the reliability and precision of predictive analytics algorithms used to identify patients needing outreach and treatment.
2. **For patients flagged for intervention, provide clinicians with meaningful recommendations and drug information that is specific to a patient's situation.** To be meaningful — and accepted by clinicians as part of their practice — the message must account for comorbidities, active treatment, recent hospitalizations and a patient's past self-management history (e.g., adherence to prescribed regimens). For drugs that require prior authorization (PA), presenting the PA requirements and initiating the process at the point of prescribing using electronic PAs increases the value of this decision support service.
3. **Develop tools for care teams to monitor patients' medication adherence and intervene when needed.** Ensuring patients take their medications as prescribed is essential to achieving health outcome targets in a population health management program. Applications now available in many EHRs and data warehouses to support these programs are designed to improve medication adherence rates. The core electronic prescribing application available in all certified EHRs has led to a greater likelihood of an initial prescription being dispensed to the patient. Decision support applications to detect gaps in care and patient noncompliance with care plans can be extended to detect medication nonadherence. This component of decision support includes algorithms to calculate the medication possession ratio (MPR), detect patients falling below a minimum MPR threshold (suggesting possible adherence problems) and trigger an alert to the patient's care team. The pharmaceutical company can enhance the effectiveness of these applications by providing drug-specific guidance to the care team on possible actions when a patient is found to be having adherence challenges. ●

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2 Part 2: HHS Moves Ahead in Personnel and Health IT

By Tony Schueth, Editor-in-Chief

According to news reports, the change from the Obama to Trump administrations has created a void at the federal level. Hundreds of key positions remain unfilled and many programs are treading water, awaiting direction from the top, an exception being the Department of Health and Human Services (HHS). Here's a quick look at some of the progress that's been made so far concerning health information technology (health IT).

Personnel.

Unlike a lot of other agencies, many of HHS' top jobs are filled — especially those related to health IT. Tom Price, MD, is now the HHS secretary. Seema Varma is in charge of the Centers for Medicare and Medicaid Services (CMS), which plays pivotal roles in adoption of health IT standards and use of health IT. John Fleming, MS, is the deputy assistant secretary for health technology reform, a newly created position. Donald Rucker, MD, now heads the Office of the National Coordinator for Health Information Technology (ONC). Genevieve Morris, formerly a senior director at Audacious Inquiry, has assumed the role of ONC's principal deputy national coordinator for health information technology. Scott Gottlieb, MD, has been confirmed as commissioner of the Food and Drug Administration, which has

some health IT responsibilities, especially when it comes to medical devices.

To be sure, other top jobs are waiting to be filled at HHS. However, the department seems to be ahead of the curve when it comes to the hiring and confirmation process for positions related to health IT.

Programs.

We are beginning to see progress in programs and regulations related to health IT and fighting the opioid crisis.

- **Tweaking health IT requirements and reducing physician burden.**
  This is happening right out of the gate. An example is CMS' Notice of Proposed Rulemaking for the Fiscal Year (FY) 2018 Hospital Inpatient Prospective Payment System (IPPS). CMS proposes increasing operating payment rates by 1.6% for general acute care hospitals that are paid under the IPPS rule, provided they successfully participate in the Hospital Inpatient Quality Reporting Program and engage in meaningful use (MU) of electronic health records (EHR). The proposed rule would eliminate payment adjustments for eligible hospitals that demonstrate that MU compliance is not possible under the ONC's Health IT Certification Program. In addition, CMS also is suggesting more general MU program changes. For 2018, the agency would modify the EHR reporting periods in both Medicare and Medicaid to at least any continuous 90-day period during the calendar year instead of from the full year requirement.
- **Moving forward with health IT standards and policy.**
  The Trump administration is rapidly moving ahead with staffing the new HIT Advisory Committee. Members are to be announced in July. The Committee was created under the 21st Century Cures Act, which sunsets and combines the existing HIT Policy and Standards Advisory Committee. Dr. Thomas Price, HHS Secretary, said as much in his keynote at the recent Health DataPalooza. He told the audience that a burdensome and rigid regulatory environment may mitigate the benefits inherent in health IT and the exchange of health care data. He also emphasized a hands-off approach to health IT oversight. That said, regulations cannot and will not go away entirely. While there may be a reduced number of regulations, HHS may need to piggyback on required rule making —

HHS' Budget in Brief shows a $22 million cut for ONC, which will have $38 million for FY 2018. The funding will be used to focus on two priorities: interoperability and EHR usability.

such as the IPPS — for issuing some of its health IT policy guidance.

- **Health IT is important, but…**

  The Trump Administration has offered several signals that health IT is important. For example, top positions related to health IT appear to have headed HHS' hiring queue. A new, very high-level position — deputy assistant secretary for health technology reform — was created. No time was wasted in getting the HIT Advisory Committee off the ground. That said, the Administration's new budget for fiscal year (FY) 2018 indicates a big budget cut for ONC. HHS' Budget in Brief shows a $22 million cut for ONC, which will be left with $38 million for FY 2018, and a staffing reduction of 26, leaving 162 employees. According to the document, the funding will be used to focus on two priorities: interoperability and EHR usability. It also suggests monies will be available for activities specified under the 21st Century Cures Act, including funding the HIT Advisory Committee; curbing information blocking; prioritizing work on standards coordination, implementation, and testing; and developing pilots to accelerate industry progress towards interoperability. It's possible that the Trump Administration is negotiating; that is, going in low for an opening bid when it comes to the budget, knowing that things will be bargained upward. Many speculate that this budget is dead on arrival and things might change as the budgeting process unfolds—especially in light of the outpouring of support for ONC by such stakeholders as the Healthcare Information and Management Systems Society (HIMSS); the College of Healthcare Information Management Executives (CHIME): the American Health Information Management Association (AHIMA); and the American Medical Informatics Association (AMIA). While it is too soon to tell the impact of next FY's budget on ONC and other health IT activities in HHS, ONC still has a key role to play if things stay as they are.

- **MACRA tweaks are likely.**

  Secretary Price has already asked for suggestions for ways to change physician reimbursement. He is apt to get an earful once physicians actually have to start complying with the EHR use and quality reporting requirements of the Medicare and CHIP Reauthorization Act (MACRA). A Deloitte survey found that half of doctors had never even heard of the new payment law. Once MACRA's aggressive compliance timelines and complicated requirements start to register with the provider community they are likely to demand changes, to which HHS is apt to be responsive. Physician pushback works. We have seen this before with other major changes, such as MU and ICD-10.

- **A new head tweak master is created?**

  John Fleming, MS, is the deputy assistant secretary for health technology reform. It is a newly created position whose duties have not been fleshed out. Recently, Secretary Price asked stakeholders to envision a reorganized HHS and what that may look like. Connecting the dots and reading the tea leaves, will health IT functions be consolidated in this shop? Will Fleming be in charge of administering and tweaking MU, MACRA and other health IT-related policies?

- **The opioid epidemic will continue to drive policy and programmatic initiatives.**

  Sadly, the opioid epidemic is not ending anytime soon. The high-level interest in the topic and its scope will continue to create new policies and programs at HHS. Health IT will be a key part of the solutions that will arise, with increasing emphasis for PDMP interoperability and use of electronic prescribing for controlled substances.

Point-of-Care Partners is following policy and regulatory developments related to health IT. Stay tuned to *HIT Perspectives* and blog posts for updates. ●

3 Part 3: New Maturity Model Will Help Spur Adoption of Electronic Prior Authorization


By Pooja Babbrah and Jocelyn Keegan, Senior Consultants

An increasing number of medications require preapproval — or prior authorization (PA) — from payers before they can be dispensed. This traditionally has been a cumbersome, time-consuming and frustrating manual administrative process for prescribers, pharmacies and payers. It determines the medications that patients ultimately receive, which are often not the drugs that were initially prescribed. The time lags inherent in today's paper-phone-fax processes also can create patient safety and quality of care concerns.

That will be changing rapidly due to 1) the overall computerization of healthcare, including nearly ubiquitous use of electronic health records (EHRs), and 2) a new electronic prior authorization (ePA) transaction that can speed advance approval of medications as well as minimize or eliminate hassles and time lags. To help spur adoption among payers and pharmacy benefit managers (PBMs), which are the decision-makers for PA approval, a new ePA maturity model was developed by Point-of-Care Partners (POCP). The model can help these key stakeholders identify their progress with ePA adoption as well as steps they can take to move forward with ePA to optimize their return on investment (ROI).

Drivers for ePA.

There are a number of drivers that will increase ePA adoption.

- **A standard is in place.** Stakeholders from across the industry – led by POCP's Tony Schueth — developed an electronic prior authorization (ePA) standard using the National Council for Prescription Drug Programs (NCPDP) standard for electronic prescriptions (SCRIPT). The ongoing goal is to incorporate the standard into the electronic health record (EHR) work flows of physicians, pharmacies and payers. A draft standard was piloted in 2011, and the standard became a reality a couple of years later. As the standard has matured over the years, EHRs and payers have become increasingly able to handle ePA transactions.
- **The business case is clear.** There are significant administrative costs associated with manual PA processing, which can be mitigated by computerized processing. According to a recent article in *Health Affairs*, physicians spend the better part of $37 billion annually ($83,000 per doctor) thrashing out PA and formulary issues with payers. According to another estimate, doctors spend 868.4 million hours on PA each year — not counting time devoted by other staff members. ePA reduces the time spent on each PA by all participants. A survey by the American Medical Association indicated that most physicians experience a delay in excess of a week for their PA request to be processed. PA also is a work-flow drag on pharmacies. In contrast, prospective ePA — which allows advance approval of an ePA request — often can be processed

...not all ePA is equal.

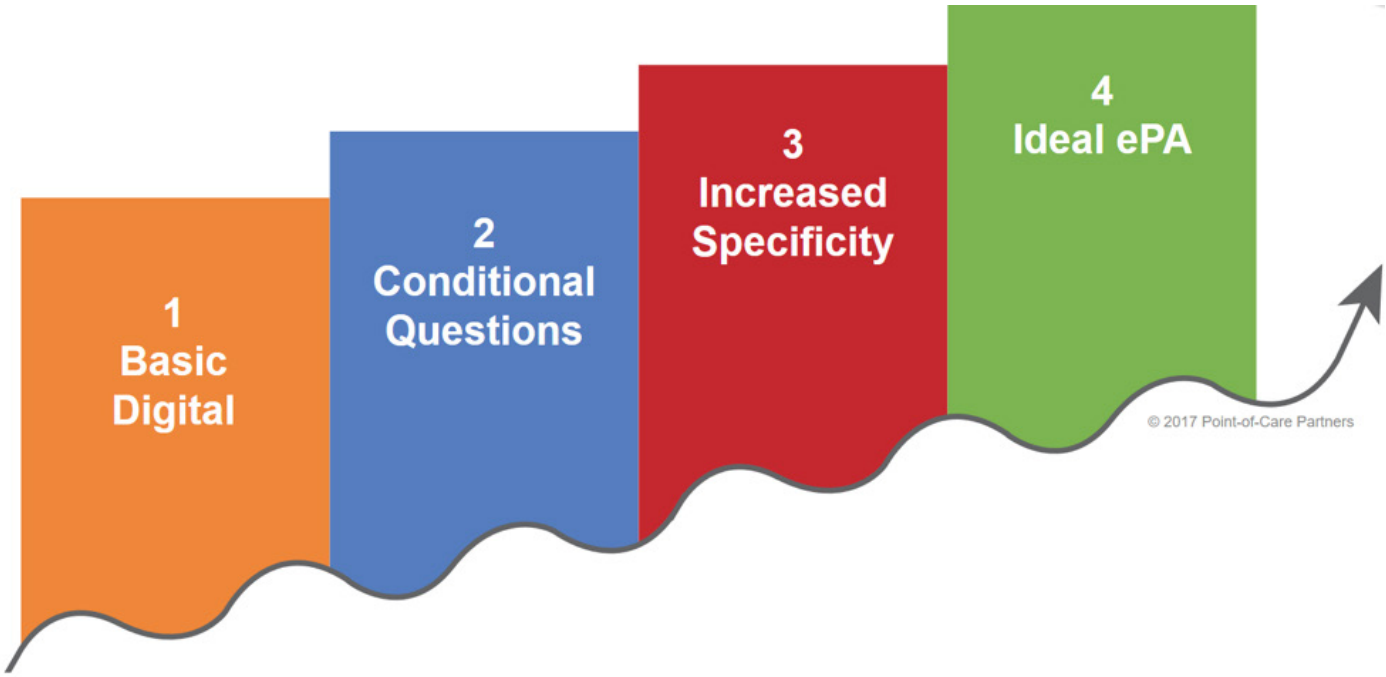
Today, anything "electronic" related to PA may be inaccurately considered ePA.

within minutes when payers are equipped to electronically accept and process PA requests, as well as return real-time responses using the NCPDP standard.

- **Patient safety and quality of care concerns.** The difficulties inherent in trying to obtain a PA significantly affect patient care and safety. Nearly 40% of PA requests (roughly 75 million) annually are abandoned due to complex procedures and policies and the hassle factor. Moreover, nearly 70% of patients encountering paper-based PA requests do not receive the medication originally prescribed.
- **State legislative mandates.** States also are beginning to recognize the benefits of ePA based on the NCPDP standard. Eleven have enacted laws mandating payer support for prescriber-initiated NCPDP-formatted PA transactions. In a newly enacted law, Indiana is going a step further with requirements for ePA transactions initiated by pharmacists. Beginning on January 1, 2018, health plans in the state must accept and respond to NCPDP-formatted ePA requests from a prescriber *or dispensing pharmacist*. Indiana's statute does NOT mandate pharmacist use of this approach or say other methods are possible nor prohibited. Even so, this is another step toward promoting widespread adoption of ePA. States watch each other. Once the ice has been broken with respect to a particular regulatory approach, other states generally follow suit. In addition, an NCPDP workgroup is moving forward with development of a use case for ePA, based on the NCPDP standard, initiated by clinical pharmacists in the postacute care setting. Such activities should also hasten more widespread and complete adoption of prospective ePA.
- **Rise of 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. Most specialty medications require PA. Automating the PA process will have increasing appeal to pharmacies, prescribers and payers alike. They will want to keep ahead of the curve by incorporating ePA for specialty medications into their workflows as well as improve the quality and safety of patient care.

Barriers to ePA adoption.

It is clear that the time is right for stakeholders to invest in prior authorization automation. However, not all ePA is equal. Today, anything "electronic" related to PA may be inaccurately considered ePA. Despite the availability and adoption of the NCPDP ePA standard, the current process



remains largely reactive, with providers and pharmacies chasing failed electronic prescriptions because they need a PA.

There are a number of reasons why PA remains a challenge for payers to move forward with prospective ePA. Each payer has evolved its use of ePA through a myriad of business and technology drivers, lines of business and customer-specific constraints. There are also varying state and local regulatory requirements. States continue to enact requirements for ePA for pharmacy and medical benefits, but the rulings vary by state and often do not mandate use of ePA based on the NCPDP standard. In addition, payers struggle with integrating ePA into internal systems — whether they are installed as software or home-grown utilization management systems. Potential inaccuracies of some data concerning PA in electronic prescribing work flows — such as the need for PA for a particular patient —are often confusing or inconclusive for prescribers. Finally, users continue to grapple with EHR design challenges, which both delay and suppress physicians' adoption of prescriber-driven ePA.

The ePA maturity model.

Based on interviews with PBMs, POCP developed an ePA maturity model. With it, payers and PBMs can understand where they are across four levels of maturity (as shown above) and learn more about proven best practices to improve the ROI on their ePA investment. One payer saw a 28% improvement in automation by reengineering supporting processes.

The model is customizable, incorporates NCPDP standards and is designed so users can identify and address gaps that are preventing PA from moving toward a totally electronic process.

Using the ePA maturity model allows payers and PBMs to:

1. **Create a framework to categorize improvement opportunities.** This provides a tool to visualize opportunities across business or client-selected categories. It also allows PBMs to identify patterns for programmatic investment and opportunities. This, in turn, allows them to acknowledge and understand areas of the business so as to avoid or apply only proven best practices. The framework can help identify lines of business that are ripe for experimentation.
2. **Honestly assess adoption of ePA. Implementation varies among EHRs and providers.** Even though the ultimate goal is full automation of the ePA process, outcomes may be improved at every step of the PA

process. In fact, any incremental improvement to improve true ePA adoption results in real savings and operational efficiency.

3. **Determine where organizational adoption lies on the ePA maturity curve.** The maturity curve has four inflection points ranging from basic digital ePA to use of conditional questions, to use of more specific questions, and finally to ideal and fully automated ePA using the NCPDP standard. This will allow payers to see at a glance where their organization lies in terms of real ePA adoption and where forward progress can be made.
4. **Develop and deliver organization-specific recommendations using proven best practices.** Using data gleaned from steps 1-3, the organization can assess its status and what must be done to move forward. The goal is to move all process and question sets as far up the maturity curve as possible. For example, the ePA maturity model can help PBMs identify potential lines of business that are ready for process improvement, discuss top strategic goals for PA and explore partnerships or pilots.

Importance of the ePA maturity model.

Pharmaceutical companies will want to pay attention to ePA and its growing maturity in the market. For example,

Any delay in therapy adversely affects adherence, patient satisfaction and ultimately patient outcomes.

- 70% of prescriptions rejected at the pharmacy require PA; 40% of those prescriptions are eventually abandoned due to the antiquated and complex, paper-based PA process.
- The PA process impacts more than 185 million prescriptions each year with nearly 75 million abandoned prescriptions.

ePA adoption will significantly affect which drugs are approved and dispensed.

- Electronic prior authorization will empower physicians and patients to discuss appropriate treatment at the point of care, allowing the physician to select the medication best suited for treatment while at the same time considering the patient's cost factors.
- Well-formed, specific, and codified question sets from payers are a critical success factor for ePA adoption. Payers that are further along on the adoption curve will have honed and standardized their PA question sets, which in turn will speed time-to-fill in pharmacies and patient pick-ups of medications.
- Mature organizations will be prepared to handle and create value from the richer patient data sets and coded data criteria from a patient's record to make a more accurate ePA determination. This is essential in the growing move toward value-based care.

Finally, ePA is coming sooner rather than later. The vast majority of PBMs now support ePA for retail drugs. There is movement to begin the automation of specialty pharmacy, where the use of the ePA transaction will be key to reducing costs and turnaround.

Moving forward.

To be sure, there is much more detail surrounding each section of POCP's ePA maturity model. POCP can provide a consistent, outside-in assessment on how to move an organization and its partners forward with investments at the points of highest potential return. Let us know how we can put the ePA maturity model to work for you.

Need to keep up with state laws and regulations concerning ePA and other issues affecting prescribers? Let POCP's Regulatory Resource Center (RRC) do the work for you. The RRC helps clients stay up to date with frequent changes in state and national regulatory requirements through such service offerings as the *ePrescribing State Law Review* and the *ePA State Navigator*. The RRC team members can help you quickly uncover answers to your most pressing regulatory questions. All clients in our premium portfolios receive complimentary access to our regulatory team members who are fully committed to providing the utmost quality in tracking and defining regulatory issues. Find out more from the RRC's director, Connie Sinclair (connie.sinclair@pocp.com). ●