Perspectives and Updates on
Health Care Information Technology

HIT Perspectives

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1 Part 1: 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 — 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

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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. •

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(2) Part 2: New Model Can Help Payers Realize Return on Investment From Electronic Prior Authorization

By *Pooja Babbrah* and *Jocelyn Keegan,* Senior Consultants

Payers increasingly are looking for ways to optimize their processes and return on investment (ROI). Electronic prior authorization (ePA) represents such an opportunity yet despite its promise, the transaction is, unfortunately, underutilized among many payers. A new ePA maturity model developed by Point-of-Care Partners (POCP) can help payers and pharmacy benefit managers (PBMs) identify their progress with ePA adoption as well as steps they can take to move forward with ePA to optimize their ROI.

Why ePA?

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. The reason: PA is based on numerous phone calls and faxes — plus the exchange of lots of paper — among physicians, pharmacies and payers. Recognizing that there has to be a better way, 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 for ePA is pretty 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. According to a survey by the American Medical Association, 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 within minutes when payers are equipped to electronically accept and process PA requests, as well as return real-time responses using the NCPDP standard.

Perhaps most importantly, 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.

Barriers to ePA adoption.

It is clear that investing in prior authorization automation is the right thing to do. However, not all ePA is equal. Today, anything "electronic" related to PA may be inaccurately
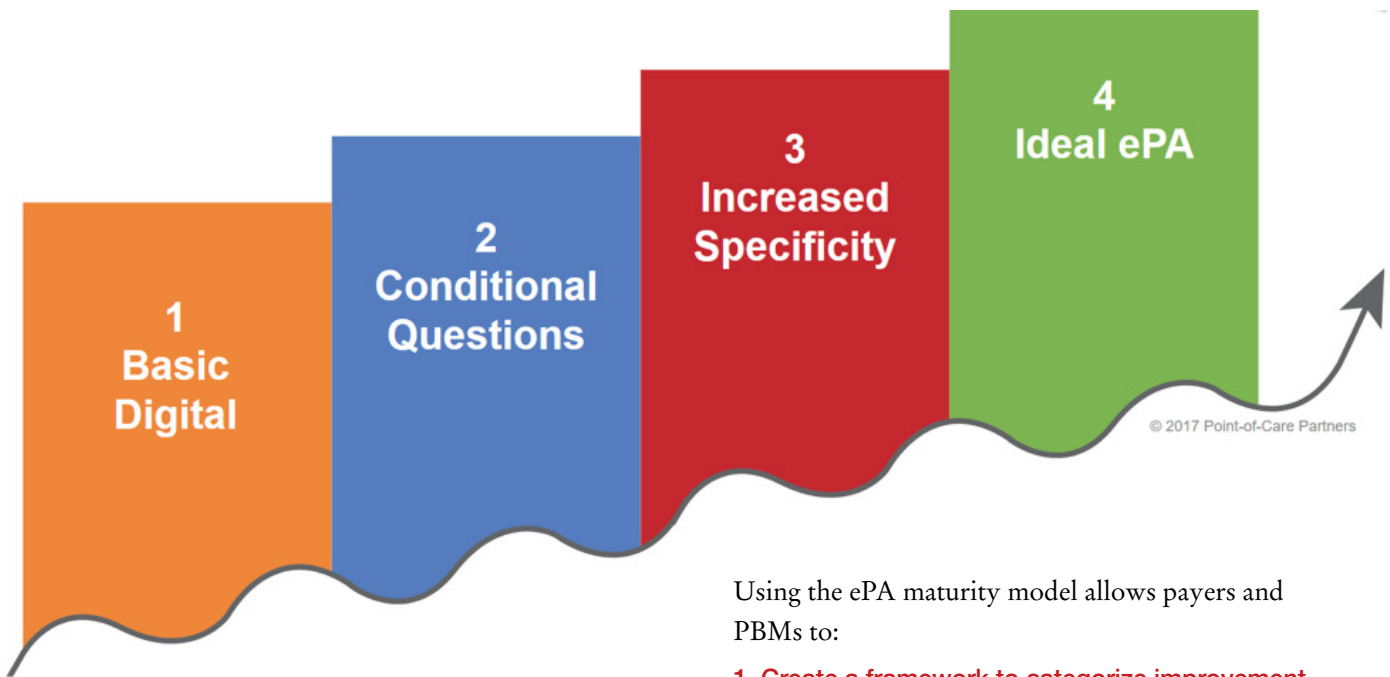
considered ePA. Despite the availability and adoption of the NCPDP ePA standard, the current process remains largely reactive, with providers and pharmacies chasing failed electronic prescriptions because they need a PA.

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

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 below) 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.

1 Basic Digital
2 Conditional Questions
3 Increased Specificity
4 Ideal ePA

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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.

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

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

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.

Benefits of the ePA maturity model. There are many benefits related to use of the ePA maturity model. Its use will empower a payer to focus on critical technical and process improvements that will increase ROI from ePA. For example, it allows payers and PBMS to:

- Reduce administrative costs and turnaround times.
- Develop a programmatic approach to improve ePA across all functions within their organization.
- Create a common model for ePA to share across the organization to support PA improvements.

Mature organizations will be prepared to handle and create value from the richer patient data set and coded data criteria from a patient's record to make a more accurate ePA determination.

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. ●

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③ Part 3:
State Lawmakers Focus on ePA and Opioid Abuse

By **Connie Sinclair,** *Senior Consultant*

Electronic prior authorization (ePA) and the nation's opioid epidemic continue to capture the attention of state legislatures, many of which are considering or enacting laws related to these important topics. Here are some of the latest trends, as compiled by Point-of-Care Partners' Regulatory Resource Center (RRC). 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*.

Electronic prior authorization.

An increasing number of medications require preapproval — or prior authorization (PA) — from payers before they can be dispensed or administered. This traditionally has been a pain point for physicians and pharmacists, who have spent a lot of time in the frustrating exchange of paper, phone calls and faxes with payers only to find out their requests have been denied. This time lag obviously poses potential health and safety threats to patients.

Now that more care processes are becoming automated, the health care industry is beginning to move toward more widespread adoption of prospective ePA based on the standard from the National Council for Prescription Drug Programs (NCPDP). For additional information, see the article in this issue of *HIT Perspectives*.

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-

63% of drug overdose deaths in 2015 involved opioids.

That's more than 33,000 people a year or 91 opioid overdose deaths per day.

formatted PA transactions. In a newly enacted law, Indiana is going a step further with requirements for ePA transactions initiated by pharmacists. Beginning 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 develop-

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ment 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. Stay tuned.

Opioid abuse.

Measures aimed at stemming the tide of opioid-related deaths top the list of laws being passed or considered. This is not surprising. These powerful and highly addictive drugs are the leading cause of the drug overdose epidemic sweeping across communities nationwide. According to the Centers for Disease Control and Prevention, 63% of drug overdose deaths in 2015 involved opioids. That's more than 33,000 people a year or 91 opioid overdose deaths per day.

Recent legislative efforts related to the prescribing of opioids fall into several categories. They include:

- **Electronic prescribing of controlled substances.** Several states — including Maine and Virginia — have joined New York to require electronic prescribing of all substances. Several other states have recently introduced similar legislation. However, specifics of the proposed mandates vary by state and will likely be amended as they are debated. Typically, there are long lead times for effective dates. Although various states will implement legislation related to opioid abuse over the next few years, there is no standard approach. Some laws will affect all controlled substances, some will deal with certain drug classes, while others will address specific drugs or drug schedules from the Drug Enforcement Administration.

- **Prescription limitations.** Several states have passed laws or regulations that place limits on prescription quantities for opioids. Not surprisingly, there are variations in terms of requirements. For example, prescription quantities are often set as a maximum number of days' supply for the initial prescription. There can be different terms for subsequent orders, and these limits likely vary by diagnosis or circumstances and even by state. Increasingly, limits must be expressed in morphine milligram equivalents, which is something most electronic health record (EHR) vendors will need to build into their work flow. Ohio recently added some data requirements. That state's board

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of pharmacy is requiring providers to place an ICD-10 or procedure code on all opioid prescriptions. This will help pharmacists better identify potential problems with a prescribed medication therapy and potential abuse. Such requirements have been suggested for years by policymakers, but Ohio is among the first states to mandate them.

- **Consultation of state prescription drug monitoring databases.** All states except Missouri have a prescription drug monitoring program (PDMP). PDMPs are independent, state-run databases of controlled substance prescriptions. Many states require prescribers to view a patient's PDMP profile when prescribing. A few states are also specifically defining PDMP integration with EHRs to legally clear the way for data sharing among these implementations. Many leading EHR vendors are implementing PDMP access within their prescribing work flow.

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