Perspectives and Updates on
Health Care Information Technology

HIT Perspectives Biopharma Insights

1 **Part 1:** Surescripts Issues 2014 National Progress Report

2 **Part 2:** Real-Time Benefit Check: Coming to the Point of Care

3 **Part 3:** Efforts Under Way to Make REMS More Efficient and Less Burdensome

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.

Contact information

Brian Bamberger
Practice Lead, Life Sciences
brian.bamberger@pocp.com
info@pocp.com

June 2015

POINT-OF-CARE PARTNERS
Health IT Management Consultants

1 Part 1: Surescripts Issues 2014 National Progress Report

By Tony Schueth, Editor-in-Chief

Surescripts just released its 2014 National Progress Report, which always shines a national spotlight on electronic prescribing (ePrescribing).

The theme this year could be "ambulatory ePrescribing: game over, what's next." It celebrates the industry's success with ePrescribing, paints a picture of what's still to be done and begins to make the case for how successful ePrescribing can translate to other areas of health information technology (healthIT).

Interestingly, the title doesn't even mention "ePrescribing," which also is not called out as a specific section this year. The contents fall into three categories: company highlights, brief summaries of the status of a handful of transactions, and an appendix that contains a summary chart for selected transactions and a chart for rankings by state of their percentage of ePrescribing of controlled substances (EPCS). The format is a slick chart book with a marketing brochure feel, replete with graphics and brief rundowns of selected accomplishments.

Selected Transactions. The report's real meat lies in write-ups about three specific transactions.

•**Medication history.** The section on medication history is an example of the report's change in focus. The narrative suggests a benefit of ePrescribing lies in making available access to real-time prescription data at the point of care — especially for hospitals' use in medication reconciliation. The savings to hospitals from medication reconciliation are estimated for a range of facilities, such as $11,704 for a small (100-bed) hospital to $1.1 million for a very large (1,000+ bed) facility. Such figures are guaranteed to get hospitals' attention, especially the bigger ones with deeper pockets. It is not clear how the estimates were derived as many factors must be taken into account to conduct such an analysis. For example, pharmacy claims data are more robust than medical claims data, but it's unclear how many pharmacies contributed to the analysis.

In terms of transaction volume, Surescripts concentrated on the hospital side of the equation. The chart in the appendix indicated that the number of hospitals conducting medication history transactions more than doubled in 2014. However, hospital volume accounted for approximately 11% of the 764 million total medication history transactions.

The report also does not discuss improving prescription quality by addressing problems associated with medication history, including data accuracy and availability. The first step toward optimizing ePrescribing's value for medication reconciliation is an analysis of how to overcome such data and process deficiencies. Then, the brains behind healthIT can figure out ways to better conduct electronic medication reconciliation and tackle transitions of care.

•**Electronic prior authorization.** Surescripts also sets the stage for electronic prior authorization (ePA) of medications as a value-add. The write-up briefly discusses some of the problems with manual PA and offers estimates of ePA savings: 4 hours per pharmacist per week or $11,000 per pharmacist per year; 5 to 8 hours per physician each week, translating to $14,000 per physician per year.

Regardless of how they are computed, those savings can make such an ePA product attractive to big chains and large group practices. Everyone needs to wring out efficiencies from the overhead, so the report shines a light on this often overlooked opportunity to save money. The patient safety aspect of ePA was mentioned in passing, with ePA cited as a means to minimize abandoned prescriptions resulting from the hassles associated with the manual PA process.

•**Electronic Prescribing for Controlled Substances (EPCS).** New this year is a report out on EPCS, which is a good news-bad news story. The good news is that EPCS is now legal in all states and the District of Columbia (Missouri very recently adopted rules in support of EPCS that will become effective in July). Transaction volume rose 400% in 2014 to 1.6 million controlled substance ePrescriptions routed through the Surecripts network. The bad news is that only roughly three-quarters of pharmacies can receive EPCS (although that number increased since

2013) and only 1.4% of providers were enabled. Interestingly, Surescripts just announced at the 2015 HealthDataPalooza (May 31 – June 3) that 3% of providers are now enabled to send electronic prescriptions for controlled substances. While this is still only 3%, we're encouraged — and not surprised — to see this start to take off due to mandatory use of such programs as with New York's I-STOP, which requires that all prescriptions be sent electronically starting in March 2016. We think the future for EPCS is bright as physicians will have to prescribe controlled substances electronically if they are to meet the higher ePrescribing thresholds that will be required for MU stage 3 (the current proposal is 80%). EPCS also will be key for providers in certain specialties, such as oncology, which have many patients using controlled substances. By the way, Point-of-Care Partners offers several regulatory updates on a subscription basis to help you keep current with the ever-changing landscape of state laws and regulations for ePrescribing, including EPCS. Visit our website for a demonstration and more information.

Transaction data. The appendix is divided into two sets of summary charts, one of which provides data for selected transactions. This is the only place to find data regarding traditional ambulatory ePrescribing per se. Surescripts routed 1.2 billion ePrescriptions in 2014 and more than two-thirds were new prescriptions.

This chart also contains a confusing statistic about percentage of ePrescribers. Surescripts claims the percentage inched upward to 56% in 2014 from 55% the previous year. According to our copy of last year's report, roughly three-quarters of ambulatory providers were ePrescribing in 2013. We suspect the discrepancy is likely due to the inclusion of all prescribers — acute and ambulatory — this year, but "chart book" format has precious little explanation, unlike in past years. To those of us who pay attention, it makes it appear as though we have gone significantly backward when, in fact, progress continues to be made. Moreover, we understand from sources outside the report that nearly 80% of ambulatory providers are ePrescribing.

State rankings based on EPCS. The second summary chart in the appendix shows state rankings on the basis of EPCS — the percentage of prescribers enabled to conduct EPCS, the percentage of pharmacies enabled to receive EPCS and the percentage of EPCS prescriptions. This stands in contrast to last year, when the rankings recognized utilization of ePrescribing based on volume of use of Surescripts' prescription benefit, medication history and prescription routing services.

The top 10 states using EPCS include many of those adopting ePrescribing early, such as Delaware, Massachusetts and Rhode Island. However, Nebraska was in the middle of the pack on traditional ePrescribing but topped the EPCS list this year (we understand largely because of a large integrated delivery network), followed by California (which, ironically, has been near the bottom of the traditional ePrescribing state rankings). Both have nearly 9% of prescribers and more than 70% of pharmacies enabled. Nebraska has 6.9% EPCS transaction volume, with California a distant second at 4.3%. New York ranks 21st, with 1.9% of prescribers and 70.3% of pharmacies enabled, but less than 1% of EPCS transactions. Obviously, New York has a long way to go in the way of EPCS if providers are going to meet I-STOP's March 2016 go-live date. Surescripts has done a huge service by shining a light on the embryonic state of EPCS, which will be useful to vendors and policy makers going forward.

What's missing. It strikes us that several pieces are missing or not specifically called out. They include:

Formulary and benefit. Precious little about the critically important aggregate flat file that Surescripts distributes using the NCPDP Formulary and Benefit (F&B) standard is found in this year's report despite concerns from prescribers about the accuracy of formulary data. We understand it may be hard to measure, but have heard anecdotally that the file is bigger and better. One deficient area that could be tracked is the PA flag.

There is also nothing about the real-time benefit check (RTBC), which promises to add accuracy and clarity to the group-level F&B paradigm. Both have implications for curbing costs and, arguably, improving health care by increasing formulary compliance and medication adherence.. (Read more in this issue of BioPharma Insights.)

Specialty pharmacy. Specialty prescribing also is not covered, but that is not surprising because these prescriptions are low in volume in the overall scheme of things and the prescription process is not yet automated enough to merit a mention in Surescripts' report. However, that is due to change in the near future because of the importance of specialty medications as high-cost drivers of the nation's drug spend, with specialty medication outlays expected to quadruple to $402 billion by 2020, and the strides being made in the industry to bring specialty prescribing into the electronic age.

Because of skyrocketing costs and use, specialty prescribing is on the radar of payers, patients and policy makers who are looking for a balance between the high costs of specialty medications and their many benefits related to health and quality of life. Moreover, it is ripe for automation. Enter ePrescribing. Standards and ePrescribing infrastructure already are available to handle the basic prescription process. Other necessary pieces, such as ePA, are emerging that will facilitate automation of other specialty prescribing processes. The industry is working to fill in the gaps, which will put specialty ePrescribing on the map in the near future.

2 Part 2: Real-Time Benefit Check: Coming to the Point of Care

By Brian Bamberger, Life Sciences Practice Lead

What is the patient's financial responsibility for a proposed medication? Are any drugs in the same therapeutic class less expensive? These are among the many questions confronting providers and patients when a medication is selected and then electronically prescribed (ePrescribed) at the point of care through the EHR. Some answers to these kinds of questions are currently provided through the formulary and benefit (F&B) check, but the data regarding individual patients are not always complete or accurate. That will be changing over time with the development and adoption of the real-time benefit check at the point of ePrescribing, which will offer significant improvements over what is available today.

The F&B transaction identifies a patient's insurance benefits, which affect how treatment decisions often are made--or delayed. Providers try to select the most appropriate, cost-effective medications for patients. Payers often use formulary tiers and prior authorization (PA) to accomplish those goals. For patients, it's not just about a treatment's efficacy, it's often just as much — if not more — about cost. They want to know how much their insurance will cover and what their copays and deductibles might be. Without this information, they are at risk for being prescribed a medication they cannot afford, leading to abandoned prescriptions or medication noncompliance — situations that result in costly comorbidities, unnecessary office visits and trips to the emergency room. Time frames also are important for getting the proper medication to the appropriate patient at the right time. For patients who are diagnosed with a rare disease or in need of a treatment requiring complex therapy, health outcomes might be affected by the lag time involved in determining whether the medication they need will be approved by their insurer, how much they will have to pay out of pocket and if alternatives are available.

One solution is the real-time benefit verification transaction at the point of ePrescribing. Use of this transaction would replace the downloaded data files that are used today, which have limitations due to latency of the updating process and the quantity and quality of the data. Real-time benefit verification will greatly improve the breadth, accuracy and effectiveness of formulary data available to the prescriber at the point of care. This will address many prescribers' perception that currently available F&B data are neither correct nor complete, which serves as a barrier to use. Moreover, having real-time benefit information in the electronic health record will allow the prescriber to see dollar copay amounts for individual patients at the point of prescribing. This will help with formulary compliance and medication adherence.

Some proposed versions of the transaction give payers the ability to mention specific alternatives to a requested drug. This information was popular in retail pharmacy messaging in the past and used to switch patients to preferred drugs, including generic alternatives. This proposal offers payers the opportunity to message prescribers away from less desirable products to selected products that may be less expensive to the payer and patient. This message will impact pharmaceutical companies by further penalizing high copay options and benefiting formulary compliance of preferred drugs. Whenever an appropriate generic alternative exists, even more savings may be found for the payer and patient. Without transparency about these messages and the decision process, pharmaceutical companies could be in the dark about the positive impact of these messages. As part of the proposed real-time benefit verification, which is currently in development, savings program offers may not be displayed with copay amounts.

Point-of-Care Partners (POCP) is monitoring some early activity by payers to develop pilots. After initially slowing down the process, a few payers are moving forward with pilots to demonstrate its value. Although it may be some time before a standard is approved, the impact will be far reaching once use gains traction.

POCP also is active in the development of — or enhancements to — other ePrescribing standards. We would be happy to explain their impact on prescribing, pharmacies and drug manufacturers.

3 Part 3: Efforts Under Way to Make REMS More Efficient and Less Burdensome

By Brian Bamberger, Health Sciences Practice Lead

The Food and Drug Administration (FDA) requires the use of REMS — risk evaluation and mitigation strategies — to manage the risks of certain drugs or biological products to ensure that their benefits outweigh risks. Look for the nature of REMS programs to start changing due to efforts aimed at increasing REMS' efficiency by making them part of the electronic prescribing (ePrescribing) work flow.

Today, REMS include complex processes for educating patients and physicians about a drug's safety and various criteria prescribers must meet to ensure safe use, such as physician certification in order to prescribe the drug, patient enrollment in a central registry, and restricted distribution of the drug to certain specialty pharmacies. Assessments, reports and audits must be done periodically and provided to the FDA and the drug's manufacturer. Currently, this involves time-consuming, labor-intensive paper/phone/fax-based processes outside the work flow of physicians and pharmacies. REMS processes are similarly burdensome for pharmaceutical manufacturers.

Recognizing the burden and inefficiency of current REMS processes, pharmaceutical manufacturers, the FDA and the pharmacy services industry have banded together in fledgling efforts to streamline REMS processes and bring them into the digital age. Considerable work currently is focused on standardizing and integrating REMS solutions into electronic health records (EHRs) through ePrescribing electronic transaction standards. Most physicians are ePrescribing these days, and EHRs are the ePrescribing vehicle for the vast majority of ePrescribers.

In fact, a REMS transaction standard was discussed at the May meeting of the National Council for Prescription Drug Programs (NCPDP), which develops and maintains a number of standards related to ePrescribing. The proposed standard would enable automated communication through the EHR between the health care provider and REMS administrator (manufacturer or outsourced). Improved communication among the parties involved will reduce administrative overhead and improve the quality of REMS processes.

To assist adoption and transaction approval by NCPDP, we believe a pilot is in order to move the process along. Even small pilots can yield valuable results. Point-of-Care Partners has extensive experience in piloting new ePrescribing transactions. Call us or drop us an email to discuss the possibilities.