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

Tony Schueth
Chief Executive Officer & Managing Partner
The Evolution of ePrescribing

- Prescriptions Transmitted Electronically
- Prescribers Prescribing Electronically
The Evolution of ePrescribing

ADOPTION

UTILIZATION

Prescriptions Transmitted Electronically
Prescribers Prescribing Electronically
The Evolution of ePrescribing

- **ADOPTION**: 84% of Ambulatory Prescribers Now Prescribing Electronically
- **UTILIZATION**: >77% of Prescriptions Now Transmitted Electronically

- **QUALITY**

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The Evolution of ePrescribing

ADOPTION

UTILIZATION

QUALITY

OPTIMIZATION

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>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.

References: CMI Media; Decision Resource Group; GHG
Current ePrescribing Flow

Physician Practice
EMR or e-Rx System

Request Eligibility, Drug History

Intermediary

Response

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

Pharmacy Dispensing System

Drug Info Database
Formulary Database

Electronic Transmission (EDI)

New Rx
Refill Request
Refill Auth/Denial Change Request
GAPS:
- Controlled Substances
- Specialty
- Discharge
- Laggards
- Long-term, Post-Acute Care
- Dental
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
Kentucky is the first state to mandate prescribers to view PDMP before prescribing.
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
Electronic Formulary Historical Timeline

- **1998**: First Formulary Data Appears
- **1999**: Merck-Medco Formularies Available
- **2000**: Rx Hub Begins
- **2001**: 3 major PBMS offer formulary dates
- **2002**: Standard format for formulary
- **2003**: Proved standard was acceptable
- **2004**: Data exchange needs to be in this format
- **2005**: NCPDP F&B Standard 1.0 Adopted
- **2006**: NCPDP Standard Pilots
- **2007**: Federal Regulations Require Use of NCPDP F&B Format (MIPPA)
- **2008**: RxHub and Surescripts Merge
- **2009**: ARRA Meaningful Use Requirements Include Drug Formulary Checks
- **2010**: Alternatives to batch update formulary info begin to appear
- **2015**: RTPBI pilots and standards discussions

Key Events:
- 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
- NCPDP F&B Standard 1.0 Adopted
- RxHub and Surescripts Merge
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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


- 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

<table>
<thead>
<tr>
<th>Performance Year</th>
<th>Payment Year</th>
<th>Maximum Incentive</th>
<th>Maximum Penalty</th>
</tr>
</thead>
<tbody>
<tr>
<td>2017</td>
<td>2019</td>
<td>4% x Z  Plus exceptional performance</td>
<td>- 4%</td>
</tr>
<tr>
<td>2018</td>
<td>2020</td>
<td>5% x Z  Plus exceptional performance</td>
<td>- 5%</td>
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<tr>
<td>2019</td>
<td>2021</td>
<td>7% x Z  Plus exceptional performance</td>
<td>- 7%</td>
</tr>
<tr>
<td>2020</td>
<td>2022</td>
<td>9% x Z  Plus exceptional performance</td>
<td>- 9%</td>
</tr>
</tbody>
</table>

- 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.
MIPS Will Begin Measuring Performance

First Year of MIPS Payments, Based on 2017 Performance

Maximum Penalty (-9%) Could Be Imposed
MIPS Facts

Who is Effected?

- Physicians
- Physicians' assistants
- Nurse practitioners

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

Alternative Payment Method (APM)

To qualify 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
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

<table>
<thead>
<tr>
<th>Country/Region</th>
<th>ePrescribing Readiness</th>
</tr>
</thead>
<tbody>
<tr>
<td>India</td>
<td>High</td>
</tr>
<tr>
<td>Indonesia</td>
<td>Medium</td>
</tr>
<tr>
<td>Thailand, Philippines, Singapore</td>
<td>Low</td>
</tr>
<tr>
<td>Bangladesh, Pakistan</td>
<td>Medium</td>
</tr>
<tr>
<td>Australia</td>
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</tr>
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</tr>
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<td>Eastern Europe</td>
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</tr>
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<tr>
<td>Africa</td>
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Thank you

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