HEALTH INFORMATION TECHNOLOGY STRATEGY & MANAGEMENT CONSULTANTS

HIT Perspectives

Perspectives and Updates on Health Information Technology

PUBLISHED BY POINT-OF-CARE PARTNERS (WWW.POCP.COM) JULY 30, 2008

ePrescribing

ePrescribing finally "Mandated" While Alternatives to Tamper-Proof Paper Determined

In our last issue, we observed that "when it rains, it pours" in alerting you to the merger of RxHub and Surescripts, and to the Drug Enforcement Agency (DEA) notice of proposed rule-making on ePrescribing. Well, we hope you kept your raincoat on because it hasn't let up. In this special issue, we provide an update on ePrescribing "mandates" and alert you to alternatives to the tamper-proof prescription pads required by the Centers for Medicare and Medicaid Services (CMS).

Congress gives ePrescribing a boost through "carrots and sticks"

The new Medicare Physician Fee fix legislation, passed on July 15, gives ePrescribing yet another big boost. As anticipated, a bill was signed into law that made ePrescribing "mandatory" in Medicare Part D. As we reported in the July 8 issue of *HIT Perspectives*, it wasn't a mandate in the way we think of the term but an incentive and penalty ("carrot and stick") that will encourage physicians to prescribe electronically.

This provision was tucked away in Section 132 of the Medicare Improvements for Patients and Providers Act of 2008. It gives non-institutional physicians (both solo and group practices) a way to earn enhanced incentive payments for ePrescribing in for Medicare patients, based on the framework established through CMS's existing Physician Quality Reporting Initiative (PQRI).

The new ePrescribing provision offers a sliding scale set of incentive bonus payments: two percent to a "successful electronic prescriber" in 2009 and 2010; a one percent bonus in 2011 and 2012; and a 0.5 percent bonus in 2013. However, if an eligible professional is not a successful electronic prescriber for the one-year reporting period, the fee schedule amount for their services would be reduced by 1 percent in 2012, 1.5 percent in 2013, and 2 percent in 2014 and beyond. Those who write too few prescriptions (determined by a formula) are exempt, as are hardship cases, which CMS will determine on a case-by-case basis.

The bonus system kicks in on January 1, 2009. This gives CMS and all of us very limited time to consider how implementation might work.

To be sure, the legislative language is pretty vague and the "devil will be in the details." Some such details were provided in a July 21 media conference call hosted by Mike Leavitt, secretary, Health and Human Services, and Kerry Weems, Acting Administrator, CMS. I was invited to participate in my role as this newsletter's editor-in-chief.

Here's what we know—and can infer—so far:

- A big driver was the potential savings of this program. The Congressional Budget Office (CBO) projected that ePrescribing and other efficiencies in medical care could save $156 billion over five years. We understand that it's not easy to get the CBO to score a program as saving costs but it's necessary to get legislation passed.
- It is unclear how the new bonus payment system will dovetail with the existing PQRI program. PQRI currently includes a "quality measure" for ePrescribing; however, Weems said that ePrescribing incentive will be additive; that is, a physician could get a total bonus of four percent (two for other PQRI and two for ePrescribing).
- The impact to providers depends on the situation. One vendor did a "back-of-the-envelope" calculation assuming 33% Medicare patients, and came up with incremental revenue of $3,366. For the 2007 PQRI program, which offered a 1.5% increase in payments, individual physicians received an average incentive payment of $600 and groups $4,750, according to Weems.
- If CMS decides to use current PQRI procedures, complexities can be anticipated. For example, CPT or HCPCS codes do not exist for ePrescribing under the current PQRI program, so CMS has specified temporary "G" codes for this purpose. If physicians go for the new ePrescribing bonus, then there would be administrative and training costs for their staff in implementing this system. For details of PQRI reporting as it currently stands, go to the PQRI portion of the CMS web site at http://www.cms.hhs.gov/PQRI/34_2007_PQRI_Educational_Resources.asp and see also http://www.cms.hhs.gov/PQRI/downloads/2008PQRIMeasureSpecifications123107.pdf?agree=yes&next=Accept
- The new statute does not define ePrescribing. This is important, as it is the second threshold requirement, beyond prescriber eligibility. For providers on the fence about buying an ePrescribing system, this could make a huge difference about what and why they buy and how much it costs. For those who have already made the investment decision could be penalized by more prescriptive requirements.

- From a federal affairs stand-point, CMS could implement this through regulation, as part of a final rule implementing the new physician fee schedule, or through administrative guidance. An ETA would be November. There will be a conference this fall (date TBD), in which CMS will provide more information.

From a public policy stand-point, questions remain about the impact. Will it increase ePrescribing adoption—and, in a backdoor way, spur the adoption of HIT? We believe that it will help drive uptake of both. Incentive payments are good, and—coupled with improved return on investment (ROI)—they should be solid motivators to get physicians to jump on board. In addition, many payers have been waiting to see what the Federal government would be doing in this regard so they could consider their own adoption incentive programs. There's no excuse to wait any longer.

To be sure, never before has there been such an array of programs and payments to help physicians adopt technologies that should save both lives and money.

Relative to these "mandates," there is still a lot to be sorted out quickly so we can meet the January 1, 2009, start date. Stay tuned or call us or drop us an eMail to help your organization figure out the impact of this provision on your lines of business and strategic planning .

Industry comes up with alternatives to tamper-proof prescription pads

The pharmacy industry has stepped up once again, this time making Medicaid prescriptions easier for physicians to write while still being compliant with federal and state anti-fraud requirements. They did so by finding alternatives to tamper-proof prescription pads, which physicians will be required to use for Medicaid prescriptions on October 1, 2008, unless they are ePrescribing, phoning or faxing prescriptions.

While it might appear that the tamper-proof pad requirement is good for ePrescribing because ePrescribing is an acceptable alternative, it's really quite a challenge. The reason is that every ePrescriber has a need for printing prescriptions, medication lists, documentation or instructions for the patient, so the ePrescribing system is linked to a printer with one tray which generally has plain paper.

What's happened is that, through efforts spearheaded by the National Council for Prescription Drug Programs (NCPDP), industry standards for copy, erasure/modification, and counterfeit resistance have been clarified. Now, though the law clearly specifies the term "prescription pad," CMS has stated that computer-generated prescriptions that are printed on special paper inserted into the printer may be used to achieve copy resistance, but it is <u>not</u> a requirement.

While an improvement, this still represents a challenge to the industry. The reason: even though computer-generated prescriptions on special paper is allowed, this would mean that ePrescribers must have printers that have both plain paper and the expensive tamper-proof paper, something that is logistically challenging. So, the industry has been working with CMS and the agency clarified its rules yet again. Now EMR- or ePrescribing-generated prescriptions may also be printed on plain paper and be fully compliant with all three categories of the tamper-resistant regulations provided they contain at least one feature from each of the three categories detailed below.

There are two technologies that might be used. One is a patented process that creates a void pantograph, which incorporates a hidden security word or image into the background of a computer-printed prescription. The image will show up when the document is copied or scanned. Another is called micro printing, which uses a strip of tiny type that can be read with a 5X magnifying glass or loupe. The type appears to be smeared when photocopied by most copying machines.

The void pantograph will require a licensing fee, which will be borne by the technology company and likely passed along to the client so, in a market with

price-sensitive customers, this is not likely to be the most popular short-term arrangement.

The alternative is micro printing, the cost of which will be negligible, provided the printer can accommodate the fine printing. We have been told that HP was consulted and most newer printers can accommodate micro printing. If they cannot, HP will provide software that can do so.

We applaud NCPDP's initiative to wrestle with this issue and CMS's flexibility. We all will benefit from making it easier for physicians to be prevent fraudulent prescriptions while serving our most vulnerable populations.

We also hope that the Drug Enforcement Agency (DEA) takes note that, working with the industry and remaining flexible, it is possible to come up with secure, cost-neutral (or low-cost) solutions that provide greater security.

Subscribe Contact Us Unsubscribe