HEALTH INFORMATION TECHNOLOGY STRATEGY & MANAGEMENT CONSULTANTS

# HIT Perspectives

Perspectives and Updates on Health Information Technology

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## ePrescribing

### CMS Holds Historic ePrescribing Conference Answering Some MIPPA Questions

*by Tony Schueth, Editor-in-Chief*

We have been saying for quite awhile that the stars are aligning for ePrescribing and align they did on October 7 in Boston at a seminal national ePrescribing conference sponsored by the Centers for Medicare and Medicaid Services (CMS). The meeting was historic for a number of reasons, which are described below, but the bottom line is this is the first time a large number of high-level stakeholders — not just the ePrescribing industry but also federal and state governments and a wide array of provider organizations — came together in such a large show of solidarity to underscore the importance of ePrescribing and work to accelerate its adoption as a prelude to remaking the nation's health care system. In addition, this was the first widespread show of support by the physician community for ePrescribing.

Highlights include:

- To our knowledge, this is the first time that such a large and star-studded event has taken place. More than 1,400 were in attendance, including federal and state officials, physicians and other health care providers, health information technology (HIT) and health association members, industry officials and vendors.
- A stellar array of speakers conveyed an unprecedented, high-level and bipartisan show of support for ePrescribing. On the dais were Governors Donald Carcieri (R) of Rhode Island and Deval Patrick (D) of Massachusetts; HHS Secretary Mike Leavitt; CMS Acting Administrator Kerry Weems; former Speaker Newt Gingrich (via satellite); Mark Merritt, President and CEO of PCMA; David Brailer, MD, PhD, and chair, Health Evolution Partners and first Health and Human Services (HHS) National Coordinator; Janet Marchibroda, CEO of the e-Health Initiative; and Kevin Hutchinson, the former CEO of SureScripts who is now CEO of Prematics, Inc. and one of the board of directors for the new AHIC 2.0.
- CMS organized and launched the meeting in only six weeks (which is very impressive if you've ever been involved in federal contracting), with a notable array of cosponsors for the meeting itself, individual sessions and other events, including: the American Association for Retired Persons; America's Health Insurance Plans; American Academy of Family Physicians (AAFP); American College of Physicians (ACP); American Medical Association (AMA); American Medical Group Association; American Optometric Association; American Pharmacists' Association; American Society for Consultant Pharmacists; Arizona Health-e Connection; Blue Cross/Blue Shield Association of America; Blue Cross/Blue Shield Association of Massachusetts; CVS/Caremark; Massachusetts Medical Society; California Healthcare Foundation; e-Health Initiative Foundation; e-Prescribe America; Florida's Agency for Health Care Administration; HealthITnow.org; Healthcare Information and Management Systems Society (HIMSS); Lahey Clinic; Massachusetts College of Pharmacy and Health Sciences; Massachusetts Health Data Consortium; Massachusetts Medical Society; Medical Group Management Association (MGMA); National Alliance of State Pharmacy

Associations; National Association of Chain Drug Stores; National Association of Community Health Centers; National Community Pharmacy Association; National Council on Prescription Drug Programs; New England Healthcare Institute; Massachusetts Technology Collaborative; Medco Health Solutions; Pharmaceutical Research and Manufacturers Association; Pharmaceutical Care Management Association; State of Tennessee; SureScripts-RxHub, LLC; Walgreens; and Wyeth.

- Widespread support for ePrescribing among the physician community was evidenced at the meeting with the release of *A Clinician's Guide to Electronic Prescribing.* It is the first comprehensive, multi-stakeholder "how to" guide to help clinicians make informed decisions regarding how and when to make the transition from paper to ePrescribing. The guide was issued by the e-Health Initiative in collaboration with the AMA, AAFP, ACP, MGMA, and Center for Improving Medication Management. Copies of the guide and other educational materials are available on the e-Health Initiative Web site at www.ehealthinitiative.org/.
- More than a dozen vendors were on hand to demonstrate ePrescribing and integration with electronic health records (EHRs), lab results and practice management systems at a HIMSS-sponsored technology solutions showcase the day and night before the meeting.
- The content of the meeting, while directed primarily at physicians, had something for everyone. Even those of us who have been around ePrescribing for years came away with some new information, which we discuss in the next article.

CMS deserves a huge amount of credit for convening this event and making it happen so quickly — and in such a meaningful, high-profile way. We hope CMS and the other stakeholders will continue to work to keep the momentum going.

## Results of the CMS ePrescribing Conference: What We Know and Don't Know

The historic CMS ePrescribing conference in Boston on October 7 was convened to provide information about ePrescribing to physicians and answer questions about how the new bonus system for ePrescribing adoption will work. As we had discussed in our last newsletter, the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) offers both carrots and sticks to spur ePrescribing adoption. We did glean some information at the conference on how MIPPA incentives will be implemented, which is summarized below. Speakers at the conference also addressed a number of other regulatory and implementation issues related to ePrescribing.

So, what do we know? The answer is a bit more than before, but a number of questions remain. Some will be addressed when the Physician Fee Schedule final rule is issued around the first week of November. It will contain some specifics about how the MIPPA bonus program will work. Other questions are still to be worked through, with details TBD. Here's a summary of where things stand. Call or e-mail us if you have questions, need clarification or want help with strategic positioning and implementation.

### What We Know About MIPPA

Under MIPPA, Medicare will offer a 2% incentive payment to eligible physicians for two years beginning in 2009. The bonus will drop to 1% in 2011 and 2012, and to 0.5% in 2013. However, nonadopters will have their Medicare payments decreased by 1% in 2012, 1.5% in 2013 and 2% in 2014

and later. Some providers will be exempt. HHS Secretary Mike Leavitt estimated the value of the incentive payments at around $1 billion.

At least in the beginning (January 1, 2009), MIPPA incentive payments appear to be based on Part B claims, although we expect clarification will be forthcoming. The bonus will be based on the proportion of self-reported patient visits that result in an ePrescription using a "qualified" system, which is at least 50% of visits for 2009 (see more details below).

Requirements are somewhat similar to those of the CMS Physician Quality Reporting Initiative (PQRI), except for the qualifying percentage (which is 80% for PQRI). Some details are on the CMS Web site at www.cms.hhs.gov/pqri. CMS will soon add an ePrescribing section, which will include a fact sheet, an "ePrescribing made simple" document, details about MIPAA and Part D standards, and a list of vendors that have informed CMS that their system complies with both Part D and PQRI requirements.

Qualified ePrescribing systems must meet the functionality requirements of PQRI measure #125:

- Generating a complete active medication list
- Selecting medications
- Printing prescriptions
- Electronically transmitting prescriptions
- Conducting safety checks
- Providing information about lower-cost alternatives
- Providing information about formulary or tiers

According to CMS, there are three steps to qualify for the MIPPA bonus:

1. The physician must obtain and regularly use a "qualified" system, which must meet all the requirements and functionalities listed in PQRI measure #125 and be compliant (to the extent possible) with the standards for ePrescribing under Part D that go into effect on April 1, 2009. Those whose system does not meet these requirements cannot report — that is, they are ineligible for the bonus.
2. When self-reporting, physicians must use the ambulatory and office visit codes, which will comprise the denominator for the bonus calculation. They also must use the "G" codes, as used in PQRI, for reporting for ePrescribing. These will be used to determine the numerator in the bonus calculation. EVERY eligible patient visit must be reported. However, some services, such as counseling and minor surgical procedures, will not qualify for incentives.
3. In addition to providing the appropriate CPT codes for the patient visit, the physician must use one of the G codes to specify one of the following:
   - G8443 — I ePrescribed using a qualified system.
   - G8445 — I did not prescribe anything at this visit. [Note: This makes sense as not all visits result in a prescription.]
   - G8446 — I did not ePrescribe for this patient event due to patient choice or prohibitions by federal and state laws. [Note: This allows for the "Drug Enforcement Agency (DEA) problem" as controlled substances currently may not be ePrescribed. This ensures that physicians who treat Medicare beneficiaries with chronic conditions and pain, for example, will not be penalized for not ePrescribing controlled substances for such patient visits.]

Successful reporting is defined as reporting on the ePrescribing measure (see

above) for at least 50% of eligible patients. There is a limitation: CPT codes that make up the denominator MUST account for at least 10% of the provider's total allowed charges for Medicare Part B covered services.

As 2009 progresses, it will become harder for physicians to meet the 50% visit threshold because it is an annual measure. Physicians who have been early ePrescribing adopters — or are in the process of implementing an ePrescribing system — definitely will have a leg up on meeting and maxing out on the MIPPA bonus requirements for 2009.

Among other things, the Medicare Physician Fee Schedule final rule, to be issued around the first week of November, will spell out the definition of a "successful ePrescriber" and services that will qualify for the MIPPA incentive payments. Feedback garnered at the conference will help CMS shape the guidance.

**What We Know About Other ePrescribing Issues**

- If they voluntarily choose to accept and use ePrescribing transactions, pharmacies must comply with the final ePrescribing standards that go into effect on April 1, 2009.
- Similarly, Part D sponsors also must all support the final ePrescribing standards going into effect on April 1, 2009, if their pharmacies or providers choose to ePrescribe for Part D-covered drugs for Part-D eligible individuals. In the meantime (and beyond April 1, 2009), they must:
    - Provide eligibility information, medication history, and formulary and benefit information if requested by the prescriber or dispenser.
    - Ensure pharmacy contracts require pharmacy compliance with Part D standards when conducting ePrescribing transactions between the pharmacy and Part D sponsor and the pharmacy and prescriber.
- Pharmacy ePrescribing costs for Part D drugs for Part D-eligible individuals are legitimate overhead costs and should be factored into dispensing fees. It has been pointed out that differential dispensing (or incentive) fees for ePrescriptions could be used to further align ePrescribing incentives for pharmacies.
- The quantitative evidence around the value proposition for ePrescribing continues to grow. The eRx Collaborative reported that in 2007, 104,000 eRxs were changed due to alerts. Researchers determined that this resulted in the prevention of 724 potential adverse drug events (ADEs). The cost savings related with avoiding these potential ADEs is estimated to be $630,000 in health care utilization.
- CMS is looking ahead to help increase the visibility of prescribers and pharmacies conducting ePrescribing (such as through directories), establishing reporting requirements for Part D sponsors, and working with the National Council for Drug Prescription Programs (NCPDP) to develop new standards and revise existing ones.
- The Certification Commission for Health Information Technology is

developing and testing criteria to certify ambulatory ePrescribing products. The certification process is set to launch in July 2009, with successful products to be certified by the end of the year.

- A pilot study is under way of RxNorm and the "codified Sig" standards. The work is being done by the RAND Corporation, under the direction of Douglas Bell, MD, PhD, and Point-of-Care Partners (POCP) is proud to be participating.
- The federal government continues its work to address shortcomings of the current ePrior Authorization transactions for medications. Under a subcontract that is ultimately with the Agency for Healthcare Research and Quality, POCP is conducting some background work on this.

**What We Don't Know**

- We don't know what will happen to those physician practices applying for the MIPPA incentives in good faith but failing to reach the threshold requirements. We don't know what will happen to those physicians who have been ePrescribing but whose system doesn't meet CMS requirements.
- The MIPPA incentive system is based on self-reporting, so one wonders if anyone who is not a qualified physician with a qualified ePrescribing system will report.
- The government can change its MIPPA reporting requirements, but details are sketchy at this point. It appears as if this will be done to transition to the use of Part D claims at some unspecified time in the future. This also will require adoption of the "5010" version of certain Health Insurance Portability and Accountability Act (HIPAA) standards and adoption of NCPDP Telecommunication Standard D.0, both of which are being proposed by CMS in other rulemaking.
- It is unclear at this point whether Medicare Advantage claims will count toward the denominator for the incentive calculation. We have heard conflicting accounts. Hopefully, this will be clarified in the forthcoming rule.
- The government could make use of the prescription origin code to simplify reporting and make bonus calculations faster and easier. As we noted in a previous issue of *HIT Perspectives*, the uptake on PQRI in general has been slow because the system is cumbersome and challenging. Moreover, those physicians who have participated are generally dissatisfied because feedback has been slow and late to physicians, according to an MGMA study. Also as noted in a previous issue of *HIT Perspectives*, the industry is working on codifying use of the code, which currently has varying uses depending on the entity submitting it.
- We don't know if MIPPA-like requirements will be extended to Medicaid. According to CMS Acting Administrator Kerry Weems in a preconference press briefing, CMS is considering extending ePrescribing incentives or requirements to Medicaid that states already could impose on their programs.
- We don't know when the DEA will issue its final guidance on

ePrescribing for controlled substances. The inability to ePrescribe controlled substances was cited consistently at the conference as a barrier to adoption and use. The DEA issued a proposal rule and received 175 comments by the September 25 deadline. We do not know how many individuals and organizations are associated with those 175 comments because we know of several "sign on" letters that had multiple signatories for a single letter. We hope the DEA will count those as separate comments from the undersigned organizations, instead of as a single comment.

- Finally, we don't know to what extent the new incentive program could prompt commercial insurers to consider offering similar financial incentives to their most valued physicians. Many commercial payers have been waiting to see what incentives CMS would offer, how they would work, and whether such a program would make sense in their environment. Will commercial payers be willing to contribute additional incentives to spur adoption or impose some sort of financial penalty for lagging adopters? POCP is monitoring these trends and advising clients about potential impacts to their business strategies.

**Odds and Ends**: MedImpact, the largest pharmacy benefit manager that does not sell drugs, joined with SureScripts-RxHub to launch an ePrescribing platform on October 14. MedImpact currently serves more than 30 million individuals nationwide. … The newlyannounced merger between Allscripts and Mysis creates one of the largest providers of EHR and practice management solutions in the United States with a client base of nearly a third of the nation's practicing physicians. AllscriptsMisys also provides information and connectivity solutions to more than 700 US hospitals and nearly 7,000 postacute and home care organizations. ... The State eHealth Alliance, which is sponsored by the National Governors' Association, has issued its inaugural report, "Accelerating Progress: Using Health Information Technology and Electronic Health Information Exchange to Improve Care." The report cites ePrescribing and safeguarding consumer privacy as pivotal to widespread health care reform. For more information, visit the alliance Web site, www.nga.org/center/ehealth. ... Congress finally passed the Ryan Haight Online Pharmacy Consumer Protection Act of 2007, which aims to prevent rogue Internet pharmacies from filling questionable or illegal prescriptions for controlled substances. As an aside, the DEA has been consistently and erroneously mixing up this problem with legitimate ePrescribing as a basis for its hesitancy to approve ePrescribing for controlled substances. Among other things, the act includes a face-to-face requirement for physicians to issue a prescription to the patient and an endorsement from the DEA before a pharmacy could dispense controlled substances via the Internet. This endorsement would supplement the existing registration a pharmacy holds for its brick-and-mortar operation and allow law enforcement to clearly identify Internet sites on which controlled substances are being dispensed. For more information, go to http://www.usdoj.gov/dea/pubs/pressrel/pr100108.html. ... The AHIC Successor organization has named its board of directors. Many are old hands at ePrescribing and their input will be extremely helpful in shaping the future direction of ePrescribing, HIT and HIE. HHS Secretary Mike Leavitt and Veterans Affairs Secretary James Peake will serve as federal liaisons to the board. HHS National Coordinator for Health Information Technology Robert Kolodner, MD, will continue to coordinate federal input into the public-private process. The 15 members of the AHIC Successor board of directors are:

- Laura Adams, President and CEO, Rhode Island Quality Institute
- Simon Cohn, MD, MPH, Associate Executive Director, Health

Information Policy, Kaiser Permanente
- Janet Corrigan, PhD, MBA, MS-Eng., President and CEO, National Quality Forum
- Arthur Davidson, MD, M, Director, Public Health Preparedness, Denver Public Health Department
- Linda Dillman, Executive Vice President, Benefits and Risk Management, Wal-Mart Stores, Inc.
- Lori Evans, MPH, MPP, Deputy Commissioner, New York State Department of Health
- Steven Findlay, MPH, Health Care Analyst and Editor, *Consumer Reports Best Buy Drugs*, Consumers Union
- Thomas Fritz, MA, MPA, CEO, Inland Northwest Health Services
- C. Martin Harris, MD, MBA, Chief Information Officer and Chairman, Information Technology Division, Cleveland Clinic
- Kevin Hutchinson, President and CEO, Prematics, Inc.
- Charles Kennedy, MD, MBA, Vice President for Health Information Technology, WellPoint, Inc.
- Michael Lardiere, LCSW, Director, Health Information Technology and Senior Advisor, Behavioral Health, National Association of Community Health Centers
- Stephen Ruberg, PhD, Senior Research Fellow, Eli Lilly & Company
- Lisa Simpson, MB, BCh, MPH, Professor, University of Cincinnati, and Director, Child Policy Research Center, Cincinnati Children's Hospital
- Paul Tang, MD, MS, Vice President and Chief Medical Information Officer, Palo Alto Medical Foundation

## Chronic Care Management

### Chronic Care Management: A New Paradigm Is Needed

*by Michael Solomon, Executive Editor*

We were reminded once again of the long and arduous journey still ahead before this nation will have an interconnected network of doctors using and sharing electronic medical records (EMRs). Perhaps the most scientific study ever conducted of doctors nationwide indicates **the needle hasn't moved significantly from the less than one-in-five doctors using an EMR** (*New England Journal of Medicine*, July 2008). Even more sobering was the finding that **only 4% are using a comprehensive suite of clinical applications.**

Meanwhile, the burden of caring for a growing population of people with chronic diseases becomes more acute with each passing day. For example, there are 24 million people with diabetes (25% of which are undiagnosed) and another 57 million with prediabetic symptoms. **Primary care doctors and clinics are in dire need of tools** to help them more efficiently and effectively care for these patients in a reimbursement environment that is not modeled to promote ongoing chronic care management.

For the thousands of primary care practices with large populations of chronically ill patients, is there any opportunity for an innovative health information technology (HIT) company to change the game and offer an alternative to the full-blown EMR? We believe the answer is a resounding YES. There is huge potential for the provision of application services that meet specific needs of chronic care management in the clinical practice. Following are an application framework and examples of implementations that

suggest a new paradigm of "**care management application services**." These could replace the need for a full-blown EMR in some practices or at the very least offer a transition to the elusive EMR adoption across the industry:

- **Disease registry services.** These help the medical group to track its chronically ill patients by disease and detect those in need of care. An example is an online registry sponsored by the state of Kansas that is being used by more than 35 doctors. Early results indicate the **registry is helping providers to implement more robust protocols for managing diabetes patients.** Duke University's Affiliated Physicians Group has reported **significant improvement in quality metrics for diabetes by using a registry** (*Healthcare IT News,* September 2008).

- **Electronic Prescribing.** Electronic prescribing with connectivity to a patient's medication history can **help clinicians detect possible adherence issues** in advance of the patient's next visit. Coupling this with a patient's personal health record system **enables the practice to reach out to the patient electronically and offer assistance if there is a problem.**

- **Demand management services.** These **detect gaps in care**, **notifying the patient and his or her doctor of reminders for follow-up care and need for screening.** These services also provide a cost-effective yet personalized communication channel to inform patients of clinical trials and potential safety issues. Capmed recently announced this type of service as a component of its personal health record. Activehealth sends patients and their providers "Care Considerations" to highlight possible gaps in care or indications of a need for follow-up.

These are just a few examples of a care management application services framework in which a **relatively simple**, **Web-based implementation can significantly improve a practice's ability to provide higher-quality services more consistently to their chronically ill patients**. The value proposition — even a return on investment calculation — to both the provider and the vendor can be compelling and real with the right approach.

**"Signals" of change in information technology (IT) for chronic care management being tracked by POCP**: A recent study affirms our position that **while the recent relaxation of the Stark-Safe Harbor rules may produce a slight uptick in EMR procurements**, **this should not be viewed as a major driver of new business.** Only four of 24 hospitals surveyed had any concrete plans in place to aid physicians in procuring EMR systems (Center for Studying Health System Change, September 2008). Thin hospital margins, declining reimbursement and physicians' culture of autonomy are significant barriers that the Stark relaxation by itself does not overcome. On a brighter note, **state Medicaid programs are ramping up IT spending.** According to the market research firm INPUT, states will be investing significantly in their IT infrastructures, particularly health information exchanges and other e-health initiatives. The South Carolina Health Information Exchange, which recently began providing doctors and clinics with access to Medicaid-beneficiaries' payer-based health records, is the latest in a series of health information exchange (HIE) initiatives involving state Medicaid programs. This trend bears watching as a **potentially significant opportunity for HIT vendors offering HIE services as well as the other types of care management application services** we've described earlier. On the other hand, recent economic downturns are

dramatically shrinking state revenues. We will be watching to see which states pass on HIT/HIE investments in an era of impending severe budget cuts and which states will look to HIT/HIE as an investment in future cost savings and increased productivity.

Odds and Ends:

The September/October issue of *Health Affairs* has two articles of interest about adoption of the patient-centered medical home. The first article addressed a University of California at San Francisco School of Medicine study which found that **medical groups have generally been slow to adopt components of the patient-centered medical home.** However, the largest practices — those with more than 140 physicians — and those owned by a hospital or HMO were the most likely to adopt critical pieces of the model. In the second article, Urban Institute researchers concluded that **implementing and operating patient-centered medical homes require specialized management expertise and physician leadership**, **as well as the capacity to develop processes and IT systems.** The authors noted that these conditions will be challenging for any practice, regardless of size. **Millions of Americans with such chronic diseases as diabetes or high blood pressure are not getting adequate treatment because they are among the nation's growing ranks of uninsured**. That is the central finding of a study published in the August 5th issue of *Annals of Internal Medicine*.

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**Dr. Michael Rapp**
Director, Quality Measurement & Health Assessment Group
Office of Clinical Standards & Quality
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